Access Plans USA, Inc.
Form 10-K
April 02, 2007

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U.S. SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

þ ANNUAL REPORT UNDER SECTION 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2006

OR

o TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to

Commission File Number: 001-15667

ACCESS PLANS USA, INC.
(Exact name of registrant as specified in its charter)

OKLAHOMA	**73-1494382**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*

4929 ROYAL LANE, SUITE 200
IRVING, TEXAS 75063
(Address of principal executive offices)

(866) 578-1665
(Registrant s telephone number)

Securities registered under Section 12(b) of the Exchange Act:
None
Securities registered under Section 12(g) of the Exchange Act:
Common Stock, $0.01 Par Value

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined under 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 Exchange Act. Yes o No þ

Indicate by check mark whether the registrant (1) filed all reports required to be filed by Section 13 or 15(d) of the Exchange Act during the past 12 months (or for such shorter periods 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 in this form, and no disclosure will 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. Yes o No þ

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer or a non-accelerated filer (as defined by Rule 12b-2 of the Act).

Large Accelerated Filer o Accelerated Filer o Non-accelerated Filer þ

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant as of June 30, 2006 (the last business day of our most recent second fiscal quarter), was $22,296,059 based on the closing sale price on that date.

As of March 30, 2007, 18,011,292 shares of the issuer s common stock, $.01 par value, were outstanding.

ACCESS PLANS USA, INC.
FORM 10-K
For the Fiscal Year Ended December 31, 2006

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CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING INFORMATION

Certain statements under the captions Item 1. Description of Business, Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations, and elsewhere in this report constitute forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended. Certain, but not necessarily all, of such forward-looking statements can be identified by the use of forward-looking terminology such as anticipates, believes, expects, may, will, or shoul other variations thereon, or by discussions of strategies that involve risks and uncertainties. Our actual results or industry results may be materially different from any future results expressed or implied by such forward-looking statements. Some of the factors that could cause actual results to differ materially are described under the heading Additional Factors That May Affect Our Future Results and include general economic and business conditions, our ability to implement our business strategies, competition, availability of key personnel, increasing operating costs, unsuccessful promotional efforts, changes in brand awareness, acceptance of new product offerings, retention of members and independent marketing representatives and changes in, or the failure to comply with government regulations. Any forward-looking statements contained in this report represent our judgment as of the date of this report. We disclaim, however, any intent or obligation to update these forward-looking statements. As a result, the reader is cautioned not to place undue reliance on these forward-looking statements.

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PART I

ITEM 1. DESCRIPTION OF BUSINESS

Access Plans USA, Inc. (Access Plans) develops and distributes quality affordable consumer driven health care programs for individuals, families, affinity groups and employer groups across the nation. Our products and programs are designed to deal with the rising costs of health care. They include health insurance plans and non-insurance health care discount programs to provide solutions for the millions of Americans who can no longer afford or do not have access to traditional health insurance coverage.

Beginning in 2007, our operations are organized under three business divisions:

Consumer Plan Division. Our Consumer Plan Division, which operates as The Capella Group, Inc. (Capella) and is referred to as the Consumer Healthcare Savings segment, develops and markets non-insurance medical discount programs through multiple distribution channels.

Insurance Marketing Division. Our Insurance Marketing Division, which operates as Insuraco USA LLC (Insuraco), provides web-based technology, specialty products and marketing of individual health insurance products and related benefit plans, primarily through a broad network of independent agency channels.

Regional Health Care Division. Our Regional Health Care Division, which operates as Access HealthSource, Inc./Access Administrators, Inc. (AAI) and is referred to as the Employer and Group Healthcare Services segment, offers third party claims administration, provider network management, and utilization management services for employer groups that utilize partially self funded strategies to finance their employee benefit programs.

The current organization of our business divisions is a result of our January 30, 2007, merger with Insurance Capital Management USA, Inc. (ICM). Other results of our merger with ICM are:

We have access to additional distribution channels, including a large network of insurance agents that ICM has recruited to sell its products;

We gained expertise in taking advantage of electronic technology and web-based services to shorten product development and implementation time;

We are able to complement our non-insurance medical discount programs with a broad range of health insurance and specialty insurance products; and

We have reorganized our management team to include key members of the ICM management team, including ICM s founder, Peter W. Nauert, who is now our President and Chief Executive Officer and the Chairman of our Board of Directors. Mr. Nauert, a former C.E.O. of two public companies, brings us significant expertise and experience in the health insurance industry.

In order to more properly reflect our broadened mission of providing access to affordable healthcare for all Americans, we changed our name from Precis, Inc. to Access Plans USA, Inc. upon the completion of our merger with ICM.

In 2006, we did not have access to ICM s products and distribution channels and operated three business segments. The majority of our revenue was derived from our discount medical programs that continue as one of our primary business segments. See Note 16 Segmented Information in the Financial Statements included elsewhere in this Annual Report. For the year ended December 31, 2006, 65.9% of our consolidated revenue was from discount medical programs and 33.7% was derived primarily from our third party administration services that adjudicate and pay medical claims for employers who maintain self-funded or partially self-funded healthcare programs. We also operated a financial services division in 2006, but results from that division were not material to our operations in 2006. Our reportable business segments in 2007 will include those of ICM.

Through 2006, the number of active members in our discount medical programs continued to decline, leading to decreased revenues from those operations. We discuss these results in detail throughout this report. We have taken significant cost-cutting actions to offset the loss in this revenue and have taken other actions, including our merger

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with ICM, to increase membership levels by developing additional distribution channels and by adding new products and services to the suite of programs we offer.

Throughout 2006, we have continued the measures and initiatives to improve our operating efficiencies and performance, especially through cost reductions. These measures and initiatives include (i) discontinuance of certain non-profitable operations, (ii) the conversion of certain of our customer service and system support functions from a fixed to a variable cost structure by outsourcing them, (iii) the termination of certain equipment capital leases, and (iv) personnel reductions and other cost reduction actions. The discontinued operations had losses of $910,000 in 2006. The other initiatives resulted in restructuring costs during the fourth quarter of 2006 of $449,000. Further, AAI recorded a $4,066,000 impairment to goodwill including tax considerations of $426,000 that resulted from current and projected reductions in earnings primarily due to a decline in the number of lives covered under plans that it administered and Capella recorded a $2,800,000 impairment to goodwill due to the continuing decline in members and revenue. Including these charges, we had a net loss of $7,724,000. Without these charges, our net income would have been $501,000.

Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, the Statements of Beneficial Ownership of Securities on Forms 3, 4 and 5 for Directors and Officers of the Company and all amendments to such reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, are available free of charge at the Securities and Exchange Commission (SEC) website at www.sec.gov. We have posted on our website, www.accessplansusa.com, our (1) Code of Conduct, (2) the charters for our Audit Committee, the Compensation Committee, and the Corporate Governance and Nominating Committee , and (3) our SEC filings.

Healthcare Industry Challenges and Market Opportunity

Our market is directly impacted by the state of turmoil and crisis in the healthcare industry.

The uninsured. It is estimated that 15.9% of all Americans, or 46.6 million individuals, were without health insurance coverage in 2005, an increase of .8 million people compared to 2004. [Source: U.S. Census Bureau Statistics published by the U.S. Department of Commerce.] In addition, 8.5% of people with incomes over $75,000 were uninsured. [Source: U.S. Census Bureau and Center on Budget and Policy Priorities, August 2006.]

The percentage of people working full-time without health insurance in 2005 was 17.7%, an increase from 17.3% in 2004. [Source: U.S. Census Bureau Statistics published by U.S. Department of Commerce.] Nationally, healthcare expenditures topped $1.9 trillion in 2004, up from $1.2 trillion in 1999. [Source: Centers for Medicare and Medicaid Services.] Costs of healthcare (in doctors offices and hospitals) for this patient population are often far higher than the amount an insured and the insurance company would pay for the same healthcare services for its insureds. The growing number of uninsured people have special needs for accessing affordable health care.

The insured and underinsured. In 2005, 59.5% of the U.S. population participated in employer-sponsored medical insurance plans, showing a steady year-by-year decrease from 62.6% in 2001. [Source: U.S. Census Bureau and Center on Budget and Policy Priorities, August 2006.] In addition, data from the Kaiser Family Foundation show that employers are requiring employees to contribute more in cost-sharing (premiums, deductibles and/or co-payments) for their health insurance. [Source: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, Annual Salary, 2006.] Between 2005 and 2006, premiums for employer-sponsored health insurance rose 7.7%, following consecutive years of double-digit premium increases. The increases are hitting small employers (under 200 workers) particularly hard. These small firms are more likely to have experienced an increase in premiums greater than 15%. These costs are not only being felt by the employer, but also by the employees. The average monthly contribution by workers for single and family healthcare coverage rose from $8 and $52, respectively, in

1988 to $52 and $248, respectively, in 2006. The average cost of family coverage is now nearly $11,480 per year, including workers contributions of nearly $2,973. Not surprisingly, employers are looking for alternatives. [Source: Employer Health Benefits 2006 Summary of Findings, published by the Kaiser Family Foundation].

Over-utilization of the healthcare system is one of the factors behind these trends. American citizens are utilizing healthcare services at an ever-increasing rate. Behind this phenomenon is the fact that insurance plans and

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healthcare management organizations are structured to encourage usage. Small co-payments, generally from $10 or $25 per office visit, encourage insured consumers to use the healthcare system more frequently because they do not perceive themselves ultimately as having to pay the full costs of the medical services received.

A number of insurers have pulled out of certain states, due to state regulations that no longer provide for a viable operating environment for many insurance companies. As a result of these health coverage cancellations, those formerly insured individuals and families are required to pay more for their insurance coverage, cannot obtain any coverage because of pre-existing conditions or simply remain uninsured for healthcare.

In addition, recently enacted federal legislation provides for tax favorable Health Savings Accounts (HSAs). Individuals with high deductible health insurance coverage can deduct contributions to their HSA from their reported income for tax purposes. In 2007, the qualifying health insurance must have a deductible of at least $1,100 for individuals and $2,200 for families and the maximum amount that can be contributed is $2,850 for individuals and $5,650 for families. Amounts contributed to the HSAs can be used for certain uninsured medical expenses, but generally cannot be used to pay for the health insurance premium. Individuals can establish HSAs without regard to their income and amounts contributed to the HSAs do not have to be used within a certain time period.

For the insured, these changes in employer-sponsored coverage also provide an increasing market for specialty plans that supplement or fill deductible or other gaps in coverage for millions of Americans.

Self-employed and small businesses. According to the U.S. Census Bureau, in 2003, there were over 18 million firms in the U.S that do not offer an employer-sponsored medical insurance plan to their employees. There were also over 3.75 million firms with fewer than 10 employees (with a total of 12.5 million employees). [Source: U.S. Census Bureau, Statistics of U.S. Businesses.] In addition, small businesses have accounted for 60-80% of net new jobs annually over the last decade [Source: Small Business Administration Office of Advocacy, June 2006]. Individuals working for such small business usually do not have access to group health insurance at affordable rates. As the number of uninsured individuals increase, the market for our non-insurance healthcare savings programs increase.

Senior population. The age 65 and over segment of the U.S. population is expected to grow from 35 million in 2000 to over 40 million by 2010, comprising 13% of the total population by 2010. [Source: U.S. Census Bureau, 2004.] While the federal Medicare program covers a portion of health care expenses for senior Americans, the gaps in coverage provide a significant market for supplemental plans.

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Our Solutions

Through our Consumer Plan Division and our Insurance Marketing Division, we provide programs that consumers use to save money on their healthcare costs. Our programs range from traditional discount medical programs that provide access to networks of providers that have agreed to provide our members with a reduced rate for services, to mini-med programs that include some amount of defined benefit insurance, to major medical insurance with a variety of deductibles. These programs are described in more detail in our discussion of our Consumer Plan Division and our Insurance Marketing Division, but here is a summary of the range of our programs:

Access Plans USA s
Complete SPECTRUM of Health Care Programs

In addition, our Insurance Marketing Division also distributes specialty insurance and benefit programs designed for the senior market (age 65 and over).

Our Regional Health Care Division provides cost-effective plan designs, claims management, cost containment, predictive modeling, wellness programs, and administrative and managed care services for organizations with self-funded or partially self-funded health care plans, including large public and private employers. Our benefit program management services successfully reduce costs and provide access to affordable health care by directing our clients to PPO providers and our own case management services. Together, these services allow employers and groups to provide substantive healthcare benefits at a fraction of the cost of traditional health insurance.

None of our products or services is materially affected by seasonal changes to our markets.

Our Consumer Plan Division

Our consumer healthcare savings membership programs are offered under the trade name of Care Entrée^{tm} or through the trade name of our private label resellers. We also have developed and are in the process of launching a

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new series of programs under the trade name of USA Healthcare Savings. Our healthcare savings programs are not managed care. Instead, they are based upon and emphasize the following factors:

Responsibility for the use of healthcare must be put back in the hands of the patient. Insurance policies with low co-pays and low deductibles have become very popular; however, these arrangements actually encourage over-utilization resulting in increased healthcare costs; and

Healthcare must be affordable for the patient, while providing the medical providers with adequate payment on a timely basis for services provided.

For years, insurance companies have been successful by obtaining healthcare for their insureds at much lower prices than that obtainable by the self-insured person. These benefits were provided through the use of preferred provider organizations (PPOs), where steerage of patients was promised to doctors, hospitals and other providers in exchange for lower rates. In our consumer healthcare savings programs, we have contracted with some of these same PPOs to provide healthcare savings to our program members.

We allow the patient and the healthcare provider to decide treatment protocols with no interference from any third party. We simply provide our members with access to healthcare providers in their geographical area that have agreed to provide their services for a discounted rate. In most cases, the consumer pays, or makes arrangements to pay, the discounted rate directly to the provider at the point of service. Some medical providers chose to send the original full priced bill to us for repricing. We reprice the bill to the discounted amount and then notify the provider and the member of the amount that should be paid. The member then pays the repriced amount directly to the provider. We are not involved in the making of payments to providers.

