HealthMarkets, Inc.
Form 10-K
March 18, 2009

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the Fiscal Year Ended December 31, 2008.

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 no. 001-14953

HealthMarkets, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**75-2044750**
(State or other jurisdiction of Incorporation or organization)	*(IRS Employer Identification No.)*

9151 Boulevard 26, North Richland Hills, Texas 76180
(Address of principal executive offices, zip code)
(817) 255-5200
(Registrant s phone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:
None

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

Class A-2 common stock
(Title of class)

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes o No þ

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 þ

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 þ No o

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K 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 þ

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act.

Large accelerated filer o	Accelerated filer o	Non-accelerated filer þ (Do not check if a smaller reporting company)	Smaller reporting company o

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

Effective April 5, 2006, all of the registrant s Class A-1 common stock (representing approximately 88.62% of its common equity at March 10, 2007) is owned by three private investor groups and members of management. The registrant s Class A-2 common stock is owned by its independent insurance agents and is subject to transfer restrictions. Neither the Class-A-1 common stock nor the Class A-2 common stock is listed or traded on any exchange or market. Accordingly, as of June 30, 2008, the last business day of the registrant s most recently completed second fiscal quarter, the aggregate market value of shares of Class A-1 and Class A-2 common stock held by non-affiliates was $-0-. As of March 2, 2009, there were 26,887,281 outstanding shares of Class A-1 common stock and 3,042,561 outstanding shares of Class A-2 common stock.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the annual information statement for the annual meeting of stockholders are incorporated by reference into Part III.

HEALTHMARKETS, INC.
and Subsidiaries

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Cautionary Statements Regarding Forward-Looking Statements

In this Annual Report on Form 10-K, unless the context otherwise requires, the terms Company, HealthMarkets, we, us, or our refer to HealthMarkets, Inc. and its subsidiaries. This report and other documents or oral presentations prepared or delivered by and on behalf of the Company contain or may contain *forward-looking statements* within the meaning of the safe harbor provisions of the United States Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements based upon management s expectations at the time such statements are made. The Company undertakes no obligation to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Forward-looking statements are subject to risks and uncertainties that could cause the Company s actual results to differ materially from those contemplated in the statements. Readers are cautioned not to place undue reliance on the forward-looking statements. All statements, other than statements of historical information provided or incorporated by reference herein, may be deemed to be forward-looking statements. Without limiting the foregoing, when used in written documents or oral presentations, the terms *anticipate, believe, estimate, expect, may, objective, plan, possible, potential, project, wil* expressions are intended to identify forward-looking statements. In addition to the assumptions and other factors referred to specifically in connection with such statements, factors that could impact the Company s business and financial prospects include, but are not limited to, those discussed under the caption *Item 1 Business, Item 1A. Risk Factors* and *Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations* and those discussed from time to time in the Company s various filings with the Securities and Exchange Commission or in other publicly disseminated written documents.

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PART I

Item 1. *Business*

Introduction

HealthMarkets, Inc., a Delaware corporation incorporated in 1984, is a holding company, and we conduct our insurance businesses through our indirect, wholly owned insurance company subsidiaries. Through these subsidiaries, we issue primarily heath insurance policies covering individuals, families, the self employed and small businesses.

Our insurance subsidiaries include The MEGA Life and Health Insurance Company (MEGA), Mid-West National Life Insurance Company of Tennessee (Mid-West) and The Chesapeake Life Insurance Company (Chesapeake). MEGA is an insurance company domiciled in Oklahoma and is licensed to issue health, life and annuity insurance policies in the District of Columbia and all states except New York. Mid-West is an insurance company domiciled in Texas and is licensed to issue health, life and annuity insurance policies in Puerto Rico, the District of Columbia, and all states except Maine, New Hampshire, New York and Vermont. Chesapeake is an insurance company domiciled in Oklahoma and is licensed to issue health and life insurance policies in the District of Columbia and all states except New Jersey, New York and Vermont. Effective December 1, 2007, the Company acquired Fidelity Life Insurance Company, an insurance company domiciled in Pennsylvania. Fidelity Life Insurance Company was redomesticated to Oklahoma on May 12, 2008 and its name was changed to HealthMarkets Insurance Company (HMIC) on July 15, 2008. HMIC is licensed to issue health and life insurance policies in the District of Columbia and all states except New York, Mississippi and New Hampshire.

The Company operates three business segments: the Insurance segment, Corporate and Disposed Operations. The Insurance segment includes the Company s Self-Employed Agency Division (SEA), the Medicare Division and the Other Insurance Division. Corporate includes investment income not allocated to the Insurance segment, realized gains or losses, interest expense on corporate debt, general expenses relating to corporate operations, variable non-cash stock-based compensation and operations that do not constitute reportable operating segments. Disposed Operations includes the former Life Insurance Division, former Star HRG Division and former Student Insurance Division. *See* Note 18 of Notes to Consolidated Financial Statements for financial information regarding our segments.

Through our SEA Division, we offer a broad range of health insurance products for individuals, families, the self-employed and small businesses. We market these products through a dedicated agency field force consisting of independent agents contracted with our insurance subsidiaries that primarily sells the Company s products. The Company has approximately 1,300 independent writing agents per week in the field selling health insurance in 44 states.

In 2007, we initiated efforts to expand into the Medicare market. In the fourth quarter of 2007, we began offering a new portfolio of Medicare Advantage Private-Fee-for-Service Plans (PFFS) in selected markets in 29 states with calendar year coverage effective for January 1, 2008. Policies were issued by our Chesapeake subsidiary, under a contract with the Centers for Medicare and Medicaid Services (CMS). In July 2008, the Company determined that it would not continue to participate in the Medicare Advantage market beyond the current plan year and our Chesapeake subsidiary terminated its agreement with CMS effective December 31, 2008. In connection with our exit from the Medicare market, we incurred employee termination costs of $2.8 million and recorded asset impairment charges of $1.1 million. *See* Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations and Note 2 of Notes to Consolidated Financial Statements.

Our Other Insurance Division consists of ZON Re-USA, LLC (ZON Re), an 82.5%-owned subsidiary, which underwrites, administers and issues accidental death, accidental death and dismemberment (AD&D), accident medical, and accident disability insurance products, both on a primary and on a reinsurance basis. We distribute these products through professional reinsurance intermediaries and a network of independent commercial insurance agents, brokers and third party administrators.

On July 11, 2006 and December 1, 2006, we sold our former Star HRG Division and Student Insurance Division, respectively, resulting in total pre-tax gains of $201.7 million. *See* Note 2 of Notes to Consolidated

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Financial Statements. On September 30, 2008, we exited our Life Insurance Division business through a reinsurance transaction pursuant to which Wilton Reassurance Company or its affiliates (Wilton) agreed to reinsure on a 100% coinsurance basis substantially all of the insurance policies associated with the Life Insurance Division, effective July 1, 2008. The reinsurance transaction resulted in a pre-tax loss of $21.5 million, of which $13.0 million was recorded as an impairment to the Life Insurance Division s deferred acquisition costs with the remainder of $8.5 million recorded in Realized gains (losses) in the Company s consolidated statement of income (loss). *See* Note 2 of Notes to Consolidated Financial Statements.

We sold these businesses and exited the Medicare Advantage market because these businesses were not part of the fundamental long term focus of the Company. We are now generally focused on business opportunities that allow us to maximize the value of our dedicated agency sales force and serve our target market of individuals, families, the self employed and small businesses.

On April 5, 2006, we completed a merger (the Merger) providing for the acquisition of the Company by affiliates of a group of private equity investors, including affiliates of The Blackstone Group, Goldman Sachs Capital Partners and DLJ Merchant Banking Partners (the Private Equity Investors). As a result of the Merger, holders of our common stock received $37.00 in cash per share. In the transaction, HealthMarkets former public shareholders received aggregate cash consideration of $1.6 billion, of which approximates $985.0 million was contributed as equity by the Private Equity Investors. The balance of the Merger consideration was financed with the proceeds of a $500.0 million term loan facility, the proceeds of $100.0 million of trust preferred securities issued in a private placement, and Company cash on hand of approximately $42.8 million. *See* Note 12 of Notes to Consolidated Financial Statements.

Our principal executive offices are located at 9151 Boulevard 26, North Richland Hills, Texas 76180-5605, and our telephone number is (817) 255-5200.

As of March 2, 2009, approximately 89% of our common equity securities are held by affiliates of three private equity investors, with the balance of our common equity securities held by current and former members of management and independent insurance agents through the Company s agent stock accumulation plans. As such, we remain subject to the periodic reporting and other requirements of the Securities Exchange Act of 1934, as amended. Our periodic SEC filings, including our annual reports on Form 10-K, quarterly reports on Form 10-Q, Current Reports on Form 8-K, and if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 are available through our web site at www.healthmarketsinc.com free of charge as soon as reasonably practicable after such material is electronically filed with, or furnished to, the SEC.

Ratings

Our principal insurance subsidiaries are rated by A.M. Best Company (A.M. Best), Fitch Ratings (Fitch) and Standard & Poor s (S&P). Set forth below are the current financial strength ratings of the principal insurance subsidiaries.

	A.M. Best	**Fitch**	**S&P**
MEGA	B++ (Good)	BBB (Good)	BBB- (Good)
Mid-West	B++ (Good)	BBB (Good)	BBB- (Good)
Chesapeake	B++ (Good)	BBB- (Good)	BB+ (Marginal)

In the table above, the A.M. Best, Fitch and S&P ratings carry a negative outlook.

In evaluating a company, independent rating agencies review such factors as the company s capital adequacy, profitability, leverage and liquidity, book of business, quality and estimated market value of assets, adequacy of policy liabilities, experience and competency of management, and operating profile. A.M. Best s ratings currently range from A++ (Superior) to F (In Liquidation). A.M. Best s ratings are based upon factors relevant to policyholders, agents, insurance brokers and intermediaries and are not directed to the protection of investors. Fitch s ratings provide an overall assessment of an insurance company s financial strength and security, and the ratings are used to support insurance carrier selection and placement decisions. Fitch s ratings range from AAA (Highest Credit Quality) to D (Default). S&P s financial strength rating is a current opinion of the financial

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security characteristics of an insurance organization with respect to its ability to pay under its insurance policies and contracts in accordance with their terms. S&P s financial strength ratings range from AAA (Extremely Strong) to D (Default).

A.M. Best has assigned to HealthMarkets, Inc. an issuer credit rating of bb+ (Fair) with a negative outlook. A.M. Best s issuer credit rating is a current opinion of an obligor s ability to meet its senior obligations. A.M. Best s issuer credit ratings range from aaa (Exceptional) to d (In Default).

Fitch has assigned to HealthMarkets, Inc. a long term issuer default rating of BB (Speculative) with a negative outlook. Fitch s long term issuer default rating is a current opinion of an obligor s ability to meet all of its most senior financial obligations on a timely basis over the term of the obligation. Fitch s long term issuer default ratings range from AAA (Highest Credit Quality) to D (Default).

S&P s Rating Services has assigned to HealthMarkets, Inc. a counterparty credit rating of BB- (Less Vulnerable) with a negative outlook. S&P s counterparty credit rating is a current opinion of an obligor s overall financial capacity to pay its financial obligations. S&P s counterparty credit ratings range from AAA (Extremely Strong) to D (Default).

Insurance Segment

Self-Employed Agency Division

Through our SEA Division, we offer a broad range of health insurance products for individuals, families, the self-employed and small businesses. These products are issued by our subsidiaries, MEGA, Mid-West and Chesapeake, and are distributed through our dedicated agency field force consisting of independent agents contracted with these insurance subsidiaries. The SEA Division generated revenues of $1.2 billion, $1.4 billion and $1.5 billion, representing 88%, 90% and 69% of our total revenue from continuing operations in 2008, 2007 and 2006, respectively. We currently have approximately 514,000 members insured or reinsured by the Company.

Traditional Health Insurance Products

Historically, our traditional health insurance product offerings have represented the focus of our product sales. Our basic hospital-medical and catastrophic hospital expense plans are designed to accommodate individual needs and include traditional fee-for-service indemnity (choice of doctor) plans and plans with preferred provider organization (PPO) features, as well as other supplemental types of coverage. Our traditional health insurance plan offerings include the following:

Our Basic Hospital-Medical Expense Plan has a $1.0 million lifetime maximum benefit for all injuries and sicknesses and $500,000 lifetime maximum benefit for each injury or sickness. Covered expenses are subject to a deductible. Covered hospital room and board charges are reimbursed at 100% up to a pre-selected daily maximum. Covered expenses for inpatient hospital miscellaneous charges, same-day surgery facility, surgery, assistant surgeon, anesthesia, second surgical opinion, doctor visits and ambulance services are reimbursed at 80% to 100% up to a scheduled maximum. This type of health insurance policy is of a scheduled benefit nature, and, as such, provides benefits equal to the lesser of the actual cost incurred for covered expenses or the maximum benefit stated in the policy. We believe that these limitations allow for more certainty in predicting future claims experience, and, as a result, we expect that future premium increases for this policy will be lower than future premium increases on our catastrophic policy.

Our Preferred Provider Plan incorporates features of a preferred provider organization, which are designed to control healthcare costs through negotiating discounts with a PPO network. Benefits are structured to

encourage the use of providers with which we have negotiated lower fees for the services to be provided. The policies that provide for the use of a PPO impose greater policyholder cost sharing if the policyholder uses providers outside of the PPO network.

Our Catastrophic Hospital Expense Plan provides a $2.0 million lifetime maximum for all injuries and sicknesses and a lifetime maximum benefit for each injury or sickness ranging from $500,000 to $1.0 million. Covered expenses are subject to a deductible and are then reimbursed at a benefit payment rate ranging

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from 50% to 100%, as determined by the policy. After a pre-selected dollar amount of covered expenses has been reached, the remaining expenses are reimbursed at 100% for the remainder of the period of confinement per calendar year. The benefits for this plan tend to increase as hospital care expenses increase and, as a result, premiums on these policies are subject to increase as overall hospital care expenses rise.

Each of our traditional health insurance products is available with a menu of various options (including various deductible levels, coinsurance percentages and limited riders that cover particular events such as outpatient, accidents, and doctors visits), enabling the insurance product to be tailored to meet the insurance needs and the budgetary constraints of the policyholder. We offer as an optional benefit the Accumulated Covered Expense (ACE) rider that provides for catastrophic coverage on our scheduled/basic plans for covered expenses under the contract that generally exceed $100,000 or, in certain cases, $75,000. The rider pays benefits at 100% after the stop loss amount is reached, up to the aggregate maximum amount of the contract for expenses covered by the rider.

CareOne and CareChoice Products

In 2006, we began shifting our product focus toward our CareOne products, some of which were designed to shift a higher proportion of premium dollars to benefits. In the states where these new products were introduced, they generally replaced the Company s traditional health insurance product offerings as the focus of new product sales, although our traditional products continue to represent the majority of our policies in force and premium.

The CareOne product portfolio includes a basic medical/surgical expense plan, two versions of a catastrophic expense PPO plan and two versions of a catastrophic expense consumer guided health plan:

The CareOne Value Plan is a Basic Medical/Surgical Expense Plan with a $2.0 million lifetime benefit for all injuries and sicknesses and $500,000 lifetime maximum benefit for each injury or sickness. Covered expenses are subject to a deductible and coinsurance. Covered inpatient and outpatient hospital charges are reimbursed up to pre-selected per-injury or sickness maximums. Surgeon, assistant surgeon, anesthesia, second surgical opinion, and ambulance services are also reimbursed to a scheduled maximum. Additional benefits are available through riders and include prescription drugs, emergency services and wellness care, among others. This type of health insurance policy is of a scheduled benefit nature, and as such, provides benefits equal to the lesser of the actual cost incurred for covered expenses or the maximum benefit stated in the policy. We believe that these limitations allow for more certainty in predicting future claims experience, and, as a result, we expect that future premium increases for this policy will be less than future premium increases on our more comprehensive policies.

The CareOne Plan and CareOne Plus Plan are Catastrophic Expense PPO Plans and provide a $5.0 million lifetime maximum for all injuries and sicknesses and a maximum benefit for each injury or sickness of $1.0 million. These plans incorporate features of a preferred provider organization, which are designed to control healthcare costs through negotiating provider discounts with a PPO network. Benefits are structured to encourage the use of providers with which we have negotiated lower fees for the services to be provided. These plans impose greater policyholder cost sharing if the policyholder uses providers outside of the PPO network. Covered expenses are subject to a deductible and are then reimbursed at a benefit payment rate ranging from 70% to 80%, as determined by the policy. After a pre-selected dollar amount of covered expenses has been reached, the remaining expenses are reimbursed at 100% for the remainder of the period of confinement per calendar year. As a premium and cost savings measure, the CareOne Plan limits payment for diagnostic services (*e.g.,* X-rays and laboratory tests) to those diagnostic services that take place within 21 days of, and are directly related to, a hospitalization or outpatient surgery. The benefits for these plans tend to increase as hospital care expenses increase and, as a result, premiums on these policies are subject to an increase as overall hospital care expenses rise.

The CareOne Select Plan and the CareOne Select Plus Plan are Catastrophic Expense Consumer Guided Health Plans and provide a $5.0 million lifetime maximum for all injuries and sicknesses and a maximum benefit for each injury or sickness of $1.0 million. These plans incorporate features of a consumer guided health plan, including information tools available on the internet or through customer service support via the telephone that provide customers with access to information about their benefits and healthcare provider cost and quality. Covered expenses are subject to a Maximum Allowable Charge (MAC), which is the

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maximum fee payable under the policy for a particular healthcare service. As a premium and cost savings measure, the CareOne Select Plan limits payment for diagnostic services (e.g., X-rays and laboratory tests) to those diagnostic services that take place within 21 days of, and are directly related to, a hospitalization or outpatient surgery. We believe that the MAC allows for more certainty in predicting future claims experience, and, as a result, we expect that future premium increases for this policy will be less than future premium increases on our catastrophic PPO policies.

We also offer HSA-compatible versions of our CareOne products. These plans known as high deductible health plans can be used with tax-advantaged health savings accounts for healthcare expenses.

In 2008, we introduced a new calendar year deductible-based PPO product called CareChoice®. The CareChoice product contains many of the same features as our CareOne and CareOne Plus Plans, but eliminates many of the internal benefit limits associated with such plans and simplifies some of the benefit structures.

2009 Product Initiatives

Our shift in market focus away from policies of a scheduled benefit nature toward our CareOne and CareChoice products, particularly those with a traditional PPO feature, resulted in the Company competing directly with a number of insurance companies focused on the larger employer group market. These companies often have a sizable market share which allows them to obtain favorable financial arrangements from healthcare providers that may not be available to us. As a result, with respect to their traditional PPO products, these companies may be able to offer more competitive pricing and/or have lower cost structures than the Company, making it difficult for the Company to compete in the markets where these companies operate. The Company is evaluating its product strategy for 2009 and expects to implement a number of changes, including a renewed emphasis on our traditional health products. In 2009 the Company expects to discontinue the marketing of its CareOne and CareChoice products in many of the states in which these plans are available. In their place, the Company intends to continue offering its traditional health products and expects to introduce several new products underwritten by Chesapeake, including a new scheduled benefit basic hospital-medical expense plan (the BasicFit℠ Plan) and a new high deductible catastrophic hospital expense plan, with deductibles ranging from $7,500 to $20,000 (the EssentialFit℠ Plan). Both new products will incorporate certain PPO features but without the added benefits of traditional, major medical PPO products.

The Company evaluates new product offerings on an ongoing basis. In the future, we may offer new product lines, including product lines focused on markets not traditionally served by the Company.

Ancillary Products

We have also developed and offer ancillary product lines designed to further protect against risks to which our core customer is typically exposed. These products are generally sold to purchasers of the Company s health insurance products, although certain ancillary products are also offered on a stand-alone basis. Our ancillary product offerings include the following:

Dental products: In the third quarter of 2008, the Company introduced a new suite of dental products that offer more varied benefit options than the dental products they replaced. The product suite offers three levels, ranging from a preventive care only option to a more costly option featuring broader benefits such as orthodontic coverage.

Vision products: Benefits offered by our vision products include an annual comprehensive eye examination, low copayments on various lens types and discounts on vision products and services.

Disability: Our disability products provide income protection against short-term disability lasting from 1 to 36 months with benefits ranging from $500 to $2,000 per month.

Life products: We offer basic term life and accidental death and dismemberment insurance products with face amounts up to $100,000.

Critical illness products: Our critical illness products provide a lump sum benefit (ranging from $10,000 to $60,000 per diagnosis) for a specified disease/condition or major organ transplant.

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Accident products: Our accident products pay a percentage of a selected benefit amount (ranging from $5,000 to $25,000 per episode) based on the number of days of hospital confinement per accident.

Hospital indemnity products: Our hospital indemnity products provide a daily benefit (ranging from $150 to $1,500 per day) for medically necessary inpatient confinements.

Third Party Product Distribution Arrangements

MEGA and Mid-West have entered into agreements to distribute health insurance products underwritten by other third-party insurance companies. The products sold under these arrangements focus on markets not traditionally served by the Company, including high risk customers. These products are distributed through our dedicated agency field force consisting of independent agents contracted with our insurance subsidiaries. Currently, the revenues generated by such arrangements are not material to the Company s financial results. The Company evaluates new distribution arrangements on an ongoing basis and may, in the future, offer new third party products.

Marketing and Sales

Substantially all of the health insurance products issued by our insurance subsidiaries are sold through independent contractor agents. (With respect to references to our sales agents as independent contractors, see discussion of Fair Labor Standards Act Agent Litigation in Note 16 of Notes to Consolidated Financial Statements). We believe that we have the largest direct selling organization in the health insurance field, with approximately 1,300 independent writing agents per week in the field selling health insurance to the individual and self employed market.

Our agents are independent contractors and all compensation that agents receive from us for the sale of insurance is based upon the agents levels of sales production. Historically, our dedicated agency sales force consisted of UGA Association Field Services (UGA) and Cornerstone America (Cornerstone) (the principal marketing divisions of MEGA and Mid-West, respectively). UGA and Cornerstone are organized into geographical regions, with each geographical region having a regional director, two additional levels of field leaders and writing agents (*i.e.,* the agents that are not involved in leadership of other agents). In the fourth quarter 2008, we initiated efforts to reorganize UGA and Cornerstone into a single agency department (the Agency Department). The Company believes that the new structure will promote economic and administrative efficiencies, help solidify brand identity and best position the Company to recruit new agents and help agents sell the Company s products in the future.

We maintain a recruiting and training program for field leaders and writing agents. The process of recruiting agents is extremely competitive. We believe that the primary factors in successfully recruiting and retaining effective agents and field leaders are our practices regarding advances on commissions, the quality of the sales leads provided to agents, the availability and accessibility of equity ownership plans, the quality of the products offered, proper training and agent incentives and support. Classroom and field training with respect to product content is required and made available to the agents under the direction of our regulated insurance subsidiaries.

We provide health insurance products covering individuals, families, the self-employed and small businesses in 44 states. As is the case with many of our competitors in this market, a substantial portion of our products are issued to members of various independent membership associations that act as the master policyholder for such products. The two principal membership associations in the self-employed market that make available to their members our health insurance products are the National Association for the Self-Employed and the Alliance for Affordable Services. The associations provide their membership access to a number of benefits and products, including health insurance underwritten by us. Subject to applicable state law, individuals generally may not obtain insurance under an association s master policy unless they are also members of the association. The agreements with these associations,

requiring the associations to continue as the master policyholder for our policies and to make our products available to their respective members, are terminable by us and the associations upon not less than one year s advance notice to the other party. While we believe that we are providing association group coverage in full compliance with applicable law, changes in our relationship with the membership associations and/or changes in the laws and regulations governing so-called association group insurance (particularly changes that

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would subject the issuance of policies to prior premium rate approval and/or require the issuance of policies on a guaranteed issue basis) could have a material adverse impact on our financial condition and results of operations.

The independent agents within our dedicated agency field force also act as field service representatives (FSRs) for the associations. In this capacity the FSRs enroll new association members and provide membership retention services. For such services, we and the FSRs receive compensation. One of our subsidiaries, HealthMarkets Lead Marketing Group Inc. (LMG), serves as our direct marketing group and generates new membership sales prospect leads for use by the FSRs (agents). LMG also provides video and print services to the associations. In addition to health insurance premiums derived from the sale of health insurance, we receive fee income from the associations, including fees associated with enrollment and member retention services, fees for association membership marketing and administrative services and fees for certain association member benefits.

LMG generates sales prospect leads for use by agents. LMG obtains leads from third party sources and utilizes a call center intended to generate leads. LMG has developed a marketing pool of approximately eighteen million prospects from various data sources. Prospects initially identified by LMG that are self-employed, small business owners or individuals may become a qualified lead by responding through one of LMG s lead channels and by expressing an interest in learning more about health insurance. We believe that agents contracted with our insurance subsidiaries, possessing the qualified leads contact information, are able to achieve a higher close rate than is the case with unqualified prospects.

