PENN TREATY AMERICAN CORP
Form 10-K/A
March 29, 2007
UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K/A

x Annual Report pursuant to section 13 or 15(d) of the Securities Exchange Act of 1934
For the fiscal year ended **December 31, 2005**

or

o Transition Report pursuant to section 13 or 15(d) of the Securities Exchange Act of 1934

For the transition period from _____to _____

Commission file number: 001-14681

PENN TREATY AMERICAN CORPORATION

(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization	23-1664166 (I.R.S. Employer Identification No.)
3440 Lehigh Street, Allentown, Pennsylvania (Address of principal executive offices)	18103 (Zip Code)

Registrant s telephone number, including area code (**610) 965-2222**

Securities registered pursuant to Section 12(b) of the Act:

Common Stock, par value $.10 per share,

Listed on the New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 402 of the Securities Act.

Yes o No x

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.

Yes o No x

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes o No x

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (section 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. o

Indicate by checkmark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filed. See

definition of accelerated filer and large accelerated filer in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer o Accelerated filer x Non-accelerated filer o

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes o No. x

Based upon the last sale price of the registrant s Common Stock on June 30, 2005, the aggregate market value of the outstanding shares of voting stock held by non-affiliates of the registrant was $117,144,191.

As of March 22, 2007, 23,290,688 shares of the registrant s Common Stock were issued and outstanding.

Documents Incorporated by Reference: None.

EXPLANATORY NOTE

THE PURPOSE OF THIS AMENDMENT IS TO ADD THE LAST PAGE, ENTITLED SIGNATURES, WHICH WAS INADVERTENTLY OMITTED FROM THE COMPANY S ANNUAL REPORT ON FORM 10-K FOR THE YEAR ENDED DECEMBER 31, 2005 FILED ON MARCH 26, 2007. EXCEPT FOR THE PAGE ENTITLED SIGNATURES ADDED HEREBY, THE ATTACHED ANNUAL REPORT ON FORM 10-K FOR THE YEAR ENDED DECEMBER 31, 2005 IS UNCHANGED FROM THE EARLIER FILED ANNUAL REPORT ON FORM 10-K.

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Explanatory Note

This is our Annual Report on Form 10-K for the year ended December 31, 2005. In this document, we present our 2005 financial statements and Management s Discussion and Analysis of Financial Condition and Results of Operations. Throughout the document, we have also included 2006 information in Part I where appropriate and available.

On March 16, 2007, we filed a Form 8-K that included all of the sections and items of this Form 10-K for the fiscal year ended December 31, 2005, except for Item 9A-Controls and Procedures, the Report of Independent Registered Public Accounting Firm, Management s Report on Internal Control Over Financial Reporting, and the Report of Independent Registered Public Accounting Firm on Internal Control Over Financial Reporting. The exhibit list was also excluded.

The audited financial statements in this Form 10-K differ from the unaudited financial statements in the Form 8-K filed on March 16, 2007 in that we adopted Staff Accounting Bulletin (SAB) No. 108, Considering the Effects of Prior Year Misstatements when Quantifying Misstatements in Current Year Financial Statements , effective for the year ended December 31, 2005. As a result of adopting SAB No. 108, we now show a cumulative effect of approximately $1.5 million as a reduction to retained earnings as of January 1, 2005. The adoption of SAB No. 108 did not impact our net loss of $13.95 million for the year ended December 31, 2005 or our book value of $10.95 per share as of December 31, 2005.

PART I

Forward-Looking Statements

Certain statements made by us in this filing may be considered forward-looking within the meaning of the Private Securities Litigation Reform Act of 1995. Although we believe that our expectations are based on reasonable assumptions within the bounds of our knowledge of our business and operations, there can be no assurance that our actual results of operations will not differ materially from our expectations. Factors which could cause actual results to differ from expectations include, among others, those described in Risk Factors beginning on page 25.

Available Information

The public may read and copy any materials we file with the SEC at the SEC s Public Reference Room located at 100 Frank Street N.E, Washington, D.C., 20549. In order to obtain information about the operation of the Public Reference Room, you may call the SEC at 1-800-732-0330. The SEC also maintains a site on the Internet that contains reports, proxy and information statements, and other information regarding issuers that file electronically with the SEC. The SEC s website is http://www.sec.gov. You can also read and download the various reports we file with the SEC from our website, https://www.penntreaty.com.

We provide access through our website to current information relating to corporate governance. Copies of our Audit Committee Charter, our Nominating and Corporate Governance Committee Charter, our Code of Ethics for the Chief Executive Officer and Senior Financial Executives, our Corporate Governance Guidelines, our Code of Business Conduct and Ethics for all employees, our Compensation Committee Charter and other matters impacting our corporate governance program are accessible on our website. Copies of these documents may also be obtained free of charge by contacting Penn Treaty American Corporation, 3440 Lehigh Street, Allentown, PA 18103, Attention: Corporate Secretary. We intend to post on our website any amendments to, or waivers from, our Code of Ethics for the Chief Executive Officer and Senior Financial Executives, which are required to be disclosed by applicable law, rule or regulation. Information contained on Penn Treaty s website is not part of this Form-10K filing.

Item 1. **Business**

(a) **The Company and the Long-term Care Insurance Industry**

Penn Treaty American Corporation

We are a provider of long-term care insurance in the United States. Our principal products are individual, defined benefit accident and health insurance policies covering long-term care services, including confinement to nursing facilities and assisted living facilities, as well as home health care. Our policies are designed to provide benefits if and when the insured is no longer capable of functioning independently. Although long-term care policies accounted for approximately 97% and 96% of our total annualized issued premium as of December 31, 2006 and 2005, respectively, we also sell Medicare supplement policies. Our total long-term care in-force premiums were approximately $307 million and $317 million at December 31, 2006 and 2005, respectively. We also own insurance agencies that sell senior-market insurance products issued by us as well as other insurers.

We introduced our first long-term nursing home insurance product in 1972 and our first home health care insurance product in 1983. Since then we have developed several new products designed to meet the changing needs of our customers. Our primary product offerings currently are:

- The Personal Freedom® policy, which provides comprehensive coverage for facility and home health care;
- The Secured Risk® product, which is a limited benefit policy designed for impaired physical risks;
- The Assisted Living Plus® policy, which provides coverage for all levels of facility care and includes an optional home health care rider;
- The Independent Living® policy, which provides coverage for home and community-based care furnished by licensed care providers, as well as unlicensed caregivers; and
- Simple LTC Solution℠, which offers a simplified approach to long-term care insurance, and provides coverage for facility and home health care services.

In 2001, we ceased new policy sales nationwide as a result of insufficient statutory surplus levels until we formulated a Corrective Action Plan (the Plan) with the Pennsylvania Insurance Department (the Department). Both Penn Treaty Network America Insurance Company (PTNA) and American Network Insurance Company (ANIC), which represent approximately 90% and 8% of our direct premium revenue, respectively, for both the years ended December 31, 2006 and 2005, are subject to the Plan. Upon the Department s approval of the Plan in February 2002, we recommenced new policy sales in 23 states, including Pennsylvania. Through the filing date of this Form 10-K, we have recommenced new policy sales in 21 additional states, including Florida and California (both subject to Corrective Orders or Letter Agreements). Florida, California and Pennsylvania accounted for approximately 16%, 14% and 11%, respectively, of our direct premium revenue for the year ended December 31, 2005 (15%, 14% and 11% for the year ended December 31, 2006). We are working with the remaining six states to recommence new policy sales.

In August of 2006 PTNA agreed to temporarily suspend new sales of Florida insurance policies pending the filing of its 2005 statutory audit report and the review by the Florida Department of Insurance Regulation (Florida OIR). Florida represented approximately 6% of new business applications prior to the temporary suspension. In November of 2006 PTNA entered into a revised voluntary consent agreement with the Florida OIR to recommence sales. We anticipate that the terms of the voluntary consent agreement will adequately accommodate our expected growth plans for the foreseeable future. The major provisions of the voluntary consent agreement, with which PTNA must comply in order to continue writing new policies in Florida, include but are not limited to, the following:

- PTNA will continue to file monthly financial reports, as it has since 2002, with the Florida OIR.
- PTNA will limit total Florida premium to current levels of approximately $48 million as of June 30, 2006, allowing for new business growth equal to lapses of existing policies. This base amount may increase as a result of any future premium rate increases on existing policies.
- PTNA will seek prior approval of the Florida OIR before commencing or terminating any new reinsurance agreements.
- PTNA will maintain a risk-based capital ratio in excess of 250%. PTNA s ratio as of December 31, 2006 and 2005 was approximately 730% and 714%, respectively.