Our programs routinely assist our members in saving an average of over 35%, and often up to 70%, on their medical costs. In 2006, we examined 166,125 repricing transactions recorded between September of 2004 and December of 2005. For the ten most commonly reported procedures, we found the following:

CPT	CPT Code Description	Code* Count	Avg.* Price	Total Price	Avg.* Reprice	Total Reprice	% Saved	Total $* Savings
99213	Office/Outpatient Visit, Est	22,230	$ 78	$ 1,742,090	$ 54	$ 1,195,689	31%	$ 546,400
36415	Routine Venipuncture	14,340	17	239,294	8	109,202	54%	130,092
99214	Office/Outpatient Visit, Est	9,257	120	1,107,947	81	745,968	33%	361,979
80061	Lipid Panel	8,087	76	617,355	22	180,687	71%	436,668
85025	Complete CBC w/Auto Diff WBC	6,523	31	201,589	13	82,840	59%	118,749
80053	Comprehen Metabolic Panel	5,945	55	326,662	18	107,756	67%	218,906
99212	Office/Outpatient Visit, Est	4,389	59	259,283	39	169,697	35%	89,586
84443	Assay Thyroid STIM Hormone	4,035	81	327,724	25	101,785	69%	225,939
99203	Office/Outpatient Visit, New	3,383	135	457,536	95	320,028	30%	137,507
88142		3,151	69	217,915	33	104,821	52%	113,093

Cytopath, C/V, Thin Layer					
	81,340	$ 5,497,395	$ 3,118,473	43%	$ 2,378,919

* The Code Count represents the total number of transactions; Avg. Price reflects the retail rates providers charge the uninsured; Avg. Reprice reflects the Care Entrée discount rate; and Total $ Savings reflects the savings by our Care Entrée[tm] members. Current Procedural Terminology (CPT®) is a registered trademark of the American Medical Association.

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Savings from dentists, vision providers, chiropractors and other services that do not require the use of a medical PPO are more difficult to track because our members pay a discounted rate at the point of service that is usually determined by a fee schedule and does not require our participation to reprice. Nevertheless, our arrangements with provider networks require that our members save on their visits. On average, we believe that our members save 10% to 50% on services from these other providers.

Our membership program encompasses all aspects of healthcare, including physicians, hospitals, ancillary services, dentists, prescription drugs, vision care, hearing aids, chiropractic and alternative care, air ambulance, 24-hour nurse hotline assistance, and long-term care. Some aspects of our programs are not available in all states. In most states, memberships in our Care Entrée™ programs range from $9.95 to $69.95 per month per family depending on the selected options, plus a one-time enrollment fee of $20.00 to $30.00. Our new USA Healthcare Savings programs range from $24.50 to $99.50 per month per family. Our third party marketing partners may sell our programs for other prices. Typically, these marketers charge from $9.95 to $120.00 per month per family.

Personal Medical Accounts. During the fourth quarter of 2002, we implemented escrow account requirements in response to the market changes in the healthcare savings industry. We called these accounts Personal Medical Accounts (PMAs). A great number of our members of our Care Entrée program were required to establish and maintain a PMA to access and provide payment for hospital services. Our private label partners were not required to offer these accounts to their members. With PMAs, we were able to pre-certify the members ability to pay based upon the available PMA balances and to process the members payments directly to the medical providers. In the fourth quarter of 2006, we discontinued the PMA program because (i) the program made our Care Entrée product more difficult to sell, (ii) the program was expensive to administer, and (iii) the pre-certification process presented risks to us because we occasionally did not receive adequate information from providers to provide an accurate estimate of what the expected procedure would cost. All PMA money on deposit with us was returned to the depositors by or during the first quarter of 2007.

Technology and Member Services

We have made substantial investments in our proprietary technology and management information systems. These systems were designed in-house and are used in most aspects of our business, including:

- maintaining member eligibility and demographic information,
- maintaining representative information including genealogy reporting,
- paying commissions,
- maintaining a database of all providers and providing provider locator services,
- re-pricing and payment of medical bills,
- drafting members accounts on a monthly basis, and
- tracking of cash receipts and revenues.

We have also established websites for our programs that provide information about the program, allow for provider searches and allow new members and representatives to enroll on-line. The websites also allow representatives, through a password protected area to access support and training files and to view their genealogy and commission

information. The websites are set up as self-replicating websites to allow representatives a copy of the websites under a unique web address.

In the fourth quarter of 2006, we entered into a one-year agreement with Lifeguard Emergency Travel, Inc. (Lifeguard). Under this agreement, Lifeguard provides certain member support services, claims administration, and fulfillment services for our members. However, we do remain responsible for providing these services to our members. Many of our own member services, claims administration and fulfillment personnel were hired or otherwise retained by Lifeguard to provide continuity of services to us and our members. We retained a senior team of operations staff with expertise in the functions provided by Lifeguard to serve as secondary customer support for our members and to also act as a quality assurance function overseeing the services provided by Lifeguard. Lifeguard s operations are on a separate floor, but within the same building as our corporate headquarters. The

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agreement with Lifeguard will renew for an additional one-year terms unless either we or Lifeguard with proper notice elects not to renew or extend the agreement. Lifeguard uses a combination of our proprietary technology and its own proprietary technology to provide services for our members.

Sales and Marketing Channels

Our products for consumers are currently offered through three distribution channels:

Network Marketing. Our Care Entrée[tm] programs are distributed by independent commission-based contractors referred to as independent marketing representatives (IMRs). Our new USA Healthcare Savings program also will be distributed through this channel. Our independent representatives become marketing representatives by paying an enrollment fee (currently $99.95) and signing a standard representative agreement, and an annual renewal fee (currently $49.95). Independent marketing representatives of Care Entrée[tm] are not required to be licensed insurance agents. Independent marketing representatives are generally paid a 20% commission on the membership fees of each member they enroll for the life of that member s enrollment with Care Entrée[tm] (subject to the representatives continuing to meet certain commission qualifications). Independent marketing representatives may also receive commissions equal to the membership fees if three or more program members are enrolled in a month. In the month of the membership sales, no override commissions are paid to the representative s upline. Independent marketing representatives may also recruit other representatives and earn override commissions on sales made by those representatives. We pay a total of up to 35% in override commissions up through seven levels of marketing representatives. In addition, we have established bonus pools that allow independent marketing representatives who have achieved certain levels to receive additional commissions measured by our revenues attributable to the Care Entrée[tm] programs.

The total regular or ongoing commissions payout, including overrides based on monthly membership sales after the enrollment month and the amount contributed by us to the bonus pools, can be as high as 60% of qualified membership sales. This division is known as:

Tele-Sales. Through national tele-sales units, this channel uses traditional direct response distribution channels: direct mail, outbound telemarketing, Internet, direct response television, direct response radio, cross-sell/upsell and alternate media. Our partners in these efforts utilize a sophisticated system of telephone and web conferencing with customers to present, explain and complete enrollment materials online. This increases the efficiency of the sale and the customer s understanding of the product.

We work with the following types of partners:

TeleService Centers

Insurance Agencies with Call Centers

Large Companies/Brands Looking for Additional Ways to Monetize Their Customer Base

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The products in this division are branded as:

Independent Agent Direct. Independent licensed insurance agents and agencies across the nation can use these plans to supplement other insurance / health care programs or on a stand-alone basis for clients who cannot afford or cannot medically qualify for traditional health insurance policies. The products in this division, in its early stages of development, are branded as:

Reliance on key customers.

No one customer represents more than 10% of the Company s overall revenue. However, a material portion of AAI s revenues is derived from its contractual relationships with a few key governmental entities.

Our Insurance Marketing Division

The revenue of our Insurance Marketing Division, organized under our subsidiary Insuraco USA LLC (Insuraco), is primarily from sales commissions paid to it by the insurance companies it represents; these sales commissions are generally a percentage of premium revenue. This division was created after our merger with ICM in the first quarter of 2007. We have not reported any results for this division for 2006.

Our strategy is to

continue to develop products for consumers to provide health care savings and/or insurance protection to families and individuals, including Americans in their retirement years,

enhance our product portfolio by adding new products developed on our current product platform,

expand into additional states where we are not currently marketing to any significant degree (including Florida, California and the upper Northeast), and

expand the number of insurance carriers that we represent.

Our three principal insurance markets are:

Major medical/individual health insurance,

Senior health insurance, managed care, life insurance and annuity, and

Specialty medical and benefit plans for affinity groups, associations, employer groups and other groups.

Distribution Channels and Operating Divisions

Our insurance marketing operations are comprised of three distribution channels and a specialty product development subsidiary:

America s Health Care/Rx Plan (AHCP). Distributing major medical and short-term medical products to small business owners, self-employed and other individuals and families through approximately 2,100 independent agents.

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Adult Care Plans/Rx America (ACP). Distributing supplemental medical, life and managed care products to senior Americans through approximately 2,900 independent agents.

National Direct USA. Distributing major medical and specialty health plans through tele-sales units.

American Benefit Resource/Rx (ABR). Specializing in the development and wholesale marketing of specialty health plans.

Our primary insurance carriers for which we market products have been:

Dollars in Thousands		**ICM Revenue**	
Insurance Company	**Products**	**2005**	**2006**
Continental General Insurance Company	Proprietary Major Medical; Proprietary HSA-qualified High Deductible plans	$ 1,340	$ 1,481
World Insurance Company	Proprietary Major Medical; HSA-qualified High Deductible plans	160	864
Empire Fire and Marine	Proprietary Major Medical; Proprietary HSA-qualified High Deductible plans	230	724
Central Reserve Life Insurance Company	Medicare Supplement; Final Expense Life Insurance	1,680	1,390
Companion Life Insurance Company	Proprietary Mini-Medical plan	610	614
Other Carriers		60	279
		$ 4,080	$ 5,352

We also market the following recently introduced products and carriers:

Insurance Company	**Products**
Guarantee Trust Life	Proprietary Major Medical and HSA-qualified High Deductible plans
Golden Rule Insurance Company	Major Medical and HSA-qualified High Deductible plans
World Corp Insurance Company	Medicare Supplement plans
The Wellpoint Family of Companies	Senior Managed Care, Medicare Advantage products and Medicare Advantage Medical Savings Accounts (MSAs)

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We have broad national sales coverage. In 2006, 14 states accounted for approximately 85% of Insuraco s revenue and an additional 32 states accounted for the remaining 15%. The largest state concentration was in Arizona. The table below sets forth estimated 2006 revenue by state:

Dollars in Thousands	2006	
State	Revenue	Percent
Arizona	$ 629	15.4%
Illinois	432	10.6%
Texas	412	10.1%
Pennsylvania	324	7.9%
Colorado	270	6.6%
Tennessee	257	6.2%
North Carolina	249	6%
Ohio	190	4.6%
Michigan	161	3.9%
Wisconsin	124	3%
Indiana	114	2.8%
West Virginia	103	2.5%
Nebraska	102	2.5%
Virginia	98	2.4%
Sub-total	3,465	84.5%
All Other States	633	15.5%
	$ 4,098	100%

Products for Consumers

Insuraco has agreements with insurance companies to access products that we offer for sale through our distribution channels. The current portfolio of these insurance and financial service products includes the following:

Major Medical / Individual Health Insurance Market. The major medical / individual health insurance market includes the following:

Major Medical Health Insurance. Insuraco s major medical products include catastrophic, comprehensive, and basic coverage options. These may include PPO benefit plans, traditional indemnity health insurance plans, and one-deductible plans.

HSA-Qualified High Deductible Plans. Recently enacted federal legislation allows individuals who establish Health Savings Accounts (HSAs) to deduct from their income taxes the amounts that they contribute to their HSA, which amounts are then used to pay for qualifying uninsured medical expenses. Insuraco markets high deductible insurance plans that qualify for the benefits of HSAs.

Short Term Medical Plans. Insuraco can provide individuals who are between jobs or who are recent graduates with low cost, limited health insurance for a limited period of time, typically six months or one year.

Senior Health Insurance, Managed Care, Life Insurance and Annuity. Senior health insurance, managed care, life insurance and annuity includes the following:

Medicare Supplement Plans. Our Medicare supplement plans provide benefits that supplement the primary benefits offered by Medicare. According to the Centers for Medicare and Medicaid Services (CMS), the number of Medicare enrollees, age 65 and over, more than doubled between 1966 and 2004, growing to 42 million from 19 million.

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Medicare Advantage Plans. Our Medicare Advantage Plans are health plan options include:

Medicare Health Maintenance Organization (HMOs)

Preferred Provider Organizations (PPO)

Private Fee-for-Service Plans

Consumers who join a Medicare Advantage Plan generally receive extra benefits and lower co-payments than in the original Medicare plan. However, they may have to utilize doctors that belong to the plan or go to certain hospitals to get services.

To join a Medicare Advantage Plan, consumers must have Medicare Part A (hospital insurance) and Part B (medical insurance). They have to pay their monthly Medicare Part B premium to Medicare. In addition, they may have to pay a monthly premium to the Medicare Advantage Plan for the extra benefits that they receive.

Part D Prescription Plans. People who have Medicare Part A or Medicare Part B can purchase insurance to pay for part of their prescription drugs. These plans are provided through private insurance companies and are available to eligible seniors who enroll within certain enrollment and eligibility periods.

Final Expense Insurance Plans. Relatively small face amount life insurance plans designed for senior Americans to help pay for funeral costs, medical bills and other final expenses.

Specialty Medical And Benefit Plans. These products offer healthcare plans for affinity groups, associations, employer groups and other groups.

Mini-Medical Plans. These plans are sometimes referred to as scheduled benefit, limited benefit or defined benefit policies. These policies are less expensive than traditional comprehensive healthcare insurance and usually require the member to undergo little or no medical underwriting. As such, they are available to all or most individuals, regardless of their health conditions. The policies usually operate on an indemnity basis, reimbursing the member for certain of his or her incurred healthcare costs. Sometimes, the policies allow the benefit to be assigned directly to the healthcare provider, eliminating the need for the member to pay the provider directly and then seek reimbursement. These policies pay a certain amount for designated healthcare services. For instance, a member could choose a program entitling him or her to $250, $500 or $1,000 per day of hospitalization, with additional scheduled benefits for intensive care stays and surgery, for up to 180 days in a calendar year.

Insuraco s Services For Agents and Agencies

Insuraco provides sales and marketing services to its national network of independent agency channels by leveraging its industry expertise and relationships to secure access to proprietary health insurance products. It has specific industry expertise in designing products that meet the needs of the consumer and that fit well within the suite of products that are sold by insurance agents and their agencies. Insuraco has relationships with numerous well established, highly-rated insurance companies.

Multiple Carriers for Specific Product Lines. Insuraco has strategically established marketing relationships with multiple insurance companies to provide a wider distribution network across the U.S. This strategy is designed to maximize marketing penetration with competitively priced products on a state-by-state basis. This strategy is also designed to provide increased flexibility and security for Insuraco s marketing channels based on ongoing changes in

carriers product, pricing and marketing plans.

Web Based Technology. Utilizing web-based technology to streamline the agent appointment and sales application processes with the insurance carriers. Insuraco s integrated agent portal gives agents access to online:

real-time rate quoting;

agent recruiting, licensing, and contracting;

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insurance application submission;

lead ordering and delivery; and

access to brochures, applications, and marketing materials.

The benefits of such services include:

a streamlined underwriting process that automatically limits application submissions,

increasing the issue and placement rate on submitted business,

a proprietary pre-scrubbed agent enrollment process that ensures complete and accurate agent contracting,

an efficient way for agents to sell and submit applications over the phone, and

a central repository that agents visit frequently to obtain important documents and updated materials.