Policy Design and Claims Management

Our traditional health insurance products are principally designed to limit coverages to the occurrence of significant events that require hospitalization. This policy design, which includes high deductibles, reduces the number of covered claims requiring processing, thereby serving as a control on administrative expenses. We seek to price our products in a manner that accurately reflects our underwriting assumptions and targeted margins, and we rely on the marketing capabilities of independent insurance agents within our dedicated agency sales force to sell these products at prices consistent with these objectives.

We maintain administrative centers with full underwriting, claims management and administrative capabilities. The Company evaluates opportunities to subcontract services of this nature on an ongoing basis. If the Company determines that these function can be performed effectively and more efficiently by third parties, it may, in the future, choose to subcontract these functions.

We have also developed an actuarial data warehouse, which is a critical risk management tool that provides our actuaries with rapid access to detailed exposure, claim and premium data. This analysis tool enhances the actuaries ability to design, monitor and adequately price the SEA Division s insurance products.

Provider Network Arrangements and Cost Management Measures

The Company utilizes a number of cost management programs to help it and its customers control medical costs. These measures include maintaining contracts with selected PPO provider networks through which our customers may obtain discounts on hospital and physician services that would otherwise not be available. Provider networks are made available on a regional basis, based on the coverage and discounts available within a particular geographic region. In situations where a customer does not obtain services from a contracted provider, the Company applies various usual and customary fees, which limit the amount paid to providers within specific geographic areas. We believe that access to provider network contracts is a critical factor in controlling medical costs, since there is often a significant difference between a network-negotiated rate and the non-discounted rate.

The Company utilizes other means to control medical costs, including providing customers with access to supplemental network discounts if savings are not obtained through a primary provider network contract; use of pre- and post-payment fee negotiation services; and use of code editing programs that evaluate claims prior to adjudication for inappropriate billing. In the first quarter of 2009, the Company introduced a new medical management program designed to coordinate care between members of its PPO products and their doctors and facilities to manage medical costs. In coordination with a third party care management vendor, the program provides these members with clinical oversight of hospital admissions.

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In addition, to control prescription drug costs, the Company maintains a contract with a pharmacy benefits management company that has approximately 62,000 participating pharmacies nationwide. We also utilize copayments, coinsurance, deductibles and annual limits to manage prescription drug costs.

Medicare

In 2007, we initiated efforts to expand into the Medicare market by establishing a Medicare Division. In the fourth quarter of 2007, we began offering a new portfolio of Medicare Advantage PFFS called HealthMarkets Care Assured Plans[sm] (HMCA Plans) in selected markets in 29 states with coverage effective for January 1, 2008. Policies were issued by our Chesapeake subsidiary, under a contract with CMS, and primarily marketed through our dedicated agency field force consisting of independent agents contracted with our insurance subsidiaries.

Our HMCA Plans were offered to Medicare eligible beneficiaries as a replacement for original Medicare and Medigap (Supplement) policies. They provided enrollees with the actuarial benefit equivalence they would receive under original Medicare, as well as certain additional benefits or benefit options, such as preventive care, pharmacy benefits and certain vision, dental and hearing services. Enrollees could obtain services from any Medicare-eligible provider who agrees to accept the HMCA Plan s terms and conditions. Enrollees may or may not pay a premium in addition to the premium payable for original Medicare. The amount of the additional premium varied, based on the level of benefits and coverage. Our initial plan offerings included the HealthMarkets Care Assured Value Plan, which had a $3,500 annual maximum out-of-pocket for covered expenses, and the HealthMarkets Care Assured Premier Plan, which had a $1,500 annual maximum out-of-pocket for covered expenses. Each plan could be purchased with Medicare Part D prescription drug coverage as an optional benefit. Coinsurance and copayment requirements varied by plan and service received.

In October 2007, the Company voluntarily suspended its Medicare marketing and enrollment activities pending a review by CMS of our compliance with regulatory requirements. In connection with this review, the Company agreed with CMS to take certain actions to ensure that it met applicable Medicare program requirements and, in November 2007, we resumed marketing and enrollment activities related to its HMCA plans. The Company believes that the suspension of Medicare marketing and enrollment activities in the fourth quarter of 2007 adversely affected enrollment of beneficiaries into our HMCA Plans for the 2008 plan year. The Company s Medicare marketing and enrollment activities were subject to ongoing review by CMS and, in April 2008, CMS requested additional materials from us as part of a follow-up review of our Medicare marketing and enrollment activities. As a result of that review, on June 6, 2008, CMS requested that the Company submit a Corrective Action Plan (CAP). The Company submitted the CAP on June 20, 2008. The CAP provided for the Company to: increase the number of providers willing to be deemed, implement a meaningful disciplinary process for agents, decrease the rate of complaints against the Company, and decrease the Company s level of rapid disenrollment/cancellations.

On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 (HR. 6331) was enacted, resulting in significant changes to the Medicare program, including the phased elimination of Medicare Advantage PFFS deeming arrangements beginning in 2011. The Company believes that this new law would have made it difficult for the Company to operate effectively in the Medicare market. In light of this changing landscape within the Medicare regulations, in July 2008, the Company decided that it would not participate in the Medicare Advantage market beyond the 2008 plan year. In October 2008, CMS informed the Company that, due to the Company s impending exit from the Medicare market, the CAP has been closed and no further reports under the CAP are required. The Company will continue to fulfill its remaining obligations under the 2008 calendar year Medicare contract with CMS.

Other Insurance

Through our 82.5%-owned subsidiary, ZON Re, we underwrite, administer and issue accidental death, AD&D, accident medical and accident disability insurance products, both on a primary and on a reinsurance basis. In the year ended December 31, 2008, ZON Re generated revenues of $29.2 million and operating income of $4.4 million.

ZON Re underwrites and manages a portfolio of personal accident reinsurance programs on behalf of MEGA for primary life, accident and health and property and casualty insurers that wish to transfer risks associated with

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certain types of primary personal accident insurance programs. Accident reinsurance provides reimbursement to primary insurance carriers for covered losses resulting from accidental bodily injury or accidental death. For its reinsurance clients, ZON Re targets national, regional and middle market insurers in the United States and select international markets. ZON Re distributes accident reinsurance products through a network of professional reinsurance intermediaries. ZON Re underwrites both treaty and facultative accident reinsurance programs, which may be offered on either a quota share or excess of loss basis. The Company has determined, as a matter of policy, that MEGA s exposure on any single reinsurance contract issued by it and underwritten by ZON Re will not exceed $1.0 million per person and $10.0 million per event.

ZON Re also underwrites and distributes a limited portfolio of primary accident insurance products issued by Chesapeake. These products are designed for direct purchase by banks, associations, employers and affinity groups and are distributed through a national network of independent commercial insurance agents, brokers and third party administrators. The Company has determined, as a matter of policy, that Chesapeake s maximum exposure on any single primary insurance contract issued by it and underwritten by ZON Re will not exceed $1.0 million per person.

In 2008, our principal insurance subsidiaries experienced downgrades in their financial strength ratings which had a negative effect on the growth of this business and our ability to maintain ZON Re s current level of operating income. As a result, we expect to exit this line of business in 2009, with the existing reinsurance business managed to final termination of substantially all liabilities.

Ceded Reinsurance

Our insurance subsidiaries reinsure portions of the coverages provided by their insurance products with other insurance companies on both an excess-of-loss and coinsurance basis. Reinsurance agreements are intended to limit an insurer s maximum loss. The maximum retention by MEGA, Mid-West and Chesapeake on one individual in the case of a life insurance policy is generally $200,000. In connection with the sale of our Life Insurance Division, substantially all of the insurance policies associated with the Life Insurance Division were reinsured by Wilton Reassurance Company or its affiliates on a 100% coinsurance basis, effective July 1, 2008. In connection with the sales in 2006 of the Company s Star HRG and Student Insurance Divisions, insurance subsidiaries of the Company entered into 100% coinsurance arrangements with each of the purchasers, pursuant to which the purchasers agreed to assume liability for future claims associated with the Star HRG Division and Student Insurance Division blocks of group accident and health insurance policies in force as of the respective closing dates. We use reinsurance for our health insurance business solely for limited purposes.

Competition

In each of our lines of business, we compete with other insurance companies or service providers. With respect to the business of our SEA Division, the market is characterized by many competitors, and our main competitors include health insurance companies, health maintenance organizations and the Blue Cross/Blue Shield plans in the states in which we write business.

Competition in our businesses is based on many factors, including quality of service, product features, price, scope of distribution, scale, financial strength ratings and name recognition. We compete, and will continue to compete, for customers and distributors with many insurance companies and other financial services companies. We compete not only for business, but also for agents and distribution relationships. Some of our competitors may offer a broader array of products than our specific subsidiaries with which they compete in particular markets, may have a greater diversity of distribution resources, may have better brand recognition, may, from time to time, have more competitive pricing, may have lower cost structures or, with respect to insurers, may have higher financial strength or claims paying ratings. Organizations with sizable market share or provider-owned plans may be able to obtain favorable financial

arrangements from healthcare providers that are not available to us. Some may also have greater financial resources with which to compete. In addition, from time to time, companies enter and exit the markets in which we operate, thereby increasing competition at times when there are new entrants. For example, several large insurance companies have entered the market for individual health insurance products. The development and growth of companies offering Internet-based connections between health care professionals and individuals, along with a variety of services, could also create additional competitors. We may lose business to

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competitors offering competitive products at lower prices, or for other reasons, which could materially adversely affect our future financial condition and results of operations.

Regulatory and Legislative Matters

Insurance Regulation

State Regulation General

Our insurance subsidiaries are subject to extensive regulation in their respective state of domicile and the other states in which they do business. Insurance statutes typically delegate broad regulatory, supervisory and administrative powers to each state s Commissioner of insurance. The method of regulation varies, but the subject matter of such regulation covers, among other things, the amount of dividends and other distributions that can be paid by the insurance subsidiaries without prior approval or notification; the granting and revoking of licenses to transact business; trade practices, including with respect to the protection of consumers; disclosure requirements; privacy standards; minimum loss ratios; premium rate regulation; underwriting standards; approval of policy forms and mandating benefits; claims payment practices; licensing of insurance agents and the regulation of agent conduct; the amount and type of investments that the insurance subsidiaries may hold; minimum reserve and surplus requirements; risk-based capital requirements; and mandatory participation in, and assessments for, risk sharing pools and guaranty funds. Such regulation is intended to protect policyholders rather than investors.

State regulation of health insurance products varies from state to state, although all states regulate premium rates, policy forms and underwriting and claims practices to one degree or another. Most states have special rules for health insurance sold to individuals or small employer groups. Many states have also adopted legislation that would make health insurance available to all small employer groups by requiring coverage of all employees and their dependents, by limiting the applicability of pre-existing conditions exclusions, by requiring insurers to offer a basic plan exempt from certain benefits as well as a standard plan, or by establishing a mechanism to spread the risk of high risk employees to all small group insurers.

Various states have, from time to time, proposed and/or enacted changes to the healthcare system that could affect the relationship between health insurers and their customers. For example, Massachusetts law requires all residents to obtain minimum levels of health insurance and requires employers with 11 or more full time employees to pay an assessment if they do not offer health insurance to these employees. Other states have adopted or proposed laws intended to require minimum levels of health insurance for previously uninsured residents, including play or pay laws requiring that employers either offer health insurance or pay a tax to cover the costs of public healthcare insurance. We cannot predict with certainty the effect that the Massachusetts law, or proposed legislation in other states, if adopted, could have on our insurance businesses and operations.

A number of states have enacted other new health insurance legislation over the past several years. These laws, among other things, mandate benefits with respect to certain medical conditions or procedures and require health insurers to offer an independent external review of certain coverage decisions. There has also been an increase in legislation regarding, among other things, prompt payment of claims, privacy of personal health information, health insurer liability, prohibition against insurers including discretionary clauses in their policy forms and relationships between health insurers and providers. We expect that this trend of increased legislation will continue. These laws may have the effect of increasing our costs and expenses.

We provide health insurance products to consumers in the individual and self-employed market. As is the case with many of our competitors in this market, a substantial portion of our products are issued to members of various independent membership associations that act as the master policyholder for such products. During 2004, we and our

insurance company subsidiaries resolved a nationwide class action lawsuit challenging the nature of the relationship between our insurance companies and the membership associations that make available to their members our insurance companies health insurance products. A number of additional lawsuits challenging, among other things, the nature of the relationship between our insurance companies and such membership associations are ongoing. *See* Note 16 of Notes to Consolidated Financial Statements. While we believe that we are providing association group coverage in full compliance with applicable law, changes in our relationship with the membership associations and/or changes in the laws and regulations governing association group insurance (particularly changes

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that would subject the issuance of policies to prior premium rate approval and/or require the issuance of policies on a guaranteed issue basis) could have a material adverse impact on our financial condition and results of operations.

Many states have also enacted insurance holding company laws that require registration and periodic reporting by insurance companies controlled by other corporations. Such laws vary from state to state, but typically require periodic disclosure concerning the corporation that controls the controlled insurer and prior notice to, or approval by, the applicable regulator of inter-corporate transfers of assets and other transactions (including payments of dividends in excess of specified amounts by the controlled insurer) within the holding company system. Such laws often also require the prior approval for the acquisition of a significant ownership interest (i.e., 10% or more) in the insurance holding company. HealthMarkets, Inc. (the holding company) and our insurance subsidiaries are subject to such laws, and we believe that we and such subsidiaries are in compliance in all material respects with all applicable insurance holding company laws and regulations.

Under the risk-based capital initiatives adopted in 1992 by the National Association of Insurance Commissioners (NAIC), insurance companies must calculate and report information under a risk-based capital formula. Risk-based capital formulas are intended to evaluate risks associated with asset quality, adverse insurance experience, losses from asset and liability mismatching, and general business hazards. This information is intended to permit regulators to identify and require remedial action for inadequately capitalized insurance companies, but it is not designed to rank adequately capitalized companies. At December 31, 2008, the risk-based capital ratio of each of our insurance subsidiaries exceeded the ratio for which regulatory corrective action would be required.

The states in which our insurance subsidiaries are licensed have the authority to change the minimum mandated statutory loss ratios to which they are subject, the manner in which these ratios are computed and the manner in which compliance with these ratios is measured and enforced. Loss ratios are commonly defined as incurred claims as a percentage of earned premiums. Most states in which our insurance subsidiaries write insurance have adopted the minimum loss ratios recommended by the NAIC, but frequently these loss ratio regulations do not apply to the types of health insurance issued by our subsidiaries. A number of states are considering the adoption of, or have adopted, laws that would mandate minimum statutory loss ratios, or increase existing minimum statutory loss ratios, for the products we offer. For example, on July 1, 2007, California regulations became effective that require a minimum medical loss ratio of 70% for individual health insurance issued after that date, as well as business issued prior to that date if it is subject to a rate revision. We have filed new products intended to address these California minimum medical loss ratio requirements. Our ability to offer these products is subject to receipt of applicable regulatory approvals, and there can be no assurance that approvals will be received. In the event that we are not in compliance with minimum statutory loss ratios mandated by regulatory authorities with respect to certain policies, we may be required to reduce or refund premiums, which could have a material adverse effect on our financial condition and results of operations.

In 2008, the California legislature passed a bill that would have required health insurers to maintain at least an 85% medical loss ratio across all lines of business by 2011. The bill was vetoed by the Governor, but similar legislation has been proposed in 2009. We believe that such legislation, if passed, would have a disproportionate effect on health insurers primarily offering products to the individual market. A number of other states in which we do business have considered, in legislation or regulation, increasing minimum medical loss ratios. We are unable to predict the impact of (i) any changes in the mandatory statutory loss ratios for individual or group policies to which we may become subject, or (ii) any change in the manner in which these minimums are computed or enforced in the future. Such changes could have a material adverse effect on our financial condition and results of operations by preventing us from doing business in certain states or resulting in a narrowing of profit margins.

The NAIC and state insurance departments are continually reexamining existing laws and regulations, including those related to reducing the risk of insolvency and related accreditation standards. To date, the increase in solvency-related

oversight has not had a significant impact on our insurance business.

State Regulation Financial and Market Conduct Examinations

Our insurance subsidiaries are required to file detailed annual statements with the state insurance regulatory departments and are subject to periodic financial and market conduct examinations by such departments. The

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Oklahoma Insurance Department (the regulator of MEGA s and Chesapeake s domicile state) and the Texas Department of Insurance (the regulator of Mid-West s state of domicile) completed during 2008 the regularly scheduled tri-annual financial exams for the year ended December 31, 2006.

State insurance departments have also periodically conducted and continue to conduct market conduct examinations of HealthMarkets insurance subsidiaries. In March 2005, HealthMarkets received notification that the Market Analysis Working Group of the NAIC had chosen the states of Washington and Alaska to lead a multi-state market conduct examination of HealthMarkets principal insurance subsidiaries (the Insurance Subsidiaries) for the examination period January 1, 2000 through December 31, 2005. The examiners issued a final examination report on December 20, 2007. *See* Note 16 of Notes to Consolidated Financial Statements.

The findings of the final examination report cite deficiencies in five major areas of operation: (i) insufficient training of agents and lack of oversight of agent activities, (ii) deficient claims handling practices, (iii) insufficient disclosure of the relationship with affiliates and the membership associations, (iv) deficient handling of complaints and grievances, and (v) failure to maintain a formal corporate compliance plan and centralized corporate compliance department.

In connection with the issuance of the final examination report, the Washington Office of Insurance Commissioner issued an order adopting the findings of the final examination report and ordering the Insurance Subsidiaries to comply with certain required actions set forth in the report. As part of the order, the Insurance Subsidiaries were required to file a detailed report specifying the business reforms, improvements and changes to policies and procedures implemented by the Insurance Subsidiaries as of March 20, 2008. This report was sent to all jurisdictions on March 28, 2008.

On May 29, 2008, the Insurance Subsidiaries entered into a regulatory settlement agreement (RSA) with the states of Washington and Alaska, as lead regulators, and three other monitoring states. Thereafter, all states (other than Massachusetts and Delaware) and the District of Columbia, Puerto Rico and Guam signed the RSA, which became effective on August 15, 2008. In connection with the RSA, the Insurance Subsidiaries paid a penalty of $20 million. The RSA includes standards for performance measurement for 13 different required actions which must be implemented on or before December 31, 2009. The Insurance Subsidiaries timely filed semi-annual reports on November 14, 2008 and February 13, 2009. On or before July 1, 2010, the monitoring states will initiate a re-examination to assess the standard for performance measurement. If the re-examination is unfavorable, the Insurance Subsidiaries are subject to additional penalties of up to $10 million.

As reported in Note 16 of the Notes to Consolidated Financial Statements, the Insurance Subsidiaries were subject to a number of other market conduct examinations or proceedings during 2008. In addition, the Insurance Subsidiaries are subject to various other pending market conduct and other regulatory examinations, inquiries or proceedings arising in the ordinary course of business. State insurance regulatory agencies have authority to levy monetary fines and penalties resulting from findings made during the course of such matters. Historically, our insurance subsidiaries have, from time to time, been subject to such fines and penalties, none of which, individually or in the aggregate, have had a material adverse effect on our financial condition and results of operations. However, the multi-state examination and other regulatory examinations, inquiries or proceedings could result in, among other things, changes in business practices that require the Company to incur substantial costs. Such results, singly or in combination, could injure our reputation, cause negative publicity, adversely affect our debt and financial strength ratings, place us at a competitive disadvantage in marketing or administering our products, or impair our ability to sell or retain insurance policies, thereby adversely affecting our business, and potentially materially adversely affecting the results of operations in a period, depending on the results of operations for the particular period. Determination by regulatory authorities that we have engaged in improper conduct could also adversely affect our defense of various lawsuits.

Federal Regulation

In 1945, the U.S. Congress enacted the McCarran-Ferguson Act, which declared the regulation of insurance to be primarily the responsibility of the individual states. Although repeal of McCarran-Ferguson is debated in the U.S. Congress from time to time, the federal government generally does not directly regulate the insurance business. However, federal legislation and administrative policies in several areas, including healthcare (including Medicare),

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pension regulation, age and sex discrimination, financial services regulation, securities regulation, privacy laws, terrorism and federal taxation, do affect the insurance business.

Privacy Regulations

The use, disclosure and secure handling of individually identifiable health information by our business is subject to federal regulations, including the privacy provisions of the federal Gramm-Leach-Bliley Act and the privacy and security regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, our privacy and security practices are subject to various state law and regulations.

HIPAA includes requirements for maintaining the confidentiality and security of individually identifiable health information and new standards for electronic healthcare transactions. The Department of Health and Human Services promulgated final HIPAA regulations in 2002. The privacy regulations required compliance by April 2003, the electronic transactions regulations by October 2003, and the security regulations by April 2005. As have other entities in the healthcare industry, we have incurred substantial costs in meeting the requirements of these HIPAA regulations and expect to continue to incur costs to maintain compliance. We have worked diligently to comply with these regulations within the time periods required and believe that we have complied.

HIPAA also requires certain guaranteed issuance and renewability of health insurance coverage for individuals and small employer groups (generally 50 or fewer employees) and limits exclusions based on pre-existing conditions.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) was enacted into law on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009. The HITECH Act contains a number of provisions that significantly expand the reach of HIPAA. For example, the law imposes varying civil monetary penalties and creates a private cause of action for HIPAA violations, extends HIPAA s security provisions to business associates, and creates new security breach notification requirements. We may incur significant costs in implementing the policies and systems required to comply with these new requirements.

HIPAA and other federal and state privacy regulations continue to evolve as a result of new legislation, regulations and judicial and administrative interpretations. Consequently, our efforts to measure, monitor and adjust our business practices to comply with these requirements are ongoing. Failure to comply could result in regulatory fines and civil lawsuits. Knowing and intentional violations of these rules may also result in federal criminal penalties.

CAN SPAM Act and Do Not Call Regulations

From time to time, the Company utilizes, either directly or through third party vendors, e-mail and telephone calls to identify prospective sales leads for use by our agents. The federal CAN SPAM Act, which became effective January 1, 2004 and is administered and enforced by the Federal Trade Commission, establishes national standards for sending bulk, unsolicited commercial e-mail. While targeting and prohibiting e-marketers to send unsolicited commercial e-mail with falsified headers, the CAN SPAM Act permits the use of unsolicited commercial e-mail if and as long as the message contains an opt-out mechanism, a functioning return e-mail address, a valid subject line indicating the e-mail is an advertisement and the legitimate physical address of the mailer. The Company is also required to comply with federal Do Not Call regulations, which require insurance companies to develop their own do not call lists and reference state and federal do not call registries before making calls to market insurance products.

While the Company has taken what it believes are reasonable steps to ensure that it, and the various third party vendors with which it does business, are in full compliance with these requirements, failure to comply could result in regulatory fines and civil lawsuits.

USA PATRIOT Act

On October 26, 2001, the International Money Laundering Abatement and Anti-Terrorist Financing Act of 2001 was enacted into law as part of the USA PATRIOT Act. The law requires, among other things, that financial institutions adopt anti-money laundering programs that include policies, procedures and controls to detect and

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prevent money laundering, designate a compliance officer to oversee the program and provide for employee training, and periodic audits in accordance with regulations proposed by the U.S. Treasury Department. The Office of Federal Asset Control requirements prohibit business dealings with entities identified as threats to national security. We have licensed software designed to help maintain compliance with these requirements and we continually evaluate our policies and procedures to comply with these regulations.

Employee Retirement Income Security Act of 1974

The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how goods and services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations subject to periodic interpretation by the United Stated Department of Labor (DOL) as well as the federal courts. ERISA places controls on how our insurance subsidiaries may do business with employers who sponsor employee health benefit plans. We believe that many of our products are not subject to ERISA because they are offered to and used by individuals, self-employed persons or employers with less than two participants who are employees as of the start of any plan year. However, some of our products or services may be subject to the ERISA regulations. During 2005 and 2006, we received inquiries from the Boston and Dallas offices of the DOL that alleged, among other things, that certain policy forms in use by our insurance subsidiaries are not ERISA compliant. The Company has resolved this matter with DOL on terms that did not have a material adverse effect on the Company s financial condition and results of operations.

Medicare

Medicare is a complex and highly regulated federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital and medical insurance benefits. During 2008, our Chesapeake subsidiary issued Medicare Advantage Private-Fee-for-Service Plans to Medicare beneficiaries under a contract with CMS. CMS performs audits of each health plan operating under a Medicare contract to determine the plan s compliance with federal regulations and contractual obligations. These audits include review of the plan s administration and management, including marketing, enrollment and disenrollment activities, claims processing and complaint systems and management information and data collection systems. CMS regulations also require submission of annual financial statements. Chesapeake terminated its agreement with CMS effective December 31, 2008, which resulted in the Company s exit from the Medicare market.