The voluntary consent agreement may be modified by the Florida OIR in the event of deteriorating financial performance on the part of PTNA. In addition PTNA may seek removal of the conditions of the voluntary consent agreement in the future if its financial strength improves or its ratings with either A.M. Best Company or Standard and Poor s increases.

Corporate Background

Penn Treaty American Corporation (Penn Treaty) is registered and approved as a holding company under the Pennsylvania Insurance Code. Penn Treaty was incorporated in Pennsylvania on May 13, 1965 under the name Greater Keystone Investors, Inc. and changed its name to Penn Treaty American Corporation on March 25, 1987. Our primary business is the sale of long-term care insurance, which we conduct through the following subsidiaries:

Penn Treaty Network America Insurance Company a Pennsylvania-domiciled insurance company;

American Network Insurance Company a Pennsylvania-domiciled insurance company; and

American Independent Network Insurance Company of New York a New York-domiciled insurance company.

Southern Security Life Insurance Company (Southern Security) In December 2006 we entered into a purchase agreement to acquire a Florida-domiciled shell insurance company. The purchase agreement is conditioned upon the approvals of the Florida and Pennsylvania Insurance Departments, which are still pending. The purchase price for Southern Security Life Insurance Company consisted of $400,000 plus the capital and surplus of Southern Security as of December 31, 2006, which was $3,861,363, plus all investment income and interest on the capital and surplus accruing between December 31, 2006 and the date of final distributions from escrow, which has not yet been determined.

We also conduct insurance agency operations through the following subsidiaries:

United Insurance Group Agency, Inc. a Michigan-based consortium of insurance agencies;

Network Insurance Senior Health Division a Florida-based insurance agency brokerage; and

Senior Financial Consultants Company a Pennsylvania-based insurance agency brokerage.

The Long-Term Care Insurance Industry

Based on the 2005 and 2006 Annual Surveys by LIMRA International:

Industry-wide long-term care insurance sales were down by approximately 8% in 2006, 5% in 2005, and 25% in 2004. Approximately $608 million in new annual policy premiums were issued in 2006 compared to $661 million in 2005 and $699 million in 2004. We believe this decrease was due primarily to the decision by several providers to cease offering long-term care insurance, to raise premiums on in-force policies and/or to introduce new products with higher prices. These actions have caused some distributors to reduce their sales focus on these products.

The total number of in-force policies at the end of 2006 exceeded 4.5 million, compared to 4.4 million at the end of 2005, with in-force annualized premium reaching $7.7 billion in 2006, compared to $7.3 billion in 2005.

Given the projected demographics of the U.S. population, the rising costs of home health care and long-term care, the associated challenges faced by Medicaid, and current and proposed state and federal legislation that support the purchase of private long-term care insurance coverage, we believe the potential for future growth remains significant.

According to a 2000 U.S. Census Bureau report, the population of senior citizens (people age 65 and over) in the United States is projected to grow from an estimated level of approximately 35 million in 2002 to approximately 70 million by 2030. Furthermore, health and medical technologies are improving life expectancy and, by extension, increasing the number of people requiring some form of long-term care. The projected growth of the target population indicates a substantial growth opportunity for companies providing long-term care insurance products. We believe that the rising cost of nursing home and home health care services, along with the increasing strain these services are having on the state and federally financed Medicaid system (which is the largest payer of long-term care services) makes long-term care insurance an attractive means to pay for these services. According to reports by the Centers for Medicare and Medicaid Services, the combined cost of home health care and nursing home care was $20.0 billion in 1980. By 2001, this cost rose to $134.9 billion, in 2003 the cost was $150 billion. In 2005, national spending on long-term care totaled $207 billion according to the

Health Policy Institute, Georgetown University. The proportion of spending on home and community based care continues to grow, accounting for 37% of total long-term care spending in 2005, compared with 19% just ten years earlier.

In February 2006, the Deficit Reduction Act of 2005 was signed into law, which included provisions permitting states to participate in long-term care partnership programs by filing Medicaid plan amendments. Under the partnership program, consumers in participating states will benefit because they will be permitted to protect assets equal to the amount of long-term care insurance benefits they use without affecting Medicaid eligibility. For example, if a partnership policyholder uses $100,000 of long-term care insurance benefits, the policyholder will be able to keep $100,000 of assets and still access Medicaid for remaining care needs. The legislation s impact on long-term care insurance sales in the short-term is uncertain as states enroll to participate in the partnership program and as consumers and financial planners begin to understand the Medicaid reforms. In the long-term, we expect the partnership feature to expand the long-term care insurance market in participating states to purchasers who would otherwise engage in Medicaid planning as an alternative to long-term care insurance, although we are unable to predict the impact this will have on our future sales.

Our Strategy

Our vision for the future is to be a leading provider of long-term care insurance solutions, with related services and products, which offer our customers and their families security through asset and income protection and the preservation of choice of eligible care providers. Our value proposition incorporates stratification of underwriting risk, innovative product development, efficient and effective underwriting, improved claims adjudication processes and an individualized service culture for agents and policyholders. We believe we can achieve this goal through profitable sales growth, diligent management of our in-force policies and ongoing service enhancements.

Sales

We believe that we are able to attract distribution and grow sales because of our individualized service culture for agents and policyholders and our ability to underwrite physically impaired risks not considered for coverage by our competitors. Because of our underwriting stratification, we are able to issue a high percentage of applications for agents thus making their sales attempts more cost effective for them.

Sales of new products are expected to be a driving force in generating profits in the future. In 2006 our issued annualized long-term care premium totaled approximately $17.6 million, or 12% below the sales level of 2005. We believe this decrease was due to the uncertainty created by the late filing of our statutory financial statements, the uncertainty created by the late filing of our 2005 Form 10-K, the amount of time that we were prohibited from selling new business in the state of Florida during 2006 and the focus by a number of our independent agents on the new Medicare Part D and fee for service products. In 2005, sales of our current generation of long-term care insurance products totaled approximately $19.9 million on an issued annualized premium basis, 18% above the sales level of 2004.

Approximately $17.1 million or 97% of the 2006 long-term care sales were generated by Field Marketing Organizations (FMOs). Approximately $19.2 million or 97% of the 2005 sales were generated by FMOs. We primarily market our long-term care insurance products through FMOs, which are generally large, independent, multi-agent networks utilized for the purpose of recruiting agents and developing networks of agents in various states. FMOs receive an override commission on business written in return for recruiting, training and motivating independent agents to place business with Penn Treaty. At December 31, 2005, we had contracts to sell our products with approximately 75 FMOs. The number of FMOs decreased in 2005 from approximately 140 at December 31, 2004 as FMOs that did not meet certain production levels were transferred under other FMOs or ceased new sales with Penn Treaty. The number of FMOs was further reduced to approximately 55 at December 31, 2006. This strategy allows us to focus our resources on FMOs that are more likely to increase production in the future. Beginning in 2006, we also began to recruit new FMOs that are interested in selling our products. We recruited five new FMOs in 2006.

The remaining sales in both 2006 and 2005 were generated through strategic alliances. These coordinated ventures with other long-term care insurance carriers offer access to our long-term care insurance products and underwriting breadth to the competitor s captive sales agents. The revenue stream, increased agent retention and partial reimbursement of underwriting expense for issued new business makes this an appealing program for other long-term care insurance carriers.

Distribution opportunities are expanding for long-term care insurance, with the product increasingly being recognized as a valuable tool for wealth advisors involved in financial planning and lifestyle programs. For financial advisors who haven t typically sold long-term care insurance to their clients, the product is a cross-selling and asset-retention vehicle. We intend to explore this and other distribution channels to maximize growth opportunities in the coming years. In February of 2007 we introduced our PersonaLTC™ platform specifically designed to help financial advisors deliver long-term care insurance solutions to their clients. We believe that our first sales from this distribution channel will occur in 2007. This platform includes:

A new simplified application process.

The use of our physically impaired underwriting capabilities to reduce the number of declined applications experienced by financial advisors.

A national co-sales specialist network that utilizes our FMOs.

While long-term care insurance has been sold by our company for over thirty years, the recent changes in legislation, aging demographics and consumer education have increased awareness for the product. The Deficit Reduction Act of 2005 (DRA), signed into law in February 2006, promotes the utilization of long-term care insurance in three distinct ways. The primary provision includes the expansion of long-term care partnership programs to all states by filing Medicaid state plan amendments. These partnership programs allow for asset protection equal to the amount of long-term care insurance benefits used without affecting their eligibility for Medicaid. Other key long-term care provisions include Medicaid reform by states and a promotion effort aimed at educating the consumer on long-term care issues. These three areas - partnership expansion, revision of Medicaid eligibility and consumer education are expected to strengthen the consumer s awareness of long-term care issues and long-term care insurance as a financing tool. Implementation will require coordination between the states and federal agencies. Because of this, the impact to sales is uncertain.