Lead Distribution Programs for Agents. For certain of its distribution channels, Insuraco uses an electronic system designed to efficiently connect insurance agents with high-quality leads. The leads are supplied by select vendors and are then compiled, sorted, and offered to agents via its on-line lead ordering and delivery system. Leads are generated through telemarketing, internet sites and direct mail.

Competitive agent commission rates supplemented by various agent incentive programs. The Company provides a comprehensive portfolio of incentives that attract agents, including annual conventions, sales contests, year-end bonuses, lead programs, and production club membership programs. By leveraging Insuraco s sales management and marketing expertise, insurance companies can focus on the administration of their products, while Insuraco takes care of managing and motivating the agent force to sell.

Working Capital Requirements. We require working capital to advance commissions to our agents prior to our receipt of the underlying commission from the insurance carrier. We have access to a sufficient amount of working capital to meet our needs, but our ability to grow this segment will depend on our ability to gain access to increasing amounts of working capital sources.

Home Office Support. This includes agent and product training, a variety of marketing materials and compilation of weekly newsletters that deliver important news and updates to our agents. Insuraco provides professional, quality training for all of its independent agents and alternative distribution channels. Its training programs include in-house and on-site training schools, DVD programs and webcast sessions. In addition to product knowledge, Insuraco trains its independent agents in market conduct standards, regulatory compliance requirements, and sales techniques. Insuraco creates, prints, and distributes a variety of marketing materials to promote its products, including magazine advertising, flyers, postcards, letters, e-mail blasts, brochures, and more. Insuraco delivers important news and updates to its agents on a timely basis with weekly e-mail newsletters. These newsletters promote, inform, and entertain with a combination of news bulletins, agent reports, and motivational articles.

Our Regional Health Care Division

We offer full third-party administration services through our wholly-owned subsidiary, AAI, that we acquired in June 2004. Through AAI, we provide a wide range of healthcare claims administration services and other cost containment procedures that are frequently required by state and local governmental entities and other large employers that have chosen to self-fund their required healthcare benefits. With AAI s services we offer a more complete suite of healthcare service products. Also through AAI, we provide individuals and employee groups with

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access to preferred provider networks, medical escrow accounts and full third-party administration capabilities to adjudicate and pay medical claims.

In 2006, AAI clients as a group were billed a total of approximately $400 million for the healthcare expenses incurred by their group members. Of this amount, the client group was responsible for paying $120 million after our repricing. This represented aggregate savings of nearly 70%.

AAI has two subsidiaries, Access Administrators, Inc. and Advantage Care Network. Access Administrators, Inc. is licensed by the Texas Department of Insurance as a third party claims administrator. AAI s utilization review services are licensed by the Texas Department of Insurance as a utilization review agent. Advantage Care Network is a comprehensive network of contracted physicians, hospitals, and other medical service providers in the El Paso/Las Cruces community that also utilizes national networks featuring over 500,000 contracted medical providers to provide access to quality and affordable health care services. Access provides health plan design and administration, claims management and processing, data and report management, quality assurance, customer service, reinsurance strategies, coordination of benefits, subrogation services and auditing for quality assurance. Access also provides access to effective pharmacy benefit management cost containment programs to serve both retail and mail order needs. As a utilization review agent, AAI clients are provided with utilization management services including prior-authorizations, utilization review, large case management, concurrent review, quality management, and coordination of care for members and their families.

AAI companies, and its predecessors, have been serving partially self-funded political subdivisions, as well as public/private employers, in the El Paso region for over twenty-five years. AAI currently manages over $400 million in claims annually, claims adjudication and processing services exceeding 700,000 claims per year, and provides effective utilization management, quality assurance, and cost containment strategies.

Our services are sold through health insurance and employee benefit brokers and agents. Our primary area of expertise is in the public-sector market. In the first quarter of 2007, AAI successfully completed an SAS 70 Type I examination by independent registered public accountants.

Competition

Consumer Plan Division. Competition for program members within the healthcare savings industry has become more intense. We offer membership programs that provide products and services similar to or directly in competition with products and services offered by our network-marketing competitors as well as the providers of the products and services through other channels of distribution. Competition for new representatives is intense, as these individuals have a variety of products that they can choose to market, whether competing with us in the healthcare market or not.

Our principal competitors are AmeriPlan, Full Access Medical, New Benefits, Inc., CAREington International, International Association of Businesses (IAB), and Family Care. We also compete with all types of network marketing companies throughout the U.S. for new representatives. Our other competitors include large retailers, financial institutions, insurance companies, preferred provider organization networks, and other organizations, which offer benefit programs to their customers. Many of our competitors have substantially larger customer bases and greater financial and other resources.

Insurance Marketing Division. We compete in the highly competitive individual health insurance industry. The major medical products and services of the insurance companies that we offer compete with large national, regional and specialty health insurers, including Assurant, and various Blue Cross/Blue Shield companies. Furthermore, senior managed care, Medicare products and Medicare Advantage medical savings accounts offered by our ACP Division compete with other national, regional and specialty insurers, including Universal American Financial Corp., Banker s

Life and Casualty, United Teachers Associates Insurance Company, Torchmark, Pacificare, United Healthcare, Mutual of Omaha, Conseco, Inc., Blue Cross organizations, US Health, and Medicare HMOs. In addition, we compete for insurance agencies and their agents to offer, sell and provide the insurance products and financial services that we offer.

Many of our competitors in the insurance marketing industry have substantially greater financial resources, broader product lines, or greater experience than we do. We compete on the basis of price, reputation, diversity of

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product offerings and flexibility of coverage, ability to attract and retain agents, and the quality and level of services provided to the independent insurance agencies and their agents.

We face additional competition due to a trend among healthcare providers and insurance companies to combine and form networks in order to contract directly with small businesses and other prospective customers to provide healthcare services. In addition, because the products and services that we offer are marketed through independent agents, most of which represent and offer insurance products of multiple insurance companies, we compete for the marketing focus of each independent agent.

Regional Healthcare Division. AAI operates in the El Paso metropolitan market and competes against regional and national health benefit plans such as Blue Cross Blue Shield, United Healthcare, CIGNA and Aetna.

Principal Competitive Factors. We believe that the principal competitive factors in our industries, some of which are not within our control, include:

the ability to maintain contracts with reputable preferred provider organization networks that offer substantial healthcare savings,

the ability to maintain contracts with reputable insurance companies and insurance agents and agencies,

the ability to attract and retain independent marketing representatives for our Consumer Plan Division,

the ability to identify, develop and offer unique membership healthcare programs,

the quality and breadth of the healthcare membership programs offered,

the quality and extent of customer service,

the ability to offer substantial savings on major-medical costs such as hospital and surgical costs,

the ability to combine the programs with affordable insurance plans that have high deductibles or set payment for hospitalization,

prices of products and service offered,

marketing expertise,

compensation plans for representatives,

the ability to hire and retain employees,

the development by others of member programs that are competitive with our programs,

responsiveness to customer needs,

the ability to satisfy investigations on the part of state attorneys general, insurance commissioners and other regulatory bodies,

the ability to finance promotions for the recruiting of members and representatives, and

the ability to effectively market the product on the Internet.

Competitive Risk. While we believe that we are a leader in the industry, there is no assurance that:

competitors will not develop their own software that re-prices medical bills or a full-service customer service function similar to ours,

our competitors will not increase their emphasis on programs similar to our programs to more effectively compete with us,

our competitors will not recruit our independent marketing representatives and insurance agents by offering more attractive sales commissions,

our competitors will not provide programs comparable or superior to our programs at lower membership fees or lower insurance premiums,

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our competitors will not adapt more quickly to evolving industry trends or changing market requirements,

new competitors will not enter the market,

other businesses such as insurance companies or preferred provider organization networks will not themselves introduce competing programs, and

competitors may not develop more effective marketing campaigns that more effectively utilize direct mail and television advertising.

This increased competition may result in price reductions, reduced gross margins and loss of market share, any of which could have a material adverse affect on our business, financial condition and results of operations.

Business Objectives and Plans

Our objective is to sustain and expand our leadership position as a provider of unique healthcare membership service programs and consumer driven healthcare solutions and as a distributor of health insurance plans. Key elements of our business plan are as follows:

Continue to Develop a Broad Spectrum of Unique Healthcare Service Programs for Broad Markets. Our focus is on the continued development and introduction of unique programs that address the health and consumer needs of targeted consumer groups. By varying the features, including discounts (medical, consumer and business services), defined benefit insurance and fully insured health plans, we are able to meet the product and pricing needs of a broad market. We anticipate that this will allow us to capture a larger share of the healthcare market through existing marketing channels and through establishment of new client relationships.

Continue to Develop a Recurring Revenue Base. For our Consumer Plan Division, growth in recurring revenue from the Care Entrée^{tm} product is dependent on our independent marketing representatives continuing to market the Care Entrée^{tm} program memberships and new USA Healthcare Savings memberships and to recruit new downline independent marketing representatives. We intend to continually increase our support for representatives to maximize the volume generated through this sales channel. Recurring revenue from wholesale and private-label clients is dependent upon the client continuously marketing our products to their customer base. We intend to continue to focus our efforts on retaining our existing clients and obtaining new wholesale and private label clients through our direct sales team.

In our Insurance Marketing Division, we intend to continue to expand our independent agent sales force, our specialty product lines, our insurance carrier companies we represent and the geographic jurisdictions in which we distribute products.

In our Regional Health Care Division, we intend to increase the revenue base of our third-party administration services by expanding the service area of AAI beyond the metropolitan area of El Paso, Texas.

Leverage and Develop Multiple Network Partners. While we currently have a contractual relationship with a well-recognized and fully developed preferred provider organization network for access to savings on doctors, hospitals, and ancillary healthcare services, we need to continuously assess the capabilities of that network and work towards providing alternative network solutions for our members.

Provide High Quality Consumer Service for Our Healthcare Membership Program. In order to achieve our anticipated growth and to ensure client, member and marketing representative loyalty, we continue to develop and invest significantly in our member service systems. We have developed a proprietary computer database system that provides our customer service representatives with immediate access to provider demographic data, re-pricing information and member information, including the components of each member program or plan and the details a member requires to properly utilize the program. In addition, we have partnered with a third party that has significant experience in providing member services and administrative services for healthcare savings programs like ours.

Provide High Quality Service for our Sales Representatives and Insurance Agents. In order to achieve our objectives of increased memberships and product sales, we concentrate on providing quality service for our sales representatives in the field. This includes ready telephone access to support personnel as well as access to websites,

conference calls and web-conferencing platforms. We enhance the value of our programs to these representatives by providing access to information and support on an ongoing basis.

Continue to Develop and Enhance Our Technology. We have incorporated numerous uses for Internet and information technology in our marketing and service functions. We plan to continue to enhance these operations to streamline and increase the efficiency of methods for our sales representatives and agents to enroll in our programs, submit applications and track their business.

Increase Tele-Sales Operations. We have initiated a number of affiliations with tele-sales centers and organizations that utilize tele-sales functions. We intend to continue pursuing these channels to broaden the distribution of our products and programs.

Develop Private-Label Product Offerings. We have implemented a number of private-label product offerings for specific markets and entities. We plan to leverage off our current administrative and product development systems to continue to provide private-label availability to organizations that can commit to significant levels of sales of these products.

Distribution of Our Products in Multiple Languages. Certain of our products are now available in Spanish, including access to customer service assistance. We plan to expand Spanish language usage among other products and implement additional languages for targeted markets where we believe there will be a significant volume of prospects.

Continue to Expand Our Third-Party Administrator Services. In response to the needs of our group customers, we have expanded our third party administrator (TPA) services. Our acquisition of AAI in 2004 allows us to offer a full-service TPA function that includes full plan administration, claims adjudication and claims management services.

Governmental Regulation

We are subject to federal, state and local laws, regulations, administrative determinations, court decisions and similar constraints (hereinafter regulations).

Possible Insurance Company Regulation. Our discount medical plans are not insurance and they do not subject us to regulation as an insurance company or a seller of insurance. However, regulations in certain states currently regulate or restrict the offering of our programs.

Occasionally, we receive inquiries from insurance commissioners in various states that require us to supply information about our discount healthcare programs, representatives, etc. to the insurance commissioner or other state regulatory agency. To date, these agencies have concurred with our view that our discount healthcare programs are not a form of insurance. There is no assurance that this situation will not change in the future, and an insurance commissioner will successfully challenge our ability to offer our programs without compliance with state insurance regulation.

State Discount Medical Program Regulation. Over the last few years, over twenty states have enacted legislation that specifically addresses the operation and marketing of discount medical programs like ours. The laws vary in scope. Some apply to discounts on all health care purchases. Some regulate only prescription discounts. Some exclude prescription discounts but regulate other services. The laws also vary in operation. Some contain only provisions that relate to the operation and marketing of discount medical plans and some require licensing and registration. Because this legislation or regulations are newly enacted or adopted, we do not know the scope and full effect on our operations, and there is a risk that compliance with such legislation and/or regulations could have material adverse affects on our operations and financial condition. There is also the risk that a state will adopt regulations or enact

legislation restricting or prohibiting the sale of our medical discount programs in the state. In addition, California views our discount medical plans as managed care and its Department of Managed Health Care has taken the position that we must seek and eventually obtain a license under the Knox-Keene Act. Compliance with these regulations on a state-by-state basis has been expensive and cumbersome.

Compliance with federal and state regulations is generally our responsibility. The medical discount plan industry is especially susceptible to charges by the media of regulatory noncompliance and unfair dealing. As is

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often the case, the media may publicize perceived non-compliance with consumer protection regulations and violations of notions of fair dealing with consumers. Our failure to comply with current, as well as newly enacted or adopted, federal and state regulations could have a material adverse effect upon our business, financial condition and results of operations in addition to the following:

non-compliance may cause us to become the subject of a variety of enforcement or private actions

compliance with changes in applicable regulations could materially increase the associated operating costs;

non-compliance with any rules and regulations enforced by a federal or state consumer protection authority may subject us or our management personnel to fines or various forms of civil or criminal prosecution; and

non-compliance or alleged non-compliance may result in negative publicity potentially damaging our reputation, network relationships, client relationships and the relationship with program members, representatives and consumers in general.

Insurance Regulations.

Government regulation of health and life insurance, annuities and healthcare coverage and health plans is a changing area of law and varies from state to state. Although we are not an insurance company, the insurance companies from which we obtain our products and financial services are subject to various federal and state regulations applicable to their operations. These insurance companies must comply with constantly evolving regulations and make changes occasionally to services, products, structure or operations in accordance with the requirements of those regulations.

Similar to the insurance companies providing products and services offered by us, we are unable to accurately predict additional government regulations that may be enacted in the future affecting the insurance industry and the offered products and service or how existing or future regulations might be interpreted.

Additional governmental regulation or future interpretation of existing regulations may increase the cost of compliance or materially affect the insurance products and services offered by us through independent insurance agencies and their agents and our operations, products or profitability.