Legislative Developments

The federal and state governments continue to consider legislative and regulatory proposals that could materially impact health insurance companies and various aspects of the current health care system, including, among other things, modifications to the existing employer-based insurance system, a quasi-regulated system of *managed competition* among health insurers and a single-payer, public program in which the government would oversee or manage the provision of health insurance coverage. Many of these proposals attempt to reduce the number of uninsured by increasing affordability and expanding access to health insurance, including proposals intended to expand eligibility for public programs and compel individuals and employers to purchase health insurance coverage. As discussed above, Massachusetts has enacted an individual health coverage mandate, and a number of other states are considering similar significant reforms In November of 2008, America s Health Insurance Plans (AHIP , a health insurance trade association) endorsed the concept of universal health insurance coverage through an individual mandate and guarantee issue coverage with no pre-existing condition exclusions. In addition, a number of states, including California, are considering legislation that would require health insurers to maintain a minimum medical loss ratio across all lines of business (in the case of California 85%). We believe that such legislation, if passed, would have a disproportionate effect on health insurers primarily offering products to the individual market and could have a material adverse effect on our business.

Some of the more significant legislative and regulatory developments that could potentially affect our business include the following:

Requiring employers to provide health insurance to employees;

Requiring individuals to purchase health insurance coverage;

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Establishing a minimum level of coverage required to satisfy health insurance mandates;

Creating an exchange or other government entity to distribute insurance coverage;

Establishing the federal government as a single payer;

Allowing individuals and/or the self-employed to collectively purchase health insurance coverage without any other affiliations;

Restricting the ability of health insurers to offer coverage under the association group model;

Guarantee issue requirements and restricting the ability of health insurers to assess the risk of applicant s based on health status;

Mandating coverage of certain conditions or specified procedures, drugs and devices;

Standardizing individual health insurance so as to restrict the ability of health insurers to significantly vary coverage, including the health care services considered to be covered or excluded, deductible and cost-sharing levels and coverage limits;

Restricting the ability of health insurers to rescind coverage based on applicant s misrepresentations or omissions; and

Extending malpractice and other liability exposure for decisions made by health insurers.

We expect the trend of increased legislative activity concerning health care reform to continue and cannot predict with certainty the effect that such proposals, if adopted, could have on our health insurance business and operations. Changes in health care policy could significantly affect our business. For example, federally mandated, comprehensive major medical insurance, if proposed and implemented, could partially or fully replace some of our current products. Many of the proposals, if adopted, could have a material adverse effect on our financial condition and results of operations.

Employees

We had approximately 1,450 employees at December 31, 2008. In connection with the sale of our Life Insurance Division, on September 30, 2008, approximately 170 employees separated from employment with the Company. On November 18, 2008, the Company implemented a strategic reduction of its remaining workforce designed to increase administrative efficiencies and better align the workforce to support the Company s business strategy going forward. The reduction affected approximately 13% of the Company s workforce or a total of approximately 225 employees and was substantially completed by December 31, 2008. We believe that the Company s relations with current employees are generally good. The agents within our dedicated agency field force are independent contractors of our insurance subsidiaries and are not employees of the Company.

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Executive Officers of the Company

The Chairman of the Company and all other executive officers listed below are elected by the Board of Directors of the Company at its Annual Meeting each year to hold office until the next Annual Meeting or until their successors are elected or appointed. None of these officers have family relationships with any other executive officer or director.

Name of Officer	Principal Position	Age	Business Experience During Past Five Years
Phillip J. Hildebrand	Director, President and Chief Executive Officer	56	Mr. Hildebrand has served as a Director and CEO of HealthMarkets, Inc. since June 2008 and as President since September 2008. He also serves as a Director, Chairman, President and Chief Executive Officer of the Company s insurance subsidiaries. Prior to joining the Company, from 1975 to 2006, Mr. Hildebrand held several senior management positions with New York Life Insurance Company before retiring in 2006 as Vice Chairman of the Board of Directors. Mr. Hildebrand currently serves as a Director of DJO Incorporated and previously served as a Director of New York Life subsidiaries in Hong Kong and Taiwan and of MacKay Shields - an institutional investment manager. He is also a past Director of the Million Dollar Round Table Foundation and LIMRA International.
Steven P. Erwin	Executive Vice President and Chief Financial Officer	65	Mr. Erwin joined the Company in September 2008 as Executive Vice President and Chief Financial Officer. He currently serves as a Director, Executive Vice President and Chief Financial Officer of the Company s insurance subsidiaries. Prior to joining the Company, he served as Senior Vice President and Chief Financial Officer for 21st Century Insurance Group, a direct-to-consumer auto insurance company, from 2006 to 2007. Mr. Erwin was Principal for Interim CFO Resources from 2002 to 2006. Prior to that, Mr. Erwin served as Executive Vice President and CFO of Health Net, Inc. from 1998 to 2002.
Anurag Chandra	Executive Vice President and Chief Administrative Officer	31	Mr. Chandra has served as Executive Vice President and Chief Administrative Officer of the Company since October 2008. He also serves as a Director, Executive Vice President and Chief Administrative Officer of the Company s insurance subsidiaries. Prior to joining the Company, Mr. Chandra served as an executive of Aquiline Capital Partners, a global financial services focused private equity firm, from 2006 to 2008. Prior to that, Mr. Chandra served as Senior Vice President of Gartmore Global Investments, Inc. and as Vice President of Nationwide Financial Services, Inc. financial services subsidiaries of Nationwide Mutual Insurance Company -

			from 2005 to 2006. Mr. Chandra served as Vice President, Operations, of Bankers Life and Casualty Company, a subsidiary of Conseco, Inc., from 2002 to 2005.
B. Curtis Westen	Executive Vice President and General Counsel	48	Mr. Westen has served as Executive Vice President and General Counsel of the Company since January 2009. He also serves as a Director, Executive Vice President and General Counsel of the Company s insurance subsidiaries. Prior to joining the Company, Mr. Westen served as Senior Vice President and Special Counsel of Health Net, Inc. from February 2007 to July 2007 and as Senior Vice President, General Counsel and Secretary of Health Net, Inc. and its predecessors from 1992 to February 2007.

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Name of Officer	Principal Position	Age	Business Experience During Past Five Years
Vicki A. Cansler	Senior Vice President, Human Resources	54	Ms. Cansler has served as Senior Vice President, Human Resources since May 2008. She also serves as Senior Vice President, Human Resources of The MEGA Life and Health Insurance Company. Prior to joining the Company, Ms. Cansler served as Senior Vice President of People Services at Blue Cross Blue Shield of Tennessee in Chattanooga from 2005 to 2008. Ms. Cansler served as Principal, Global Director of Human Resources, for Booz, Allen & Hamilton in the Washington D.C. area from 2003 to 2005.
Anthony M. Garcia	Senior Vice President, Agency	45	Mr. Garcia has served as Senior Vice President, Agency, of the Company since November 2008 and is responsible for all administrative operations within the HealthMarkets Agency Department. Mr. Garcia also serves as a Vice President of the Company s insurance subsidiaries. Earlier in 2008, he served as President of Cornerstone America (a division of Mid-West National Life Insurance Company of Tennessee). Mr. Garcia served as President of the HealthMarkets Administrative Services Group from 2005 to 2008 and as President of UGA-Association Field Services (a division of The MEGA Life and Health Insurance Company) from 2004 to 2005. Prior to joining the Company, Mr. Garcia served in senior strategy, operations and general management positions at Household International/HSBC from 1999 to 2004.
Jack V. Heller	Senior Vice President, Agency	47	Mr. Heller has served as Senior Vice President, Agency, of the Company since November 2008 and is responsible for all field operations within the HealthMarkets Agency Department. Mr. Heller also serves as a Vice President of the Company s insurance subsidiaries. Earlier in 2008, he served as President of UGA - Association Field Services (a division of The MEGA Life and Health Insurance Company). Prior to joining the Company, he served for 11 years as a Regional Sales Leader for UGA.
Timothy J. Roach	Senior Vice President and Chief Marketing Officer	49	Mr. Roach joined the Company in August 2008 and serves as Senior Vice President and Chief Marketing Officer of the Company and its insurance subsidiaries. Prior to joining the Company, Mr. Roach served as the Chief Marketing Officer for Secure Horizons, the Medicare Advantage business within UnitedHealth Group, from 2007 to 2008. Prior to that, Mr. Roach served as Vice President of International Marketing and General Manager, Americas, for Ernest & Julio Gallo Winery from 2004 to 2006. Mr. Roach served in a

number of management and marketing roles at S.C. Johnson & Sons from 1996 to 2004.

Item 1A. ***Risk Factors***

The following factors could impact our business and financial prospects:

We may lose business to competitors offering competitive products at lower prices.

We compete, and will continue to compete, for customers and distributors with many insurance companies and other financial services companies. We compete not only for the business of customers, but also for agents and distribution relationships. Our competitors may offer a broader array of products than we do, have a greater diversity of distribution resources, have better brand recognition, have more competitive pricing or have higher financial strength or claims paying ratings. Competitors with sizable market share or provider-owned plans may be able to obtain favorable financial arrangements from healthcare providers that are not available to us.

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Failure to accurately estimate medical claims and healthcare costs may have a significant impact on our financial condition and results of operations.

If we are unable to accurately estimate medical claims and control healthcare costs, our results of operations may be materially and adversely affected. We estimate the cost of future medical claims and other expenses using actuarial methods based upon historical data, medical inflation, product mix, seasonality, utilization of healthcare services and other relevant factors. We establish premiums based on these methods. The premiums we charge our customers generally are fixed for six-month or one-year periods, and costs we incur in excess of our medical claim projections generally are not recovered in the contract year through higher premiums.

Failure to comply with extensive state and federal regulations could subject us to fines, penalties and suspensions, which could have a material adverse effect on our financial condition and results of operations.

We are subject to extensive governmental regulation and supervision. *See* Item 1. Business Regulatory and Legislative Matters for additional information. Most insurance regulations are designed to protect the interests of policyholders rather than stockholders and other investors. This regulation, generally administered by a department of insurance in each state in which we do business, relates to, among other things:

licensing of insurers and their agents;

sales and marketing practices;

training and oversight of agents;

handling of consumer complaints and grievances;

approval of policy forms and premium rates;

standards of solvency, including risk-based capital measurements, which are a measure developed by the National Association of Insurance Commissioners and used by state insurance regulators to identify insurance companies that potentially are inadequately capitalized;

restrictions on the nature, quality and concentration of investments;

restrictions on transactions between insurance companies and their affiliates;

restrictions on the size of risks insurable under a single policy;

requiring deposits for the benefit of policyholders;

requiring certain methods of accounting;

prescribing the form and content of records of financial condition required to be filed; and

requiring reserves for losses and other purposes.

State insurance departments also conduct periodic examinations of the affairs of insurance companies through, among other things, financial and market conduct examinations, and require the filing of annual and other reports relating to the financial condition of insurance companies, holding company issues and other matters. Regulatory agencies have

imposed substantial fines against us in the past, and may impose substantial fines against us in the future if they determine that we have not complied with applicable laws and regulations. *See* Note 16 to Notes to Consolidated Financial Statements.

There is also substantial federal regulation of our business. Laws and regulations adopted by the federal government, including the Sarbanes-Oxley Act of 2002, the Gramm-Leach-Bliley Act, HIPAA, the USA PATRIOT Act and Do Not Call regulations, establish administrative and compliance requirements applicable to the Company.

Our business depends on compliance with applicable laws and regulations and our ability to maintain valid licenses and approvals for our operations. Regulatory authorities have broad discretion to grant, renew or revoke licenses and approvals. Regulatory authorities may deny or revoke licenses for various reasons, including the violation of regulations. In some instances, we follow practices based on our interpretations of regulations, or those that we believe to be generally followed by the industry, which may be different from the requirements or

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interpretations of regulatory authorities. If we do not have the requisite licenses and approvals and do not comply with applicable regulatory requirements, the insurance regulatory authorities could preclude or temporarily suspend us from carrying on some or all of our activities or otherwise penalize us. That type of action could have a material adverse effect on our business. Our failure to comply with new or existing government regulation could subject us to significant fines and penalties. Our efforts to measure, monitor and adjust our business practices to comply with current laws are ongoing. Failure to comply with enacted regulations could result in significant fines, penalties or the loss of one or more of our licenses.

Changes in government regulation could increase the costs of compliance or cause us to discontinue marketing our products in certain states.

We conduct business in a heavily regulated industry. *See* Item 1. Business Regulatory and Legislative Matters for additional information. Changes in the level of government regulation or in the laws and regulations themselves could increase the costs of compliance and result in significant changes to our operations, including potentially causing us to discontinue marketing our products in certain states. Such changes could have a material adverse effect on our financial condition and results of operations.

The new Presidential administration and members of Congress have indicated that they intend to enact federal health care reform measures in the near future. Many of these proposals attempt to reduce the number of uninsured by increasing affordability and expanding access to health insurance, including proposals intended to expand eligibility for public programs and compel individuals and employers to purchase health insurance coverage. Certain of these proposals, if implemented, could partially or fully replace some of our current products.

In addition, a number of states in which we do business are considering legislation intended to increase affordability or expand coverage of the uninsured. For example, in 2008, the California legislature passed a bill that would have required health insurers to maintain at least an 85% medical loss ratio across all lines of business by 2011. The bill was vetoed by the Governor, but similar legislation has been proposed in 2009. We believe that such legislation, if passed, would have a disproportionate effect on health insurers primarily offering products to the individual market and could have a material adverse effect on our business, including causing us to discontinue marketing our products in states where such legislation is passed.

Some of the more significant additional legislative and regulatory developments that could potentially affect our business include the following:

Requiring employers to provide health insurance to employees;

Requiring individuals to purchase health insurance coverage;

Establishing a minimum level of coverage required to satisfy health insurance mandates;

Creating an exchange or other government entity to distribute insurance coverage;

Establishing the federal government as a single payer;

Allowing individuals and/or the self-employed to collectively purchase health insurance coverage without any other affiliations;

Restricting the ability of health insurers to offer coverage under the association group model;

Guarantee issue requirements and restricting the ability of health insurers to assess the risk of applicant s based on health status;

Mandating coverage of certain conditions or specified procedures, drugs and devices;

Standardizing individual health insurance so as to restrict the ability of health insurers to significantly vary coverage, including the health care services considered to be covered or excluded, deductible and cost-sharing levels and coverage limits;

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Restricting the ability of health insurers to rescind coverage based on applicant s misrepresentations or omissions; and

Extending malpractice and other liability exposure for decisions made by health insurers.

We expect the trend of increased legislative activity concerning health care reform to continue and cannot predict with certainty the effect that such proposals, if adopted, could have on our health insurance business and operations. Changes in health care policy could significantly affect our business. Many of the proposals, if adopted, could have a material adverse effect on our financial condition and results of operations.

We must comply with restrictions on customer privacy and information security, including taking steps to ensure compliance by our business associates with HIPAA.

The use, disclosure and secure handling of individually identifiable health information by our business is subject to federal regulations, including the privacy provisions of the federal Gramm-Leach-Bliley Act and the privacy and security regulations promulgated under HIPAA. *See* Item 1. Business Regulatory and Legislative Matters for additional information. The HIPAA regulations establish significant criminal penalties and civil sanctions for non-compliance. Our privacy and security practices are also subject to various state laws and regulations. The HIPAA regulations require, among other things, that we enter into specific written agreements with business associates to whom individually identifiable health information is disclosed. Although our contracts with business associates provide for appropriate protections of such information, we may have limited control over the actions and practices of our business associates. Compliance with HIPAA and other state and federal privacy and security regulations have required us to implement changes in our programs and systems to maintain compliance and may in the future result in significant expenditures due to necessary systems changes, the development of new administrative processes and the effects of potential noncompliance by our business associates.

Failure to comply with the terms of the regulatory settlement agreement arising out of the multi-state market conduct examination of our principal insurance subsidiaries could have a material adverse effect on our financial condition and results of operations.

In March 2005, we received notification that the Market Analysis Working Group of the NAIC had chosen the states of Washington and Alaska to lead a multi-state market conduct examination of our principal insurance subsidiaries, MEGA, Mid-West and Chesapeake (the Insurance Subsidiaries). On May 29, 2008, the Insurance Subsidiaries entered into a regulatory settlement agreement (RSA) with the states of Washington and Alaska, as lead regulators, and three other monitoring states. Thereafter, all states (other than Massachusetts and Delaware) and the District of Columbia, Puerto Rico and Guam signed the RSA, which became effective on August 15, 2008. In connection with the RSA, the Insurance Subsidiaries paid a penalty of $20 million. The RSA includes standards for performance measurement for 13 different required actions which must be implemented on or before December 31, 2009. The Insurance Subsidiaries timely filed semi-annual reports on November 14, 2008 and February 13, 2009. On or before July 1, 2010, the monitoring states will initiate a re-examination to assess the standard for performance measurement. If the re-examination is unfavorable, the Insurance Subsidiaries are subject to additional penalties of up to $10 million. *See* Note 16 of Notes to Consolidated Financial Statements.

The Company s insurance subsidiaries are subject to various other pending market conduct and other regulatory examinations, inquiries or proceedings arising in the ordinary course of business. State insurance regulatory agencies have authority to levy significant fines and penalties and require remedial action resulting from findings made during the course of such matters. Market conduct or other regulatory examinations, inquiries or proceedings could result in, among other things, changes in business practices that require the Company to incur substantial costs. Such results,

singly or in combination, could injure our reputation, cause negative publicity, adversely affect our debt and financial strength ratings, place us at a competitive disadvantage in marketing or administering our products or impair our ability to sell or retain insurance policies, thereby adversely affecting our business, and potentially materially adversely affecting the results of operations in a period, depending on the results of operations for the particular period. Determination by regulatory authorities that we have engaged in improper conduct could also adversely affect our defense of various lawsuits.

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Changes in our relationship with membership associations that make available to their members our health insurance products and/or changes in the laws and regulations governing so-called association group insurance could have a material adverse effect on our financial condition and results of operations.

As is the case with many of our competitors in the self-employed market, a substantial portion of our health insurance products are issued to members of various independent membership associations that act as the master policyholder for such products. The two principal membership associations in the self-employed market that make available to their members our health insurance products are the National Association for the Self-Employed and the Alliance for Affordable Services. The associations provide their members access to a number of benefits and products, including health insurance underwritten by us. Subject to applicable state law, individuals generally may not obtain insurance under an association s master policy unless they are also members of the association. The agreements with these associations requiring the associations to continue as the master policyholder for our policies and to make our products available to their respective members are terminable by us or the association upon not less than one year s advance notice to the other party. A termination of our agreements with these associations would be fundamentally disruptive to our marketing efforts. We would be unable to offer products through the association master policy and, in certain states, could be required to seek approval of new policy forms and premium rates before resuming marketing efforts. In the event of a termination, the associations could market alternative health insurance products to their association members.

The independent agents within our dedicated agency field force also act as field service representatives (FSRs) for the associations. In this capacity, the FSRs enroll new association members and provide membership retention services. For such services, we and the FSRs receive compensation. One of our subsidiaries, HealthMarkets Lead Marketing Group, Inc., serves as our direct marketing group and generates new membership sales prospect leads for use by the FSRs. HealthMarkets Lead Marketing Group also provides video and print services to the associations. In addition to health insurance premiums derived from the sale of health insurance, we receive fee income from the associations, including fees associated with enrollment and member retention services, fees for association membership marketing and administrative services and fees for certain association member benefits.

While we believe that we are providing association group coverage in full compliance with applicable law, changes in our relationship with the membership associations and/or changes in the laws and regulations governing so-called association group insurance, particularly changes that would subject the issuance of policies to prior premium rate approval and/or require the issuance of policies on a guaranteed issue basis, could have a material adverse impact on our financial condition and results of operations.

Negative publicity regarding our business practices and about the health insurance industry in general may harm our business and could have a material adverse effect on our financial condition and results of operations.

The health and life insurance industry and related products and services we provide attracts negative publicity from consumer advocate groups and the media. Negative publicity regarding the industry generally or our Company in particular may result in increased regulation and legislative scrutiny as well as increased litigation, which may further increase our costs of doing business and adversely affect our profitability by impeding our ability to market our products and services, requiring us to change our products or services or increasing the regulatory burdens under which we operate.

Our failure to secure and enhance cost-effective healthcare provider network contracts may result in a loss of insureds and/or higher medical costs and could have a material adverse effect on our financial condition and results of operations.

Our results of operations and competitive position could be adversely affected by our inability to enter into or maintain satisfactory relationships with networks of hospitals, physicians, dentists, pharmacies and other healthcare providers. The failure to secure cost-effective healthcare provider network contracts, the inability to maintain rental access to health care provider networks, or the refusal of health care providers to honor the discounts obtained through such networks, may result in a loss of insureds or higher medical costs. In addition, the inability to

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contract with provider networks, the inability to terminate contracts with existing provider networks and enter into arrangements with new provider networks to serve the same market, and/or the inability of providers to provide adequate care, could have a material adverse effect on our financial condition and results of operations.

HealthMarkets inability to obtain funds from its insurance subsidiaries may cause it to experience reduced cash flow, which could affect the Company s ability to pay its obligations to creditors as they become due.

We are a holding company, and our principal assets are our investments in our separate operating subsidiaries, including our regulated insurance subsidiaries. Our ability to fund our cash requirements is largely dependent upon our ability to access cash from our subsidiaries. Our insurance subsidiaries are subject to regulations that limit their ability to transfer funds to us. We have a significant amount of debt outstanding that contains restrictive covenants. If we are unable to obtain funds from our insurance subsidiaries, we will experience reduced cash flow, which could affect our ability to pay our obligations to creditors as they become due.

Current unfavorable economic conditions could adversely affect our business.

General economic, financial market and political conditions could have a material adverse effect on our financial condition and results of operations. Recently, concerns over inflation, energy costs, geopolitical issues, the availability and cost of credit, the global mortgage market, a declining global real estate market, and the loss of consumer confidence and a reduction in consumer spending have contributed to increased volatility and diminished expectations for the economy and the markets going forward. These market conditions expose us to a number of risks, including risks associated with the potential financial instability of our customers. If our customer base experiences cash flow problems and other financial difficulties, it could, in turn, adversely impact the sale of our insurance products. For example, our customers may modify, delay or cancel plans to purchase our products, or may choose to reduce the level of coverage purchased from us. In addition, if our customers experience financial issues, they may not be able to pay, or may delay payment of, accounts receivable that are owed to us. Further, our customers or potential customers may force us to compete more vigorously on factors such as price and service to retain or obtain their business. A significant decline in the sale of our products and the inability of current and/or potential customers to pay their premiums as a result of unfavorable economic conditions may adversely affect our business, including our revenues, profitability and cash flow. In addition, general inflationary pressures may affect the costs of health care, increasing the costs of paying claims.

In addition, we are subject to extensive laws and regulations that are administered and enforced by a number of different governmental authorities, including, but not limited to, state insurance regulators, the U.S. Securities and Exchange Commission and state attorneys general. In light of the difficult economic conditions, some of these authorities are considering or may in the future consider enhanced or new regulatory requirements intended to prevent future crises or to otherwise assure the stability of institutions under their supervision. These authorities may also seek to exercise their supervisory or enforcement authority in new or more robust ways. All of these possibilities, if they occurred, could affect the way we conduct our business and manage our capital, either of which in turn could have a material adverse effect on our financial condition and results of operations.

The value of our investments is influenced by varying economic and market conditions and a decrease in value could have an adverse effect on our financial condition and results of operations and liquidity.

Our investment portfolio is comprised primarily of investments classified as securities available for sale. The fair value of our available for sale securities was $805.2 million and represented approximately 42% of our total consolidated assets at December 31, 2008. These investments are carried at fair value, and the unrealized gains or losses are included in accumulated other comprehensive loss as a separate component of shareholders equity, unless the decline in value is deemed to be other than temporary. For our available for sale investments, if a decline in value

is deemed to be other than temporary, the security is deemed to be other than temporarily impaired and it is written down to fair value and the loss is recorded as an expense in earnings. In accordance with applicable accounting standards, we review our investment securities to determine if declines in fair value below cost are other than temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis (or more frequently if certain indicators arise), using both quantitative and qualitative factors, to

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determine whether a decline in value is other than temporary. In its review, management considers the following indicators of impairment: fair value significantly below cost; decline in fair value attributable to specific adverse conditions affecting a particular investment; decline in fair value attributable to specific conditions, such as conditions in an industry or in a geographic area; decline in fair value for an extended period of time; downgrades by rating agencies from investment grade to non-investment grade; financial condition deterioration of the issuer and situations where dividends have been reduced or eliminated or scheduled interest payments have not been made.