The aging demographic continues to expand this market segment as nearly eight thousand of the 78 million Baby Boomers turn 60 every day (source: www.census.gov - Press Release January 3, 2006). The Baby Boomers are learning about long-term care issues as they care for aging parents - many without adequate resources for the care, medications, and choices that face them.

There are a myriad of chronic health conditions that exist in various population segments in the United States. Advances in wellness, diagnostics and pharmacology have allowed many people to live active and stable lives despite these health conditions. Hypertension, diabetes, osteoarthritis, obesity and cancer are examples of prevalent co-morbid conditions that we evaluate for long-term care insurance in our physically impaired risk product line. Consumers are highly complex individuals and their medical conditions are equally complex. Early diagnosis and excellent management of conditions is evaluated by our underwriters. We offer five different underwriting classes based on an applicant s health and overall risk. Significant surcharges are added to our base rate so that we are able to offer coverage to a wide variety of risks. Although this approach is common in other lines of insurance such as life and disability, we believe our approach is unique to the long-term care insurance marketplace. We believe this underwriting breadth distinguishes us from our competition and allows our agents to offer coverage to many additional applicants.

Management of In-Force Policies

As a leading provider of long-term care insurance with over 30 years of issued polices and historical long-term care data, we currently manage multiple product generations (new and revised products introduced at different times in our history), including facility only, home health care only, comprehensive, tax-qualified, and non tax-qualified business. Our in-force policies written before December 31, 2001 have demonstrated a high degree of volatility, requiring recurrent evaluations and multiple rounds of premium rate increases. All of our in-force policies are reviewed at least quarterly in order to identify any trends that are different than previously anticipated. If negative trends are identified, we take action to correct these trends. These actions include premium rate increases or a voluntary reduction of the level of benefits in exchange for a reduced premium rate increase or no premium rate increase. In addition to premium rate increases, we also manage our in-force policies through improvements to our claims adjudication processes and general and administrative expense management. Policies written after December 31, 2001 have not needed any premium rate increases and we do not currently anticipate that they will need premium rate increases.

(b) Insurance Products

Since 1972, we have developed, marketed and sold defined benefit accident and health insurance policies designed to be responsive to changes in:

- the characteristics and needs of the senior insurance market;
- governmental regulations and governmental benefits available for senior citizens; and
- the health and long-term care delivery systems.

As of December 31, 2006 and 2005, approximately 97% and 96%, respectively, of our total annualized premiums in-force was derived from long-term care policies. We evaluate input from both our independent agents and our policyholders with respect to the changing needs of the long-term care market. In addition, our representatives regularly attend regulatory meetings, industry consortiums and seminars to monitor significant trends in the long-term care industry.

The following table sets forth, at the dates indicated, information related to our policies in force:

	(annualized premiums in $000's) December 31, 2006		2005		2004	
Long-term care:						
Annualized premiums	$ 307,045	96.6%	$ 316,785	95.7%	$ 326,030	95.3%
Number of policies	153,597		160,700		172,324	
Average premium per policy	$ 1,999		$ 1,971		$ 1,892	
Disability insurance:						
Annualized premiums	$ 208	0.1%	$ 248	0.1%	$ 1,426	0.4%
Number of policies	704		819		3,357	
Average premium per policy	$ 295		$ 303		$ 425	
Medicare supplement:						
Annualized premiums	$ 8,467	2.6%	$ 11,472	3.4%	$ 11,890	3.5%
Number of policies	4,415		5,975		7,887	
Average premium per policy	$ 1,918		$ 1,920		$ 1,508	
Life insurance:						
Annualized premiums	$ 2,027	0.6%	$ 2,245	0.7%	$ 2,480	0.7%
Number of policies	3,748		4,086		4,456	
Average premium per policy	$ 541		$ 549		$ 557	
Other insurance:						
Annualized premiums	$ 148	0.1%	$ 166	0.1%	$ 257	0.1%
Number of policies	1,395		1,554		1,847	
Average premium per policy	$ 106		$ 107		$ 139	
Total annualized premiums in force	$ 317,895	100.0%	$ 330,916	100.0%	$ 342,083	100.0%
Total Policies	163,859		173,134		189,871	

Our long-term care insurance policies provide benefits for either care provided in a long-term care facility or care received in one s home (home health care), or they can cover both. Policies that include coverage for long-term care facilities provide benefits for confinement to nursing facilities as well as assisted living facilities. Our policies generally require that the insured need assistance with at least two activities of daily living or have cognitive impairment that makes it unsafe for them to live unsupervised in order to be eligible for benefits. Most of our non-tax-qualified policies (deemed such because they do not meet the requirements for a tax-qualified policy established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)) also permit the insured to become eligible for benefits upon the care being prescribed as necessary by a physician.

Benefits paid for long-term care facility confinement are generally paid on an expense-incurred basis, subject to a daily maximum selected at the time the policy was issued, ranging from $60 to $300 per day. Some of our older policies pay the policy s full daily maximum as an indemnity benefit without regard to the expense incurred. Benefits are paid for as long as the insured remains eligible, or until the policy s maximum benefit period has been exhausted. Maximum benefit periods range from one to 10 years, or an unlimited option. Effective January 1, 2007, we are no longer selling policies with an unlimited benefit period. The maximum benefit period we are now selling is seven years.

Many policies also offer benefits for home health care services. Nurses, home health aides, certified nurse s aides and physical therapists are typically covered for the care/services they provide in the insured s home. Some policies also cover private, unlicensed caregivers and family members, subject to our pre-approval. Home health care benefits are paid on an expense-incurred basis and are generally subject to the same requirements and limitations as facility benefits, such as the daily maximum and maximum benefit period described above.

Our long-term care insurance policies can also cover other long-term care providers and services, such as adult day care and hospice care. Most policies include waiver of premium benefits that waive the premiums payable for the duration of the claim once the insured has received benefits for 90 days, and restoration of benefits features that permit the benefits of the policy to be replenished after the insured has recovered and been independent for a specified period of time. Many also include an inflation feature, purchased as a rider to the base policy, which is intended to allow the benefit amounts purchased to keep pace with the rising costs of care.

Our current product offerings include the following:

Personal Freedom® policy. Our Personal Freedom® policy (offered since 1996) provides comprehensive coverage in that it covers both facility care and home health care. The Personal Freedom® policy represented 46% and 42% of our 2006 and 2005 issued business, respectively.

Secured Risk® policy. Our Secured Risk® policy (offered since 1998) provides limited facility care benefits to people who would not, due to health conditions, qualify for the more traditional long-term care insurance policy. An optional home care rider, offering limited coverage, is also available to those who qualify. This policy includes limitations not required in our other policies, such as waiting periods for pre-existing conditions, mandatory elimination periods (deductibles) of at least 100 days, and maximum benefit periods of no more than three years. It does not include many of the features found in our other policies, such as waiver of premium benefits and restoration of benefits. The Secured Risk® policy represented 37% and 32% of our policies issued in 2006 and 2005, respectively.

Assisted Living® policy. The Assisted Living® policy (offered since 1999) provides facility coverage only and is a lower-priced alternative to the Personal Freedom® policy. When coupled with an optional home health care rider, the Assisted Living® policy offers benefits similar to those of the Personal Freedom® policy. The Assisted Living® policy represented 7% and 14% of our policies issued in 2006 and 2005, respectively.

Independent Living® policy. The Independent Living® policy (offered since 1994) provides coverage for all levels of home health care. The Independent Living® policy represented 7% and 9% of our policies issued in 2006 and 2005, respectively.

Simple LTC Solution℠ policy. The Simple LTC Solution℠ policy, (offered since 2005) provides a simplified, more affordable approach to long-term care insurance. This policy covers facility and home health care, but does not include many of the additional features found in our Personal Freedom policy. It includes cost-controlling features such as an automatic deductible, an ongoing policyholder co-payment, and limited benefit dollars that do not restore. The Simple LTC℠ Solution policy represented 1% and 2% of our policies issued in 2006 and 2005, respectively.

Riders. We offer numerous optional riders to our base policies, including home health care coverage, inflation protection, shared care (which allows spouses to share benefits) and non-forfeiture benefit, (which guarantees certain paid-up benefits in the event the policy lapses in the future).

Tax qualified and non-qualified policies. Following the enactment of HIPAA, we began offering a tax qualified policy, which allows for certain income tax deductions for premium payments and provides benefit payments that are not

subject to tax. We continue to offer both tax-qualified and non-tax-qualified policies, with the non-tax-qualified policies generally offering access to benefits at lower levels of disability, while not offering the same preferential tax treatment as a tax-qualified policy. Tax qualified policies represented 90% and 85% of our policies issued in 2006 and 2005, respectively.