We must rely on the insurance companies that provide the insurance products and financial services offered by Insuraco to carefully monitor state and federal legislative and regulatory activity as it affects their insurance products and services. The Company believes that the insurance products and financial services that we offer comply in all material respects with all applicable federal and state regulations.

We work closely with independent associations that provide discounts and other benefits to groups of consumers. Among the benefits afforded to the members of such associations are varying forms of insurance. Our ability to offer insurance products that we are authorized to distribute to these associations for inclusion in their benefit packages may be affected by governmental regulation or future interpretation of existing regulations that may increase the cost of regulatory compliance or affect the nature and scope of products that we may make available to such associations.

Product Claims and Advertising. The Federal Trade Commission and certain states regulate advertising, product claims, and other consumer matters, including advertising of our products. All advertising, promotional and solicitation materials used by marketing representatives require our approval prior to use. The Federal Trade Commission may institute enforcement actions against companies for false and misleading advertising of consumer products. In addition, the Federal Trade Commission has increased its scrutiny of the use of testimonials, including

those used by us and our marketing representatives. We have not been the target of Federal Trade Commission enforcement action.

There is no assurance that:

the Federal Trade Commission will not question our advertising or other operations in the future,

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a state will not interpret product claims presumptively valid under federal law as illegal under that state s regulations, or

future Federal Trade Commission regulations or decisions will not restrict the permissible scope of such claims.

We are also subject to the risk of claims by marketing representatives and their customers who may file actions on their own behalf, as a class or otherwise, and may file complaints with the Federal Trade Commission or state or local consumer affairs offices. These agencies may take action on their own initiatives against us for alleged advertising or product claim violations, or on a referral from independent marketing representatives, customers or others. Remedies sought in these actions may include consent decrees and the refund of amounts paid by the complaining independent marketing representatives or consumer, refunds to an entire class of independent marketing representatives or customers, client refunds, or other damages, as well as changes in our method of doing business. A complaint based on the practice of one marketing representative, whether or not we authorized the practice, could result in an order affecting some or all of our marketing representatives in a particular state. Also, an order in one state could influence courts or government agencies in other states considering similar matters. Proceedings resulting from these complaints could result in significant defense costs, settlement payments or judgments and could have a material adverse effect on us.

Network Marketing Organization. Our network marketing system is subject to a number of federal and state regulations administered by the Federal Trade Commission and various state agencies. These regulations are generally directed at ensuring that advancement, within a network marketing organization, is based on sales of the organization s products rather than investment in the organization or other non-sales related criteria. For instance, in certain markets there are limits on the extent that marketing representatives may earn royalties on sales generated by marketing representatives that were not directly sponsored by the marketing representative.

Our network marketing organization and activities are subject to scrutiny by various state and federal governmental regulatory agencies to ensure compliance with various types of laws and regulations. These laws and regulations include securities, franchise investment, business opportunity and criminal laws prohibiting the use of pyramid or endless chain types of selling organizations. The compensation structure of these selling organizations is very complex, and compliance with all of the applicable laws is uncertain in light of evolving interpretation of existing laws and the enactment of new laws and regulations pertaining to this type of product distribution. As of the date of this report, we are not aware of any legal actions pending or threatened by any governmental authority against us regarding the legality of our network marketing operations.

As of December 31, 2006, we had marketing representatives in 43 states and the District of Columbia. We review the requirements of various states, as well as seek legal advice, regarding the structure and operation of our network marketing to ensure that it complies with all of the applicable laws and regulations pertaining to network sales organizations. Based on these efforts and the experience of our management, we believe that we are in compliance with all applicable federal and state regulatory requirements. We have not obtained no-action letters or advance rulings from any federal or state security regulator or other governmental agency concerning the legality of our network operations, nor are we relying on a formal opinion of counsel to that effect. We accordingly are subject to the risk that one or more of our network marketing organizations could be found to not comply with applicable laws and regulations. Our failure to comply with these regulations could have a material adverse effect on us in a particular market or in general.

We are subject to the risk of challenges to the legality of our network marketing organization, including claims by our marketing representatives, both individually and as a class. Most likely these claims would be based on the network

marketing organization allegedly being operated as an illegal pyramid scheme in violation of federal securities laws, state unfair practice and fraud laws, and the Racketeer Influenced and Corrupt Organizations Act. In the event of challenges to the legality of our network marketing organization by distributors, we would be required to demonstrate that our network marketing organization complies with applicable regulatory laws. A final ruling against us could result in a material liability. Moreover, even if we were successful in defending against these challenges, the costs of such defense, both in dollars spent and in management time, could be material and adversely affect our operating results and financial condition. In addition, the negative publicity of these challenges could adversely affect our revenues and ability to attract and retain marketing representatives.

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Healthcare Regulation and Reform. Government regulation and reform of the healthcare industry may also affect the manner in which Insuraco conducts its business in the future. There continues to be diverse legislative and regulatory initiatives at both the federal and state levels to affect aspects of the nation s health care system. The Gramm-Leach-Bliley Act mandated restrictions on the disclosure and safeguarding of our insureds financial information. The USA Patriot Act placed new federal compliance requirements relating to anti-money laundering, customer identification and information sharing.

In addition, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires certain guaranteed issuance and renewability of health insurance coverage for individuals and small employer groups and limits exclusions on pre-existing conditions. HIPAA has also mandated the adoption of extensive standards for the use and disclosure of health information. HIPAA also mandated the adoption of standards for the exchange of electronic health information in an effort to encourage overall administrative simplification and enhance the effectiveness and the efficiency of the healthcare industry.

HIPAA s Security standards became effective April 20, 2005 and further mandated that specific requirements be met relating to maintaining the confidentiality and integrity of electronic health information and protecting it from anticipated hazards or uses and disclosures that are not permitted.

Our re-pricing software systems are considered HIPAA compliant. We previously engaged a consulting firm to assist us in our efforts to continuously comply with all other HIPAA regulations. We believe that we are in compliance with these regulations. We plan to continually audit our compliance, and accordingly cannot give assurance that our costs of continuing to comply with HIPAA will not be material to us. Sanctions for failing to comply with standards issued pursuant to HIPAA include criminal penalties and civil sanctions.

In addition to federal regulation and reform, many states have enacted, or are considering, various healthcare reform statutes. These reforms relate to, among other things, managed care practices, prompt pay payment practices, health insurer liability and mandated benefits. Most states have also enacted patient confidentiality laws that prohibit the disclosure of confidential information. As with all areas of legislation, the federal regulations establish minimum standards and preempt conflicting state laws that are less restrictive but will allow state laws that are more restrictive. The Company expects that this trend of increased legislation will continue. We are unable to predict what state reforms will be enacted or how they would affect our business.

E-Commerce Regulation. The Company may be subject to additional federal and state statutes and regulations in connection with our product strategy, which includes Internet services and products. On an increasingly frequent basis, federal and state legislators are proposing laws and regulations that apply to Internet based commerce and communications. Areas being affected by this regulation include user privacy, pricing, content, taxation, copyright protection, distribution and quality of products, and services. To the extent that our products and services would be subject to these laws and regulations, the sale of our products and our business could be harmed.

Legislative Developments. Numerous proposals to reform the current healthcare system have been introduced in the U.S. Congress and in various state legislatures. Proposals have included, 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. Changes in health care policy could significantly affect our business. Legislation has been introduced from time to time in the U.S. Congress that could result in the federal government assuming a more direct role in regulating insurance companies.

The Company is unable to evaluate new legislation that may be proposed and when or whether any legislation will be enacted and implemented. However, many of the proposals, if adopted, could have a material adverse effect on the

Company s business, financial condition or results of operations; while others, if adopted, could potentially benefit the Company s business.

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Employees

As of December 31, 2006, we had 114 full-time employees in the following departments:

Department	Number of Employees
Customer Services and Claims Administration	64
Executive and Administration	11
Information Services	9
Provider Relations	3
Finance and Accounting	7
Sales and Marketing	3
Data Entry	1
Quality Assurance	9
Utilization Review and Management	7

The total number of our employees after we completed the merger with ICM in January 2007 increased to 131. Our future performance depends in significant part upon the continued service of our key technical and management personnel, and our continuing ability to attract and retain highly qualified and motivated personnel in all areas of our operations. Competition for qualified personnel is intense. We provide no assurance that we can retain key managerial and technical employees, or that we can attract, assimilate or retain other highly qualified personnel in the future. Our employees are not represented by a labor union. We have not experienced any work stoppages, and consider our employee relations to be good.

ITEM 1A. RISK FACTORS

Our Risk Factors

The matters discussed below and elsewhere in this report should be considered when evaluating our business operations and strategies. Additionally, there may be risks and uncertainties that we are not aware of or that we currently deem immaterial, which may become material factors affecting our operations and business success. Many of the factors are not within our control. We provide no assurance that one or more of these factors will not:

adversely affect the market price of our common stock,

adversely affect our future operations,

adversely affect our business,

adversely affect our financial condition,

adversely affect our results of operations,

require significant reduction or discontinuance of our operations,

require us to seek a merger partner, or

require us to sell additional stock on terms that are highly dilutive to our shareholders.

THIS REPORT CONTAINS CAUTIONARY STATEMENTS RELATING TO FORWARD LOOKING INFORMATION.

We have included some forward-looking statements in this section and other places in this report regarding our expectations. These forward-looking statements involve known and unknown risks, uncertainties and other factors that may cause our actual results, levels of activity, performance or achievements, or industry results, to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. Some of these forward-looking statements can be identified by the use of forward-looking terminology including believes, expects, may, will, should or anticipates or the

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negative thereof or other variations thereon or comparable terminology, or by discussions of strategies that involve risks and uncertainties. You should read statements that contain these words carefully because they:

discuss our future expectations,

contain projections of our future operating results or of our future financial condition, or

state other forward-looking information.

We believe it is important to discuss our expectations. However, it must be recognized that events may occur in the future over which we have no control and which we are not accurately able to predict. Any forward-looking statements contained in this report represent our judgment as of the date of this report. We disclaim, however, any intent or obligation to update these forward-looking statements. As a result, the reader is cautioned not to place undue reliance on these forward-looking statements.

DURING 2006, 2005 AND 2004 WE HAVE INCURRED LOSSES FROM OPERATIONS IN THE CONSUMER PLAN DIVISION AND REGIONAL HEALTHCARE DIVISION AND THESE LOSSES MAY CONTINUE.

During 2006, 2005 and 2004 we incurred losses from continuing operations of $6,814,000, $13,229,000 and $1,657,000, respectively and net losses of $7,724,000, $13,371,000 and $1,956,000, respectively. As part of those operating losses and net losses, we incurred goodwill impairment charges of $6,866,000 including tax considerations of $426,000, $12,900,000 and $2,000,000 in 2006, 2005 and 2004, respectively. In 2006, we recorded goodwill impairment charges of $4,066,000 including tax considerations of $426,000 for AAI and $2,800,000 for Capella, respectively. In 2005, we recorded a goodwill impairment charge of $12,900,000 related to Capella. In 2004, we recorded a goodwill impairment charge of $2,000,000 related to Foresight, Inc. (Foresight). Before the goodwill impairment charges, income from continuing operations was $52,000 in 2006 and $343,000 in 2004 and a loss of $329,000 in 2005. The operating loss before goodwill impairment charges in 2005 was primarily attributable to the continuing costs associated with our Care Entrée[tm] medical savings program. There is no assurance that losses from our Care Entrée[tm] medical savings program will not continue or that our other operations will become or continue to be profitable in 2007 or thereafter.

OUR REVENUES IN THE CONSUMER PLAN DIVISION ARE LARGELY DEPENDENT ON THE INDEPENDENT MARKETING REPRESENTATIVES, WHOSE REDUCED SALES EFFORTS OR TERMINATION MAY RESULT IN SIGNIFICANT LOSS OF REVENUES.

Our success and growth depend in large part upon our ability to attract, retain and motivate the network of independent marketing representatives who principally market our Care Entrée[tm] medical savings program and the USA Healthcare Savings products that we are introducing in 2007. Our independent marketing representatives typically offer and sell the Care Entrée[tm] program on a part-time basis, and may engage in other business activities. These marketing representatives may give higher priority to other products or services, reducing their efforts devoted to marketing our Care Entrée[tm] program. Also, our ability to attract and retain marketing representatives could be negatively affected by adverse publicity relating to our Care Entrée[tm] program and operations.

Under our network marketing system, the marketing representatives downline organizations are headed by a relatively small number of key representatives who are responsible for a substantial percentage of our total revenues. The loss of a significant number of marketing representatives, including any key representatives, for any reason, could adversely affect our revenues and operating results, and could impair our ability to attract new distributors.

A LARGE PART OF OUR REVENUES ARE DEPENDENT ON KEY RELATIONSHIPS WITH A FEW PRIVATE LABEL RESELLERS AND WE MAY BECOME MORE DEPENDENT ON SALES BY A FEW PRIVATE LABEL RESELLERS.

Our revenues from sales of our independent marketing representatives have declined and continue to decline. As a result, we have become more dependent on sales made by private label resellers to whom we sell our discount medical programs. If sales made by our independent marketing representatives continue to decline or if our efforts

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to increase sales through private label resellers succeed, we may become more dependent on sales made by our private label resellers. Because a large number of these sales may be made by a few resellers, our revenues and operating results may be adversely affected by the loss of our relationship with any of those private label resellers.

DEVELOPMENT AND MAINTENANCE OF RELATIONSHIPS WITH PREFERRED PROVIDER ORGANIZATIONS ARE CRITICAL AND THE LOSS OF SUCH RELATIONSHIPS COULD HAVE A MATERIAL ADVERSE EFFECT ON OUR BUSINESS.

As part of our business operations, we must develop and maintain relationships with preferred provider organizations within each market area that our services are offered. Development and maintenance of these relationships with healthcare providers within a preferred provider organization is in part based on professional relationships and the reputation of our management and marketing personnel. Because many members that receive healthcare services are self-insured and responsible for payment for healthcare services received, failure to pay or late payments by members may negatively affect our relationship with the preferred provider organizations. Consequently, preferred provider organization relationships may be adversely affected by events beyond our control, including departures of key personnel and alterations in professional relationships and members failures to pay for services received. The loss of a preferred provider organization within a geographic market area may not be replaced on a timely basis, if at all, and may have a material adverse effect on our business, financial condition and results of operations.

WE CURRENTLY RELY HEAVILY ON ONE KEY PREFERRED PROVIDER ORGANIZATION AND THE LOSS OF OR A CHANGE IN OUR RELATIONSHIP WITH THIS PROVIDER COULD HAVE A MATERIAL ADVERSE EFFECT ON OUR BUSINESS.