The current economic environment and recent volatility of the securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. During the year ended December 31, 2008, we recorded $26.0 million of charges for other than temporary impairment of securities. Given the current volatile market conditions and the significant judgments involved, there is continuing risk that further declines in fair value may occur and material other than temporary impairments may result in realized losses in future periods which could have a material adverse effect on our financial condition and results of operations.

Adverse securities and credit market conditions could have a material adverse affect on our liquidity or our ability to obtain credit on acceptable terms.

The securities and credit markets have been experiencing extreme volatility and disruption. In some cases, the markets have exerted downward pressure on the availability of liquidity and credit capacity for certain issuers. We need liquidity to make payments for benefits, claims and commissions, service the Company s debt obligations and pay operating expenses. Our primary sources of cash on a consolidated basis have been premium revenue from policies issued, investment income, and fees and other income. In the event we need access to additional capital to pay our operating expenses, make payments on our indebtedness, pay capital expenditures or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant. Our access to additional financing will depend on a variety of factors such as market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, as well as the possibility that customers or lenders could develop a negative perception of our long- or short-term financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and, in such case, we may not be able to successfully obtain additional financing on favorable terms.

Failure of our insurance subsidiaries to maintain their current insurance ratings could have a material adverse effect on our financial condition and results of operations.

Our principal insurance subsidiaries are currently rated by A.M. Best, Fitch and S&P and experienced downgrades in financial strength ratings during 2008. These ratings are subject to periodic review by the ratings agencies and there can be no assurances that we will be able to maintain these current ratings. A downward adjustment in rating by A.M. Best, Fitch and/or S&P of our insurance subsidiaries could have a material adverse effect on our financial condition and results of operations. If our ratings are lowered from their current levels, our competitive position could be materially adversely affected and it could be more difficult for us to market our products. Rating agencies may take action to lower our ratings in the future due to, among other things, perceived concerns about our liquidity or solvency, the competitive environment in the insurance industry, which may adversely affect our revenues, the inherent uncertainty in determining reserves for future claims, which may cause us to increase our reserves for claims, the outcome of pending litigation and regulatory investigations, which may adversely affect our financial position and reputation and possible changes in the methodology or criteria applied by the rating agencies. In addition, rating agencies have come under recent scrutiny over their ratings practices and could, as a result, become more conservative in their methodology and criteria, which could adversely affect our ratings. Finally, rating agencies or regulators could increase capital requirements for the Company or its subsidiaries which in turn, could negatively affect our financial position as well.

We may not have enough statutory capital and surplus to continue to write business.

Our continued ability to write business is dependent on maintaining adequate levels of statutory capital and surplus to support the policies we write. Our new business writing typically results in net losses on a statutory basis

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during the early years of a policy. The resulting reduction in statutory surplus, or surplus strain, limits our ability to seek new business due to statutory restrictions on premium to surplus ratios and statutory surplus requirements. If we cannot generate sufficient statutory surplus to maintain minimum statutory requirements through increased statutory profitability, reinsurance or other capital generating alternatives, we will be limited in our ability to realize additional premium revenue from new business writing, which could have a material adverse effect on our financial condition and results of operations or, in the event that our statutory surplus is not sufficient to meet minimum premium to surplus and risk-based capital ratios in any state, we could be prohibited from writing new policies in such state.

Our reserves for current and future claims may be inadequate and any increase to such reserves could have a material adverse effect on our financial condition and results of operations.

We calculate and maintain reserves for current and future claims using assumptions about numerous variables, including our estimate of the probability of a policyholder making a claim, the severity and duration of such claim, the mortality rate of our policyholders, the persistency or renewal of our policies in force and the amount of interest we expect to earn from the investment of premiums. The adequacy of our reserves depends on the accuracy of our assumptions. We cannot assure you that our actual experience will not differ from the assumptions used in the establishment of reserves. Any variance from these assumptions could have a material adverse effect on our financial condition and results of operations.

Litigation or settlements thereof may result in financial losses or harm our reputation and may divert management resources.

Current and future litigation with private parties or governmental authorities may result in financial losses, harm our reputation and require the dedication of significant management resources. We are regularly involved in litigation. The litigation naming us as a defendant ordinarily involves our activities as an insurer. In recent years, many insurance companies, including us, have been named as defendants in class actions relating to market conduct or sales practices.

For our general claim litigation, we establish reserves based on experience to satisfy judgments and settlements in the normal course. Management expects that the ultimate liability, if any, with respect to general claim litigation, after consideration of the reserves maintained, will not be material to the consolidated financial condition of the Company. Nevertheless, given the inherent unpredictability of litigation, it is possible that an adverse outcome in certain claim litigation involving punitive damages could, from time to time, have a material adverse effect on our consolidated results of operations in a period, depending on the results of our operations for the particular period.

Given the expense and inherent risks and uncertainties of litigation, we regularly evaluate litigation matters pending against us, including those described in Note 16 of Notes to Consolidated Financial Statements, to determine if settlement of such matters would be in the best interests of the Company and its stockholders. The costs associated with any such settlement could be substantial and, in certain cases, could result in an earnings charge in any particular quarter in which we enter into a settlement agreement. Although we have recorded litigation reserves which represent our best estimate on probable losses, our recorded reserves might prove to be inadequate to cover an adverse result or settlement for extraordinary matters. Therefore, costs associated with the various litigation matters to which we are subject and any earnings charge recorded in connection with a settlement agreement could have a material adverse effect on our consolidated results of operations in a period, depending on the results of our operations for the particular period.

Changes in our relationship with the agents who sell our products resulting from Fair Labor Standards Act litigation could require us to revise our business practices.

HealthMarkets is a party to actions filed under the Fair Labor Standards Act (FLSA) in which plaintiffs (consisting of former district sales leaders and regional sales leaders in the Cornerstone America independent agent hierarchy) allege that that they were employees within the meaning of the FLSA and are therefore entitled to recover unpaid overtime wages under the terms of the FLSA. In October 2008, the United States Fifth Circuit Court of Appeals affirmed the trial court s ruling in favor of plaintiffs on the issue of their status as employees under the

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FLSA and remanded the case to the trial court for further proceedings. *See* Note 16 of Notes to Consolidated Financial Statements. As a result of this ruling, the Company is in the process of evaluating various changes in its relationship with agents, including the structure of its sales force and the manner in which we contract, communicate and interact with agents. At present, it is unclear what effect these matters, and the changes under consideration by the Company, may have on the Company s consolidated financial condition and results of operations.

We have recently experienced significant turnover in senior management. If we are unable to manage the succession of our key executives, it could adversely affect our business.

Over the past year, we have experienced a high turnover in our senior management team. Although we have succession plans in place and have employment arrangements with our key executives, these do not guarantee that the services of these key executives will continue to be available to us. We would be adversely affected if we fail to adequately plan for future turnover of our senior management team.

Acquisitions, divestitures and other significant transactions may adversely affect our business.

We continue to evaluate the profitability of our existing businesses and operations. From time to time, we review potential acquisitions and divestitures in light of our core businesses and growth strategies. The success of any such acquisition or divestiture depends, in part, upon our ability to identify suitable buyers or sellers, negotiate favorable contract terms and, in many cases, obtain governmental approval. For acquisitions, success is also dependent upon efficiently integrating the acquired business into the Company s existing operations. For divestures, in the event the structure of the transaction results in continuing obligations by the buyer to us or our customers, a buyer s inability to fulfil these obligations could lead to future financial loss on our part. In addition, any divestiture could result in significant asset impairment charges, including those related to goodwill and other intangible assets. For example, the reinsurance transaction involving our former Life Insurance Division resulted in a pre-tax loss of $21.5 million, of which $13.0 million was recorded as an impairment to the Life Insurance Division s deferred acquisition costs with the remainder of $8.5 million recorded in Realized gains (losses) in the Company s consolidated statement of income (loss). *See* Note 2 of Notes to Consolidated Financial Statements. In addition, potential acquisitions or divestitures present financial, managerial and operational challenges, including diversion of management attention from existing businesses, difficulty with integrating or separating personnel and financial and other systems, increased expenses, assumption of unknown liabilities, indemnities and potential disputes with the buyers or sellers.

A failure of our information systems to provide timely and accurate information could have a material adverse effect on our financial condition and results of operations.

Information processing is critical to our business, and a failure of our information systems to provide timely and accurate information could have a material adverse effect on our financial condition and results of operations. The failure to maintain an effective and efficient information system or disruptions in our information system could cause disruptions in our business operations, including (a) failure to comply with prompt pay laws; (b) loss of existing insureds; (c) difficulty in attracting new insureds; (d) disputes with insureds, providers and agents; (e) regulatory problems; (f) increases in administrative expenses; and (g) other adverse consequences.

Natural disasters, could severely damage or interrupt our systems and operations and result in an adverse effect on our business.

Natural disasters such as fire, flood, earthquake, tornado, power loss, virus, telecommunications failure, break-in or similar event could severely damage or interrupt our systems and operations, result in loss of data, and/or delay or impair our ability to service our customers. We have in place a disaster recovery plan which is intended to provide us with the ability to maintain our operations in the event of a natural disaster. However, there can be no assurance that

such adverse effects will not occur in the event of a disaster. Any such disaster or similar event could have a material adverse effect on our financial condition and results of operations.

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Item 1B. ***Unresolved Staff Comments***

None

Item 2. ***Properties***

We currently own and occupy our executive offices located at 9151 Boulevard 26, North Richland Hills, Texas 76180-5605 and 8825 Bud Jensen Drive, North Richland Hills, Texas 76180-5605 comprising in the aggregate approximately 281,000 and 30,000 square feet, respectively, of office and warehouse space. In addition, we lease office space at various locations.

Item 3. ***Legal Proceedings***

See Note 16 of Notes to Consolidated Financial Statements, the terms of which are incorporated by reference herein.

Item 4. ***Submissions of Matters to a Vote of Security Holders***

The Company held a Special Meeting of Stockholders on November 21, 2008. As of September 30, 2008 (the record date for the meeting) 31,026,166 shares of common stock were issued and 29,779,355 shares of common stock were outstanding, consisting of 26,896,325 shares of Class A-1 common stock and 2,883,030 shares of Class A-2 common stock.

The only matter submitted to a vote of security holders at the Special Meeting of Stockholders was a proposal seeking approval of an amendment to the HealthMarkets 2006 Management Stock Option Plan (the 2006 Plan), in order to increase the number of shares of the Company s Class A-1 common stock issuable under the 2006 Plan, the number of shares issuable to any individual participant in any year and the number of shares that may be granted as incentive stock options within the meaning of Section 422 of the Internal Revenue Code of 1986, as amended, in each case, by 1,750,000 shares, from 1,489,741 to 3,239,741. The results of the voting for the proposal to amend the 2006 Plan were as follows:

For	Against	Abstain
26,848,143	0	0

PART II

Item 5. ***Market for Registrant s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Shares of the Company s Class A-1 and Class A-2 common stock are not listed for trading on The New York Stock Exchange or any other exchange and are not readily tradable or salable in any public market. As of March 2, 2009, there were approximately 30 holders of record of Class A-1 common stock and 1,035 holders of record of Class A-2 common stock.

On May 3, 2007, the Company s Board of Directors declared an extraordinary cash dividend of $10.51 per share for Class A-1 and Class A-2 common stock to holders of record as of close of business on May 9, 2007, payable on May 14, 2007. In connection with the extraordinary cash dividend, the Company paid dividends to stockholders in the aggregate of $317.0 million. The Company did not declare or pay dividends on shares of its common stock in 2008.

During the year ended December, 2008, the Company issued an aggregate of 112,354 unregistered shares of its Class A-1 common stock to newly-appointed executive officers of the Company. In particular, the Company issued 40,901 unregistered non-vested shares in accordance with employment agreements and executive officers of the Company purchased 71,453 shares of the Company s Class A-1 common stock for aggregate consideration of $2.3 million (or $32.66 per share). Such sale of securities was made in reliance upon the exemption from registration provided by Section 4(2) of the Securities Act of 1933, as amended (and/or Regulation D promulgated

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thereunder) for transactions by an issuer not involving a public offering. The proceeds of such sale were used for general corporate purposes.

Issuer Purchases of Equity Securities

Set forth below is a summary of the Company s purchases of shares of HealthMarkets, Inc. Class A-1 common stock during each of the months in the twelve-month period ended December 31, 2008.

	Issuer Purchase of Equity Securities Class A-1			
Period	Total Number of Shares Purchased(1)	Average Price Paid per Share ($)	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares That May yet Be Purchased Under the Plan or Program
01/1/08-01/31/08				
02/1/08-02/28/08				
03/1/08-03/31/08				
04/1/08-04/30/08				
05/1/08-05/31/08				
06/1/08-06/30/08	91,577	34.80		
07/1/08-07/31/08				
08/1/08-08/31/08				
09/1/08-09/30/08	56,725	24.00		
10/1/08-10/31/08				
11/1/08-11/30/08	8,861	23.37		
12/1/08-12/31/08	10,166	23.37		
Totals	167,329	29.84		

(1) The number of shares purchased other than through a publicly announced plan or program includes 167,329 Class A-1 shares purchased from current or former officers of the Company. These shares were reflected as treasury shares on the Company s Consolidated Balance Sheet at the time of purchase.

Set forth below is a summary of the Company s purchases of shares of HealthMarkets, Inc. Class A-2 common stock during each of the months in the twelve-month period ended December 31, 2008:

	Issuer Purchase of Equity Securities Class A-2
	Total Number of

Period	Total Number of Shares Purchased(1)	Average Price Paid per Share ($)	Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares That May yet Be Purchased Under the Plan or Program
01/1/08-01/31/08	54,983	42.03		
02/1/08-02/28/08				
03/1/08-03/31/08	53,562	35.00		
04/1/08-04/30/08	442,662	35.01		
05/1/08-05/31/08	270,563	34.80		
06/1/08-06/30/08	160,680	34.80		
07/1/08-07/31/08	169,814	34.80		
08/1/08-08/31/08	205,722	24.00		
09/1/08-09/30/08	61,689	24.00		
10/1/08-10/31/08	115,779	24.00		
11/1/08-11/30/08	60,233	23.37		
12/1/08-12/31/08	79,443	23.37		
Totals	1,675,130	31.68		

(1) The number of shares purchased other than through a publicly announced plan or program includes 1,595,239 Class A-2 shares purchased from the stock accumulation plans established for the benefit of the Company s

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agents and 79,891 Class A-2 shares purchased from former participants in the stock accumulation plans. These shares were reflected as treasury shares on the Company s Consolidated Balance Sheet at the time of the purchase.

Securities Authorized for Issuance under Equity Compensation Plans

The following table sets forth certain information with respect to shares of the Company s Class A-1 and Class A-2 common stock that may be issued under HealthMarkets equity compensation plans as of December 31, 2008:

Plan Category	Number of Securities to be Issued upon Exercise of Outstanding Options, Warrants and Rights (a)	Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)
Equity compensation plans approved by security holders	2,183,257(1)	$ 30.74	3,548,333(2)
Equity compensation plans not Approved by security holders	1,259,412(3)	N/A	3,868,633(4)
Total	3,442,669	$ 19.50	7,416,966

(1) Includes 28,408 stock options exercisable at a weighted average exercise price of $7.34 under the UICI 1987 Stock Option Plan. Also includes 2,154,849 stock options granted at a weighted average exercise price of $31.05 under the HealthMarkets 2006 Management Stock Option Plan.

(2) Includes securities available for future issuance as follows: UICI 1987 Stock Option Plan, 2,537,195 shares; HealthMarkets 2006 Management Stock Option Plan, 1,011,138 shares.

(3) Includes (a) 796,690 shares issuable upon vesting of matching credits granted to participants under the Agency Matching Total Ownership Plan and (b) 462,722 shares issuable upon vesting of matching credits granted to participants under the Matching Agency Contribution Plan.

(4) Includes securities available for future issuance as follows: Agents Matching Total Ownership Plan, 1,627,019 shares; Matching Agency Contribution Plan, 2,241,614 shares.

Item 6. ***Selected Financial Data***

The following selected consolidated financial data as of and for each of the five years in the period ended December 31, 2008 has been derived from the audited consolidated financial statements of the Company. The following data should be read in conjunction with the consolidated financial statements and the notes thereto and *Management s Discussion and Analysis of Financial Condition and Results of Operations* included herein.

	Year Ended December 31,				
	2008	2007	2006	2005	2004
	(In thousands, except per share amounts and operating ratios)				
Income Statement Data:					
Revenues from continuing operations	$ 1,416,860	$ 1,583,822	$ 2,134,341	$ 2,110,915	$ 2,061,130
Income (loss) from continuing operations before income taxes	(77,205)	117,621	350,870	310,804	221,075
Income (loss) from continuing operations	(48,357)	68,439	216,634	201,445	145,284
Income (loss) from discontinued operations	(5,098)	1,720	21,104	2,056	16,274
Net income (loss)	$ (53,455)	$ 70,159	$ 237,738	$ 203,501	$ 161,558

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	Year Ended December 31,				
	2008	2007	2006	2005	2004
	(In thousands, except per share amounts and operating ratios)				
Per Share Data:					
Earnings (loss) per share from continuing operations:					
Basic earnings (loss) per common share	$ (1.60)	$ 2.25	$ 6.20	$ 4.37	$ 3.16
Diluted earnings (loss) per common share	$ (1.60)	$ 2.18	$ 6.07	$ 4.31	$ 3.07
Earnings (loss) per share from discontinued operations:					
Basic earnings (loss) per common share	$ (0.17)	$ 0.06	$ 0.60	$ 0.04	$ 0.34
Diluted earnings (loss) per common share	$ (0.17)	$ 0.06	$ 0.59	$ 0.04	$ 0.33
Earnings (loss) per share:					
Basic earnings (loss) per common share	$ (1.77)	$ 2.31	$ 6.80	$ 4.41	$ 3.50
Diluted earnings (loss) per common share	$ (1.77)	$ 2.24	$ 6.66	$ 4.35	$ 3.40
Operating Ratios:					
Health Ratios:					
Loss ratio	65%	57%	57%	57%	61%
Expense ratio	36	38	32	31	33
Combined health ratio	101%	95%	89%	88%	94%
Balance Sheet Data:					
Total investments, cash and cash overdraft.	$ 1,127,945	$ 1,495,910	$ 1,834,481	$ 1,773,554	$ 1,709,973
Total assets	1,916,713	2,155,582	2,594,829	2,371,530	2,345,658
Total policy liabilities	973,046	1,001,406	1,135,174	1,174,264	1,258,671
Total debt	481,070	481,070	556,070	15,470	15,470
Stockholders equity	197,925	306,260	524,385	871,081	714,145
Stockholders equity per share	$ 6.68	$ 10.03	$ 17.53	$ 18.88	$ 15.62

Loss ratio. The loss ratio is defined as benefits, claims and settlement expenses as a percentage of earned premiums (excludes Life Insurance Division).

Expense ratio. The expense ratio is defined as underwriting, acquisition and insurance expenses as a percentage of earned premiums (excludes Life Insurance Division).

Item 7. ***Management s Discussion and Analysis of Financial Condition and Results of Operations***

The following discussion should be read in conjunction with HealthMarkets consolidated financial statements and the related notes included elsewhere in this Form 10-K. This discussion contains certain statements which may be considered forward-looking. Actual results and the timing of events may differ significantly from those expressed or implied in such forward-looking statements due to a number of factors, including those set forth in the section entitled Risk Factors and elsewhere in this Form 10-K.

Additionally, the Company may also disclose financial information on a non-GAAP basis when management uses this information and believes this information will be valuable to investors in measuring the quality of our

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financial performance, identifying trends in our results and providing more meaningful period-to-period comparisons.

Overview

The Company operates three business segments, the Insurance segment, Corporate and Disposed Operations. The Insurance segment includes the Company s Self-Employed Agency Division (SEA), the Medicare Division and the Other Insurance Division. Corporate includes investment income not allocated to the Insurance segment, realized gains or losses, interest expense on corporate debt, general expenses relating to corporate operations, variable non-cash stock-based compensation and operations that do not constitute reportable operating segments. Disposed Operations includes the former Life Insurance Division, former Star HRG Division and former Student Insurance Division.

Through our SEA Division, we offer a broad range of health insurance products for individuals, families, the self-employed and small businesses. Our plans are designed to accommodate individual needs and include basic hospital-medical expense plans, plans with preferred provider organization (PPO) features, catastrophic hospital expense plans, as well as other supplemental types of coverage.

We market these products to the self-employed and individual markets through independent agents contracted with our insurance subsidiaries. The Company has approximately 1,300 independent writing agents per week in the field selling health insurance in 44 states.

In 2007, we initiated efforts to expand into the Medicare market. In the fourth quarter of 2007, we began offering a new portfolio of Medicare Advantage Private-Fee-for-Service Plans (PFFS) called HealthMarkets Care Assured PlansSM (HMCA Plans) in selected markets in 29 states with calendar year coverage effective for January 1, 2008. Policies were issued by our Chesapeake subsidiary, under a contract with the Centers for Medicare and Medicaid Services (CMS). The HMCA Plans were offered to Medicare eligible beneficiaries as a replacement for original Medicare and Medigap (Supplement) policies. They provided enrollees with the actuarial benefit equivalence they would receive under original Medicare, as well as certain additional benefits or benefit options, such as preventive care, pharmacy benefits, and vision, dental and hearing services. In July 2008, the Company determined it would not continue to participate in the Medicare business after the 2008 plan year.

Our Other Insurance Division consists of ZON Re-USA, LLC (ZON Re), an 82.5%-owned subsidiary, which underwrites, administers and issues accidental death, accidental death and dismemberment (AD&D), accident medical, and accident disability insurance products, both on a primary and on a reinsurance basis. We distribute these products through professional reinsurance intermediaries and a network of independent commercial insurance agents, brokers and third party administrators. We expect to exit this line of business in 2009, with the existing reinsurance business managed to final termination of substantially all liabilities.

Exit from Life Insurance Division Business

On September 30, 2008 (the Closing Date), HealthMarkets, LLC, a subsidiary of the Company, completed the transactions contemplated by the Agreement for Reinsurance and Purchase and Sale of Assets dated June 12, 2008 (the Master Agreement). Pursuant to the Master Agreement, Wilton Reassurance Company or its affiliates (Wilton) acquired substantially all of the business of the Company s Life Insurance Division, which operated through The Chesapeake Life Insurance Company (Chesapeake), Mid-West National Life Insurance Company of Tennessee (Mid-West) and The MEGA Life and Health Insurance Company (MEGA) (collectively the Ceding Companies), and all of the Company s 79% equity interest in each of U.S. Managers Life Insurance Company, Ltd. and Financial Services Reinsurance, Ltd. As part of the transaction, under the terms of the Coinsurance Agreements (the Coinsurance Agreements) entered into with each of the Ceding Companies on the Closing Date, Wilton has agreed,

effective July 1, 2008 (the Coinsurance Effective Date), to reinsure on a 100% coinsurance basis substantially all of the insurance policies associated with the Company s Life Insurance Division (the Coinsured Policies).

Under the terms of the Coinsurance Agreements, Wilton has assumed responsibility for all insurance liabilities associated with the Coinsured Policies. The Ceding Companies have transferred to Wilton cash in an amount equal

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to the net statutory reserves and liabilities corresponding to the Coinsured Policies, which amount was approximately $344.5 million. Wilton has agreed to be responsible for administration of the Coinsured Policies, subject to certain transition services to be provided by the Ceding Companies to Wilton. The Ceding Companies remain primarily liable to the policyholders on those policies with Wilton assuming the risk from the Ceding Companies pursuant to the terms of the Coinsurance Agreements. As a result, in accordance with guidance provided in Financial Accounting Standard No. 113, *Accounting and Reporting for Reinsurance of Short-Duration and Long-Duration Contracts*, the Company reported and will continue to report the policy liabilities ceded to Wilton under Policy liabilities and record a corresponding asset as Reinsurance recoverable ceded policy liabilities on its consolidated balance sheet.

The Company and the Ceding Companies received total consideration of approximately $139.2 million, including $134.5 million in aggregate ceding allowances with respect to the reinsurance of the Coinsured Policies. Under certain circumstances, the Master Agreement also provides for the payment of additional consideration to the Company following the closing based on the five year financial performance of the Coinsured Policies. The reinsurance transaction resulted in a pre-tax loss of $21.5 million, of which $13.0 million was recorded as an impairment to the Life Insurance Division s deferred acquisition costs (DAC) with the remainder of $8.5 million recorded in Realized gains (losses) in the Company s consolidated statement of income (loss).