We employ the use of multiple risk underwriting classes that permit us to offer coverage to individuals that are considered healthy, as well as those with significant medical conditions. This tiered approach requires the policyholder to pay a premium that correlates with his/her health at the time of application and the risk associated therewith. Our Secured Risk® policy is reserved for those in the highest-risk class.

(c) Marketing

Historically, our business has been concentrated in a few key states. During 2006 and 2005, approximately 40% and 41%, respectively, of our direct premium revenue came from sales of policies in California, Florida and Pennsylvania. In 2001, we ceased new policy sales nationwide as a result of our statutory surplus levels until we formulated the Plan with the Department. Upon the Department s approval of the Plan in February 2002, we recommenced new policy sales in 23 states, including Pennsylvania. We have now recommenced new policy sales in 21 additional states, including California and Florida. We are working with the remaining six states to recommence new policy sales.

The following table summarizes our sales of both long-term care and Medicare supplement new policies in the periods indicated (in thousands):

	2006	2005	2004
Number of new policies sold	8	9	8
Annualized premiums	$17,906	$21,018	$17,969

Markets. The following chart shows premium revenues by state (dollar amounts in thousands):

		($000)			Current
	Year	Year Ended December 31,			Year %
State	Entered	2005	2004	2003	of Total
Arizona	1988	$ 13,190	$ 13,671	$ 13,947	4%
California	1992	43,826	46,585	45,618	14%
Florida	1987	49,090	50,435	55,907	16%
Illinois	1990	17,341	17,535	17,104	6%
New Jersey	1996	7,305	6,756	6,887	2%
North Carolina (2)	1990	8,775	9,430	9,366	3%
Ohio	1989	8,677	9,248	9,970	3%
Pennsylvania	1972	35,143	39,392	43,850	11%
Texas	1990	15,469	15,742	15,803	5%
Virginia	1989	21,789	22,477	23,008	7%
Washington	1993	9,995	10,270	10,060	3%
All Other States (1)(2)		78,916	78,344	70,426	26%
All States		$309,516	$319,885	$321,946	100%

(1) Includes all states with premiums of less than two percent of total premiums in 2005.
(2) We have not recommenced new policy sales in North Carolina or in 5 other states which are included in All Other States.

Distribution Partners. Approximately $17.1 million or 97% of the 2006 long-term care sales were generated by FMOs. Approximately $19.2 million or 97% of the 2005 sales were generated by FMOs. We primarily market our long-term care insurance products through FMOs, which are generally large, independent, multi-agent networks utilized for the purpose of recruiting agents and developing networks of agents in various states. FMOs receive an override commission on business written in return for recruiting, training and motivating independent agents to place business with Penn Treaty. At December 31, 2005, we had contracts to sell our products with approximately 75 FMOs. The number of FMOs decreased in 2005 from approximately 140 at December 31, 2004 as FMOs that did not meet certain production levels were transferred

under other FMOs or ceased new sales with Penn Treaty. The number of FMOs was further reduced to approximately 55 at December 31, 2006. This strategy allows us to focus our resources on FMOs that are more likely to increase production in the future. Beginning in 2006, we also began to recruit new FMOs that are interested in selling our products. We recruited five new FMOs in 2006.

The remaining sales in both 2006 and 2005 were generated through strategic alliances. These coordinated ventures with other long-term care insurance carriers offer access to our long-term care insurance products and underwriting breadth to the competitor s captive sales agents. The revenue stream, increased agent retention and partial reimbursement of underwriting expense for issued new business makes this an appealing program for other long-term care insurance carriers.

Distribution opportunities are expanding for long-term care insurance, with the product increasingly being recognized as a valuable tool for wealth advisors involved in financial planning and lifestyle programs. For financial advisors who haven t typically sold long-term care insurance to their clients, the product is a cross-selling and asset-retention vehicle. We intend to explore this and other distribution channels to maximize growth opportunities in the coming years. In February of 2007 we introduced our PersonaLTC™ platform specifically designed to help financial advisors deliver long-term care insurance solutions to their clients. We believe that our first sales from this distribution channel will occur in 2007. This platform includes:

A new simplified application process.

The use of our physically impaired underwriting capabilities to reduce the number of declined applications experienced by financial advisors.

A national co-sales specialist network that utilizes our FMOs.

(d) Administration

Underwriting

We believe that the underwriting process through which we choose to accept or reject an applicant for insurance is critical to our success. We have offered long-term care insurance products for over 30 years and we believe we have benefited significantly from our longstanding focus on this specialized line. Through our experience, we have been able to establish a system of underwriting designed to permit us to process our new business and assess the risks presented with new applications more effectively and efficiently. This experience has also enabled us to devise a risk stratification system whereby we can accept a broad array of risks with correspondingly appropriate premium levels.

Applicants for long-term care insurance are required to complete applications and answer detailed medical questions about their health history, medications, and other personal information. Additionally, each applicant must complete a telephonic or face-to-face interview conducted by an employee of our underwriting department or a nurse through an outside agency. These interviews are used to verify the information provided on the application, as well as obtain additional insight into an applicant s physical abilities, activity level, living situation and cognitive functioning.

As part of these interviews, all applicants are screened for cognitive impairment, a major contributor to the need for long-term care services. For those under age 65, the Delayed Word Recall screen is utilized. For those 65 and older, the Minnesota Cognitive Acuity Screen (MCAS) is performed. Unless the underwriting department determines that an in-home assessment is required, the MCAS is generally conducted telephonically for applicants between 65 and 74 years of age. For those ages 75 and over, an in-home assessment incorporating the MCAS is required. Depending on the applicant s health history, copies of an applicant s medical records are also frequently required. Our underwriting evaluation process not only assesses the risk the applicant currently represents, but also takes into account how existing health conditions and risk factors are likely to progress and affect an applicant s level of independence as he or she ages.

We use multiple rate classifications as a means to approve a greater number of applicants by obtaining the appropriate premiums for additional risk levels. Applicants are placed in different risk classes for acceptance and premium calculation based on medical conditions and level of activity. We have an underwriting points-based scoring system, which provides consistent underwriting and rate classification for applicants with similar medical histories and conditions. We currently offer Preferred, Premier, Select and Standard risk classifications. We are able to offer the equivalent of a fifth

underwriting class through our Secured Risk® product, which allows us to accept applicants who would not otherwise qualify for traditional long-term care insurance products.

Claims

Our long-term care insurance policies provide coverage for the full continuum of long-term care services including home health care, assisted living facilities and skilled nursing home services. Consumers may purchase policies that cover services in one of these settings with a stand alone policy, or they may purchase a comprehensive policy which provides benefits for services received in each of these health care settings.

Our long-term care insurance claims are managed internally by interdisciplinary teams of claim examiners and registered nurse case managers. New claims are assigned to both a claim examiner and a registered nurse case manager for the lifecycle of that claim. This allows the examiner and case manager to become well acquainted with the circumstances of the claim, the provider(s) being utilized, the plan of care development and compliance, and the claimant s progress toward achieving rehabilitative milestones.

Our registered nurse case managers conduct a preliminary medical review of new claims and work with the policyholder, care providers, and attending physicians in developing an appropriate and effective plan of care for each individual policyholder. The registered nurse case managers utilize a frequency review protocol which incorporates policyholder demographics, diagnosis and medical condition acuity.

Our evaluation process for determining benefit eligibility for new claims, as well as re-evaluating continued eligibility for existing claims, includes the use of our internally developed, face to face functional and cognitive assessment tool. Registered nurses, employed by external vendors, use our assessment tool to capture important medical, functional, and cognitive needs information. The use of our internally developed assessment tool serves to standardize the format and enhance the consistency, quality and relevance of the information we receive from each of the external vendors we utilize.

We believe the recent addition of a consulting Medical Director to our claim/case management operation, together with the continuing expansion of our preferred provider network, and broadening claim audit and fraud investigation departments will help us to continue to better manage costs.

Systems Operations

We maintain our own computer system for most aspects of our operations, including policy issuance, billing, claims processing, commissions, premiums and general ledger. We consider it critical to continue to provide the quality of service for which we believe we are known by our policyholders and agents. We believe that our overall systems are an integral component in delivering that service. We, amongst other things, are working on developing new business process management techniques and practices to ensure quality control, reduce operating expense and institutionalize our intellectual capital. Our goals include the development of repeatable processes that will result in more efficient practices, while we continue to invest in our knowledge workers.