Private Healthcare Systems (PHCS), a division of MultiPlan, Inc., is the preferred provider organization through which most of our members obtain savings on medical services through our Care Entrée program. The loss of PHCS as a preferred provider organization or a disruption of our members access to PHCS could affect our ability to retain our members and could, therefore, adversely affect our business. While we currently enjoy a good relationship with PHCS and MultiPlan, there are no assurances that we will continue to have a good relationship with them in the future, or that MultiPlan, having recently acquired PHCS, may choose to change its business strategy in a way that adversely affects us by either limiting or terminating our members access to the PHCS network or by entering into agreements with our competitors to provide their members access to PHCS.

WE FACE COMPETITION FOR MARKETING REPRESENTATIVES AS WELL AS COMPETITIVE OFFERINGS OF HEALTHCARE PRODUCTS AND SERVICES.

Within the healthcare savings membership industry competition for members is becoming more intense. We offer membership programs that provide products and services similar to or directly in competition with products and services offered by our network-marketing competitors as well as the providers of such products and services through other channels of distribution. Some of our private label resellers have chosen to sell a product that is competitive to ours in order to maintain multiple sources for their products. Others may also choose to sell competing products. Furthermore, marketing representatives have a variety of products that they can choose to market, whether competing with us in the healthcare market or not.

Our business operations compete in two channels of competition. First, we compete based upon the healthcare products and services offered. These competitors include companies that offer healthcare products and services through membership programs much like our programs, as well as insurance companies, preferred provider organization networks and other organizations that offer benefit programs to their customers. Second, we compete with all types of network marketing companies throughout the U.S. for new marketing representatives. Many of our competitors have substantially larger customer bases and greater financial and other resources.

We provide no assurance that our competitors will not provide healthcare benefit programs comparable or superior to our programs at lower membership prices or adapt more quickly to evolving healthcare industry trends or changing industry requirements. Increased competition may result in price reductions, reduced gross margins,

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and loss of market share, any of which could adversely affect our business, financial condition and results of operations. There is no assurance that we will be able to compete effectively with current and future competitors.

GOVERNMENT REGULATION MAY ADVERSELY AFFECT OR LIMIT OUR OPERATIONS.

Most of the discount medical programs that we offer through our Consumer Plan Division are sold without the need for an insurance license by any federal, state or local regulatory licensing agency or commission. In comparison, companies that provide insurance benefits and operate healthcare management organizations and preferred provider organizations are regulated by state licensing agencies and commissions. These regulations extensively cover operations, including scope of benefits, rate formula, delivery systems, utilization review procedures, quality assurance, enrollment requirements, claim payments, marketing and advertising. Several states have enacted laws and regulations overseeing discount medical plans. We do not know the full extent of these regulations and additional states may also impose regulation. Our need to comply with these regulations may adversely affect or limit our future operations. The cost of complying with these laws and regulations has and will likely continue to have a material effect on our financial position.

Government regulation of health and life insurance, annuities and healthcare coverage and health plans is a changing area of law and varies from state to state. Although we are not an insurance company, the insurance companies from which we obtain our products and financial services are subject to various federal and state regulations applicable to their operations. These insurance companies must comply with constantly evolving regulations and make changes occasionally to services, products, structure or operations in accordance with the requirements of those regulations. We may also be limited in how we market and distribute our products and financial services as a result of these laws and regulations.

WE HAVE A FIDUCIARY RESPONSIBILITY TO OUR MEMBERS THROUGH OUR TOTAL CARE AND ESSENTIAL CARE PROGRAM OFFERINGS. IN THIS CAPACITY, WE COULD BE LIABLE FOR THE LOSS OF MEMBERS FUNDS DEPOSITED WITH US IN PERSONAL MEDICAL ACCOUNTS.

In the fourth quarter of 2002, we initiated a medical savings program through our Total Care and Essential Care programs that were processed through our subsidiary, Foresight, and are now processed through our subsidiary, Access Administrators, Inc., as a third-party administrator. Under this medical savings program, funds collected from members are held in Personal Medical Accounts for the benefit of the member as a source of payment for healthcare services obtained through our Total Care and Essential Care programs. Under the medical savings program we have a fiduciary responsibility to our members for the funds held for their benefit much like a trustee. In the unforeseen event of a loss of these funds while being held by us or our failure to implement and maintain adequate internal controls, we will be responsible and liable to the affected members for any such loss, including any consequential damages suffered by the members, which liability could be substantial. We have terminated this program and the amounts held in our members Personal Medical Accounts has been returned to the individual account holders. Nevertheless, our risk for the funds that had been held in those accounts remains with regard to previously completed transactions.

AS A RESULT OF THE INTRODUCTION OF PERSONAL MEDICAL ACCOUNTS, OUR FINANCIAL POSITION AND RESULTS OF OPERATIONS MAY CONTINUE TO BE ADVERSELY IMPACTED BY A DECREASE IN THE NUMBER OF HEALTHCARE SAVINGS PROGRAM MEMBERSHIPS THAT WE CAN SELL AND MAINTAIN.

While we believe that the introduction of our Personal Medical Accounts (PMAs) was an important product evolution, the initial impact of this introduction has negatively affected our business. This impact is the result of additional difficulties in selling and maintaining memberships in our program because of the added complexity. Although we have terminated our PMA program, there is no assurance that we will be able to overcome these difficulties, and we

may not be able to increase the number of memberships that are sold and maintained. As a result, our financial position and results of operations may be negatively affected.

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THE FAILURE OF OUR NETWORK MARKETING ORGANIZATION TO COMPLY WITH FEDERAL AND STATE REGULATION COULD RESULT IN ENFORCEMENT ACTION AND IMPOSITION OF PENALTIES, MODIFICATION OF OUR NETWORK MARKETING SYSTEM, AND NEGATIVE PUBLICITY.

Our network marketing organization is subject to federal and state laws and regulations administered by the Federal Trade Commission and various state agencies. These laws and regulations include securities, franchise investment, business opportunity and criminal laws prohibiting the use of pyramid or endless chain types of selling organizations. These regulations are generally directed at ensuring that product and service sales are ultimately made to consumers (as opposed to other marketing representatives) and that advancement within the network marketing organization is based on sales of products and services, rather than on investment in the company or other non-retail sales related criteria.

The compensation structure of a network marketing organization is very complex. Compliance with all of the applicable regulations and laws is uncertain because of:

the evolving interpretations of existing laws and regulations, and

the enactment of new laws and regulations pertaining in general to network marketing organizations and product and service distribution.

Accordingly, there is the risk that our network marketing system could be found to not comply with applicable laws and regulations that could:

result in enforcement action and imposition of penalty,

require modification of the marketing representative network system,

result in negative publicity, or

have a negative effect on distributor morale and loyalty.

Any of these consequences could have a material adverse effect on our results of operations as well as our financial condition.

THE LEGALITY OF OUR NETWORK MARKETING ORGANIZATION IS SUBJECT TO CHALLENGE BY OUR MARKETING REPRESENTATIVES, WHICH COULD RESULT IN SIGNIFICANT DEFENSE COSTS, SETTLEMENT PAYMENTS OR JUDGMENTS, AND COULD HAVE A MATERIAL ADVERSE EFFECT ON OUR RESULTS OF OPERATIONS AND FINANCIAL CONDITION.

Our network marketing organization is subject to legality challenge by our marketing representatives, both individually and as a class. Generally, these challenges would be based on claims that our marketing network program was operated as an illegal pyramid scheme in violation of federal securities laws, state unfair practice and fraud laws and the Racketeer Influenced and Corrupt Organizations Act. Proceedings resulting from these claims could result in significant defense costs, settlement payments, or judgments, and could have a material adverse effect on us.

WE MAY HAVE EXPOSURE AND LIABILITY RELATING TO NON-COMPLIANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 AND THE COST OF COMPLIANCE COULD BE MATERIAL.

In April 2003 privacy regulations promulgated by The Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA imposes extensive restrictions on the use and disclosure of individually identifiable health information by certain entities. Also as part of HIPAA, the Department of Health and Human Services has issued final regulations standardizing electronic transactions between health plans, providers and clearinghouses. Healthcare plans, providers and claims administrators are required to conform their electronic and data processing systems to HIPAA electronic transaction requirements. While we believe we are currently compliant with these regulations, we cannot be certain of the extent to which the

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enforcement or interpretation of these regulations will affect our business. Our continuing compliance with these regulations, therefore, may have a significant impact on our business operations and may be at material cost in the event we are subject to these regulations. Sanctions for failing to comply with standards issued pursuant to HIPAA include criminal and civil sanctions.

DISRUPTIONS IN OUR OPERATIONS DUE TO IMPLEMENTATION OF OUR MANAGEMENT INFORMATION SYSTEM MAY OCCUR AND COULD ADVERSELY AFFECT OUR CLIENT RELATIONSHIPS.

We recently transitioned to our new management information system. This is a proprietary system and we do not rely on any third party for its support and maintenance. There is no assurance that we will be able to continue operating without experiencing any disruptions in our operations or that our relationships with our members, marketing representatives or providers will not be adversely affected or that our internal controls will not be adversely affected.

WE HAVE MANY COMPETITORS AND MAY NOT BE ABLE TO COMPETE EFFECTIVELY WHICH MAY LEAD TO A LACK OF REVENUES AND DISCONTINUANCE OF OUR OPERATIONS.

We compete with numerous well-established companies that design and implement membership programs and other healthcare programs. Some of our competitors may be companies that have programs that are functionally similar or superior to our programs. Most of our competitors possess substantially greater financial, marketing, personnel and other resources than us. They may also have established reputations relating to their programs.

Due to competitive market forces, we may experience price reductions, reduced gross margins and loss of market share in the future, any of which would result in decreases in sales and revenues. These decreases in revenues would adversely affect our business and results of operations and could lead to discontinuance of operations. There can be no assurance that:

- we will be able to compete successfully;
- our competitors will not develop programs that render our programs less marketable or even obsolete; or
- we will be able to successfully enhance our programs when necessary.

THE GOODWILL ACQUIRED PURSUANT TO OUR ACQUISITIONS OF THE CAPELLA GROUP AND AAI MAY BECOME FURTHER IMPAIRED AND REQUIRE A WRITE-DOWN AND THE RECOGNITION OF AN IMPAIRMENT EXPENSE THAT MAY BE SUBSTANTIAL.

In connection with our acquisitions of The Capella Group and AAI, we recorded goodwill that had an aggregate asset value of $7,466,000 at December 31, 2006. This carrying value has been reduced through impairment charges of $6,866,000 including tax considerations of $426,000 in 2006, $12,900,000 in 2005, and $2,000,000 in 2004. In the event that the goodwill is determined to be further impaired for any reason, we will be required to write-down or reduce the value of the goodwill and recognize an additional impairment expense. The impairment expense may be substantial in amount and, in such case, adversely affect the results of our operations for the applicable period and may negatively affect the market value of our common stock.

OUR SUBSIDIARY, AAI, DERIVES A LARGE PERCENTAGE OF ITS INCOME FROM A FEW KEY CLIENTS AND THE LOSS OF ANY OF THOSE CLIENTS COULD HAVE A MATERIAL ADVERSE EFFECT ON OUR RESULTS OF OPERATIONS AND FINANCIAL CONDITION.

AAI provides full service third-party administration services to adjudicate and pay medical claims for employers who have self-funded all or any portion of their healthcare costs. Their primary market is governmental entities in the metropolitan area of El Paso, Texas, including cities and school districts. There is a limited number of these types of entities within that metropolitan area. During 2006 we incurred a $4,066,000 goodwill impairment charge including tax considerations of $426,000 as a result of the reduction in the number of lives covered under plans we administer. There is no assurance that AAI will obtain renewal or extension of those contracts in 2007. The

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loss of any of these contractual relationships will adversely affect on our operating results and the loss of more than one of these contractual relationships could have a material adverse effect on our financial condition.

WE MAY FIND IT DIFFICULT TO INTEGRATE ICM S BUSINESS AND OPERATIONS WITH OUR BUSINESS AND OPERATIONS.

Although we believe that ICM s marketing and distribution of insurance products and financial services will complement and fit well with our business and the need for marketing of our healthcare savings programs and third-party claims administration services, ICM s business is new to us. Our unfamiliarity with this business may make it more difficult to integrate ICM s operations with ours. We will not achieve the anticipated benefits of the merger-acquisition unless we successfully integrate the operations of ICM and its subsidiaries. There can be no assurance that this will occur.

WE ARE DEPENDENT ON THIRD PARTY SERVICE PROVIDERS AND THE FAILURE OF SUCH SERVICE PROVIDERS TO ADEQUATELY PROVIDE SERVICES TO US COULD AFFECT OUR FINANCIAL RESULTS BECAUSE SUCH FAILURE COULD AFFECT OUR RELATIONSHIP WITH OUR CUSTOMERS.

As a cost efficiency measure, we have entered into agreements with third parties for their provision of services to us in exchange for a monthly fee normally calculated on a per member basis. These services include the enrollment of members through different media, operation of a member-services call center, claims administration, billing and collection services, and the production and distribution of fulfillment member marketing materials. One of these is our agreement with Lifeguard Emergency Travel, Inc. (Lifeguard) for the provision of these services to many of our members and prospective members. As a result of these outsourcing agreements, we may lose direct control over these key functions and operations. The failure by Lifeguard or any of our other third party service providers to perform the services to the same or similar level of quality that we could provide could adversely affect our relationships with our members, customers, marketing representatives and our ability to retain and attract members, customers, marketing representatives and, accordingly, have a material adverse effect on our financial condition and results of operations.

THE AVAILABILITY OF OUR INSURANCE PRODUCTS AND FINANCIAL SERVICES ARE DEPENDENT ON OUR STRATEGIC RELATIONSHIPS WITH VARIOUS INSURANCE COMPANIES AND THE UNAVAILABILITY OF THOSE PRODUCTS AND SERVICES FOR ANY REASON MAY RESULT IN SIGNIFICANT LOSS OF REVENUES.

We are not an insurance company and only market and distribute insurance products and financial services developed and offered by insurance companies. We must develop and maintain relationships with insurance companies that provide products and services for a particular market segment (the elderly, the young family, etc.) that we in turn make available to the independent agents with whom they have contracted to sell the products and services to the individual consumer. Of the eight insurance companies with whom ICM and its subsidiaries had strategic relationships prior to our acquisition, more than 95% of 2006 and 2005 revenue of ICM and its subsidiaries was attributable to the insurance products and financial services offered by five of the companies. Thus, we are dependent on a relatively small number of insurance companies to provide product and financial services for sale through our channels.

Development and maintenance of relationships with the insurance companies may in part be based on professional relationships and the reputation of our management and marketing personnel. Consequently, the relationships with insurance companies may be adversely affected by events beyond our control, including departures of key personnel and alterations in professional relationships. Our success and growth depend in large part upon our ability to establish and maintain these strategic relationships, contractual or otherwise, with various insurance companies to provide their

products and services, including those insurance products and financial services that may be developed in the future. The loss or termination of these strategic relationships could adversely affect our revenues and operating results. Furthermore, the loss or termination may also impair our ability to maintain and attract new insurance agencies and their agents to distribute the insurance products and services that we offer.