The Master Agreement and Coinsurance Agreements provide for certain financial settlements following the Closing Date, including, without limitation, settlements with respect to the cash transferred to Wilton for statutory reserves and liabilities corresponding to the Coinsured Policies, and the cash flows arising out of the Coinsured Policies between the Coinsurance Effective Date and the Closing Date. We are currently in the process of resolving the financial settlements with Wilton; however, there can be no assurance that the financial settlements will be favorably resolved. The failure to favorably resolve the financial settlements could result in additional expense recorded; however, we do not currently believe that the outcome of the financial settlements will have a material adverse effect on the Company s financial condition and results of operations.

In connection with these transactions the Company incurred $6.5 million in investment banker fees and legal fees recorded as Other expense on the Company s consolidated statement of income (loss) for the year ended December 31, 2008. The Company also incurred $6.4 million of employee and lease termination costs and other costs recorded in Underwriting, acquisition and insurance expenses, on its consolidated statement of income (loss) during 2008. In addition, the Company incurred interest expense of $3.1 million during 2008 associated with the use of the cash transferred to Wilton during the period from the Coinsurance Effective Date to the Closing Date. The Ceding Companies also wrote-off DAC of $101.1 million, representing all of the deferred acquisition costs associated with the Coinsured Policies subject to the transaction, which is included in the realized loss on the transaction. This write-off of DAC correspondingly reduced the related deferred tax assets by $36.7 million. *See* Note 2 of Notes to Consolidated Financial Statements for additional information.

Exit from the Medicare Market

In late 2007, we expanded into the Medicare market by offering a new portfolio of Medicare Advantage PFFS called HMCA Plans in selected markets in 29 states with calendar year coverage effective for January 1, 2008. On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 (HR. 6331) was enacted, resulting in significant changes to the Medicare program. These changes include, among other things, the phased elimination of Medicare Advantage PFFS deeming arrangements with providers beginning in 2011. Based on our determination that this new law would make it difficult for the Company to operate effectively in the Medicare market, in July 2008, we decided that the Company would not participate in the Medicare Advantage marketplace beyond the current year. We will continue to fulfill our remaining obligations under the 2008 calendar year Medicare contract with CMS.

2006 Sales of Student Insurance Division and Star HRG Division

In July 2006 and December 2006, in two separate transactions, we sold the assets comprising our former Star HRG Division and our former Student Insurance Division. In connection with these sales, we recorded an aggregate

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pre-tax gain in 2006 of $201.7 million, of which $101.5 million was attributable to the Star HRG transaction and $100.2 million was attributable to the Student Insurance transaction.

As part of the sale transactions, insurance subsidiaries of the Company entered into 100% coinsurance arrangements with each of the purchasers, pursuant to which (a) the purchasers agreed to assume liability for all future claims associated with the policies in force as of the respective closing dates and (b) the Company s insurance subsidiaries transferred to the purchasers cash in an amount equal to the actuarial estimate of those future claims. While under the terms of the coinsurance agreements the Company s insurance subsidiaries have recorded a ceded liability for all future claims made on the insurance policies in force at the closing date, as the insurance subsidiaries remain primarily liable on those policies. Accordingly, at December 31, 2008 and 2007 the Company continues to report the policy liabilities ceded to and assumed by the purchasers under the coinsurance agreements as Policy liabilities , with a corresponding Reinsurance recoverable ceded policy liabilities asset on its consolidated balance sheet. In addition, the Company will continue to report in future periods the residual results of operations of these businesses (anticipated to consist solely of residual wind-down expenses and any true-up provision associated with the sales, primarily of the Student Insurance Division) in continuing operations and classified as Disposed Operations. *See* Note 2 of Notes to Consolidated Financial Statements for additional information regarding the terms of the sales of the Star HRG Division and Student Insurance Division assets.

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Results of Operations

The table below sets forth certain summary information about our consolidated operating results for each of the three most recent fiscal years:

	Year Ended December 31,				
	2008	Percentage Increase (Decrease)	2007	Percentage Increase (Decrease)	2006
	(Dollars in thousands)				
Revenue:					
Health Premiums	$ 1,262,412	(4)%	$ 1,311,733	(22)%	$ 1,671,571
Life premiums and other considerations	38,024	(46)%	70,460	7%	65,675
	1,300,436	(6)%	1,382,193	(20)%	1,737,246
Investment income	60,235	(35)%	92,231	0%	92,615
Other income	80,047	(24)%	105,923	2%	103,936
Realized gains (losses)	(23,858)	(787)%	3,475	(98)%	200,544
Total revenues	1,416,860	(11)%	1,583,822	(26)%	2,134,341
Benefits and Expenses:					
Benefits, claims, and settlement expenses	856,994	7%	801,783	(20)%	996,617
Underwriting, acquisition and insurance expenses	494,077	(8)%	536,168	(10)%	597,766
Other expenses	101,298	20%	84,641	(45)%	154,265
Interest expense	41,696	(4)%	43,609	25%	34,823
Total benefits and expenses	1,494,065	2%	1,466,201	(18)%	1,783,471
Income (loss) from continuing operations before income taxes	(77,205)	(166)%	117,621	(66)%	350,870
Federal income tax expense (benefit)	(28,848)	(159)%	49,182	(63)%	134,236
Income (loss) from continuing operations	(48,357)	(171)%	68,439	(68)%	216,634
Income (loss) from discontinued operations (net of income tax)	(5,098)	(396)%	1,720	(92)%	21,104
Net income (loss)	$ (53,455)	(176)%	$ 70,159	(70)%	$ 237,738

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As more fully discussed above, the Company entered into Coinsurance Agreements in connection with its exit from the Life Insurance Division business during 2008 and sold the assets comprising our former Star HRG Division and our former Student Insurance Division in 2006. HealthMarkets management believes that comparisons between years are most meaningful after the reclassification and netting of the operating revenues and expenses attributable to these divisions to the line item Income (loss) from disposed operations, net of income tax, which is a non-GAAP measure:

	Year Ended December 31,				
	2008	Percentage Increase (Decrease)	2007	Percentage Increase (Decrease)	2006
	(Dollars in thousands)				
Revenue:					
Health Premiums	$ 1,261,497	(4)%	$ 1,309,549	(4)%	$ 1,361,480
Life premiums and other considerations	2,502	(7)%	2,695	0%	2,691
	1,263,999	(4)%	1,312,244	(4)%	1,364,171
Investment income	49,919	(30)%	71,629	7%	67,142
Other income	79,095	(24)%	104,452	5%	99,275
Realized gains (losses)	(23,983)	(790)%	3,475	(98)%	200,544
Total revenues	1,369,030	(8)%	1,491,800	(14)%	1,731,132
Benefits and Expenses					
Benefits, claims, and settlement expenses	824,280	10%	748,344	1%	740,436
Underwriting, acquisition and insurance expenses	455,421	(9)%	500,621	6%	470,825
Other expenses	101,198	21%	84,546	(45)%	153,988
Interest expense	41,696	(4)%	43,609	25%	34,823
Total benefits and expenses	1,422,595	3%	1,377,120	(2)%	1,400,072
Income (loss) from continuing operations before income taxes	(53,565)	(147)%	114,680	(65)%	331,060
Federal income tax expense (benefit)	(19,943)	(141)%	48,223	(62)%	127,573
Income (loss) from continuing operations (excluding disposed operations)	(33,622)	(151)%	66,457	(67)%	203,487
Income (loss) from discontinued operation, net of tax	(5,098)	(396)%	1,720	(92)%	21,104
Income (loss) excluding disposed operations	(38,720)	(157)%	68,177	(70)%	224,591
Income (loss) from disposed operations, net of tax	(14,735)	(843)%	1,982	(85)%	13,147

Net income (loss)	$ (53,455)	(176)%	$ 70,159	(70)%	$ 237,738

Revenue

Our revenues consist primarily of premiums derived from sales of our indemnity, PPO and life insurance policies. Premiums on health insurance contracts are recognized as earned over the period of coverage on a pro rata basis. Premiums on traditional life insurance are recognized as revenue when due. Revenues also include investment income derived from our investment portfolio and other income, which consists primarily of income derived by the SEA Division from ancillary services and membership marketing and administrative services provided to the membership associations that make available to their members the Company s health insurance products.

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The table below sets forth premium by insurance division for each of the three most recent fiscal years (excluding for all periods presented premium associated with our former Life Insurance Division, Star HRG Division and Student Insurance Division):

	Year Ended December 31,		
	2008	2007	2006
		(In thousands)	
Premium:			
Self-Employed Agency Division	$ 1,140,499	$ 1,282,249	$ 1,330,298
Medicare	96,369		
Other Insurance	27,131	29,995	33,873
Total premium	$ 1,263,999	$ 1,312,244	$ 1,364,171

Benefits and Expenses

The Company s expenses consist primarily of insurance claims expense and expenses associated with the underwriting and acquisition of insurance policies. Claims expenses consist primarily of payments to physicians, hospitals and other healthcare providers under health policies and include an estimated amount for incurred but not reported and unpaid claims. Underwriting, acquisition and insurance expenses consist of direct expenses incurred across all insurance lines in connection with issuance, maintenance and administration of in-force insurance policies, including amortization of deferred policy acquisition costs, commissions paid to agents, administrative expenses and premium taxes. The Company also incurs other direct expenses in connection with generating income derived by the SEA Division from ancillary services and membership marketing and administrative services provided to the membership associations that make available to their members the Company s health insurance products.

Business Segments

The following is a comparative discussion of results of operations for the Company s business segments and divisions the Insurance segment, Corporate and Disposed Operations, which consists of the Life Insurance Division, the Student Insurance Division and the Star HRG Division.

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Revenues and income (loss) from continuing operations before federal income taxes (operating income (loss)) for each of the Company s business segments and divisions in 2008, 2007 and 2006 was as follows:

	Year Ended December 31,		
	2008	2007	2006
	(In thousands)		
Revenues:			
Insurance:			
Self-Employed Agency Division	$ 1,248,434	$ 1,417,952	$ 1,462,088
Medicare Division	96,725		
Other Insurance	29,205	31,866	35,337
Total Insurance	1,374,364	1,449,818	1,497,425
Corporate:	(5,166)	42,771	234,617
Intersegment Eliminations	(167)	(789)	(910)
Total revenues excluding disposed operations	1,369,031	1,491,800	1,731,132
Disposed Operations:			
Life Insurance Division	47,704	92,022	87,782
Student Insurance Division			240,050
Star HRG	125		75,377
Total Disposed Operations	47,829	92,022	403,209
Total revenues	$ 1,416,860	$ 1,583,822	$ 2,134,341

	Year Ended December 31,		
	2008	2007	2006
	(In thousands)		
Income (loss) from continuing operations before federal income taxes:			
Insurance:			
Self-Employed Agency Division	$ 55,634	$ 150,449	$ 236,466
Medicare Division	(14,858)	(12,424)	
Other Insurance	4,418	7,909	5,488
Total Insurance	45,194	145,934	241,954
Corporate:	(98,759)	(31,254)	89,106
Total operating income (loss) excluding disposed operations	(53,565)	114,680	331,060
Disposed Operations:			
Life Insurance Division	(23,399)	2,550	5,264
Student Insurance Division	(359)	192	12,238
Star HRG Division	118	199	2,308

Total Disposed Operations	(23,640)	2,941	19,810
Total income (loss) from continuing operations before federal income taxes	$ (77,205)	$ 117,621	$ 350,870

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Insurance

Set forth below is certain summary financial and operating data for the Company s Insurance segment for each of the three most recent fiscal years:

	Year Ended December 31,				
	2008	Percentage Increase (Decrease)	2007	Percentage Increase (Decrease)	2006
	(Dollars in thousands)				
Revenues:					
Earned premium revenue	$ 1,263,999	(4)%	$ 1,312,244	(4)%	$ 1,364,171
Investment income	31,324	(3)%	32,439	(2)%	33,165
Other income	79,041	(25)%	105,135	5%	100,089
Total revenues	1,374,364	(5)%	1,449,818	(3)%	1,497,425
Expenses:					
Benefits, claims and settlement expenses	824,279	10%	748,344	1%	740,436
Underwriting, acquisition and insurance expenses	462,345	(8)%	501,844	10%	455,133
Other expenses	42,546	(21)%	53,696	(10)%	59,902
Total expenses	1,329,170	2%	1,303,884	4%	1,255,471
Operating income	$ 45,194	(69)%	$ 145,934	(40)%	$ 241,954

The Insurance segment includes the Company s SEA Division, the Medicare Division and Other Insurance Division. Management reviews results of operations for the Insurance segment by reviewing each of the above mentioned divisions.

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Self-Employed Agency Division

Set forth below is certain summary financial and operating data for the Company s SEA Division for each of the three most recent fiscal years:

	Year Ended December 31,				
	2008	Percentage Increase (Decrease)	2007	Percentage Increase (Decrease)	2006
	(Dollars in thousands)				
Revenues:					
Earned premium revenue	$ 1,140,499	(11)%	$ 1,282,249	(4)%	$ 1,330,298
Investment income	29,149	(5)%	30,840	(3)%	31,809
Other income	78,786	(25)%	104,863	5%	99,981
Total revenues	1,248,434	(12)%	1,417,952	(3)%	1,462,088
Expenses:					
Benefits, claims and settlement expenses	729,747	(1)%	735,701	2%	721,688
Underwriting, acquisition and insurance expenses	420,508	(12)%	478,106	8%	444,032
Other expenses	42,545	(21)%	53,696	(10)%	59,902
Total expenses	1,192,800	(6)%	1,267,503	3%	1,225,622
Operating income	$ 55,634	(63)%	$ 150,449	(36)%	$ 236,466
Other operating data:					
Loss ratio	64.0%	(12)%	57.4%	6%	54.3%
Expense ratio	36.9%	(1)%	37.3%	12%	33.3%
Combined health ratio	100.9%	7%	94.7%	8%	87.6%
Operating margin	4.9%	(58)%	11.7%	(34)%	17.8%
Average number of writing agents in period	1,264	(33)%	1,874	(13)%	2,143
Submitted annualized volume	$ 461,317	(32)%	$ 680,060	(14)%	$ 791,152

Loss Ratio. The loss ratio is defined as benefits expense as a percentage of earned premium revenue.

Expense Ratio. The expense ratio is defined as underwriting, acquisition and insurance expenses as a percentage of earned premium revenue.

Operating Margin. Operating margin is defined as operating income as a percentage of earned premium revenue.

Submitted Annualized Volume. Submitted annualized premium volume in any period is the aggregate annualized premium amount associated with health insurance applications submitted by the Company s agents in such period for

underwriting by the Company.

Year Ended December 31, 2008 versus December 31, 2007

For 2008, the SEA Division reported operating income of $55.6 million compared to $150.4 million in 2007, a decrease of $94.8 million or 63.0%. The decrease in operating income is primarily attributable to a decrease in earned premium revenue of 11.1% and a decrease in investment and other income of 20.5%, which was slightly offset by a decrease in total expenses of 6.0%. Operating income in the SEA Division as a percentage of earned premium revenue (*i.e.*, operating margin) in 2008 was 4.9% compared to 11.7% in 2007.

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Earned premium revenue at the SEA Division was $1.1 billion in 2008 compared to $1.3 billion in 2007, a decrease of $141.8 million or 11.1%. This decrease is primarily attributable to a decrease in submitted annualized premium volume and a decrease in the average number of policies in force during the year. With respect to submitted annualized premium volume, the Company experienced a decrease of $218.8 million, or 32.2% in 2008 from $680.1 million in 2007 to $461.3 million in 2008. The decrease in earned premium revenue reflects an attrition rate that exceeds the pace of new sales. With respect to new sales, the Company is experiencing increased competition in the marketplace, as well as a decrease of approximately 32.6% in the average number of writing agents in our dedicated agency sales force. In addition, there was an increased focus, particularly in the first quarter of 2008, on our new Medicare products offered, which led to a decreased focus on our core health products in the SEA Division. The Company exited the Medicare Advantage marketplace on December 31, 2008 and its focus for 2009 will return to the Company s core health products. With respect to the average number of polices in force during the year, the decrease is attributable to a decrease in new policies issued during 2008 compared to prior year and lower persistency on existing policies. Total policies in force decreased by 42,700 policies or 13.2% during the year to approximately 281,700 during 2008 as compared to approximately 324,400 during 2007.

The increase in the loss ratio reflects an ongoing gradual shift in product mix to the Company s CareOne product suite and other PPO products which are designed to provide a higher proportion of premium dollars as benefits. For the last two years the Company s sales efforts have been focused on new PPO type products, which, by design, have a higher loss ratio than the Company s previous products that were largely per occurrence or scheduled benefit products. In addition, as previously disclosed, during 2007, the Company made various refinements to the claim liability estimates.

Underwriting, acquisition and insurance expenses decreased to $420.5 million in 2008 from $478.1 million in 2007, a decrease of $57.6 million or 12.0%. The decrease partially reflects the variable nature of certain expenses, including commission expenses and premium taxes, which are included in these amounts. Commission expenses and premium taxes generally vary in proportion to earned premium revenue. This decrease from 2007 also resulted from a $20.0 million expense associated with the settlement of the multi-state market conduct examination recognized in 2007 and an $8.0 million asset impairment charge in 2007 associated with two technology assets that we determined were no longer of value to the Company.

Other income and other expenses both decreased in the current period compared to the prior year period. Other income largely consists of fee and other income received for sales of association memberships by our dedicated agency sales force. Sales of association memberships by our dedicated agency sales force tend to move in tandem with sales of health insurance policies; consequently, this decrease in other income is consistent with the decline in earned premiums and new sales. Other expenses consist of amounts incurred for bonuses and other compensation provided to the agents, which are based on policy sales during the current year.

Year Ended December 31, 2007 versus December 31, 2006

For 2007, the SEA Division reported operating income of $150.4 million compared to $236.5 million in 2006, a decrease of $86.1 million or 36.4%. Operating margin in 2007 was 11.7% compared to 17.8% in 2006. Operating income for the SEA Division in 2007 was negatively impacted by a decrease in earned premium revenue, an increase in the loss ratio, and an increase in underwriting, acquisition and insurance expenses.

Earned premium revenue at the SEA Division decreased by $48.0 million or 3.6% to $1.3 billion in 2007 compared to $1.3 billion in 2006. This decrease in earned premium revenue was primarily attributable to a slight decrease in policy persistency rates, a decline in submitted annualized premium volume, and a decrease in the conversion rate of submitted policies to issue policies. The period over period decrease in submitted annualized premium volume was due to a decrease in the average number of writing agents in the field from 2,143 during 2006 to 1,874 during 2007. In addition, the productivity of the writing agents decreased 6.6% based on the average number of weekly applications

submitted per writing agent. The decrease in conversion experience on submitted policies was at least partly expected as it reflects the implementation of more rigorous underwriting procedures.

Benefits expense increased in 2007 compared to 2006 as reflected in the loss ratio of 57.4% versus 54.3%, respectively. The increase in the loss ratio reflects an ongoing gradual shift in product mix to the Company s CareOne product suite and other PPO products which are designed to provide a higher proportion of premium

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dollars as benefits. The amount of benefit expenses reported each year is impacted by the estimate of claim liabilities. *See* discussion below in Critical Accounting Policies in the sections titled Estimates of Claim Liabilities and Changes in SEA Claim Liability Estimates.

Underwriting, acquisition and insurance expenses increased to $478.1 million in 2007 from $444.0 million in 2006, an increase of $34.1 million or 7.7%. In 2007, the Company recognized a $20.0 million expense associated with the potential settlement of the multi-state market conduct examination (*See* Note 16 of Notes to Consolidated Financial Statements) and an $8.0 million asset impairment charge in 2007 associated with two technology assets that we determined were no longer of value to the Company. In addition, we incurred consulting and professional fees for various operational and technology focused initiatives that were new in 2007.

Medicare Division

Set forth below is certain summary financial and operating data for the Company s Medicare Division for each of the two most recent fiscal years:

	2008	2007
	(Dollars in thousands)	
Revenues:		
Earned premium revenue	$ 96,369	$
Investment income	356	
Total revenues	96,725	
Benefits and expenses:		
Benefits expenses	80,305	
Underwriting, acquisition and insurance expenses	31,278	12,424
Total expenses	111,583	12,424
Operating income (loss)	$ (14,858)	$ (12,424)
Other operating data:		
Loss ratio	83.3%	
Expense ratio	32.5%	
Combined ratio	115.8%	

Loss ratio. The loss ratio represents total benefit expenses as a percentage of earned premium revenue.

Expense ratio. The expense ratio represents underwriting, acquisition and insurance expenses as a percentage of earned premium revenue.

In 2007, we initiated efforts to expand into the Medicare market. In the fourth quarter of 2007, we began offering a new portfolio of Medicare Advantage PFFS called HMCA Plans in selected markets in 29 states with calendar year coverage effective for January 1, 2008. Policies were issued by our Chesapeake subsidiary, under a contract with CMS.

In July 2008, the Company decided that it would not participate in the Medicare Advantage marketplace beyond the current year. The Company will continue to fulfill its remaining obligation under the 2008 calendar year Medicare contract.

Year Ended December 31, 2008 versus December 31, 2007

The Medicare Division produced $96.4 million in earned premium in 2008 on 118,961 member months. The Company had approximately 9,975 enrolled members as of December 31, 2008. Benefit expenses for 2008 of $80.3 million resulted in a loss ratio of 83.3% consistent with the Company s expectations after adjusting for the actual member risk scores as provided by CMS. Underwriting, acquisition and insurance expenses of $31.3 million for 2008 and $12.4 for 2007 include commissions, marketing costs, and all administrative and operating costs.

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Additionally, the underwriting, acquisition and insurance expenses in 2008 include a minimum volume guarantee fee and contract termination cost of $4.9 million payable to the Company s third-party administrator in connection with the decision to exit the Medicare Advantage PFFS market.

In connection with its exit from the Medicare market, the Company also incurred employee termination costs of $2.8 million and recorded asset impairment charges of $1.1 million for 2008, which were recorded in Underwriting, acquisition and insurance expenses on the consolidated statement of income (loss). The asset impairment charges were primarily related to certain Medicare specific technology projects in development. The Company believes that its exit from the Medicare market will not, in the aggregate, have a material adverse effect on the Company s consolidated financial position, but may potentially have a material adverse effect on the results of operations or cash flows in any given accounting period.

Other Insurance

Set forth below is certain summary financial and operating data for the Company s Other Insurance Division for each of the three most recent fiscal years:

	Year Ended December 31,				
	2008	Percentage Increase (Decrease)	2007	Percentage Increase (Decrease)	2006
	(Dollars in thousands)				
Revenues:					
Earned premium revenue	$ 27,131	(10)%	$ 29,995	(11)%	$ 33,873
Investment income	1,819	14%	1,599	18%	1,356
Other income	255	(6)%	272	152%	108
Total revenues	29,205	(8)%	31,866	(10)%	35,337
Expenses:					
Benefits, claims and settlement expenses	14,228	13%	12,643	(33)%	18,748
Underwriting, acquisition and insurance expenses	10,559	(7)%	11,314	2%	11,101
Total expenses	24,787	3%	23,957	(20)%	29,849
Operating income	$ 4,418	(44)%	$ 7,909	44%	$ 5,488
Other operating data:					
Loss ratio	52.4%	24%	42.2%	(24)%	55.3%
Expense ratio	38.9%	3%	37.7%	15%	32.8%
Combined ratio	91.3%	14%	79.9%	(9)%	88.1%
Operating margin	16.3%	(38)%	26.4%	63%	16.2%

Loss Ratio. The loss ratio is defined as benefits expense as a percentage of earned premium revenue.

Expense Ratio. The expense ratio is defined as underwriting, acquisition and insurance expenses as a percentage of earned premium revenue.

Operating Margin. Operating margin is defined as operating income as a percentage of earned premium revenue.

Our Other Insurance Division consists of ZON Re, which underwrites, administers and issues accidental death, accidental death and dismemberment, accident medical, and accident disability insurance products, both on a primary and on a reinsurance basis. We expect to exit this line of business in 2009, with the existing reinsurance business managed to final termination of substantially all liabilities.

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Year Ended December 31, 2008 versus December 31, 2007

In 2008, ZON Re generated operating income of $4.4 million compared to $7.9 million in 2007, a decrease of $3.5 million or 44.3%. The results for 2008 reflect adverse claim experience, in particular the impact of a large catastrophic claim on reinsured excess loss business in the amount of $2.3 million. The decrease in underwriting, acquisition and insurance expenses for the current year includes a decrease in the incentive compensation plan tied to the current period profitability and a decrease in litigation expenses compared to the prior year periods.

Earned premium revenues were $27.1 million in 2008 as compared with $30.0 million in 2007, a decrease of $2.9 million or 9.7%. In 2008, our principal insurance subsidiaries experienced downgrades in their financial strength ratings which had a negative effect on the growth of this business and our ability to maintain ZON Re s current level of operating income. As such, we expect to exit this line of business in 2009, with the existing reinsurance business managed to final termination of substantially all liabilities.