In addition, for us to effectively leverage our core operating strengths and support new distribution channels, we plan to implement those technologies that will enable us to deliver high service level standards and claims processing efficiencies. We are investing in those technology solutions that leverage our existing infrastructure and prepare us for future business process and service level efficiencies critical to our core competencies.

We have an outsourcing agreement with a computer services vendor providing for the daily operations of our systems, future program development and assurance of continued operations in the event of a disaster or business interruption.

(e) Premiums

Our long-term care policies provide for guaranteed renewability, at the option of the policyholder, at then current premium rates. The policyholder may elect to pay premiums on a monthly, quarterly, semi-annual or annual basis.

Premium rates for all lines of insurance are subject to state regulations, which vary greatly among jurisdictions. Premium rates for our insurance policies have been established through a cooperative effort involving our actuarial staff with the assistance of our actuarial consultants and after consultation with executive management. At the time of the filing of this Form 10-K there is no in-house actuarial staff. While we are currently searching to fill actuarial staff positions, we continue to utilize our consulting actuaries for all work related to pricing and premium rate increases. All premium rates, including changes to previously approved premium rates, must be approved by the insurance regulatory authorities in each state. However, regulators may not approve the premium rate increases we request, may approve them only with respect to certain types of policies, or may approve increases that are smaller than those we request.

In the past, we have filed with and received approval from certain state insurance departments to increase policy premium rates. These premium rate increases have resulted from a) claims experience that has differed from our expectations at time of original policy issuance, and b) development of alternative forms of facility care (assisted living centers) that were not contemplated at time of original policy issuance, but for which we have frequently made payment under the terms of our existing facility-based policy forms.

We have, and are continuing to, file and implement premium rate increases on the majority of our policies sold prior to 2002. When we file for premium rate increases there is an assumption related to an increased number of people lapsing due to the premium rate increases and therefore an assumption related to anti-selection as a result of the premium rate increases. Anti-selection is the lapsation of policies held by healthier policyholders, leading to a higher expected ratio of claims to premiums in future periods.

In 2005, we settled a national class action suit brought against us as a result of premium rate increases. A significant component of this settlement was the addition of a contingent non-forfeiture benefit to many of our existing policyholders. This benefit may enable participating policyholders to receive a paid-up benefit in the event of lapse in the future following additional premium rate increases that surpass threshold levels established in the settlement agreement.

(f) Future Policy Benefits, Claims Reserves and Deferred Acquisition Costs

Our insurance policies are accounted for as long duration contracts. As a result, there are two components of policyholder liabilities. The first is a policy reserve liability for future policyholder benefits, represented by our estimate of the present value of future benefits less future premium collection. These reserves are calculated based on assumptions that include estimates for mortality, morbidity, interest rates, premium rate increases, expenses and persistency. The assumptions are based on industry experience, our historical results and recent trends.

The second is a reserve for claims which have already been incurred, whether or not they have yet been reported. The amount of reserves relating to claims incurred is determined by periodically evaluating statistical information with respect to the number and nature of historical claims. We regularly review our claims reserves, and any adjustments to previously established claims reserves are recognized in operating income in the period that the need for such adjustments becomes apparent.

In connection with the sale of our insurance policies, we defer and amortize the policy acquisition costs over the related premium paying periods throughout the life of the policy. Deferred costs are costs that are directly related to, and vary with, the acquisition of new premiums. These costs include the variable portion of commissions, which are defined as the first year commissions less ultimate renewal commissions, and variable general and administrative expenses related to policy sales, underwriting and issuance. Deferred costs are amortized over the life of the policy based upon actuarial assumptions, including persistency of policies in-force. In the event that a policy lapses prematurely due to death or termination of coverage, the remaining unamortized portion of the deferred amount is immediately recognized as expense in the current period.

The net amortization of deferred policy acquisition costs is affected by new business generation, imputed interest on prior reserves and policy persistency. The amortization of deferred costs is generally offset largely by the deferral of costs

associated with new premium generation. However, the level of new premium sales during the 2005 and 2004 periods produced less expense deferral than needed to offset amortized costs.

We assess the recoverability of our unamortized DAC asset on a quarterly basis, through actuarial analysis. To determine recoverability, the present value of anticipated future premiums less future costs and claims are added to current reserve balances. If this amount is greater than the current unamortized DAC then the DAC is deemed recoverable. If this amount is less than the current unamortized DAC, then we impair our DAC and record a charge in our current period results of operations. The DAC recoverability analysis includes our most recent assumptions for persistency, morbidity, interest rates, expenses and premium rate increases, all or any of which may be different than the assumptions utilized in establishing our benefit reserves.

We have utilized both an in-house actuarial staff and a firm of actuarial consultants to assist us in establishing reserves. At the time of the filing of this Form 10-K there is no in-house actuarial staff. While we are currently searching to fill actuarial staff positions, we continue to utilize our consulting actuaries for all work related to the establishment of reserves. Additionally, actuaries assist us in the documentation of our reserve methodology and in determining the adequacy of our reserves and their underlying assumptions, a process that has resulted in adjustments to our reserve levels. Although we believe that our reserves are adequate to cover all policy liabilities, we cannot assure you that reserves are adequate or that future claims experience will be similar to, or accurately predicted by, our past or current claims experience.

(g) Reinsurance

Reinsurance Agreement with Imagine International Reinsurance Limited

Effective June 30, 2005, we entered into an agreement to reinsure, on a 100% quota share basis, substantially all of our long-term care insurance policies in-force as of December 31, 2001 with Imagine International Reinsurance Limited (the Imagine Agreement). This agreement does not qualify for reinsurance treatment in accordance with Accounting Principles Generally Accepted in the United States of America (GAAP) because it does not result in the reasonable probability that the reinsurer may realize a significant loss. This is due to a number of factors related to the agreement, including an experience refund provision, expense and risk charges due to the reinsurer that escalate over the life of the agreement and an aggregate limit of liability. Therefore, the agreement is being accounted for in accordance with deposit accounting for reinsurance contracts. However, the agreement meets the requirements to qualify for reinsurance treatment under statutory accounting rules, which requires a reinsurance agreement to transfer risk to the reinsurer, but does not require the reasonable probability of a significant loss required under GAAP.

The Imagine Agreement allows us to withhold all funds due to the reinsurer as a funds withheld liability, which is only recorded for statutory accounting purposes. In addition, the agreement allows us to recapture the reinsured policies on any January 1, commencing January 1, 2008. In the event we elect to commute the agreement and recapture the reinsured policies, we will be entitled to an experience refund equal to the funds withheld liability (except as further described below). For deposit accounting purposes, the experience refund and the funds withheld liability are offset as a net deposit amount.

The funds withheld liability and the corresponding experience refund are comprised of (1) an initial premium of approximately $1.039 billion equal to the statutory reserves for the reinsured policies at the effective date, plus (2) future investment income, plus (3) future premiums, less (4) future losses paid, less (5) an initial ceding commission of $60 million, less (6) future expense allowances less (7) future expense and risk charges.

The expense allowance from the reinsurer, limited to a maximum of 25% of premiums collected, is equal to:

1. Renewal commissions paid to our agents, not to exceed 10.5% of premiums collected; plus
2. 9.2% of premiums collected; plus
3. 4.0% of paid claims.

The quarterly expense and risk charge is equal to the sum of (1) 0.25% of total ceded statutory reserves at the end of a quarter; and (2) 0.50% of the value of the combination of any letters of credit or funds deposited in trust by the reinsurer as of the beginning of the quarter. In addition, we paid the reinsurer an initial expense and risk charge of $2.92 million, which is being amortized to expense over 42 months, the estimated life of the agreement.

The Imagine Agreement contains an aggregate limit of liability, which limits the ultimate liability for paid claims of the reinsurer. The aggregate limit of liability is equal to:

1. $100 million, plus
2. the initial premium, less
3. the initial ceding allowance, plus
4. the cumulative premiums collected after the effective date, less
5. the cumulative expense allowances reimbursed after the effective date, plus
6. the cumulative investment income after the effective date

As noted above, the Imagine Agreement contains commutation provisions and allows us to recapture the reinsured policies as of January 1, 2008, or on January 1 of any year thereafter. If the agreement is commuted on January 1, 2008, we will be obligated to pay an early termination fee equal to two quarters of expense and risk charges. We intend, but are not required, to commute the agreement on January 1, 2009. Additionally, the agreement contains certain covenants and conditions that, if breached, may result in the immediate commutation of the agreement and the payment of all expense and risk charges from the period of the breach through January 1, 2008. We were not in violation of these covenants as of and for this period ended December 31, 2005 or as of the date of the filing of this Form 10-K.