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WE ARE DEPENDENT UPON INDEPENDENT INSURANCE AGENCIES AND THEIR AGENTS TO OFFER AND SELL OUR INSURANCE PRODUCTS AND FINANCIAL SERVICES.

We are principally dependent upon independent insurance agencies and their agents to offer and sell the insurance products and financial services that we offer and distribute. These insurance agencies and their agents may offer and distribute insurance products and financial services that are competitive with ours. These independent agencies and their agents may give higher priority and greater incentives (financial or otherwise) to other insurance products or financial services, reducing their efforts devoted to marketing and distribution of the insurance products and financial services that we offer. Also, our ability to attract and retain independent insurance agencies could be negatively affected by adverse publicity relating to our products and services or our operations.

Furthermore, of the approximately 5,000 independent agents with whom ICM and its subsidiaries had active distribution and marketing relationships prior to our acquisition, more than 80% of the revenues of ICM and its subsidiaries was attributable to the product sales and financial services through approximately 1,000 independent insurance agents. These agents report through approximately 20 independent general agencies. Thus, we are dependent on a small number of independent insurance agencies for a very significant percentage of our total insurance products and financial services revenue.

Development and maintenance of the relationships with independent insurance agencies and their agents may in part be based on professional relationships and the reputation of our management and marketing personnel. Consequently, these relationships may be adversely affected by events beyond our control, including departures of key personnel and alterations in professional relationships. The loss of a significant number of the independent insurance agencies (and their agents), as well as the loss of a key agency or its agents, for any reason, could adversely affect our revenue and operating results, or could impair our ability to establish new relationships or continue strategic relationships with independent insurance agencies and their agents.

WE FACE INTENSE COMPETITION IN THE MARKET PLACE FOR OUR PRODUCTS AND SERVICES AS WELL AS COMPETITION FOR INSURANCE AGENCIES AND THEIR AGENTS FOR THE MARKETING OF THE PRODUCTS AND SERVICES OFFERED.

Instead of utilizing captive or wholly-owned insurance agencies for the offer and sale of its products and services, we utilize independent insurance agencies and their agents as the principal marketing and distribution channel. Competition for independent insurance agencies and their agents is intense. Also, competition from products and services similar to or directly in competition with the products and services that we offer is intense, including those products and services offered and sold through the same channels utilized for distribution of our insurance products and financial services. Under arrangements with the independent insurance agencies, the agencies and their agents may offer and sell a variety of insurance products and financial services, including those that compete with the insurance products and financial services that we offer.

Thus, our business operations compete in two channels of competition. First, we compete based upon the insurance products and financial services offered. This competition includes products and services of insurance companies that compete with the products and services of the insurance companies that we offered and sell. Second, we compete with all types of marketing and distribution companies throughout the U.S. for independent insurance agencies and their agents. Many of our competitors have substantially larger bases of insurance companies providing products and services, and longer-term established relationships with independent insurance agencies and agents for the sale and distribution of products and services, as well as greater financial and other resources.

There is no assurance that our competitors will not provide insurance products and financial services comparable or superior to those products and services that we offer at lower costs or prices, greater sales incentives (financial or otherwise) or adapt more quickly to evolving insurance industry trends or changing industry requirements. Increased competition may result in reduced margins on product sales and services, less than anticipated sales or reduced sales, and loss of market share, any of which could materially adversely affect our business and results of operations. There can be no assurance that we will be able to compete effectively against current and future competitors.

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WE ARE HIGHLY DEPENDENT ON PETER W. NAUERT AND THE LOSS OF HIS SERVICES WOULD HAVE A SUBSTANTIAL ADVERSE EFFECT ON OUR OPERATIONS AND FINANCIAL RESULTS.

We are highly dependent upon Peter W. Nauert. Mr. Nauert s management skills, reputation and contacts within the insurance industry, including insurance companies and insurance agencies and their agents, are key elements of our business plans. The loss of the services of Mr. Nauert would adversely affect the anticipated growth and success we expect to obtain following completion of our merger with ICM.

ITEM 1B. UNRESOLVED STAFF COMMENTS

We are not an accelerated filer or a large accelerated filer (as such items are defined in Rule 12b-2 of the Exchange Act) or a well-known seasoned issuer (as such term is defined under Rule 405 of the Securities Act). While this item is not required, we can report that as of the date of this report, there are no pending unresolved comments received from the staff of the Securities and Exchange Commission.

ITEM 2. PROPERTIES

Our corporate offices, operations, and insurance agency are located in 17,612 square feet at 4929 Royal Lane, Suite 200, Irving, Texas 75063. The offices are occupied under a lease agreement with an unaffiliated third party that expires November 15, 2011. We lease an additional 2,471 square feet for storage from the same unaffiliated third party under a separate lease that expires January 2, 2010.

AAI occupies 16,780 square feet at 7430 Remcon Circle, Building C, El Paso, Texas, 79912. These offices are occupied under a lease agreement with a unaffiliated third party that expires May 31, 2011. This property was owned by an affiliated party through January 2007. The rates in this lease were compared to market rates prior to its execution to ensure that the terms of the lease were consistent with an impartial, arms-length arrangement. Total payments of $169,000 were paid to the affiliated party under this agreement in 2006.

We consider our leased office space to be adequate for our needs. In the event we are required to relocate our office upon termination of the existing leases, we believe other office space is available on comparable lease terms.

The following table presents our commitment under these leases.

Dollars in Thousands	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
Total operating leases on real property, net of sublease income	$ 2,104	$ 402	$ 924	$ 778	$

ITEM 3. LEGAL PROCEEDINGS

In the normal course of business, the Company may become involved in litigation or in settlement proceedings relating to claims arising out of the Company s operations. Except as described below, the Company is not a party to any legal proceedings, the adverse outcome of which, individually or in the aggregate, could have a material adverse effect on the Company s business, financial condition and results of operations.

Kirk, et al v Precis, Inc. and David May. On September 8, 2003, the case styled Robert Kirk, Individually and D/B/A US Asian Advisors, LLC, Eugene M. Kennedy, P.A., Stewart & Associates, CPA s, P.A. and Kimberly Decamp, Plaintiffs vs. Precis, Inc. and David May, Defendants was initiated in the District Court of Tarrant County, Texas, Case No. 236 201 468 03. The plaintiffs Robert Kirk (doing business as US Asian Advisors, LLC or U.S. Asian Capital Investors, LLC), Kimberly Decamp and Stewart & Associates, CPA s, P.A. held warrants exercisable for the purchase of 9,000, 48,000 and 4,000 shares, respectively, of the Company s common stock for $9.00 per share on or before February 8, 2005. The plaintiffs Eugene M. Kennedy, P.A. and Kimberly Decamp held stock options that expired on June 30, 2003, and that were exercisable for 15,000 and 170,000 shares, respectively, of the Company s common stock for $9.37 per share. David May was our Secretary and Vice President and General Counsel through January 5, 2004.

The plaintiffs alleged that they were not allowed to exercise their stock options and warrants in May 2003 due to actions and inactions of Mr. May and that these actions and inactions constitute fraud, misrepresentation,

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negligence and legal malpractice. All communications with Mr. May were through the plaintiffs broker, Burt Martin Arnold Securities, Inc. Plaintiffs sought damages equal to the difference between the exercise price of the stock options or warrants and the market value of the Company s common stock on May 7, 2002 (presumably the closing sale price of $15.75) or an aggregate sum of $1,592,050, plus exemplary damages and costs.

On July 13, 2005, the court entered a judgment in the Company s favor, ordering that the plaintiffs take nothing by way of their lawsuit. The order set aside a previous jury verdict in favor of the plaintiffs. The trial court s judgment was affirmed by the Court of Appeals for the Second Judicial District of Texas. The plaintiffs may appeal the appellate court s decision to the Texas Supreme Court. While the Company cannot offer any assurance as to the outcome of the appeal, the Company believes that there exists no basis on which the judgment in the Company s favor will be overturned.

Zermeno v Precis. The case styled *Manuela Zermeno, individually and on behalf of the general public; and Juan A. Zermeno, individually and on behalf of the general public v Precis, Inc., an Oklahoma corporation and Does 1 through 100, inclusive* was filed on August 14, 2003 in the Superior Court of the State of California for the County of Los Angeles.

A second case styled *California Foundation for Business Ethics, Inc., a California non-profit corporation, v Precis, Inc., and Does 1 through 100, inclusive* was filed on September 9, 2003, in the Superior Court of the State of California for the County of Los Angeles.

The two above cases were removed to the United States District Court for the Central District of California and consolidated by order of the court, on December 4, 2003.

The Zermeno plaintiffs are former members of the Care Entrée[tm] discount healthcare program who allege that they (for themselves and for the general public) are entitled to injunctive, declaratory, and equitable relief. Plaintiffs First Amended Complaint set forth three distinct claims under California law. Plaintiffs first cause of action alleged that the operation of our Care Entrée[tm] program violates Health and Safety Code §445 (Section 445) that governs medical referral services. Next, Plaintiffs alleged that they are entitled to damages under Civil Code §§1812.119 and 1812.123, which are part of the broader statutory scheme governing the operation of discount buying organizations, Civil Code 1812. 100 *et. Seq.* (Section 1812.100). Plaintiffs third cause of action sought relief under Business and Professions Code § 17200, California s Unfair Competition Law (Section 17200).

The Company fully settled all the claims brought by the California Foundation for Business Ethics, Inc. With the Zermeno plaintiffs, the Company settled the causes of action related to Civil Code §§ 1812.100. The claim under Section 445 and the related claim under Section 17200 remain pending and have been assigned to the Superior Court of California, Los Angeles County under case number BC 300788. A negative result in this case would have a material affect on the Company s financial condition and would limit the Company s ability (and that of other healthcare discount programs) to do business in California.

Management believes that the Company have complied with all applicable statutes in the state of California and regulations. Although management believes the Plaintiffs claims are without merit, the Company cannot provide any assurance regarding the outcome or results of this litigation.

State of Texas v The Capella Group, Inc. et al. The State of Texas filed a lawsuit against our subsidiary, The Capella Group, Inc. d/b/a Care Entrée, and Equal Access Health, Inc. (including various names under which Equal Access Health, Inc. does business) on April 28, 2005. Equal Access Health is a third party marketer of our discount medical card programs, but is otherwise not affiliated with our subsidiaries or us. The lawsuit alleges that Care Entrée, directly and through at least one other party that resells Care Entrée s services to the public, violated certain provisions of the

Texas Deceptive Trade Practices Consumer Protection Act. The lawsuit seeks, among other things, injunctive relief, unspecified monetary penalties and restitution. We believe that the allegations are without merit and are vigorously defending this lawsuit. The lawsuit was filed in the 98th District Court of Travis County, Texas as case number GV501264. We have always insisted that our programs be sold in an honest and forthright manner and have worked to protect the interests of consumers in Texas and all other states. Unfavorable findings in this lawsuit could have a material adverse effect on our financial condition and results of operations. No assurance can be provided regarding the outcome or results of this litigation.

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Investigation of National Center for Employment of the Disabled, Inc. and Access HealthSource, Inc.(AAI) In June 2004 the Company acquired AAI and its subsidiaries from National Center for Employment of the Disabled, Inc. (now known as Ready One Industries, NCED). Robert E. Jones, the C.E.O. of NCED was elected to and served on the Company s Board of Directors until his March 2006 resignation. Frank Apodaca, the President and C.E.O. of AAI served as Chief Administrative Officer for NCED. He also served on the Board of Directors of NCED until his resignation in March 2006. Until July 2006, his employment agreement with the Company allowed him to spend up to 20% of his time on matters related to NCED s operations. NCED is one of the Company s greater than 10% shareholders as a result of shares it received from the Company s acquisition of AAI. The 16,780 square feet of office space we lease for our AAI operation in El Paso as described in Item 2 was owned by NCED through January 2007. The rates in this lease were compared to market rates prior to its execution to ensure that the terms of the lease were consistent with an impartial, arms-length arrangement. Total payments of $169,000 were paid to NCED under this agreement in 2006. AAI also earned revenue from NCED of $729,000 and $684,000 in 2005 and 2006, respectively.

NCED provides services to the United States government under various contracts that were awarded to NCED under a federal program that encouraged the use of facilities whose work force is composed of 75% or more disabled workers. In 2006, investigations into NCED revealed that it may not have employed a sufficient number of disabled workers to meet the program s requirements. Although the Company believes that AAI was not involved in the contracting for NCED s federal contracts and was not involved in NCED s operations either before or after the Company s acquisition of AAI, the investigation of NCED may lead to allegations that either AAI or Mr. Apodaca were involved in inappropriate or illegal activities. The investigation of NCED may also lead to other investigations of AAI contracting processes and operations. There are currently no legal actions related to this matter pending against AAI or Mr. Apodaca. Because of these investigations and any related allegations or charges and the associated unfavorable publicity, AAI may lose its local government clients. The loss of these clients and the resulting loss of revenue could have a material adverse effect on the Company s financial condition and result of operations.