Benefits expenses were $14.2 million in 2008 as compared with $12.6 million in 2007, an increase of $1.6 million or 12.7%. Benefits expenses increased in both dollars and in relation to earned premium revenue as expressed by the loss ratio of 52.4% in 2008, which is 24.2% higher than the loss ratio in 2007 of 42.2%. The increase in the loss ratio in 2008 reflected unfavorable claim experience in the current year related to a large catastrophic claim.

Year Ended December 31, 2007 versus December 31, 2006

Earned premium revenue decreased by $3.9 million or 11.5% to $30.0 million in 2007 compared to $33.9 million in 2006. During 2007, we experienced an increase in competitive pressure, which impacted new and renewal business.

Benefits expenses decreased in both dollars and in relation to earned premium revenue as expressed by the loss ratio of 42.2% in 2007, or 23.7% lower than the loss ratio in 2006 of 55.3%. The reduction in the loss ratio in 2007 reflected favorable claim experience in the current year including refinements to the reserve calculations.

Corporate

Corporate includes investment income not otherwise allocated to the Insurance segment, realized gains and losses on sale of investments, interest expense on corporate debt, variable stock-based compensation and general expenses relating to corporate operations. In 2006, the incremental costs associated with the acquisition of the Company by the Private Equity Investors were reported in Corporate.

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Set forth below is a summary of the components of operating income (loss) at the Company s Corporate segment for each of the three most recent fiscal years:

	Year Ended December 31,				
	2008	Percentage Increase (Decrease)	2007	Percentage Increase (Decrease)	2006
	(Dollars in thousands)				
Operating income (loss):					
Investment income on equity	$ 18,817	(52)%	$ 39,538	16%	$ 34,135
Realized gains (losses) on investments	(20,527)	NM	5,201	NM	1,518
Realized gain on sale of Student Insurance	5,000	NM	1,200	NM	100,166
Realized gain (loss) on sale of Life Insurance Division	(8,456)	NM		NM	
Realized gain on sale of Star HRG		NM		NM	101,497
Expense related to early extinguishment of debt		NM	(2,926)	11%	(2,637)
Merger transaction expenses		NM		NM	(48,019)
Interest expense on corporate debt	(41,696)	(4)%	(43,609)	25%	(34,823)
Variable stock-based compensation benefit (expense)	6,758	NM	482	NM	(16,603)
General corporate expenses and other	(58,655)	(88)%	(31,140)	(32)%	(46,128)
Operating income (loss)	$ (98,759)	NM	$ (31,254)	NM	$ 89,106

NM: Not meaningful

Year Ended December 31, 2008 versus December 31, 2007

Corporate reported an operating loss in 2008 of $98.8 million, compared to operating loss of $31.3 million in 2007.

Investment income not allocated to the Insurance segment (investment income on equity) decreased $20.7 million, from $39.5 million in 2007 to $18.8 million in 2008. The decrease is primarily related to a decrease in income on our equity investments, a decrease in the average fixed maturities balance and a decrease in the short-term rates from prior year.

Interest expense on corporate debt decreased $1.9 million from $43.6 million in 2007 to $41.7 million in 2008. The decrease is due to a lower outstanding principal balance in 2008 on corporate debt reflecting a $75.0 million principal payment in the second quarter of 2007. However, the Company incurred additional interest expense of $3.1 million during 2008 associated with the use of the cash transferred to Wilton during the period from the Coinsurance Effective Date of the Life Insurance Division transaction (July 1, 2008) and the actual Closing Date (September 30, 2008).

The Company recognized realized losses of $20.5 million during 2008 as compared to realized gains of $5.2 million during 2007. Realized losses for 2008 were primarily due to impairment charges recognized on certain fixed maturities investments of $26.0 million. These impairment charges resulted from other than temporary reductions in

the fair value of these investments compared to the Company s cost basis. *See* Note 4 of Notes to Consolidated Financial Statements for additional information. Additionally, realized losses for 2008 includes $8.5 million of losses related to the Coinsurance Agreements entered into in connection with the Life Insurance Division, which was partially offset by the realization of $5.5 million of contingent consideration associated with the sale of the former Student Insurance Division. *See* Note 2 of Notes to Consolidated Financial Statements for additional information.

We maintain, for the benefit of our independent agents, various stock-based compensation plans. In connection with these plans, we record a non-cash variable stock-based compensation benefit or expense based on the

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performance of the fair value of the Company s common stock. The Company recorded a variable stock-based compensation benefit of $6.8 million for 2008 as compared with a $482,000 benefit in 2007. The 2008 benefit is primarily a reflection of a 46% decrease in the value of the Company s share price on December 31, 2008 as compared to December 31, 2007.

General corporate expenses increased $27.5 million from $31.1 million during 2007 to $58.7 million during 2008. The increase is primarily due to $19.2 million of employee termination costs incurred during 2008 associated with the departure of several corporate executives, as well as additional employee termination costs associated with the strategic reduction of our remaining workforce implemented on November 18, 2008. Additional expenses included in general corporate expenses for 2008 include $6.5 million of broker, legal and transaction fees related to the Life Insurance Division transaction.

Year Ended December 31, 2007 versus December 31, 2006

Corporate reported an operating loss in 2007 of $31.3 million, compared to operating income of $89.1 million in 2006. On a comparative basis, the 2006 results were particularly impacted by the total $201.7 million of gains resulting from the sales of the Star HRG and Student Insurance Divisions partially offset by the $48.0 million of Merger costs.

Investment income not allocated to the Insurance segment (investment income on equity) increased $5.4 million, from $34.1 million in 2006 to $39.5 million in 2007. The increase primarily reflects particularly favorable earnings on an international fund investment which is not anticipated to recur based on the most recent activity in that market and a reduction in the size of our commitment to that investment vehicle.

Interest expense on corporate debt of $43.6 million in 2007 represents an $8.8 million or 25.3% increase over the $34.8 million incurred in 2006. This increase in interest expense is a function of a greater average outstanding debt balance in 2007 associated with the additional borrowings undertaken in connection with the Merger transaction in 2006. *See* Note 8 of Notes to Consolidated Financial Statements.

In 2007, we recognized a benefit of $482,000 in connection with variable stock-based compensation as compared to an expense of $16.6 million in 2006. These results primarily reflect a decrease in the fair value of our common stock on December 31, 2007 as compared to December 31, 2006.

General corporate expenses of $31.1 million in 2007 represented a $15.0 million decrease from the $46.1 million spent in 2006. The 2006 results included substantially more costs for a corporate branding initiative and other professional fees incurred for various special projects that were undertaken following the Merger.

Disposed Operations

Our Disposed Operations segment includes the former Life Insurance Division, former Star HRG Division and former Student Insurance Division.

On September 30, 2008, the Company exited the Life Insurance Division business through a reinsurance transaction effective July 1, 2009. On July 11, 2006 and December 1, 2006, the Company completed the sales of the assets formerly comprising its Star HRG and Student Insurance Divisions, respectively. *See* Note 2 of Notes to Consolidated Financial Statements.

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The table below sets forth income (loss) from continuing operations for our Disposed Operations for the years ended December 31, 2008, 2007 and 2006:

	December 31,		
	2008	2007	2006
	(In thousands)		
Income (loss) from Disposed Operations before federal income taxes:			
Life Insurance Division	$ (23,399)	$ 2,550	$ 5,264
Student Insurance Division	(359)	192	12,238
Star HRG Insurance Division	118	199	2,308
Total Disposed Operations	$ (23,640)	$ 2,941	$ 19,810

Life Insurance Division

Set forth below is certain summary financial and operating data for the Company s Life Insurance Division for the years ended December 31, 2008, 2007 and 2006:

	December 31,		
	2008	2007	2006
	(Dollars in thousands)		
Revenue			
Earned premium revenue	$ 36,437	$ 69,949	$ 65,716
Investment income	10,315	20,602	20,222
Other income	952	1,471	1,844
Total revenue	47,704	92,022	87,782
Benefits and Expenses			
Benefit, claims and settlement expenses	32,576	54,041	44,459
Underwriting, acquisition and insurance expenses	38,527	35,431	38,059
Total expenses	71,103	89,472	82,518
Operating income (loss)	$ (23,399)	$ 2,550	$ 5,264

Year Ended December 31, 2008 versus December 31, 2007

Effective July 1, 2008, Wilton agreed to reinsure on a 100% coinsurance basis substantially all of the insurance policies associated with the Company s former Life Insurance Division business. As such, the results of operations for 2008 are not comparable to results of operations for 2007 and 2006.

The Company s Life Insurance Division reported an operating loss in 2008 of $23.4 million compared to operating income of $2.6 million in 2007. The decrease in operating income for 2008 reflects a $13.0 million impairment charge

to underwriting, acquisition and insurance expenses as a result of the decision to exit this business. Based upon the consideration expected to be received in connection with the coinsurance arrangement, the Company recorded an impairment charge to DAC during 2008. *See* Note 2 of Notes to Consolidated Financial Statements. In addition, the Company incurred expenses in 2008 related to employee severance of $4.1 million and facility lease termination costs of $2.3 million. Also contributing to the decrease in operating income for 2008 was a strengthening of the future policy and contract benefit reserves of $3.9 million incurred in the first half of 2008 for certain interest sensitive whole life products.

Year Ended December 31, 2007 versus December 31, 2006

The Life Insurance Division reported operating income in 2007 of $2.6 million compared to operating income of $5.3 million in 2006, a decrease of $2.7 million. This decrease was largely attributable to a $9.6 million increase in benefits expenses partially offset by a $4.2 million increase in premium and a $2.6 million decrease in underwriting, acquisition and insurance expenses.

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Earned premium revenue at the Life Insurance Division increased to $69.9 million in 2007 compared to $65.7 million in 2006, an increase of $4.2 million or 6.4%. This increase reflects a greater level of renewal premiums from sales that originated in 2006 and prior years through our relationships with two independent marketing companies. The number of policies in force grew during 2007 as new sales exceeded the deterioration in existing blocks of business of older products.

Benefits expenses increased substantially in 2007 to $54.0 million from $44.5 million in 2006. This $9.5 million or 21.3% increase resulted from unusually adverse mortality experience. Underwriting, acquisition and insurance expenses decreased in 2007 to $35.4 million from $38.1 million in 2006, a decrease of $2.7 million or 7.1%. This reduction in expenses reflects a decrease in new sales and a decrease in the amortization of DAC based on more current actuarial assumptions.

In 2007, the Company s Life Insurance Division generated annualized paid premium volume (i.e., the aggregate annualized life premium amount associated with new life insurance policies issued by the company) of $18.4 million compared to $20.0 million in 2006.

Student Insurance Division

Set forth below is certain summary financial and operating data for the Company s former Student Insurance Division for each of the three most recent fiscal years:

	Year Ended December 31,		
	2008	**2007**	**2006**
	(Dollars in thousands)		
Revenues:			
Earned premium revenue	$	$	$ 233,280
Investment income			4,882
Other income			1,888
Total revenues			240,050
Expenses:			
Benefits, claims and settlement expenses	139	(634)	165,334
Underwriting, acquisition and insurance expenses	220	442	62,478
Total expenses	359	(192)	227,812
Operating income (loss)	$ (359)	$ 192	$ 12,238

The Company s Student Insurance Division (which offered tailored health insurance programs that generally provided single school year coverage to individual students at colleges and universities) reported an operating loss of $359,000 in 2008 and operating income of $192,000 in 2007 and $12.2 million in 2006. Very little activity has occurred in the Student Insurance Division since the sale on December 1, 2006.

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Star HRG Division

Set forth below is certain summary financial and operating data for the Company s former Star HRG Division (which designed, marketed and administered limited benefit health insurance plans for entry level, high turnover and hourly employees) for each of the three most recent fiscal years:

	Year Ended December 31,		
	2008	2007	2006
	(Dollars in thousands)		
Revenues:			
Earned premium revenue	$	$	$ 74,079
Investment income			369
Other income	125		929
Total revenues	125		75,377
Expenses:			
Benefits, claims and settlement expenses		32	46,387
Underwriting, acquisition and insurance expenses	7	(231)	26,682
Total expenses	7	(199)	73,069
Operating income	$ 118	$ 199	$ 2,308

The Company s Star HRG Division reported operating income of $118,000 in 2008, $199,000 in 2007 and $2.3 million in 2006. Very little activity has occurred in the Star HRG Division since it was sold on July 11, 2006.

Liquidity and Capital Resources

Consolidated

Historically, the Company s primary sources of cash on a consolidated basis have been premium revenue from policies issued, investment income, and fees and other income. The primary uses of cash have been payments for benefits, claims and commissions under those policies, servicing of the Company s debt obligations and operating expenses.

The Company has entered into several financing agreements designed to strengthen both its capital base and liquidity, the most significant of which are described below. Each of these agreements is discussed in more detail in our consolidated financial statements and related notes included elsewhere in the Form 10-K.

The following table sets forth additional information with respect to the Company s debt:

	Maturity Date	Interest Rate	December 31, 2008	December 31, 2007
2006 credit agreement:				

Term loan	2012	5.75%	$ 362,500	$ 362,500
$75 million revolver				
Trust preferred securities:				
UICI Capital Trust I	2034	5.65%	15,470	15,470
HealthMarkets Capital Trust I	2036	5.05%	51,550	51,550
HealthMarkets Capital Trust II	2036	8.37%	51,550	51,550
Total			$ 481,070	$ 481,070

In connection with the Merger, the Company borrowed $500.0 million under a term loan credit facility and issued $100.0 million of Floating Rate Junior Subordinated Notes during 2006.

We regularly monitor our liquidity position, including cash levels, credit line, principal investment commitments, interest and principal payments on debt, capital expenditures and matters relating to liquidity and to

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compliance with regulatory requirements. We maintain a line of credit in excess of anticipated liquidity requirements. As of December 31, 2008, HealthMarkets had a $75 million unused line of credit available to it.

Holding Company

HealthMarkets, Inc. is a holding company, the principal asset of which is its investment in its wholly owned subsidiary, HealthMarkets, LLC (collectively referred to as the holding company). The holding company s ability to fund its cash requirements is largely dependent upon its ability to access cash, by means of dividends or other means, from HealthMarkets, LLC. HealthMarkets, LLC s principal assets are its investments in its separate operating subsidiaries, including its regulated insurance subsidiaries.

Domestic insurance companies require prior approval by insurance regulatory authorities for the payment of dividends that exceed certain limitations based on statutory surplus and net income. During 2009, the Company s domestic insurance companies are eligible to pay, without prior approval of the regulatory authorities, aggregate dividends in the ordinary course of business to HealthMarkets, LLC of approximately $69.9 million. However, as it has done in the past, the Company will continue to assess the results of operations of the regulated domestic insurance companies to determine the prudent dividend capability of the subsidiaries, consistent with HealthMarkets practice of maintaining risk-based capital ratios at each of the Company s domestic insurance subsidiaries significantly in excess of minimum requirements.

At December 31, 2008, 2007 and 2006, the aggregate cash and cash equivalents and short-term investments held at HealthMarkets, Inc. and HealthMarkets, LLC was $232.1 million, $42.5 million and $311.5 million, respectively. Set forth below is a summary statement of aggregate cash flows for HealthMarkets, Inc. and HealthMarkets, LLC for each of the three most recent years:

	Year Ended December 31,		
	2008	2007	2006
	(In thousands)		
Cash and cash equivalents and short-term investments on hand at beginning of year	$ 42,505	$ 311,481	$ 151,423
Sources of cash:			
Dividends from domestic insurance subsidiaries	249,600	171,200	213,200
Dividends from offshore insurance subsidiaries	3,500	5,040	6,950
Dividends from non-insurance subsidiaries	30,058		1,607
Contribution by private equity firms			985,000
Debt proceeds			600,000
Proceeds from non-consolidated qualifying special purpose entity related to the promissory note received as consideration in the sale of Star HRG			144,294
Proceeds from other financing activities	18,301	54,185	27,870
Proceeds from stock option activities	335	1,164	337
Net tax treaty payments from subsidiaries	19,328	36,029	40,499
Net investment activities	8,665		3,221
Total sources of cash	329,787	267,618	2,022,978

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	Year Ended December 31,		
	2008	2007	2006
	(In thousands)		
Uses of cash:			
Cash to operations	(38,585)	(26,508)	(34,173)
Contributions/investment in subsidiaries	(6,654)	(15,484)	(635)
Interest on debt	(30,289)	(36,911)	(23,808)
Repayment of debt		(75,000)	(62,500)
Financing activities	(6,587)	(3,800)	(150)
Dividends paid to shareholders		(316,996)	
Purchases of HealthMarkets common stock	(58,054)	(41,535)	(8,744)
Net investment activities		(20,360)	
Merger transaction costs			(120,921)
Treasury stock purchase in Merger			(1,611,989)
Total uses of cash	(140,169)	(536,594)	(1,862,920)
Cash and cash equivalents on hand at end of year	$ 232,123	$ 42,505	$ 311,481
Cash and cash equivalents and short-term investments at HealthMarkets, Inc.	$ 30,748	$ 17,175	$ 48,578
Cash and cash equivalents and short-term investments at HealthMarkets, LLC.	201,375	25,330	262,903
Cash and cash equivalents and short-term investments on hand at end of year	$ 232,123	$ 42,505	$ 311,481

Sources of Cash and Liquidity

During 2008, 2007 and 2006, the holding company received an aggregate of $283.2 million, $176.2 million and $221.8 million, respectively, in cash dividends from our subsidiaries.

In 2008 and 2007, the holding company received $18.3 million and $54.2 million, respectively, in proceeds from other financing activities largely consisting of $14.8 and $50.4 million, respectively, in proceeds from subsidiaries to acquire shares in the agent stock plans. The corresponding amount in 2006 was $20.4 million. The 2007 activity was unusually greater than 2006 and 2008 in large part due to a $27.9 million reinvestment of the extraordinary cash dividend in May 2007.

On April 5, 2006, the holding company received $985.0 million for the purchase of common stock by the Private Equity Investors in connection with the Merger.

In April 2006, the holding company utilized proceeds from additional indebtedness of $600.0 million, consisting of $500.0 million under a term loan credit facility and $100.0 million of Floating Rate Junior Subordinated Notes to finance the Merger.

During 2006, the holding company received a total of $144.3 million in distributions from the non-consolidated qualifying special purpose entity, Grapevine Finance LLC. Of this total, $72.4 million resulted from a principal repayment by CIGNA on the $150.8 million note issued as consideration in the sale of Star HRG. The other $71.9 million resulted from Grapevine s issuance of senior secured notes.

Uses of Cash and Liquidity

During 2008, 2007 and 2006, the holding company paid $58.1 million, $41.5 million and $8.7 million, respectively, to repurchase shares of its common stock from former officers and former and current participants of the agent stock plans.

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In 2008, 2007 and 2006, the holding company paid $30.3 million, $36.9 million and $23.8 million, respectively in interest on outstanding debt, of which $17.8 million, $25.5 million and $22.0 million, respectively, related to the $362.5 million term loan facility.

During 2007 and 2006, the holding company made principal prepayments of $75.0 million and $62.5 million, respectively, on the term loan.

During 2007, the holding company paid an extraordinary cash dividend of $317.0 million.

In connection with the Merger, on April 15, 2006, the holding company utilized $1.6 billion to repurchase 43,567,252 shares of its common stock. Additionally, the holding company expended significant amounts of cash for expenses related to the Merger totaling $120.9 million.

Contractual Obligations and Off Balance Sheet Arrangements

Set forth below is a summary of the Company s consolidated contractual obligations at December 31, 2008:

	Payment Due by Period				
	Total	Less Than 1 Year	1-3 Years	3-5 Years	More Than 5 Years
			(In thousands)		
Corporate debt	$ 481,070	$	$	$ 362,500	$ 118,570
Future policy benefits(1)	486,174	29,993	48,633	45,350	362,198
Claim liabilities(1)	415,748	340,319	72,317	2,124	988
Student loan commitments(2)	116,893	10,760	21,999	29,780	54,354
Capital lease obligations	180	180			
Operating lease obligations	10,248	4,875	2,907	2,312	154
Total	$ 1,510,313	$ 386,127	$ 145,856	$ 422,066	$ 536,264

(1) In connection with the sales of the Company s former Life Insurance Division and Student Insurance Division, insurance subsidiaries of the Company entered into 100% coinsurance arrangements with each of the purchasers, pursuant to which the purchasers agreed to assume liability for future benefits associated with the Life Insurance and Student Insurance businesses. *See* Note 7 of Notes to Consolidated Financial Statements for additional information with respect to these coinsurance arrangements.

(2) In accordance with the terms of the Coinsurance Policies, Wilton will fund student loans; provided, however, that Wilton will not be required to fund any student loan that would cause the aggregate par value of all such loans funded by Wilton, following the Coinsurance Effective Date, to exceed $10.0 million. *See* Note 16 of Notes to Consolidated Financial Statements for additional information with respect to student loan commitments.

At each of December 31, 2008 and 2007, the Company had $33.9 million and $14.3 million, respectively, of letters of credit outstanding relating to its insurance operations.

Critical Accounting Policies and Estimates

The Company s discussion and analysis of its consolidated financial condition and results of operations are based upon the Company s consolidated financial statements, which have been prepared in accordance with GAAP. The preparation of these financial statements requires the Company to make estimates and judgments that affect the reported amounts of assets, liabilities, revenues and expenses and related disclosure of contingent assets and liabilities. On an on-going basis, the Company evaluates its estimates, including those related to health and life insurance claims, bad debts, investments, intangible assets, income taxes, financing operations and contingencies and litigation. The Company bases its estimates on historical experience and on various other assumptions that are believed to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates under different assumptions or conditions.

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The Company believes the following critical accounting policies affect its more significant judgments and estimates used in the preparation of its consolidated financial statements, which are discussed in more detail below:

valuations of assets and liabilities requiring fair value estimates, including but not limited to:

investments, including the recognition of other-than-temporary impairments;

allowance for doubtful accounts;

the amount of claims liabilities expected to be paid in future periods;

the realization of deferred acquisition cost;

the carrying amount of goodwill and other intangible assets;

the amortization period of intangible assets;

stock-based compensation plan forfeitures;

the realization of deferred taxes;

reserves for contingencies, including reserves for losses in connection with unresolved legal matters; and

other matters that affect the reported amounts and disclosure of contingencies in the financial statements.

Estimates, by their nature, are based on judgment and available information. Therefore, actual results could differ from those estimates and could have a material impact on the consolidated financial statements.

Investments

The Company has classified its investments in securities with fixed maturities as either available for sale or trading. Fixed maturities classified as available for sale and equity securities have been recorded at fair value, and unrealized investment gains and losses are reflected in stockholders equity. Trading investments have been recorded at fair value, and investment gains and losses are reflected in Realized gains (losses) on the statement of income (loss).

Investments are reviewed quarterly (or more frequently if certain indicators arise) to determine if they have suffered an impairment of value that is considered other than temporary. Management s review considers the following indicators of impairment: fair value significantly below cost; decline in fair value attributable to specific adverse conditions affecting a particular investment; decline in fair value attributable to specific conditions, such as conditions in an industry or in a geographic area; decline in fair value for an extended period of time; downgrades by rating agencies from investment grade to non-investment grade; financial condition of the issuer deterioration and situations where dividends have been reduced or eliminated or scheduled interest payments have not been made. Management monitors investments where two or more of the above indicators exist. If investments are determined to be other than temporarily impaired, a loss is recognized at the date of determination.

Testing for impairment of investments requires significant management judgment. The identification of potentially impaired investments, the determination of their fair value and the assessment of whether any decline in value is other than temporary are the key judgment elements. The discovery of new information and the passage of time can significantly change these judgments. Revisions of impairment judgments are made when new information becomes

known, and any resulting impairments are made at that time. The economic environment and volatility of securities markets increase the difficulty of determining fair value and assessing investment impairment. The same influences tend to increase the risk of potentially impaired assets.

Investment in a Non-Consolidated Subsidiary

On August 3, 2006, Grapevine was incorporated in the State of Delaware as a wholly owned subsidiary of HealthMarkets, LLC. On August 16, 2006, the Company distributed and assigned to Grapevine the $150.8 million promissory note (CIGNA Note) and related Guaranty Agreement issued by Connecticut General Corporation in the Star HRG sale transactio*n. See* Note 10 of Notes to Consolidated Financial Statements. On August 16, 2006, Grapevine issued $72.4 million of its senior secured notes to an institutional purchaser collateralized by Grapevine s

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assets including the CIGNA Note. The net proceeds from the senior secured notes were distributed to HealthMarkets, LLC.