In the event we do not commute the Imagine Agreement on or before January 1, 2009, the expense and risk charge paid to the reinsurer will increase by 50 percent. In the event we do not commute the agreement on or before January 1, 2011, but commute at a later date, the experience refund will not exceed the statutory reserves as of the date of commutation, resulting in our forfeiture of any accumulated statutory profits for which we otherwise may have been entitled.

In order to commute the agreement and remain in compliance with requisite regulatory minimum standards, we will need to have a risk based capital ratio of at least 200%. While our current modeling and actuarial projections suggest that our RBC ratio will be at or slightly above 200% and therefore we will be able to commute the 2001 Imagine Agreement on January 1, 2009, we also believe that we should have an additional margin for any adverse development in order to recapture the block of business. We believe that alternatives such as modifications to the current reinsurance agreement, new reinsurance agreements, or additional capital issuances are available to obtain the necessary margin, if needed. These projections include assumptions related to premiums (new sales, persistency, and the timing of premium rate increases), investment income, expense levels, incurred claims (paid claims plus change in claim reserves) and changes in our future policyholder benefits. If there is any negative variance in our assumptions related to these projections, we may not be able to commute the Imagine Agreement on January 1, 2009, as planned, which could have a material adverse affect on our financial condition and results of operations. In the event we determine that commutation of the Imagine Agreement is unlikely on or before January 1, 2009, but likely at some future date, we will include additional annual expense and risk charges in our unamortized deferred acquisition cost (DAC) recoverability analysis. As a result, we could impair the value of our DAC asset and record the impairment in our financial statements at that time.

The agreement further requires that we maintain our financial position in good standing, including covenants regarding our financial strength ratings and risk-based capital ratios. The agreement provides for the reinsurer to require the immediate repayment of the funds withheld liability in the event of a deterioration of our financial strength. As a result of such deterioration, our expense and risk charges could be increased by 25 percent, although any additional expense and risk charges would be refunded, with interest, upon commutation of the agreement if on or before January 1, 2010.

Our agreement requires us to file premium rate increases within 30 days of our determination of need for these increases. Failure to file such rate increases within the prescribed time is defined in the agreement as a Material Breach Event, which, if uncorrected would ultimately lead to a reduction in the reinsurer s liability to reimburse claims made in the future under the agreement. Although we filed our premium rate increases more than 30 days after our determination of need in 2006, thereby creating a Material Breach Event, the Reinsurer considers our ultimate filings to be sufficient to cover our obligations under the agreement and has not reduced the aggregate limit of liability.

2005 Reinsurance Agreement with Imagine International Reinsurance Limited

Effective October 1, 2005, we entered into an agreement to reinsure, on a 75% quota share basis, our long-term care insurance policies issued between October 1, 2005 and September 30, 2006 with Imagine International Reinsurance Limited (the 2005 Imagine Agreement). This agreement has been extended through September 30, 2007. This agreement does not

qualify for reinsurance treatment in accordance with GAAP because it does not result in the reasonable probability that the reinsurer may realize a significant loss. This is due to a number of factors related to the agreement, including an experience refund provision, expense and risk charges due to the reinsurer that escalate over the life of the agreement and an aggregate limit of liability. Therefore, the agreement is being accounted for in accordance with deposit accounting for reinsurance contracts. However, the agreement meets the requirements to qualify for reinsurance treatment under statutory accounting rules, which requires a reinsurance agreement to transfer risk to the reinsurer, but does not require the reasonable probability of a significant loss required under GAAP.

The 2005 Imagine Agreement allows us to withhold all funds due to the reinsurer as a funds withheld liability, which is only recorded for statutory purposes. In addition, the agreement allows us to recapture the reinsured policies on any September 30, commencing on September 30, 2008. In order to recapture any policies reinsured under the 2005 Imagine Agreement, we are required to first or concurrently recapture policies reinsured under the Imagine Agreement for polices issued December 31, 2001 or prior.

Reinsurance Agreements with Centre Solutions (Bermuda) Limited

Effective December 31, 2001, we entered into an agreement with Centre Solutions (Bermuda) Limited to reinsure substantially all of our long-term care policies then in force (the 2001 Centre Agreement) This agreement was commuted on May 24, 2005. We recorded a termination fee paid to Centre of $18.3 million related to the early commutation of this agreement.

Upon the entrance of the 2001 Centre Agreement, the reinsurer was originally granted four tranches of warrants to purchase shares of non-voting convertible preferred stock. The warrants were forfeited as part of the early commutation. The value of the warrants was recorded as a deferred reinsurance premium and was being expensed over the life of the reinsurance agreement. The remaining value of approximately $7.3 million was recorded as an expense in the second quarter of 2005.

The reinsurance agreement also granted the reinsurer an option to participate in reinsuring new business sales on a quota share basis. In August 2002, the reinsurer exercised its option to reinsure up to 50% of future sales, subject to a limitation of the reinsurer s risk (the 2002 Centre Agreement). On March 29, 2004, the reinsurer notified us of its decision to cease reinsuring newly issued policies on or after August 1, 2004. The 2002 Centre Agreement was commuted effective February 1, 2005 and all policies previously reinsured under the agreement were recaptured. The Company recorded a gain of $815,000 as a result of the recapture and does not currently have reinsurance for long-term care insurance policies issued between August 1, 2004 and September 30, 2005.

Other Reinsurance

We contract for reinsurance to increase the number and size of the policies we may underwrite and as a tool to manage statutory surplus strain associated with new business growth. Reinsurance is utilized by insurance companies to insure their liability under policies written to their policyholders. By transferring, or ceding, certain amounts of premium (and the risk associated with that premium) to reinsurers, we can limit our exposure to risk. However, if a reinsurance company becomes insolvent or otherwise fails to honor its obligations under any reinsurance agreements, we would remain fully liable to the policyholder.

We have a reinsurance agreement with General Re Life Corporation with respect to home health care policies with benefit periods exceeding 36 months. No new policies have been reinsured under this agreement since 1998. Reinsurance recoveries related to this contract were the subject of arbitration that was resolved in 2006. See Item 3 Legal Proceedings for a description of current legal proceedings. We also have a reinsurance agreement with General Re Life Corporation with respect to certain home health and nursing home claims. The claims ceded are either in excess of 60 months, $250,000 or $350,000 depending on the policy type. There have been no new policies reinsured under this agreement since 2001. In addition we also had a coinsurance agreement with General Re Life Corporation on a previously acquired block of long-term care business, whereby 66% was ceded to a third party. This coinsurance agreement was recaptured as part of our arbitration settlement and the policies are no longer reinsured. See Item 3 Legal Proceedings for a description of current legal proceedings.

We have an agreement with Lincoln Heritage Life Insurance Company to cede 100% of certain whole life and deferred annuity policies on an assumption basis effective December 31, 2002. Upon approval from state insurance departments in which the policies were issued, or policyholder approval as may be prescribed by state regulation, we will no longer record these policies in our financial statements.

In 2001, we ceded substantially all of our disability policies to Assurity Life Insurance Company on a 100% quota share assumption basis. All policies have been legally assumed by Assurity Life Insurance Company as of December 31, 2005 and there are no longer any reinsurance recoverable balances.

Subsequent to December 31, 2005, we ceded substantially all of our remaining life policies to Liberty Bankers Life Insurance Company on a 100% quota share assumption basis. Upon approval from state insurance departments in which the policies were issued, or policyholder approval as may be prescribed by state regulation, we will no longer record these policies in our financial statements.

The following table shows our historical use of reinsurance:

		Reinsurance Recoverable	
Company	A.M. Best Rating	December 31, 2005	December 31, 2004
		(in thousands)	
General Re Life Corporation	A+	$27,322	$17,193
Assurity Life Insurance Company	A-	-	3,264
Lincoln Heritage Life Insurance Company	A-	2,623	2,862
Other (1)		87	99

(1) Reinsurance recoverables of less than $50 are combined.

(h) Investments

We have categorized all of our investment securities as available for sale because they may be sold in response to changes in interest rates, prepayments and similar factors. Investments in this category are reported at their current market value with net unrealized gains and losses, net of the applicable deferred income tax effect, being added to or deducted from total shareholders equity on the balance sheet. The increase in our investment securities is due to the investments we received at the time we commuted the 2001 Centre Agreement. As of December 31, 2005, shareholders equity was decreased by $15.9 million due to unrealized losses of $24.6 million in the investment portfolio. The amortized cost and estimated market value of our available for sale investment portfolio as of December 31, 2005 and 2004 are as follows (amounts in thousands):

	December 31, 2005			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Market Value
U.S. Treasury securities and obligations of U.S. Government authorities and agencies	$ 222,346	$ 49	$ (3,057)	$ 219,338
Mortgage backed securities	138,161	20	(3,151)	135,030
Municipal Bonds	24,547	-	(497)	24,050
Corporate securities	639,491	55	(17,911)	621,635
	$1,024,545	$ 124	$ (24,616)	$1,000,053

	December 31, 2004			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Market Value
U.S. Treasury securities and obligations of U.S. Government authorities and agencies	$ 34,795	$ 298	$ (237)	$ 34,856
Mortgage backed securities	1,874	21	(16)	1,879

Debt securities issued by foreign governments	384	20	(2)	402
Corporate securities	21,892	245	(103)	22,034
	$ 58,945	$ 584	$ (358)	$ 59,171

Our investment portfolio consists primarily of investment grade fixed income securities. Income generated from this portfolio is largely dependent on prevailing levels of interest rates at the time of original purchase. Due to the duration of our investments (approximately 11 years), investment income does not immediately reflect changes in market interest rates.