States General Life Insurance Company. In February 2005, States General Life Insurance Company (SGLIC) was placed in permanent receivership by the Texas Insurance Commission (The State of Texas v States General Life Insurance Company, Cause No. GV-500484, in the 126th District Court of Travis County, Texas.) Pursuant to letters dated October 19, 2006, the Special Deputy Receiver (the SDR) of SGLIC asserted certain claims against ICM, its subsidiaries, Peter W. Nauert, ICM s Chairman and Chief Executive Officer, and G. Scott Smith, a former Executive Officer of ICM, totaling $2,839,000. The SDR is seeking recovery of certain SGLIC funds that it alleges were inappropriately transferred and paid to or for the benefit of ICM, its subsidiaries and Messrs. Nauert and Smith. These claims are based upon assertions of Texas law violations, including prohibitions against self-dealing, participation in breach of fiduciary duty and preferential and fraudulent transfers. Mr. Nauert was in control and Chairman of the Board of SGLIC when it was placed in receivership by the Texas Insurance Commission. The Company, its subsidiaries and Messrs. Nauert and Smith intend to exercise their full rights in defense of the SDR s asserted claims. The SDR filed its own action against SGLIC, pending in the 126th District Court of Travis County, Texas under cause No. GV-500484 and against Messrs. Nauert and Smith, ICM, certain subsidiaries of ICM and other parties, in the 126th District Court of Travis County, Texas under cause No. D-1-GN-06-4697. Access Plans has been named as a defendant in this action as a successor-in-interest to ICM. We can not make any assurance of the outcome of this matter. An adverse ruling in these cases would have a material adverse effect on our financial position and operations. In connection with our merger-acquisition of ICM and its subsidiaries, Mr. Nauert and the Peter W. Nauert Revocable Trust have agreed to fully indemnify ICM and us against any losses resulting from this matter.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

We held our annual meeting of shareholders on December 29, 2006. At this meeting, we asked our shareholders to vote on the election of our Board of Directors and on the ratification of the engagement of our independent registered

public accounting firm. Of the 13,512,763 shares of our Common Stock outstanding as of the record date for the meeting, 7,765,880 were represented and voted at the meeting. At the meeting, the following directors were elected: Kent H. Webb, M.D., Nicholas J. Zaffiris, J. French Hill, Kenneth S. George and Russell

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Cleveland. Eugene Becker had previously announced that he would not stand for-election to the Board of Directors and his term, therefore, expired upon the election of directors. The only other matter voted upon at the meeting was the ratification of the engagement of Hein & Associates LLP to audit of our financial results for year ended December 31, 2006

The vote results were as follows:

Item	For	Votes Against	Abstained	Total
Ratification of Hein & Associates LLP	7,742,350	23,100	430	7,765,880
Election of Kent H. Webb as director	7,599,267	163,769	2,844	7,765,880
Election of Nicholas J. Zaffiris as director	7,177,579	585,457	2,844	7,765,880
Election of J. French Hill as director	7,697,450	65,400	3,030	7,765,880
Election of Kenneth S. George as director	7,694,086	68,950	2,844	7,765,880
Election of Russell Cleveland as director	7,620,002	143,034	2,844	7,765,880

PART II

ITEM 5. MARKET FOR COMMON EQUITY AND RELATED STOCKHOLDER MATTERS

Our common stock is traded in the over-the-counter market and is quoted on the Nasdaq Capital Market System under the symbol AUSA (formerly PCIS). Prior to February 9, 2000, there was no public trading market for our common stock. The closing sale prices reflect inter-dealer prices without adjustment for retail markups, markdowns or commissions, and may not reflect actual transactions. The following table sets forth the high and low closing sale prices of our common stock during the calendar quarters presented, as reported by the Nasdaq Capital Market System.

For more information on us, please refer to our website at www.accessplansusa.com.

Quarter Ended	Closing Sale Price Common Stock High	Low
March 31, 2005	$ 2.72	$ 1.69
June 30, 2005	$ 1.94	$ 0.78
September 30, 2005	$ 1.51	$ 1.01
December 31, 2005	$ 1.97	$ 1.54
March 31, 2006	$ 1.67	$ 1.25
June 30, 2006	$ 1.69	$ 1.12
September 30, 2006	$ 2.46	$ 1.58
December 31, 2006	$ 2.01	$ 1.34

On March 30, 2007, the closing sale price of the common stock as quoted on the Nasdaq Capital Market was $2.35. On March 30, 2007, there were approximately 255 record holders of our common stock.

The market price of our common stock is subject to significant fluctuations in response to, and may be adversely affected by:

variations in quarterly operating results,

changes in earnings estimates by analysts,

adverse earnings or other financial announcements of our customers or clients,

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announcements and introductions of product or service innovations or new contracts by us or our competitors, and

general stock market conditions.

In order to continue inclusion of our common stock on the Nasdaq Capital Market the minimum listing requirements must be met. If we fail to meet the minimum requirements, our common stock will be de-listed by Nasdaq and will become tradable on the over-the-counter market, which will adversely affect the sale price of our common stock. In this event, our common stock will then be traded in the over-the-counter market and may become subject to the penny stock trading rules.

The over-the-counter market is volatile and characterized as follows:

the over-the-counter securities are subject to substantial and sudden price increases and decreases;

at times the price (bid and ask) information for the securities may not be available;

if there are only one or two market makers, there is a risk that the dealers or group of dealers may control the market in our common stock and set prices that are not based on competitive forces; and

the actual sale price ultimately obtained for a block of stock may be substantially below the quoted bid price.

Consequently, the market price of our common stock will be adversely affected if our common stock ceases to be included on the Nasdaq Capital Market.

Dividend Policy

Our dividend policy is to retain our earnings, if any, to support the expansion of our operations. Our board of directors does not intend to pay cash dividends on our common stock in the foreseeable future. Any future cash dividends will depend on future earnings, capital requirements, our financial condition and other factors deemed relevant by our board of directors.

Securities Authorized For Issuance Under Equity Compensation Plans.

The following table sets forth as of December 31, 2006, information related to each category of equity compensation plan approved or not approved by our stockholders, including individual compensation arrangements with our non-employee directors. The equity compensation plans approved by our stockholders are our 1999 Stock Option Plan, our 2002 Stock Option Plan and our 2002 IMR Stock Option Plan. All stock options, warrants and rights to acquire our equity securities are exercisable for or represent the right to purchase our common stock.

	Options and Warrants		Number of Securities Remaining Available
Plan Category	**Number of Shares Underlying Unexercised**	**Weighted Average Exercise Price of Outstanding**	**for Future Issuance Under Equity Compensation Plans(1)**

Equity compensation plans approved by our stockholders:				
2002 Non employee stock option plan	475,000	$	1.99	
2002 IMR stock option plan	116,354		4.66	
1999 stock option plan	836,000		1.99	579,294
	1,427,354		2.21	579,294

(1) The number of shares of our common stock remaining available for issuance under equity compensation plans is after excluding the number of securities issuable upon exercise of outstanding options and warrants

Unregistered Securities Sold During Preceding Three Years

Access HealthSource, Inc (AAI). We acquired AAI in June 2004. The purchase price was in part based upon a multiple of 3.22 of the earnings before interest, taxes, depreciation and amortization of AAI for a 2004, 2005 and

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2006. The total purchase price is $8,244,000 of which $3,632,000 was paid by issuance and delivery of 2,145,483 shares of our common stock to Ready One Industries (formerly NCED). In connection with our merger-acquisition of AAI, no sales commissions or other remuneration were paid and the common stock shares were issued pursuant to Sections 3(b) and 4(6) of the Securities Act of 1933, as amended (the Securities Act)

Insurance Capital Management USA Inc. On January 30, 2007, we completed our merger with Insurance Capital Management USA, Inc. (ICM). Under the terms of the merger, the shareholders of ICM received shares of our common stock based on the adjusted earning before income tax, depreciation and amortization (EBITDA) of ICM and its acquired subsidiaries. On the closing date, the ICM shareholders received a total of 4,498,529 of our shares. ICM shareholders may receive up to an additional 2,257,853 common stock shares of the Company if the acquired ICM companies achieve adjusted EBITDA of $1,250,000 over four consecutive calendar quarters ending on or before December 31, 2007. Based on a preliminary review of adjusted EBITDA for the acquired ICM companies for the year ended in December 2006, approximately 2,111,400 shares will be issued to ICM shareholders during the second quarter of 2007. In connection with our merger-acquisition of ICM no sales commissions or other remuneration were paid and the common stock shares were issued pursuant to Sections 3(b) and 4(6) of the Securities Act.

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ITEM 6. SELECTED FINANCIAL DATA

The selected statement of operations and cash flow data presented below for each of the three years ended on December 31, 2006, 2005 and 2004 and the balance sheet data as of December 31, 2006 and 2005 have been derived from our consolidated financial statements included elsewhere in this report.

Dollars in Thousands	2006	2005	2004	2003	2002
Service revenues	$ 21,974	$ 30,028	$ 37,413	$ 40,224	$ 40,455
Operating expenses:					
Cost of operations	10,514	13,138	15,826	12,043	10,208
Sales and marketing	5,463	7,486	11,358	15,212	16,702
General and administrative	6,776	9,769	10,385	6,014	5,694
Impairment charge for goodwill	6,440	12,900	2,000		
Total operating expenses	29,193	43,293	39,569	33,269	32,604
Operating (loss) income	(7,219)	(13,265)	(2,156)	6,955	7,851
Other expense:					
Interest income (expense), net	355	159	(57)	(153)	(67)
Net (loss) income before taxes	(6,864)	(13,106)	(2,213)	6,802	7,784
Provision for income taxes (benefit) expense	(50)	123	(556)	2,524	2,662
(Loss) income from continuing operations	(6,814)	(13,229)	(1,657)	4,278	5,122
Gain on sale of operations, net of taxes		300			
(Loss) earnings from discontinued operations, net of taxes	(910)	(442)	(299)	(189)	356
Net (loss) earnings	(7,724)	(13,371)	(1,956)	4,089	5,478
Preferred stock dividend					14
Net (loss) earnings applicable to common stockholders	$ (7,724)	$ (13,371)	$ (1,956)	$ 4,089	$ 5,464
(Loss) earnings per share:					
Basic					
Continuing operations	$ (0.51)	$ (1.06)	$ (0.14)	$ 0.36	$ 0.43
Discontinued operations	$ (0.07)	$ (0.01)	$ (0.03)	$ (0.01)	$ 0.03
Diluted					

Continuing operations	$ (0.51)	$ (1.06)	$ (0.14)	$ 0.36	$ 0.43
Discontinued operations	$ (0.07)	$ (0.01)	$ (0.03)	$ (0.01)	$ 0.03
Weighted average number of common shares outstanding					
Basic	13,486,562	12,432,591	11,921,946	11,848,789	11,790,650
Diluted	13,486,562	12,432,591	11,921,946	11,924,214	11,996,222

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Dollars in Thousands	2006	2005	2004	2003	2002
Cash Flows Data:					
Net cash provided by operating activities	$ 725	$ 514	$ 1,759	$ 7,819	$ 3,989
Net cash used in investing activities	$ (3,263)	$ (1,822)	$ (2,595)	$ (945)	$ (920)
Net cash used in financing activities	$ (241)	$ (964)	$ (1,969)	$ (1,398)	$ (1,213)

Dollars in Thousands	December 31, 2006	2005
Balance Sheet Data:		
Cash and cash equivalents	$ 3,232	$ 6,011
Unrestricted short-term investments	200	
Restricted short-term investments	1,420	250
Current assets	6,876	14,954
Working capital	3,996	4,692
Total assets	16,320	30,864
Current liabilities	2,880	10,262
Total liabilities	2,928	10,500
Stockholder s equity	13,392	20,364

(1) We acquired AAI in 2004 for a purchase price of $8,244,000. The total includes cash payments of $4,232,000 and distribution of 2,145,483 shares with a value of $3,632,000 paid to the seller and acquisition costs of $380,000 through December 31, 2006.

(2) Certain reclassifications have been made to prior period financial information to conform to the current presentation of the financial information.

(3) For the years ended December 31, 2006, 2005, and 2004 outstanding stock options on 43,575, 25,375, and 54,864 shares, respectively, were not included in the calculation of fully diluted earnings per share because the inclusion would have been anti-dilutive.

ITEM 7. MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Overview

Consumer Healthcare Savings. We offer savings on healthcare services throughout the United States to persons who are uninsured and under-insured. These savings are offered by accessing the same preferred provider organizations (PPOs) that are utilized by many insurance companies. These programs are sold primarily through a network marketing strategy under the name Care Entrée.tm We design these programs to benefit healthcare providers as well as the network members. Providers commonly give reduced or preferred rates to PPO networks in exchange for steerage of patients. However, the providers must still file claim forms and wait 30 to 60 days to be paid for their services. Our programs utilize these same networks to obtain the same savings for the Care Entrée[tm] program members. However, the healthcare providers are paid immediately for their services and are not required to file claim forms. We provide transaction facilitation services to both the program member and the healthcare provider.

Our Independent Marketing Representatives (IMRs) may enroll as representatives by paying an enrollment fee and signing a standard representative agreement. We pay independent marketing representatives commissions equal to 20% of the membership fees of members they enroll for the life of that members enrollment. Independent marketing representatives can also recruit other representatives and earn override commissions on sales made by those recruited representatives. In the month of membership sales, no override commissions are paid to the representative s upline. The total regular or ongoing commissions payout, including overrides on monthly

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membership sales after the enrollment month and our contribution to the bonus pools, is up to 60% of qualified membership sales.

We also design healthcare membership programs for employer groups and third party marketers. Memberships in these programs are offered and sold by direct marketing through direct sales or in-bound direct marketing. We believe that our clients, their members and the vendors of the products and services offered through the programs, all benefit from our membership service programs. The products and services are bundled, priced and marketed utilizing relationship marketing strategies or inbound direct marketing to target the profiled needs of the clients particular member base. Our memberships sold by third-party organizations are generally marketed using the third-party s name or brand or under our wholesale brand For Your Good Health. We refer to these programs and membership sales as wholesale programs or private label programs. While the services offered to consumers by these private label programs are generally similar to the services we offer through Care Entrée[tm], each of the private label programs can bundle our services to fit the needs of their consumers. For instance, some of our private label programs do not offer a self-funded escrow program to their members.

Employer and Group Healthcare Services. For governments and other large, self-funded employers seeking to reduce their costs of provided employee healthcare benefits, we offer a more streamlined version of our healthcare products and programs. In these cases, we offer access to healthcare through our network of providers and the efficient repricing of bills through our proprietary systems. We can offer these services on a price based on either the number of participants per month or as a percentage of savings on healthcare costs actually realized. Through AAI, we provide a wide range of healthcare claims administration services and other cost containment procedures that are frequently required by governments and other employers who have chosen to self fund their employee healthcare benefits. With the services of AAI, we offer a more complete suite of healthcare services. We are able to provide individuals and employee groups access to preferred provider networks, medical savings accounts and full third party administration capabilities to adjudicate and pay medical claims. AAI s primary area of expertise is in the public sector market.

Financial Services (Discontinued). Until December 2006, we reported the financial results of our wholly-owned subsidiary Care Financial of Texas, L.L.C. (Care Financial) and Care 125 in this segment. Care Financial offered high deductible and scheduled benefit insurance policies and Care 125 offered life insurance and annuities, along with Healthcare Savings Accounts (HSAs), Healthcare Reimbursement Arrangements (HRAs) and medical and dependent care Flexible Spending Accounts (FSAs). Care 125 was discontinued in December 2006 and Care Financial s results of operations for 2006 were immaterial and are now included in the Corporate and Other segment.

Rental Purchase And Club Membership Programs (Discontinued). Until December 2005, through Foresight, we designed club membership programs for rental-purchase companies, financial organizations, employer groups, retailers and association-based organizations. Memberships in these programs were offered and sold as part of a point-of-sale transaction or by direct marketing through direct mail or as inserts. Program members are offered and provided our third-party vendors products and services. The products and services were bundled, priced and marketed to target the profiled needs of the clients particular customer base. Most of our club membership programs were sold by third-party organizations, generally in connection with a point-of-sale transaction. We referred to these programs and membership sales as wholesale programs. In December 2005, we sold substantially all of the assets of this subsidiary and discontinued its operations.

Operational Review

The year ended December 31, 2006 was another year of significant challenge. We implemented member escrow accounts during the fourth quarter of 2002 in response to the market changes in the healthcare savings industry, and on October 1, 2003, we expanded the escrow requirements to all programs offering access to medical doctors and physicians. As a result of this change, we required all of our members (other than those whose memberships are sold

by our private label partners) to fund and maintain Personal Medical Accounts (PMAs) to provide the healthcare providers with a form of payment assurance prior to receipt of healthcare services. As of December 2006, we discontinued these PMAs and returned the funds held in escrow to the appropriate members.