Grapevine is a non-consolidated qualifying special purpose entity as defined in SFAS No. 140, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*. As a qualifying special purpose entity, HealthMarkets does not consolidate the financial results of Grapevine. Instead, the Company accounts for its residual interest in Grapevine as an investment in fixed maturity securities pursuant to EITF 99-20, *Recognition of Interest Income and Impairment on Purchase and Retained Beneficial Interests in Securitized Financial Assets*.

The Company measures the fair value of its residual interest in Grapevine using a present value model incorporating the following two key economic assumptions: (1) the timing of the collections of interest on the CIGNA Note, payments of interest expense on the senior secured notes and payment of other administrative expenses and (2) an assumed yield observed on a comparable CIGNA bond.

Fair Value Measurement

As discussed in Notes 1 and 3 of Notes to Consolidated Financial Statements, the Company adopted SFAS No. 157 effective January 1, 2008. SFAS No. 157 establishes a framework for measuring fair value that includes a hierarchy used to classify the inputs used in measuring fair value. The hierarchy prioritizes the inputs to valuation techniques used to measure fair value into three levels. The level in the fair value hierarchy within which the fair value measurement falls is determined based on the lowest level input that is significant to the fair value measurement. The levels of the fair value hierarchy are as follows:

Level 1 Unadjusted quoted market prices for identical assets or liabilities in active markets which are accessible by the Company.

Level 2 Observable prices in active markets for similar assets or liabilities. Prices for identical or similar assets or liabilities in markets that are not active. Directly observable market inputs for substantially the full term of the asset or liability, such as interest rates and yield curves at commonly quoted intervals, volatilities, prepayment speeds, default rates, and credit spreads. Market inputs that are not directly observable but are derived from or corroborated by observable market data.

Level 3 Unobservable inputs based on the Company s own judgment as to assumptions a market participant would use, including inputs derived from extrapolation and interpolation that are not corroborated by observable market data.

As discussed in more detail below, the determination of fair value for certain assets and liabilities may require the application of a greater degree of judgment given current market conditions, as the ability to value assets can be significantly impacted by a decrease in market activity. The Company evaluates the various types of securities in its investment portfolio to determine the appropriate level in the fair value hierarchy based upon trading activity and the observability of market inputs. The Company employs control processes to validate the reasonableness of the fair value estimates of its assets and liabilities, including those estimates based on prices and quotes obtained from independent third party sources. The Company s procedures generally include, but are not limited to, initial and on-going evaluation of methodologies used by independent third parties and monthly analytical reviews of the prices against current pricing trends and statistics.

Where possible, the Company utilizes quoted market prices to measure fair value. For investments that have quoted market prices in active markets, the Company uses the quoted market price as fair value and includes these prices in the amounts disclosed in Level 1 of the hierarchy. When quoted market prices in active markets are unavailable, the

Company determines fair values using various valuation techniques and models based on a range of observable market inputs including pricing models, quoted market price of publicly traded securities with similar duration and yield, time value, yield curve, prepayment speeds, default rates and discounted cash flow. In most cases, these estimates are determined based on independent third party valuation information, and the amounts are disclosed in Level 2 of the fair value hierarchy. Generally, the Company obtains a single price or quote per instrument from independent third parties to assist in establishing the fair value of these investments.

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If quoted market prices and independent third party valuation information are unavailable, the Company produces an estimate of fair value based on internally developed valuation techniques, which, depending on the level of observable market inputs, will render the fair value estimate as Level 2 or Level 3. On occasions when pricing service data is unavailable, the Company may rely on bid/ask spreads from dealers in determining fair values. When dealer quotations are used to assist in establishing the fair value, the Company obtains one quote per instrument. The quotes obtained from dealers or brokers are generally non-binding. When dealer quotations are used, the Company uses the mid-mark as fair value. When broker or dealer quotations are used for valuation or price verification, greater priority is given to executable quotes. As part of the price verification process, valuations based on quotes are corroborated by comparison both to other quotes and to recent trading activity in the same or similar instruments.

Historically, the Company had not experienced a circumstance where it had determined that an adjustment to a quote or price received from an independent third party valuation source was required. To the extent the Company determines that a price or quote is inconsistent with actual trading activity observed in that investment or similar investments, or if the Company does not think the quote is reflective of the market value for the investment, the Company will internally develop a fair value using this observable market information and disclose the occurrence of this circumstance. During the year ended December 31, 2008, the Company determined that the non-binding quote received from an independent third party broker for a particular collateralized debt obligation investment did not reflect fair value. In accordance with guidance provided in FSP 157-3, the Company determined the fair value of this security based on other internally developed approaches, which are discussed in Note 3 of Notes to Consolidated Financial Statements.

Claims Liabilities

The Company establishes liabilities for benefit claims that have been reported but not paid and claims that have been incurred but not reported under health and life insurance contracts. The claim liability estimate, as determined, is expected to be adequate under reasonably likely circumstances. The estimate is developed using actuarial principles and assumptions that consider a number of items, including, but not limited to, historical and current claim payment patterns, product variations, the timely implementation of rate increases and seasonality. The Company does not develop ranges in the setting of the claims liability reported in the financial statements.

For the majority of health insurance products in the SEA Division, the Company s claim liabilities are estimated using the developmental method, which involves the use of completion factors for most incurral months, supplemented with additional estimation techniques, such as loss ratio estimates, in the most recent incurral months. This method applies completion factors to claim payments in order to estimate the ultimate amount of the claim. These completion factors are derived from historical experience and are dependent on the incurred dates of the claim, as well as the dates a payment is made against the claim. The completion factors are selected so that they are equally likely to be redundant as deficient.

In estimating the ultimate level of claims for the most recent incurral months, the Company uses what it believes are prudent estimates that reflect the uncertainty involved in these incurral months. An extensive degree of judgment is used in this estimation process. For healthcare costs payable, the claim liability balances and the related benefit expenses are highly sensitive to changes in the assumptions used in the claims liability calculations. With respect to health claims, the items that have the greatest impact on the Company s financial results are the medical cost trend, which is the rate of increase in healthcare costs, and the unpredictable variability in actual experience. Any adjustments to prior period claim liabilities are included in the benefit expense of the period in which adjustments are identified. Due to the considerable variability of healthcare costs and actual experience, adjustments to health claim liabilities usually occur each quarter and may be significant.

The Company establishes the claims liability dependent upon the incurred dates, with certain adjustments, as described below. With respect to the SEA Division, for certain products introduced prior to 2008, claims liabilities for the cost of all medical services related to a distinct accident or sickness are recorded at the earliest date of diagnosis or treatment, even though the medical services associated with such accident or sickness might not be rendered to the insured until a later financial reporting period. A break in occurrence of a covered benefit service of

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more than six months will result in the establishment of a new incurred date for subsequent services. A new incurred date is established if claims payments continue for more than thirty-six months without a six month break in service.

For products introduced in 2008, claim payments are considered incurred on the date the service is rendered, regardless of whether the sickness or accident is distinct or the same. This is consistent with the assumptions used in the pricing of these products, which represent less than 10% of the total claim liability of the SEA Division at December 31, 2008.

The SEA Division also makes various refinements to the claim liabilities as appropriate. These refinements estimate liabilities for circumstances such as inventories of pending claims in excess of historical levels and disputed claims. When the level of pending claims appears to be in excess of normal levels, the Company typically establishes a liability for excess pending claims. The Company believes that such an excess pending claims liability is appropriate under such circumstances because of the operation of the developmental method used to calculate the principal claim liability, which method develops or completes paid claims to estimate the claim liability. When the pending claims inventory is higher than would ordinarily be expected, the level of paid claims is correspondingly lower than would ordinarily be expected. This lower level of paid claims, in turn, results in the developmental method yielding a smaller claim liability than would have been yielded with a normal level of paid claims, resulting in the need for augmented claim liabilities.

With respect to Other Insurance, the Company assigns incurred dates based on the date of loss, which estimates the liability for all payments related to a loss at the end of the applicable financial period in which the loss occurs.

With respect to Disposed Operations, the Company primarily assigns incurred dates based on the date of service, which estimates the liability for all medical services received by the insured prior to the end of the applicable financial period. Adjustments are made in the completion factors to account for pending claim inventory changes and contractual continuation of coverage beyond the end of the financial period. However, for the workers compensation business that was part of the Life Insurance Division operations, for which the Company still retains some risk, the Company assigns incurred dates based on the date of loss.

The completion factors and loss ratio estimates in the most recent incurral months are the most significant factors affecting the estimate of the claim liability. The Company believes that the greatest potential for variability from estimated results is likely to occur at its SEA Division. The following table illustrates the sensitivity of these factors and the estimated impact to the December 31, 2008 unpaid claim liability for the SEA Division. We believe that the scenarios selected are reasonable based on the Company s past experience, however, future results may differ.

Completion Factor(a)		Loss Ratio Estimate(b)	
Increase (Decrease) in Factor	**Increase (Decrease) in Estimated Claim Liability (In thousands)**	**Increase (Decrease) in Ratio(c)**	**Increase (Decrease) in Estimated Claim Liability (In thousands)**
0.015	$ (28,426)	6	$ 29,773
0.010	(19,750)	3	14,886
0.005	(10,151)	(3)	(14,886)
(0.005)	10,374	(6)	(29,773)
(0.010)	20,864	(9)	(44,659)
(0.015)	31,471	(12)	(59,545)

(a) Impact due to change in completion factors for incurred months prior to the most recent five months.

(b) Impact due to change in estimated loss ratio for the most recent five months.

(c) For example, if the loss ratio increased from 50% to 56% this would be an increase of 6.

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Set forth below is a summary of claim liabilities by business unit at each of December 31, 2008, 2007 and 2006:

	At December 31,		
	2008	2007	2006
	(In thousands)		
Self-Employed Agency Division	$ 348,044	$ 371,861	$ 417,571
Other Insurance	15,493	13,747	14,289
Medicare	19,773		
Disposed Operations(1)	1,122	12,198	12,690
Subtotal	384,432	397,806	444,550
Reinsurance recoverable(2)	31,316	37,293	72,582
Total claim liabilities	$ 415,748	$ 435,099	$ 517,132

(1) Reflects claims liabilities associated with the Company s former Life Insurance Division, former Student Insurance Division and former Star HRG Division. The claims liabilities remaining at December 31, 2008, 2007 and 2006 primarily represent the liability associated with a closed block of workers compensation business previously offered by the Company through its former Life Insurance Division.

(2) Reflects liability related to unpaid losses recoverable. The amount associated with Disposed Operations in 2008, 2007 and 2006 is $26.6 million, $33.3 million, and $69.3 million, respectively.

The developmental method used by the Company to estimate most of its claim liabilities produces a single estimate of reserves for both in course of settlement (ICOS) and incurred but not reported (IBNR) claims on an integrated basis. Since the IBNR portion of the claim liability represents claims that have not been reported to the Company, this portion of the liability is inherently more imprecise and difficult to estimate than other liabilities. A separate IBNR or ICOS reserve is estimated from the combined reserve by allocating a portion of the combined reserve based on historical payment patterns. Approximately 81-83% of the Company s claim liabilities represent IBNR claims.

Set forth in the table below is the summary of the incurred but not reported claim liability by business unit at each of December 31, 2008, 2007 and 2006:

	At December 31,		
	2008	2007	2006
	(In thousands)		
Self Employed Agency Division	$ 289,096	$ 309,462	$ 346,060
Other Insurance	15,474	13,700	14,177
Medicare Division	19,773		
Disposed Operations(1)	10	3,957	5,436
Subtotal	324,353	327,119	365,673

Reinsurance recoverable	10,554	32,270	65,341
Total IBNR claim liability	334,907	359,389	431,014
ICOS claim liability	60,079	70,687	78,877
Reinsurance recoverable	20,762	5,023	7,241
Total ICOS claim liability	80,841	75,710	86,118
Total claim liability	$ 415,748	$ 435,099	$ 517,132
Percent of IBNR to Total	81%	83%	83%

(1) Reflects incurred claims liabilities associated with the Company s former Life Insurance Division, former Student Insurance Division and former Star HRG Division.

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Claims Liability Development Experience

Activity in the claims liability is summarized as follows:

	Year Ended December 31,		
	2008	2007	2006
	(In thousands)		
Claims liability at beginning of year, net of reinsurance	$ 397,806	$ 444,550	$ 546,001
Less: Claims liability paid on business disposed	(10,694)		(68,617)
Add:			
Incurred losses, net of reinsurance, occurring during:			
Current year	858,855	851,575	1,059,032
Prior years	(23,157)	(75,024)	(90,697)
Total incurred losses, net of reinsurance	835,698	776,551	968,335
Deduct:			
Payments for claims, net of reinsurance, occurring during:			
Current year	545,368	535,987	664,220
Prior years	293,010	287,308	336,949
Total paid claims, net of reinsurance	838,378	823,295	1,001,169
Claims liability at end of year, net of related reinsurance recoverable (2008 $31,316; 2007 $37,293; 2006 $72,582)	$ 384,432	$ 397,806	$ 444,550

Set forth in the table below is a summary of the claims liability development experience (favorable) unfavorable by business unit in the Company s Insurance segment for each of the years ended December 31, 2008, 2007 and 2006:

	Year Ended December 31,		
	2008	2007	2006
	(In thousands)		
Self-Employed Agency Division	$ (20,305)	$ (75,552)	$ (85,784)
Other Insurance	(2,931)	734	(2,530)
Disposed Operations	79	(206)	(2,383)
Total favorable development	$ (23,157)	$ (75,024)	$ (90,697)

Impact on SEA Division. As indicated in the table above, incurred losses developed at the SEA Division in amounts less than originally anticipated due to better-than-expected experience on the health business in each of the years.

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For the SEA Division, the favorable claims liability development experience in the prior year s reserve for each of the years ended December 31, 2008, 2007, and 2006 is set forth in the table below by source:

	Year Ended December 31,		
	2008	2007	2006
	(In thousands)		
Development in the most recent incurral months	$ (14,744)	$ (25,957)	$ (31,949)
Development in completion factors	2,495	(9,536)	(4,606)
Development in reserves for regulatory and legal matters	(1,888)	(14,991)	(4,762)
Development in ACE rider	(5,784)	(13,670)	(29,726)
Development in non-renewed blanket policies	(149)	(6,669)	
Development in large claim reserve			(10,555)
Other	(235)	(4,729)	(4,186)
Total favorable development	$ (20,305)	$ (75,552)	$ (85,784)

The total favorable claims liability development experience for 2008, 2007 and 2006 in the amount of $20.3 million, $75.6 million and $85.8 million, respectively, represented 5.5%, 18.1% and 19.5% of total claim liabilities established for the SEA Division as of December 31, 2007, 2006 and 2005, respectively.

Development in the most recent incurral months and development in completion factors

As indicated in the table above, considerable favorable development ($12.2 million, $35.5 million and $36.6 million for the year ended December 31, 2008, 2007 and 2006, respectively) is associated with the estimate of claim liabilities for the most recent incurral months and development of completion factors. In estimating the ultimate level of claims for the most recent incurral months, the Company uses what it believes are prudent estimates that reflect the uncertainty involved in these incurral months. An extensive degree of judgment is used in this estimation process. For healthcare costs payable, the claim liability and the related benefit expenses are highly sensitive to changes in the assumptions used in the claims liability calculations. With respect to health claims, the items that have the greatest impact on the Company s financial results are the medical cost trend, which is the rate of increase in healthcare costs, and the unpredictable variability in actual experience. Over time, the developmental method replaces anticipated experience with actual experience, resulting in an ongoing re-estimation of the claims liability. Since the greatest degree of estimation is used for more recent periods, the most recent prior year is subject to the greatest change. Recent actual experience has produced lower levels of claims payment experience than originally expected. *See* discussion below regarding *Changes in SEA Claim Liability Estimates*.

Development in reserves for regulatory and legal matters

The Company experienced favorable development for each of the three years presented in the table above associated with its reserves for regulatory and legal matters due to settlements of certain matters on terms more favorable than originally anticipated.

Development in the ACE rider

The Accumulated Covered Expense (ACE) rider is an optional benefit rider available with certain scheduled/basic health insurance products that provides for catastrophic coverage for covered expenses under the contract that

generally exceed $100,000 or, in certain cases, $75,000. This rider pays benefits at 100% after the stop loss amount is reached up to the aggregate maximum amount of the contract for expenses covered by the rider. Development in the ACE rider is presented separately due to the greater level of volatility in the ACE product resulting from the nature of the benefit design where there are less frequent claims but larger dollar value claims. The development experience presented in the table above is largely attributable to development in the most recent incurral months and development in the completion factors. *See* discussion below regarding *Changes in the SEA Claim Liability Estimates*.

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Cancellation of Blanket Policies

In 2008 and 2007, the SEA Division benefited from favorable development in its claim liability of $149,000 and $6.7 million, respectively, related to its reserve for benefits provided through group blanket contracts to the members of certain associations. These contracts were terminated at the end of 2006 and the Company s subsequent actual experience was favorable in comparison to the reserve estimates established prior to the termination of the contracts.

Development in large claim reserve

During 2006, the Company determined that sufficient provision for large claims could be made within its normal reserve process, thus eliminating the need for the separate large claim reserve and producing favorable development in the amount of $10.6 million. Since this reserve was eliminated in 2006, there is no development, either favorable or unfavorable, related to this reserve in either 2008 or 2007.

Other

The remaining favorable development in the prior year s claim liability was $235,000, $4.7 million and $4.2 million in 2008, 2007, and 2006, respectively, which in each year represents less than 1.1% of the total claim liability established at the end of each preceding year.

Impact on Other Insurance

The favorable claim liability development experience at ZON Re in 2008 of $2.9 million was due to the release of excess reserves. The unfavorable claim liability development experience in 2007 of $734,000 was due to certain large claims reported in 2007 associated with claims incurred in prior years. The favorable claim liability experience of $2.5 million in 2006 is due to the release of reserves held at December 31, 2005 for catastrophic excess of loss contracts expiring during 2006.

Impact on Disposed Operations

During 2008 and 2007, the development of the claim liabilities for the Disposed Operations showed a small unfavorable development of $79,000 and a small favorable development of $206,000, respectively. The products of the Company s former Student Insurance and Star HRG Divisions consist principally of health insurance. In general, health insurance business, for which incurred dates are assigned based on date of service, has a short tail, which means that a favorable development or unfavorable development shown for prior years relates primarily to actual experience in the most recent prior year. Also included in Disposed Operations is the development experience for each of the years presented of a closed block of workers compensation business at the former Life Insurance Division.

The favorable claim liability development experience at the Student Insurance Division in 2006 was $478,000. This favorable development was due to claims in the current year developing more favorably than indicated by the loss trends used to determine the claim liability at December 31 of the preceding year.

The favorable claims liability development experience at Star HRG Division of $1.4 million in 2006 included the effects of claims in 2006 developing more favorably than indicated by the loss trends in 2005 used to determine the claim liability at December 31, 2005.

Changes in SEA Claim Liability Estimates

As discussed above, the SEA Division reported particularly favorable experience development on claims incurred in prior years in the reported values of subsequent years. As discussed below, a significant portion of the favorable experience development was attributable to the recognition of the patterns used in establishing the completion factors that were no longer reflective of the expected future patterns that underlie the claim liability.

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In response to evaluating these results, the Company has recognized the nature of its business is constantly changing. As such, HealthMarkets has refined its estimates and assumptions used in calculating the claim liability estimate to regularly accommodate the changing patterns immediately as they emerge.

As a result of these efforts, no additional refinements to the claim liability estimation techniques were found to be necessary during 2008 over and above the regular update of the completion factors, the impact of which are included in the benefit expense of the period in which the update occurred.

In prior reporting periods the Company made the following changes in estimate, by year, as described below:

2007 Change in Claim Liability Estimates. During 2007, the Company made the following refinements to its claim liability estimate.

The claim liability was reduced by $12.3 million resulting from a refinement to the estimate of unpaid claim liability specifically for the most recent incurral months. In particular, the Company reassessed its claim liability estimates among product lines between the more mature scheduled benefit products that have more historical data and are more predictable, and the newer products that are less mature, have less historical data and are more susceptible to adverse deviation.

A reduction in the claim liability of $11.2 million was attributable to an update of the completion factors used in the developmental method of estimating the unpaid claim liability to reflect more recent claims payment experience.

The Company made certain refinements to reduce its estimate of the claim liability for the ACE rider totaling $10.9 million. These refinements were attributable to updates of the completion factors used in estimating the claim liability for the ACE rider, reflecting an increasing reliance on actual historical data for the ACE rider in lieu of large claim data derived from other products.

2006 Change in Claim Liability Estimates. During 2006, the Company made the following refinements to its claim liability estimate.

The Company reduced the claim liability estimate by $11.2 million due to refinements of the estimate of the unpaid claim liability for the most recent incurral months. This update to the calculation distinguished between more mature products with reliable historical data and newer or lower volume products that had not established a reliable historical trend.

During 2006, the Company reduced the claim liability estimate by a total of $25.1 million for the ACE rider. These reductions were attributable to an update of the completion factors used in estimating the claim liability, reflecting both actual historical data for the ACE rider and historical data derived from other products. In 2005, the completion factors were calculated with more emphasis placed on historical data derived from other products since there was insufficient data related to the ACE product rider to provide accurate and reliable completion factors.

Acquisition Costs

Health Policy Acquisition Costs

The Company incurs various costs in connection with the origination and initial issuance of its health insurance policies, including underwriting and policy issuance costs, costs associated with lead generation activities and

distribution costs (*i.e.,* sales commissions paid to agents). The Company defers those costs that vary with production. The Company generally defers commissions paid to agents and premium taxes with respect to the portion of health premium collected but not yet earned and the Company amortizes the deferred expense over the period as premium is earned. Costs associated with generating sales leads with respect to the health business issued through the SEA Division are capitalized and amortized over the average life of a policy, which approximates a two-year period. Other underwriting and policy issuance costs (which the Company estimates are more fixed than variable) are expensed as incurred.

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2006 Change in Accounting Policy

At December 31, 2006, the Company changed its accounting policy, effective January 1, 2006, with respect to the amortization of a portion of DAC associated with commissions paid to agents.

The Company formerly capitalized commissions and premium taxes associated with its SEA Division business, classified as DAC, and amortized all of these costs over the period (and in proportion to the amount) that the associated unearned premium was earned. The Company utilized this accounting methodology in preparing its reported 2006 interim financial statements.

Following adoption of SEC Staff Accounting Bulletin No. 108, *Considering the Effects of Prior Year Misstatements when Quantifying Misstatements in the Current Year Financial Statements* (SAB No. 108), the Company performed an analysis to determine the appropriate portion of commissions to be deferred over the lives of the underlying policies. Generally, the first year and second year commission rates are higher than the renewal year commission rates, and, as such, the Company has determined that the preferred approach is to capitalize the excess commissions associated with those earlier years and amortize the capitalized costs ratably over the estimated life of the policy. Accordingly, the Company has elected to change its accounting methodology by amortizing the first and second year excess commissions ratably over the average life of the policy which approximates a two year period.

The Company elected to utilize the one time special transition provisions of SAB 108 and recorded an adjustment to retained earnings effective January 1, 2006 to reflect this change in accounting policy with respect to the capitalization and amortization of DAC associated with excess first and second year commissions. As of January 1, 2006, the change in accounting policy resulted in an increase in the Company s capitalized DAC of $77.6 million, a related increase to its deferred tax liability by $27.1 million, and a net increase to shareholders equity of $50.5 million. The adoption of this new accounting policy had the effect of increasing reported underwriting, acquisition and insurance expenses (classified to its SEA Division) in 2006 by $15.5 million and, correspondingly, reducing after-tax net income by $10.1 million.

Other

The cost of business acquired through acquisition of subsidiaries or blocks of business is determined based upon estimates of the future profits inherent in the business acquired. Such costs are capitalized and amortized over the estimated premium-paying period. Anticipated investment income is considered in determining whether a premium deficiency exists. The amortization period is adjusted when estimates of current or future gross profits to be realized from a group of products are revised. We monitor and assess the recoverability of these capitalized costs on a quarterly basis and, as of December 31, 2008, we believe these costs are recoverable. Traditionally, such costs have been primarily related to acquisitions by the Company s former Life Insurance Division. At December 31, 2008, the Company did not have any remaining capitalized costs related to the cost of business acquired through acquisition of subsidiaries or blocks of business.

Goodwill and Other Identifiable Intangible Assets

The Company accounts for goodwill and other intangibles according to Financial Accounting Standards Board (FASB) Statement of Financial Accounting Standards (SFAS) No. 142, *Goodwill and Other Intangible Assets* (SFAS No. 142). SFAS No. 142 requires that goodwill and other intangible assets with indefinite useful lives be tested for impairment at least annually or more frequently if certain indicators arise. An impairment loss would be recorded in the period such determination was made. SFAS No. 142 also requires that intangible assets with estimable useful lives be amortized over their respective estimated useful lives to their estimated residual values and reviewed for impairment. The Company amortizes its intangible assets with estimable useful lives over a period ranging from five

to twenty-five years. *See* Note 5 of Notes to Consolidated Financial Statements.