Our funds are invested by professional investment management firms under the direction of our management team in accordance with investment guidelines approved by the Investment Committee of the Board of Directors. Although our investment guidelines stress diversification of risks and conservation of principal and liquidity, our investments are subject to market risks, as well as risks inherent to individual securities. Investment losses could significantly decrease our book value, thereby affecting our ability to conduct business.

We do not match the duration of assets and liabilities, which could subject us to interest rate risk from the investment of new cash flows that are inadequate to meet our future claims payments. In addition, we are limited by the Plan with the Pennsylvania Insurance Department as to the types of new investments that we may purchase. We are also limited by our statutory surplus in terms of the level of realized loss we can incur in order to sell existing assets and purchase new investments. This could, and has, limited our ability to realign the duration of our investment portfolio and to maximize our investment yield. Our future earnings could be limited as a result of these limitations.

Our operating results are affected by the performance of our investment portfolio. Our investment portfolio contains fixed income investments and may be adversely affected by changes in interest rates. Volatility in interest rates could also have an adverse effect on our investment income and operating results. For example, if interest rates decline, funds reinvested will earn less than the maturing investment.

Interest rates are highly sensitive to many factors, including monetary and fiscal policies and domestic and international political conditions. Although we take measures to manage the risks of investing in changing interest rate environment, we may not be able to effectively mitigate interest rate sensitivity. Our mitigation efforts include maintaining a high quality portfolio to reduce the effect of interest rate changes on book value. A significant increase in interest rates could have a material adverse effect on our book value.

(i) Selected Financial Information: Statutory Basis

The following table shows certain ratios derived from our insurance regulatory filings with respect to our accident and health policies presented in accordance with accounting principles prescribed or permitted by insurance regulatory authorities, which differ from the presentation under GAAP and which also differ from the presentation under statutory accounting rules for purposes of demonstrating compliance with statutorily mandated loss ratios.

	Year ended December 31,		
	2006	2005	2004
Loss Ratio (1) (4)	35.8%	177.6%	69.6%
Expense ratio (2) (4)	73.0%	(78.6)%	52.1%
Combined loss and expense ratio	108.8%	99.0%	121.7%
Persistency (3)	91.9%	88.8%	88.7%

(1) Loss ratio is defined as incurred claims and increases in policy reserves divided by collected premiums.

(2) Expense ratio is defined as commissions and expenses, net of ceding allowances from reinsurers, divided by collected premiums.

(3) We measure persistency as the continuation of a benefit unit, or an increment of $10 of coverage per day offered under a policy, that remains in-force from one year to the next.

(4) The 2006, 2005 and 2004 loss ratios and expense ratios are significantly affected by the statutory accounting for reinsurance agreements. The 2006 ratios are impacted by our Imagine Agreement and an assumption reinsurance agreement related to our life insurance policies. The 2005 ratios are impacted by the commutation of the 2001 Centre Agreement and the 2005 Centre Agreement and the subsequent entry into the Imagine Agreement. The expense ratio is negative in 2005 due to a ceding allowance of $60 million received upon entering the Imagine reinsurance agreement, which is netted against expenses as described in (2) above. The loss ratio in 2005 is higher than 2004 or 2006 because the premium we ceded to Imagine exceeded the amount we received upon commutation of the Centre Agreements, resulting in a smaller numerator being utilized in the ratio.

Statutory accounting practices. State insurance regulators require our insurance subsidiaries to have statutory surplus at a level sufficient to support existing policies and new business growth. Under statutory accounting rules, we charge costs associated with sales of new policies against earnings as such costs are incurred. These costs, together with required reserves, generally exceed first year premiums and, accordingly, cause a reduction in statutory surplus during periods of increasing first year sales. The commissions paid to agents are generally higher for new policies than for renewing policies. Because statutory accounting requires commissions to be expensed as paid, growth in first year policies generally results in higher expense ratios.

(j) Insurance Industry Rating Agencies

The financial strength ratings assigned to our insurance company subsidiaries by A.M. Best Company, Inc. and Standard & Poor s Insurance Rating Services, two independent insurance industry rating agencies, affect our ability to expand and to attract new business. A.M. Best s ratings for the industry range from A++ (superior) to F (in liquidation). Standard & Poor s ratings range from AAA (extremely strong) to CC (extremel weak). A.M. Best and Standard & Poor s insurance company ratings are based upon factors of concern to policyholders and insurance agents and are not directed toward the protection of investors. Our subsidiaries that are rated have A.M. Best ratings of B and Standard & Poor s ratings of B . In July, 2006, both A.M. Best and Standard & Poor s assigned our ratings to credit watch, with negative outlook pending the filing of this Form 10-K. We believe that a downgrade of either of these ratings would have an adverse effect upon our ability to sell new policies, including, but not limited to, the potential for certain key states (including Florida) to suspend our ability to write new business in those states.

Certain distributors will not sell our products unless we have a more favorable financial strength rating. Similarly, certain prospective customers may decline to purchase new policies because of a perceived risk of non-payment of policy benefits due to our financial condition. Our inability to achieve improved ratings could have a material adverse effect on our financial condition and results of operations.

(k) Competition

We operate in a highly competitive industry. We believe that competition is based on a number of factors, including service, products, premiums, commission structure, financial strength, industry ratings, name recognition, and distribution channels. We compete with a large number of national insurers who offer similar products through similar distribution channels, smaller regional insurers and specialty insurers, many of whom have considerably greater financial resources, larger and more diverse networks of agents, and higher ratings than we do. We also are subject to competition resulting from changes in the Medicare and Medicaid benefit plans, especially as it relates to home and community based services and long-term care facility coverage.

We also actively compete in an intense market that is developing combination products with life insurance, annuity, and other financial plans. The expansion of these product features outside of the traditional insurance arena has brought increased competition and pressure to develop alternate business and product lines for long-term care insurance. We also may be adversely affected if we do not seek appropriate affiliations and are required to compete with other financial institutions. Our ability to compete in the long-term care insurance arena will be dependent on our ability to develop new products and necessary affiliations.

Our products are distributed through networks of agents who independently sell our products. We compete with other insurance companies in product offerings, commission rates, underwriting, claim adjudication, and service. Our business may suffer if we are unable to recruit and retain independent agents, networks of agents, or develop alternative distribution channels.

We continue to compete in an industry that is changing. New regulations and products continue to be introduced for the funding of long-term care services. In order to keep pace with any new developments, we may need to expend significant capital to offer new products, develop partnerships, expand distribution channels, and train our agents and employees to sell and administer our products and services.

(l) Government Regulation

General

Insurance companies are subject to supervision and regulation in all states in which they transact business. Penn Treaty is registered and approved as a holding company under the Pennsylvania Insurance Code. Our insurance company subsidiaries are chartered in the states of Pennsylvania, New York and Florida.

The extent of regulation of insurance companies varies, but generally derives from state statutes which delegate regulatory, supervisory and administrative authority to state insurance departments. Although many states insurance laws and regulations are based on models developed by the National Association of Insurance Commissioners (NAIC), and are therefore similar, variations among the laws and regulations of different states are common.

The NAIC is a voluntary association of all of the state insurance commissioners in the United States. The primary function of the NAIC is to develop model laws on key insurance regulatory issues that can be used as guidelines for individual states in adopting or enacting insurance legislation. While the NAIC model laws are accorded substantial deference within the insurance industry, these laws are not binding on insurance companies unless adopted by states, and variation from the model laws by states is common. In March 2006, the NAIC recognized that long-term care insurance is not just a product for senior citizens, but is a diverse product for various ages. The NAIC initiated the Long-Term Care Working Group which reports directly to Life B Committee and is responsible for the development of Model Act and Regulation for long-term care and gives guidance to members of the NAIC on long-term care issues. We believe that this is an important function and we maintain an active presence through committee representation and NAIC meetings.

Most states mandate minimum benefit standards and policy lifetime loss ratios for long-term care insurance policies and for other accident and health insurance policies. A significant number of states, including Pennsylvania and Florida, have adopted the NAIC model regulation that requires new business rates to contain a margin for moderately adverse experience. Companies use loss ratios to achieve that margin. Currently, Pennsylvania, Florida and California have a proposed minimum loss ratio of 60% for both individual and group long-term care insurance policies. Certain states, including New Jersey and New York, have adopted a minimum loss ratio of 65% for long-term care. The states in which we are licensed have the authority to change these minimum ratios, the manner in which these ratios are computed and the manner in which compliance with these ratios is measured and enforced.

In December 1986, and as subsequently modified, the NAIC adopted the Long-Term Care Insurance Model Act (the Model Act), to promote the availability of long-term care insurance policies, to protect applicants for such insurance and to facilitate flexibility and innovation in the development of long-term care coverage. The Model Act establishes standards for long-term care insurance, including provisions relating to disclosure and performance standards for long-term care insurers, incontestability periods, non-forfeiture benefits, severability, penalties and administrative procedures. Model regulations were also developed by the NAIC to implement the Model Act. Some states have also adopted standards relating to agent compensation for long-term care insurance.

Some state legislatures have, since 2000, adopted NAIC proposals to limit significant premium rate increases on long-term care insurance products. These states have required that new long-term care policies sold after the adoption of the NAIC proposals include additional margin for moderately adverse deviation in claims expectations. This additional margin included in the original pricing of policies is designed to partially protect policyholders from future premium rate increases. In the past, we have been generally successful in obtaining premium rate increases when necessary. We currently have premium rate increases on file with various state insurance departments. If we are unable in the future to obtain premium rate increases, or in the event of legislation limiting premium rate increases, we believe it would have a material adverse impact on our financial condition, results of operations and future earnings.

The Pennsylvania Insurance Department, the New York Insurance Department, the Florida Department of Insurance Regulation and the insurance regulators in other jurisdictions have broad administrative and enforcement powers relating to the granting, suspending and revoking of licenses to transact insurance business, the licensing of agents, the regulation of premium rates and trade practices, the content of advertising material, the form and content of insurance policies and financial statements and the nature of permitted investments. In addition, regulators have the power to require insurance companies to maintain certain deposits, capital, and surplus and reserve levels calculated in accordance with prescribed statutory standards. The NAIC has developed minimum capital and surplus requirements utilizing certain risk-based factors associated with various types of assets, credit, underwriting and other business risks. This calculation, commonly referred to as Risk-Based Capital, serves as a benchmark for the regulation of insurance company solvency by state insurance regulators. The primary purpose of such supervision and regulation is the protection of policyholders, not investors.

In February 2006, Congress passed the Deficit Reduction Act (DRA), which has significant implications for Medicaid and long-term care insurance. Medicaid, with both federal and state funds, has traditionally been the largest payer for long-term care facilities. The DRA seeks to tighten eligibility access, which has been expanded in recent decades through loopholes, and in turn further promotes the use of long-term care insurance as a vehicle for individual financing of these costs. Three distinct areas that will impact the potential market for long-term care insurance include: 1) Medicaid eligibility restrictions, 2) expansion of state sponsored long-term care partnership programs, and 3) education of the benefits of long-term care insurance through state sponsored long-term care websites and federally funded long-term care awareness campaigns. We believe that the partnership expansion coupled with tightening of the Medicaid eligibility standards provides a tremendous growth opportunity for long-term care insurance.

Under the Health Insurance Portability and Accountability Act (HIPAA), premiums paid for eligible long-term care insurance policies are treated as deductible medical expenses for federal income tax purposes. The deduction is limited to a specified dollar amount ranging from $270 to $3,400, with the amount of the deduction increasing with the age of the taxpayer. In order to qualify for the deduction, the insurance contract must, among other things, provide for limitations on pre-existing condition exclusions, prohibitions on excluding individuals from coverage based on health status and guaranteed renewability of health insurance coverage. Although we offer tax-deductible policies, we continue to offer a variety of non-deductible policies as well. We have long-term care policies that qualify for tax exemption under HIPAA in all states in which we are currently selling new policies.

We are also subject to the insurance holding company laws of Pennsylvania and of the other states in which we are licensed to do business. These laws generally require insurance holding companies and their subsidiary insurers to register and file certain reports, including information concerning their capital structure, ownership, financial condition and general business operations. Further, states often require prior regulatory approval of changes in control of an insurer and of inter-company transfers of assets within the holding company structure. The Pennsylvania Insurance Department, the New York Insurance Department and the Florida Department of Insurance Regulation must approve the purchase of more than 10% of the outstanding shares of our common stock by one or more parties acting in concert, and may subject such party or parties to the reporting requirements of the insurance laws and regulations of Pennsylvania, New York and Florida, and to the prior approval and/or reporting requirements of other jurisdictions in which we are licensed. In addition, our officers and directors and those of our insurance subsidiaries and our 10% shareholders are subject to the reporting requirements of the insurance laws and regulations of Pennsylvania, New York and Florida, as the case may be, and may be subject to the prior approval and/or reporting requirements of other jurisdictions in which they are licensed.

States also restrict the dividends our insurance subsidiaries are permitted to pay. Dividend payments will depend on profits arising from the business of our insurance company subsidiaries, computed according to statutory formulae. Under the insurance laws of Pennsylvania, New York and Florida, where our insurance subsidiaries are domiciled, insurance companies can pay ordinary dividends only out of earned surplus. In addition, under Pennsylvania law, our Pennsylvania insurance subsidiaries (including our primary insurance subsidiary) must give the Department at least 30 days advance notice of any proposed extraordinary dividend and cannot pay such a dividend if the Department disapproves the payment during that 30-day period. For purposes of that provision, an extraordinary dividend is a dividend that, together with all other dividends paid during the preceding twelve months, exceeds the greater of 10% of the insurance company s surplus as shown on the company s last annual statement filed with Department or its statutory net income as shown on that annual statement. Statutory earnings are generally lower than earnings reported in accordance with generally accepted accounting principles due to the immediate or accelerated recognition of all costs associated with premium growth and benefit reserves. Additionally, our Plan requires the Department to approve all dividend requests made by PTNA, regardless of normal statutory requirements for allowable dividends. We believe that the Department is unlikely to consider any dividend request in the foreseeable future as a result of PTNA s current statutory surplus position. Although not stipulated in the Plan, this

requirement is likely to continue until such time as PTNA meets normal statutory allowances, including reported net income and positive cumulative earned surplus.

Under New York law, our New York insurance subsidiary (American Independent Network Insurance Company of New York) must give the New York Insurance Department 30 days advance notice of any proposed dividend and cannot pay any dividend if the regulator disapproves the payment during that 30-day period. In addition, our New York insurance company must obtain the prior approval of the New York Insurance Department before paying any dividend that, together with all other dividends paid during the preceding twelve months, exceeds the lesser of 10% of the insurance company s surplus as of the preceding December 31 or its adjusted net investment income for the year ended the preceding December 31.

Under Florida law, our Florida insurance subsidiary (Southern Security Life Insurance Company), the purchase of which remains subject to regulatory approval, must give the Florida Department of Insurance Regulation 30 days advance notice of any proposed extraordinary dividend or any other extraordinary distribution to our shareholders and cannot pay such a dividend or distribution if the regulator disapproves the payment during that 30-day period. For purposes of that provision, an extraordinary dividend or extraordinary distribution is any dividend or distribution that exceeds the greater of (i) the lesser of 10% of the insurance company s surplus or net gain from operations, not including realized capital gains; (ii) 10% of surplus, with dividends payable constrained to unassigned funds minus 25% of unrealized capital gains; or (iii) the lesser of 10% of surplus or net investment income (net gain before capital gains) plus a 2 year carryforward with dividends payable constrained to unassigned funds minus 25% of unrealized capital gains; but shall not include prorata distributions of any class of our Florida insurance subsidiary s own securities.

PTNA and ANIC have not paid any dividends to Penn Treaty in 2004, 2005 or 2006 and are unlikely in the foreseeable future to be able to make dividend payments due to insufficient statutory surplus and anticipated earnings. However, our New York subsidiary is not subject to the Plan and in March 2002 we received a dividend from our New York subsidiary of $651,000. The New York subsidiary has not paid any dividends in 2004, 2005 or 2006. Southern Security Life Insurance Company has not paid any dividends to Penn Treaty in 2004, 2005 or 2006.

Periodically, the federal government has considered adopting a national health insurance program. Although it does not appear that the federal government will enact an omnibus health care reform law in the near future, the passage of such a program could have a material impact on our operation