Accounting for Agent Stock Accumulation Plans

The Company sponsors a series of stock accumulation plans (the Agent Plans) established for the benefit of its independent insurance agents and independent sales representatives. Unvested benefits under the agent plans

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vest in January of each year. The Company has established a liability for future unvested benefits under the Agent Plans and adjusts such liability based on the fair value of the Company s common stock. As such, the Company has experienced, and will continue to experience, unpredictable stock-based compensation charges, depending upon fluctuations in the fair value of HealthMarkets Class A-2 common stock. These unpredictable fluctuations in stock based compensation charges may result in material non-cash fluctuations in the Company s results of operations. *See* discussion above under the caption Variable Stock-Based Compensation and Note 13 of Notes to Consolidated Financial Statements.

Deferred Taxes

The Company records deferred tax assets to reflect the impact of temporary differences between the financial statement carrying amounts and tax bases of assets. Realization of the net deferred tax asset is dependent on generating sufficient future taxable income. The amount of the deferred tax asset considered realizable, however, could be reduced in the near term if estimates of future taxable income during the carryforward period are reduced.

The Company establishes a valuation allowance when management believes, based on the weight of the available evidence, that it is more likely than not that some portion of the deferred tax asset will not be realized. The Company considers future taxable income and ongoing prudent and feasible tax planning strategies in assessing the continued need for a recorded valuation allowance. Establishing or increasing the valuation allowance would result in a charge to income in the period such determination was made. In the event the Company were to determine that it would be able to realize its deferred tax assets in the future in excess of its net recorded amount, an adjustment to the deferred tax asset would increase income in the period such determination was made.

Loss Contingencies

The Company is subject to proceedings and lawsuits related to insurance claims and other matters. *See* Note 16 of Notes to Consolidated Financial Statements. The Company is required to assess the likelihood of any adverse judgments or outcomes to these matters, as well as potential ranges of probable losses. A determination of the amount of accruals required, if any, for these contingencies is made after careful analysis of each individual issue. The required accruals may change in the future due to new developments in each matter or changes in approach, such as a change in settlement strategy in dealing with these matters.

Risk Management

The Company encounters risk in the normal course of business and therefore we have designed risk management processes to help manage such risks. The Company is subject to varying degrees of market risks, inflation risk, operational risks and liquidity risks (*see* Liquidity and Capital Resources discussion above) and monitors these risks on a consolidated basis.

Market Risks

Market risk is the risk of loss arising from adverse changes in market rates and prices. Market risk is directly influenced by the volatility and liquidity in the markets in which the related underlying assets are traded.

Sensitivity analysis is defined as the measurement of potential loss in future earnings, fair values or cash flows of market sensitive instruments resulting from one or more selected hypothetical changes in interest rates and other market rates or prices over a selected time. In the Company s sensitivity analysis model, a hypothetical change in market rates is selected that is expected to reflect reasonably possible near-term changes in those rates. Near term is defined as a period of time going forward up to one year from the date of the consolidated financial statements.

In this sensitivity analysis model, the Company uses fair values to measure its potential loss. The primary market risk to the Company s market sensitive instruments is interest rate risk. The sensitivity analysis model uses a 100 basis point change in interest rates to measure the hypothetical change in fair value of financial instruments included in the model. For invested assets, duration modeling is used to calculate changes in fair values. Duration on invested assets is adjusted to call, put and interest rate reset features.

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The sensitivity analysis model increases the loss in fair value of market sensitive instruments by $41.7 million based on a 100 basis point increase in interest rates as of December 31, 2008. This loss value only reflects the impact of an interest rate increase on the fair value of the Company s financial instruments.

The Company uses interest rate swaps as part of its risk management activities to protect against the risk of changes in prevailing interest rates adversely affecting future cash flows associated with $300.0 million of the $362.5 million term loan debt. Approximately $129.5 million of the Company s remaining outstanding debt at December 31, 2008, was exposed to the fluctuation of the three-month London Inter-bank Offer Rate (LIBOR). The sensitivity analysis shows that if the three-month LIBOR rate changed by 100 basis points (1%), the Company s interest expense would change by approximately $1.3 million.

The Company s Investment Committee monitors the investment portfolio of the Company and its subsidiaries. The Investment Committee receives investment management services from external professionals and from the Company s in-house investment management team. The internal investment management team monitors the performance of the external managers as well as directly managing approximately 84% of the investment portfolio.

Investments are selected based upon the parameters established in the Company s investment policies. Emphasis is given to the selection of high quality, liquid securities that provide current investment returns. Maturities or liquidity characteristics of the securities are managed by continually structuring the duration of the investment portfolio to be consistent with the duration of the policy liabilities. Consistent with regulatory requirements and internal guidelines, the Company invests in a range of assets, but limits its investments in certain classes of assets, and limits its exposure to certain industries and to single issuers.

Fixed maturity securities represented 78.3% and 88.0% of the Company s total investments at December 31, 2008 and 2007, respectively. Fixed maturity securities at December 31, 2008 consisted of the following:

	December 31, 2008	
	Carrying Value	% of Total Carrying Value
	(Dollars in thousands)	
U.S. and U.S. Government agencies	$ 37,808	4.7%
Corporate bonds and municipals	555,825	69.0%
Mortgage-backed securities issued by U.S. Government agencies and authorities	112,506	14.0%
Other mortgage and asset backed securities	92,927	11.5%
Other	5,960	0.8%
Total fixed maturity securities	$ 805,026	100.0%

Corporate bonds, included in the fixed maturity portfolio, consist primarily of short term and medium term investment grade bonds. The Company s investment policy with respect to concentration risk limits individual investment grade bonds to 3% of assets and non-investment grade bonds to 2% of assets. The policy also limits the investments in any one industry to 20% of assets. As of December 31, 2008, the largest concentration in any one investment grade corporate bond was $87.5 million, which represented 8.5% of total invested assets. This security was received as payment on the sale of the Student Insurance Division. To limit its credit risk, the Company has taken out $75.0 million of credit default insurance on this bond, reducing its default exposure to $19.8 million, or 1.9% of total

invested assets. The largest concentration in any one non-investment grade corporate bond was $4.3 million, which represented less than 1% of total invested assets. The largest concentration to any one industry was less than 10%. Additionally, due primarily to long standing conservative investment guidelines, our direct exposure to sub prime investments and auction rate securities is limited to 3.2% of investments.

Included in the fixed maturity portfolio are mortgage-backed securities, including collateralized mortgage obligations, mortgage-backed pass-through certificates and commercial mortgage-backed securities. To limit its credit risk, the Company invests in mortgage-backed securities that are rated investment grade by the public rating agencies. The Company s mortgage-backed securities portfolio is a conservatively structured portfolio that is concentrated in the less volatile tranches, such as planned amortization classes and sequential classes. The

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Company seeks to minimize prepayment risk during periods of declining interest rates and minimize duration extension risk during periods of rising interest rates. The Company has less than 1% of its investment portfolio invested in the more volatile tranches.

A quality distribution for fixed maturity securities at December 31, 2008 is set forth below:

	December 31, 2008	
Rating	**Carrying Value**	**% of Total Carrying Value**
	(Dollars in thousands)	
U.S. Government and AAA	$ 322,311	40.0%
AA	117,917	14.6%
A	255,690	31.8%
BBB	92,253	11.5%
Less than BBB	16,855	2.1%
	$ 805,026	100.0%

The Company regularly monitors its investment portfolio to attempt to minimize its concentration of credit risk in any single issuer. Set forth in the table below is a schedule of all investments representing greater than 1% of the Company s aggregate investment portfolio at December 31, 2008 and 2007, excluding investments in U.S. Government securities:

	December 31,			
	2008		2007	
	Carrying Amount	**% of Total Carrying Value**	**Carrying Amount**	**% of Total Carrying Value**
	(Dollars in thousands)			
Issuer Fixed Maturities:				
UnitedHealth Group(1)	$ 87,466	8.5%	$ 92,393	6.2%
Morgan Stanley Dean Witter			22,560	1.5%
Household Finance Corporation			15,035	1.0%
Federal National Mortgage Corporation			15,028	1.0%
General Electric Capital Corporation			15,022	1.0%
Issuer Short-term investments:				
Fidelity Institutional Money Market Fund(2)	$ 123,793	12.0%	$ 88,657	6.0%
SEI Government Fund(2)	24,143	2.3%		
Merrill Lynch Government Fund(2)	27,594	2.7%		

(1)

Represents security received from the purchaser as consideration upon sale of the Company s former Student Insurance Division on December 1, 2006. To reduce the Company s credit risk, the Company has taken out $75.0 million of credit default insurance on this security, reducing the Company s default exposure to $19.8 million.

(2) Funds are diversified institutional money market funds that invest solely in United States dollar denominated money market securities issued by governments and their agencies.

The Company recognized $26.0 million of net realized losses in 2008 from other than temporary impairments of fixed maturity securities and other invested assets. For the year ended December 31, 2008, the Company had gross unrealized losses in our investments of $58.9 million. While we believe that these impairments are temporary and that we have the intent and ability to hold such securities until maturity or recovery, given the current market conditions and the significant judgments involved, there is a continuing risk that further declines in fair value may occur and additional material other than temporary impairments may be recorded in future periods.

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Inflation Risk

Inflation historically has had a significant impact on the health insurance business. In recent years, inflation in the costs of medical care covered by such insurance has exceeded the general rate of inflation. Under basic hospital medical insurance coverage, established ceilings for covered expenses limit the impact of inflation on the amount of claims paid. Under catastrophic hospital expense plans and preferred provider contracts, covered expenses are generally limited only by a maximum lifetime benefit and a maximum lifetime benefit per accident or sickness. Thus, inflation may have a significantly greater impact on the amount of claims paid under catastrophic hospital expense and preferred provider plans as compared to claims under basic hospital medical coverage. As a result, trends in healthcare costs must be monitored and rates adjusted accordingly. Under the health insurance policies issued in the self-employed market, the primary insurer generally has the right to increase rates upon 30-60 days written notice and subject to regulatory approval in some cases.

The annuity and universal life-type policies issued directly and assumed by the Company are significantly impacted by inflation. Interest rates affect the amount of interest that existing policyholders expect to have credited to their policies. However, the Company believes that the annuity and universal life-type policies are generally competitive with those offered by other insurance companies of similar size, and the investment portfolio is managed to minimize the effects of inflation.

Operational Risks

Operational risk is inherent in our business and may, for example, manifest itself in the form of errors, breaches in the system of internal controls, business interruptions, fraud or legal actions due to operating deficiencies or noncompliance with regulatory requirements. The Company maintains a framework including policies and a system of internal controls designed to monitor and manage operational risk and provide management with timely and accurate information.

Privacy Initiatives

The business of insurance is primarily regulated by the states and is also affected by a range of legislative developments at the state and federal levels. Recently-adopted legislation and regulations governing the use and security of individuals nonpublic personal data by financial institutions, including insurance companies, may have a significant impact on the financial condition and results of operations. *See* Item 1. Business Regulatory and Legislative Matters.

Other Matters

The state of domicile of each of the Company s domestic insurance subsidiaries imposes minimum risk-based capital requirements that were developed by the NAIC. The formulas for determining the amount of risk-based capital specify various weighting factors that are applied to financial balances and premium levels based on the perceived degree of risk. Regulatory compliance is determined by a ratio of a company s regulatory total adjusted capital, as defined, to its authorized control level risk-based capital, as defined. Companies specific trigger points or ratios are classified within certain levels, each of which requires specified corrective action. At December 31, 2008, the risk-based capital ratio of each of our insurance subsidiaries exceeds the ratio for which regulatory corrective action would be required.

Dividends paid by domestic insurance companies out of earned surplus in any year are limited by the law of the state of domicile. *See* Item 5. Market for Registrant s Common Stock and Related Stockholder Matters and Note 12 of Notes to Consolidated Financial Statements.

Recently Issued Accounting Pronouncements

See Recently Issued Accounting Pronouncements in Note 1 of Notes to Consolidated Financial Statements for information regarding new accounting pronouncements.

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Item 7A. ***Quantitative and Qualitative Disclosures about Market Risk***

Quantitative and qualitative disclosures about market risk are included under the caption Management s Discussion and Analysis of Financial Condition and Results of Operations Risk Management.

Item 8. ***Financial Statements and Supplementary Data***

The audited consolidated financial statements of the Company and other information required by this Item 8 are included in this Form 10-K beginning on page F-1.

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosure***

None.

Item 9A. ***Controls and Procedures***

Disclosure Controls and Procedures

The Company maintains a set of disclosure controls and procedures designed to ensure that information required to be disclosed in reports that it files or submits under the Securities Exchange Act of 1934, as amended (the Exchange Act), is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission rules and forms. In addition, the disclosure controls and procedures ensure that information required to be disclosed is accumulated and communicated to management, including the principal executive officer and principal financial officer, allowing timely decisions regarding required disclosure. Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of our disclosure controls and procedures, as such term is defined under Rule 13a-15(e) promulgated under the Exchange Act. Based on this evaluation, our principal executive officer and our principal financial officer concluded that our disclosure controls and procedures were effective as of the end of the period covered by this annual report.

Management s Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f). The Company s internal control system was designed to provide reasonable assurance to the Company s management and its Board of Directors regarding the preparation and fair presentation of published financial statements. However, internal control systems, no matter how well designed, cannot provide absolute assurance. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

The Company s management assessed the effectiveness of the Company s internal control over financial reporting as of December 31, 2008. Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework contained in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO Report).

Based on our evaluation under the framework in the COSO Report our management concluded that our internal control over financial reporting was effective as of December 31, 2008.

This annual report does not include an attestation report of the Company s registered public accounting firm regarding internal control over financial reporting. Management s report was not subject to attestation by the Company s registered public accounting firm pursuant to temporary rules of the Securities and Exchange Commission that permit the Company to provide only management s report in this annual report.

During the Company s fourth fiscal quarter, there has been no change in the Company s internal control over financial reporting that has materially affected, or is reasonably likely to materially affect, the Company s internal controls over financial reporting.

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Item 9B. ***Other Information***

None

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance***

See the Company s Information Statement to be filed in connection with the 2009 Annual Meeting of Shareholders, which is incorporated herein by reference.

For information on executive officers of the Company, reference is made to the item entitled Executive Officers of the Company in Part I of this report.

Item 11. ***Executive Compensation***

See the Company s Information Statement to be filed in connection with the 2009 Annual Meeting of Stockholders, which is incorporated herein by reference.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

See the Company s Information Statement to be filed in connection with the 2009 Annual Meeting of Stockholders, which is incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

See the Company s Information Statement to be filed in connection with the 2009 Annual Meeting of Stockholders, which is incorporated herein by reference. *See* Note 15 of Notes to Consolidated Financial Statements.

Item 14. ***Principal Accountant Fees and Services***

See the Company s Information Statement to be filed in connection with the 2009 Annual Meeting of Stockholders, of which the subsection captioned Independent Registered Public Accounting Firm is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) *Financial Statements*

The following consolidated financial statements of HealthMarkets and subsidiaries are included in Item 8:

	Page
Report of Independent Registered Public Accounting Firm	F-2
Consolidated Balance Sheets December 31, 2008 and 2007	F-3
Consolidated Statements of Income (Loss) Years ended December 31, 2008, 2007 and 2006	F-4
Consolidated Statements of Stockholders Equity and Comprehensive Income (Loss) Years ended December 31, 2008, 2007 and 2006	F-5
Consolidated Statements of Cash Flows Years ended December 31, 2008, 2007 and 2006	F-6
Notes to Consolidated Financial Statements	F-7
Financial Statement Schedules	
Schedule II Condensed Financial Information of Registrant December 31, 2008, 2007 and 2006:	
HealthMarkets (Holding Company)	F-88
Schedule III Supplementary Insurance Information	F-91
Schedule IV Reinsurance	F-93
Schedule V Valuation and Qualifying Accounts	F-94

All other schedules for which provision is made in the applicable accounting regulations of the Securities and Exchange Commission are not required under the related instructions or are not applicable and therefore have been omitted.

Exhibits:

The response to this portion of Item 15 is submitted as a separate section of this 10-K entitled Exhibit Index.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

HealthMarkets, Inc.

By: /s/ Phillip J. Hildebrand*

Phillip J. Hildebrand
President and Chief Executive Officer

Date: March 18, 2009

Pursuant to the requirements of Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ PHILLIP J. HILDEBRAND* Phillip J. Hildebrand	President, Chief Executive Officer and Director	March 18, 2009
/s/ STEVEN P. ERWIN* Steven P. Erwin	Executive Vice President and Chief Financial Officer	March 18, 2009
/s/ CONNIE PALACIOS* Connie Palacios	Deputy Controller and Acting Principal Accounting Officer	March 18, 2009
/s/ CHINH E. CHU* Chinh E. Chu	Chairman of the Board	March 18, 2009
/s/ JASON GIORDANO* Jason Giordano	Director	March 18, 2009
/s/ ADRIAN M. JONES* Adrian M. Jones	Director	March 18, 2009
/s/ MURAL R. JOSEPHSON* Mural R. Josephson	Director	March 18, 2009

/s/ DAVID MCVEIGH*	Director	March 18, 2009
David McVeigh		
/s/ SUMIT RAJPAL*	Director	March 18, 2009
Sumit Rajpal		
/s/ KAMIL M. SALAME*	Director	March 18, 2009
Kamil M. Salame		
/s/ STEVEN J. SHULMAN*	Director	March 18, 2009
Steven J. Shulman		
*By: /s/ STEVEN P. ERWIN	(Attorney-in-fact)	March 18, 2009
Steven P. Erwin (Attorney-in-fact)		

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ANNUAL REPORT ON FORM 10-K

ITEM 8, ITEM 15(A)(1) and (2), (C), and (D)

FINANCIAL STATEMENTS and SUPPLEMENTAL DATA

FINANCIAL STATEMENT SCHEDULES

CERTAIN EXHIBITS

YEAR ENDED DECEMBER 31, 2008

HEALTHMARKETS, INC.

and

SUBSIDIARIES

NORTH RICHLAND HILLS, TEXAS

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors
HealthMarkets, Inc.:

We have audited the accompanying consolidated balance sheets of HealthMarkets, Inc. and subsidiaries (the Company) as of December 31, 2008 and 2007, and the related consolidated statements of income (loss), consolidated statements of stockholders equity and comprehensive income (loss), and consolidated statements of cash flows for each of the years in the three-year period ended December 31, 2008. In connection with our audits of the consolidated financial statements, we have also audited the financial statement schedules as listed in the Index at Item 15(a). These consolidated financial statements and financial statement schedules are the responsibility of the Company s management. Our responsibility is to express an opinion on these consolidated financial statements and financial statement schedules based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. The Company is not required to have, nor were we engaged to perform, an audit of its internal control over financial reporting. Our audit included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company s internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of HealthMarkets, Inc. and subsidiaries as of December 31, 2008 and 2007, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2008, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedules, when considered in relation to the consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

As discussed in Note 1 to the consolidated financial statements, effective January 1, 2006, HealthMarkets, Inc. adopted Securities and Exchange Commission Staff Accounting Bulletin No. 108 (SAB 108), *Considering the Effects of Prior Year Misstatements when Quantifying Misstatements in the Current Year Financial Statements*, and the provisions of Statement of Financial Accounting Standards No. 123R (revised 2004), *Share-Based Payment*, respectively. The Company used the one time special transition provisions of SAB 108 and recorded an adjustment to retained earnings effective January 1, 2006 for correction of prior period errors in recording deferred acquisition costs.

KPMG LLP

Dallas, Texas
March 18, 2009

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HEALTHMARKETS, INC.
and Subsidiaries

CONSOLIDATED BALANCE SHEETS

	December 31, 2008	2007
	(In thousands, except per share data)	
ASSETS		
Investments:		
Securities available for sale		
Fixed maturities, at fair value (cost: 2008 $855,137; 2007 $1,314,069)	$ 805,026	$ 1,304,424
Equity securities, at fair value (cost: 2008 $178; 2007 $300)	210	346
Trading securities, at fair value	11,937	
Policy loans	177	14,279
Short-term and other investments, at fair value (cost: 2008 $210,256; 2007 $163,727)	210,256	162,552
Total Investments	1,027,606	1,481,601
Cash and cash equivalents	100,339	14,309
Investment income due and accrued	9,078	14,527
Due premiums	3,847	4,055
Reinsurance receivable	7,122	4,211
Reinsurance recoverable ceded policy liabilities	384,801	68,821
Agent and other receivables	26,142	63,956
Deferred acquisition costs	72,151	197,979
Property and equipment, net	63,198	69,939
Goodwill and other intangible assets	87,555	89,194
Recoverable federal income taxes	10,177	4,962
Assets held for sale	91,795	110,355
Other assets	32,902	31,673
	$ 1,916,713	$ 2,155,582
LIABILITIES AND STOCKHOLDERS EQUITY		
Policy liabilities:		
Future policy and contract benefits	$ 486,174	$ 463,277
Claims	415,748	435,099
Unearned premiums	61,491	92,266
Other policy liabilities	9,633	10,764
Accounts payable and accrued expenses	58,453	69,510
Other liabilities	93,472	110,624
Deferred federal income taxes	23,495	84,968
Debt	481,070	481,070
Liabilities held for sale	87,042	99,109

Net liabilities of discontinued operations	2,210	2,635
	1,718,788	1,849,322
Commitments and Contingencies (Note 16)		
Stockholders Equity:		
Preferred stock, par value $0.01 per share authorized 10,000,000 shares, none issued		
Common Stock, Class A-1, par value $0.01 per share authorized 90,000,000 shares, 27,000,062 issued and 26,887,281 outstanding in 2008, 27,000,062 issued and 26,899,056 outstanding in 2007; Class A-2, par value $0.01 per share authorized 20,000,000 shares, 4,026,104 issued and 2,741,240 outstanding in 2008, 3,952,204 issued and 3,623,266 outstanding in 2007	310	310
Additional paid-in capital	54,004	55,754
Accumulated other comprehensive loss	(41,970)	(13,132)
Retained earnings	227,686	281,141
Treasury stock, at cost (112,781 Class A-1 common shares and 1,284,864 Class A-2 common shares in 2008, 101,006 Class A-1 common shares and 328,938 Class A-2 common shares in 2007)	(42,105)	(17,813)
	197,925	306,260
	$ 1,916,713	$ 2,155,582

See accompanying notes to consolidated financial statements.

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HEALTHMARKETS, INC.
and Subsidiaries

CONSOLIDATED STATEMENTS OF INCOME (LOSS)

	Year Ended December 31,		
	2008	2007	2006
	(In thousands, except per share data)		
REVENUE			
Health premiums	$ 1,262,412	$ 1,311,733	$ 1,671,571
Life premiums and other considerations	38,024	70,460	65,675
	1,300,436	1,382,193	1,737,246
Investment income	60,235	92,231	92,615
Other income	80,047	105,923	103,936
Realized gains (losses)	(23,858)	3,475	200,544
	1,416,860	1,583,822	2,134,341
BENEFITS AND EXPENSES			
Benefits, claims, and settlement expenses	856,994	801,783	996,617
Underwriting, acquisition and insurance expenses	494,077	536,168	597,766
Other expenses, (includes amounts paid to related parties of $16,751, $14,228 and $21,230 in 2008, 2007 and 2006, respectively)	101,298	84,641	154,265
Interest expense	41,696	43,609	34,823
	1,494,065	1,466,201	1,783,471
Income (loss) from continuing operations before income taxes	(77,205)	117,621	350,870
Federal income tax expense (benefit)	(28,848)	49,182	134,236
Income (loss) from continuing operations	(48,357)	68,439	216,634
Income (loss) from discontinued operations, (net of income tax (expense) benefit of $2,745, $(927) and $18,000 in 2008, 2007 and 2006, respectively)	(5,098)	1,720	21,104
Net income (loss)	$ (53,455)	$ 70,159	$ 237,738
Basic earnings per share:			
Income (loss) from continuing operations	$ (1.60)	$ 2.25	$ 6.20
Income (loss) from discontinued operations	(0.17)	0.06	0.60
Net income (loss) per share, basic	$ (1.77)	$ 2.31	$ 6.80
Diluted earnings per share:			
Income (loss) from continuing operations	$ (1.60)	$ 2.18	$ 6.07
Income (loss) from discontinued operations	(0.17)	0.06	0.59

Net income (loss) per share, diluted	$ (1.77)	$ 2.24	$ 6.66

See accompanying notes to consolidated financial statements.

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HEALTHMARKETS, INC.
and Subsidiaries

CONSOLIDATED STATEMENTS OF STOCKHOLDERS EQUITY AND COMPREHENSIVE INCOME (LOSS)