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Our healthcare membership base was approximately 32,000 members as of December 31, 2006, as compared to 38,000 members as of December 31, 2005 and 57,000 members as of December 31, 2004, a decrease of approximately 6,000 members or 15.8% during 2006. The reduction in our healthcare membership base resulted from declining market share in the healthcare savings market, due in part to the implementation of the required PMAs, as well as provider acceptance issues in some markets. Also, our independent marketing representative base experienced a significant reduction in 2003 through 2006.

We believe that the PMA requirements implemented in late 2002 negatively impacted our membership base and consequently our revenues and net earnings in 2006, 2005 and 2004. These accounts were implemented to help provide assurance of payment to the healthcare providers and accordingly, their continued willingness to provide healthcare services to our members. This strategic move was thought to be necessary as many healthcare providers throughout the United States were reluctant to accept a health discount card. In order to address the issues of assurance of payment to the providers and acceptance of the discount cards by those providers, we have recently implemented enhanced levels of customer advocacy in lieu of PMAs. For healthcare cases that are anticipated to cost a significant amount, we assign a personal negotiator who will review our member s financial situation and explain cost savings options that they may want to discuss with their physician. Depending on their financial resources, our negotiator may pursue a variety of options with the hospital or other healthcare facility to make payment arrangements upfront including helping the member apply for financial assistance or negotiating a reduced down payment or discounted fee.

We have also developed a line of affordable insurance products that are sometimes referred to as scheduled benefit, limited benefit or defined benefit products. These products may be less expensive than traditional comprehensive healthcare insurance and usually do not require the member to undergo any medical underwriting. As such, they are available to all individuals, regardless of health condition. The products usually operate on an indemnity basis, reimbursing the member for certain of his or her incurred costs. Sometimes, the products allow the benefit to be assigned directly to the provider, eliminating the need for the member to pay the provider directly and then seek reimbursement. These products pay a defined amount for services. For instance, a member could choose a program entitling him or her to a benefit payment of $250, $500 or $1,000 per day of hospitalization, with additional scheduled benefits for intensive care stays and surgery, for up to 180 days. The sale of some of these programs requires an insurance license. In this case, we will sell the products only through our representatives that hold the appropriate license. Some of these programs, however, will be offered at no cost to the member as part of the member s enrollment in an association. In this case, the sale of the membership does not require a license in most states. We commenced sales of these new products in the first quarter of 2006. While it is too early to assess the market acceptance of these new products, it is hoped that they and our enhanced customer advocacy will address the issues of assurance of payment to the providers and acceptance of the discount cards by those providers more successfully than the escrow or PMA products.

Our operating results benefited from the acquisition of AAI in June of 2004. In 2006, AAI experienced current and projected reductions in earnings due largely to a decline in the number of lives covered under plans that are administered by AAI and recorded a $4,066,000 impairment to goodwill including tax considerations of $426,000. Excluding this charge, AAI contributed revenues of $7,409,000 and net earnings (after taxes) of $1,237,000 in 2006. In 2005, AAI contributed revenues of $8,288,000 and net earnings (after taxes) of $1,609,000. While included in operations for only slightly more than six months during 2004, AAI contributed $3,670,000 or 10% to our 2004 revenue and $299,000 of net earnings (after taxes) to partially offset our other losses.

In 2005, we introduced Vergance, a new network marketing distribution channel as a division of the Company. Vergance offered wellness products, including nutraceuticals under the retail name Natrience, and discounted healthcare services under the retail name QuickCare. Vergance was discontinued in the second quarter of 2006.

Critical Accounting Policies

Revenue Recognition. Revenue recognition varies based on source.

Healthcare Membership Revenues. We recognize our Care Entrée[tm] program membership revenues, other than initial enrollment fees, on each monthly anniversary date. Membership revenues are reduced by the

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amount of estimated refunds. For members that are billed directly, the billed amount is collected almost entirely by electronic charge to the members credit cards, automated clearinghouse or electronic check. The settlement of those charges occurs within a day or two. Under certain private label arrangements, our private label partners bill their members for the membership fees and our portion of the membership fees is periodically remitted to us. During the time from the billing of these private-label membership fees and the remittance to us, we record a receivable from the private label partners and record an estimated allowance for uncollectible amounts. The allowance of uncollectible receivables is based upon review of the aging of outstanding balances, the credit worthiness of the private label partner and its history of paying the agreed amounts owed.

Membership enrollment fees, net of direct costs, are deferred and amortized over the estimated membership period that averages eight to ten months. Independent marketing representative fees, net of direct costs, are deferred and amortized over the term of the applicable contract. Judgment is involved in the allocation of costs to determine the direct costs netted against those deferred revenues, as well as in estimating the membership period over which to amortize such net revenue. We maintain a statistical analysis of the costs and membership periods as a basis for adjusting these estimates from time to time.

AAI Third Party Administration. AAI s principal sources of revenues include administrative fees for third party claims administration, network provider fees for the preferred provider network and utilization and management fees. These fees are based on monthly or per member per month fee schedules under specified contractual agreements. Revenues from these services are recognized in the periods in which the services are performed and when collection is reasonably assured.

Commission Expense. Commissions are paid to our independent marketing representatives in the month following the month in which a member has enrolled in or renewed our Care Entrée[tm] program. Commissions are only paid in the following month when we have received the related monthly membership fees. We do not pay advanced commissions on membership sales. Commissions are based on established commission schedules and are determined and accrued based upon the recognition of the related healthcare membership revenue, as described above.

Acquisitions. In 2004, we acquired AAI for an ultimate purchase price of $8,244,000 (after contingent consideration) that included $7,764,000 of goodwill, $274,000 of working capital and $206,000 of fixed assets. In 2006, AAI recorded a $4,066,000 impairment to goodwill including tax considerations of $426,000 that resulted from current and projected reductions in earnings primarily due to a decline in the number of lives covered under plans that it administers.

Fixed Assets. Property and equipment are carried at cost less accumulated depreciation and amortization. Depreciation and amortization are provided using the straight-line method over the estimated useful lives of the related assets for financial reporting purposes. Leasehold improvements are depreciated using the straight-line method over the shorter of their estimated useful lives or the lease term.

The estimation of useful lives is based, in part, upon past experience with similar assets and upon our plans for the utilization of the assets in the future. We periodically review fixed assets, including software, whenever events or changes in circumstances indicate that their carrying amounts may not be recoverable or their depreciation or amortization periods should be accelerated. When any value impairment is determined to exist, the related assets are written down to their fair value. If we determine that the remaining useful life, based upon known events and circumstances, should be shortened, the depreciation or amortization of the related asset is adjusted on a prospective, going-forward basis based upon the shortened useful lives.

Intangible Asset Valuation. Our intangible assets consisted primarily of $7,466,000 of goodwill as of December 31, 2006. Goodwill represents the excess of acquisition costs over the fair value of net assets acquired. Goodwill is not

amortized. In 2006, AAI recorded a $4,066,000 impairment to goodwill including tax considerations of $426,000 that resulted from current and projected reductions in earnings primarily due to a decline in the number of lives covered under plans that it administered and Capella recorded a charge of $2,800,000 due to the continuing decline in members and revenues. In 2005, Capella recorded a charge of $12,900,000 due to continuing decline in members and revenues to a lower level than previously predicted and pending litigation and regulatory

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activity that was announced in the second quarter. In 2004, our intangible assets were reduced by $2,000,000 to reflect impairment of the goodwill related to our acquisition in 2000 of Foresight.

Significant judgments and estimates were required in connection with the impairment test to determine the estimated future cash flows and fair value of the reporting unit. We retained and engaged an independent valuation consultant to estimate fair values of AAI and Capella using discounted cash flow projections and other valuation methodologies in evaluating and measuring a potential goodwill impairment charges. Based upon management s cash flow projections and the consultant s independent valuation, we recorded a goodwill impairment related to AAI and Capella in 2006 and Capella in 2005, as previously discussed. To the extent that, in the future, our estimates change or our stock price decreases, further goodwill write-downs may occur. Those assessments of the carrying value of goodwill were each reviewed and approved by our Audit Committee of our Board of Directors.

Income Taxes. Income taxes are provided for the tax effects of transactions reported in the financial statements and consist of taxes currently due plus deferred taxes related primarily to differences between the basis of assets and liabilities for financial and income tax reporting. The net deferred tax assets and liabilities represent the future tax return consequences of those differences, which will either be taxable or deductible when the assets and liabilities are recovered or settled. During 2006, we evaluated the probability of recognizing the benefit of deferred tax assets through the reduction of taxes otherwise payable in the future and increased the allowance by $339,000 from $116,000 to $455,000 against the carrying amount of the deferred tax assets because in our opinion it is more probable than not that some of those assets will not be realized.

Reclassifications. Certain prior period amounts have been reclassified to conform to the current period s presentation.

Results of Operations

Consumer Healthcare Savings. The operating results for our Consumer Healthcare Savings segment were as follows:

Dollars in Thousands	**For the Twelve Months Ended December 31,**						
	2006	**Dollar Change**	**Percent Change**	**2005**	**Dollar Change**	**Percent Change**	**2004**
Revenues	$ 14,483	$ (6,677)	(31.6)%	$ 21,160	$ (11,465)	(35.1)%	$ 32,625
Operating expenses:							
Cost of operations	5,581	(2,254)	(28.8)%	7,835	(5,315)	(40.4)%	13,150
Sales and marketing	4,775	(1,701)	(26.3)%	6,476	(4,098)	(38.8)%	10,574
General and administrative	4,381	(1,936)	(30.6)%	6,317	(1,389)	(18.0)%	7,706
Total operating expenses	14,737	(5,891)	(28.6)%	20,628	(10,802)	(34.4)%	31,430
Operating income	$ (254)	$ (786)	(147.7)%	$ 532	$ (663)	(55.5)%	$ 1,195
Percent of Revenue:							
Revenues	100%			100%			100%
Operating expenses:							
Cost of operations	38.5%			37.0%			40.3%

Sales and marketing	33.0%	30.6%	32.4%
General and administrative	30.2%	29.9%	23.6%
Total operating expenses	101.8%	97.5%	96.3%
Operating income	(1.8)%	2.5%	3.7%

Service Revenues. Our Consumer Healthcare Savings programs having been under continuing pressure from increasing competition and regulatory scrutiny, as well as the unwillingness of some healthcare providers to accept our savings cards based on concerns over assurance of payment. In late 2002, we implemented an escrow account requirement to address provider concerns over assurance of payment. While this feature had

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shown limited success in improving acceptance by providers, it made our programs more complex and difficult to sell. As of December 2006, we discontinued these PMAs and returned the funds that we held in those accounts to own customers. In some of the states in which we have a significant number of members, especially Florida, Texas and California, our healthcare savings products are under scrutiny and criticism by state regulators and officials. This regulatory scrutiny has impaired our ability to market these products in those states and elsewhere, further contributing to the decline in membership enrollments and increases in terminated memberships. The table below reflects the decline in our Consumer Healthcare Savings program membership over the preceding eight fiscal quarters:

Care Entrée Membership

(Count at End of Quarter)

	1st Qtr 2005	2nd Qtr 2005	3rd Qtr 2005	4th Qtr 2005	1th Qtr 2006	2nd Qtr 2006	3rd Qtr 2006	4th Qtr 2006
lember Count nd of Quarter	51,895	46,514	41,958	37,952	37,281	35,823	34,020	31,826
ercent Change	(8.88)%	(10.37)%	(9.79)%	(9.54)%	(1.77)%	(3.91)%	(5.03)%	(6.45)%
verage revenue er member, net f sales and arketing costs	$ 25.70	$ 26.24	$ 26.16	$ 24.03	$ 23.86	$ 22.54	$ 22.40	$ 22.32

Although the implementation of PMA requirements negatively impacted our membership base and consequently our revenues and net earnings in 2004, 2005 and 2006, the escrow requirements were thought to be necessary to provide some assurance of payment to the healthcare providers and, accordingly, their continued willingness to accept our health discount cards and provide healthcare services to our members. In order to address the issues of assurance of payment to the providers and acceptance of the discount cards by those providers, we have recently implemented enhanced levels of customer advocacy in lieu of PMAs. We have also developed a line of affordable insurance products that are sometimes referred to as scheduled benefit, limited benefit or defined benefit policies. These products may be less expensive than traditional comprehensive health insurance and usually do not require the member to undergo any medical underwriting. As such, they are available to all individuals, regardless of health condition. We commenced sales of these new products in the first quarter of 2006. While it is too early to assess the market acceptance of these new products, it is hoped that they and our enhanced customer advocacy will address the issues of assurance of payment to the providers and acceptance of the discount cards by those providers more successfully than the escrow or PMA products.

Throughout 2006, we have continued the measures and initiatives commenced earlier in the year to improve our operating efficiencies and performance, especially through cost reductions. These measures and initiatives include (i) the conversion of certain of our customer service and system support functions from a fixed to a variable cost structure by outsourcing them, (ii) the termination of certain equipment capital leases, and (iii) personnel reductions and other cost reduction actions. The resulting restructuring costs incurred during the fourth quarter of 2006 for these initiatives were $449,000 that included write-off of assets no longer used of $252,000, outsourcing vendor integration and moving costs of $145,000 and personnel severance costs of $52,000. These measures have successfully reduced the cost structure associated with our Care Entrée™ and private label membership programs. During the first quarter of 2006, we resumed sales of our consumer healthcare savings products to on or our former private-label reseller who, in early 2005, had discontinued sales of those products.

Cost of Operations. The decrease in cost of operations from 2005 to 2006 was due to decreases in variable costs of $1,273,000 primarily due to decreased provider network costs and bank fees related to the decreased revenue, along with reductions in fixed costs of $1,216,000 primarily related to termination of certain equipment leases and personnel reductions related to 2005 cost reduction initiatives, offset by fourth quarter 2006 restructuring costs of $235,000 for certain leased equipment and inventory write-offs and personnel severance costs related to our outsourcing initiative. The decrease in cost of operations from 2004 to 2005 is also due to decreases in provider network costs and bank fees related to decreased revenue and reductions in equipment lease and personnel costs related to 2005 cost reduction initiatives.

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Sales and Marketing Expenses. The decreases in sales and marketing expenses from 2005 to 2006 and from 2004 to 2005 were primarily due to decreases in commissions related to the decreased membership revenue of the Care Entrée[tm] program of $2,170,000 and $4,470,000, respectively. These commission decreases were accentuated by the departure of independent marketing representatives from the upper ranks of our multi-level marketing network through which our Care Entrée[tm] program is offered and elimination of the associated over-ride commissions, resulting in a lower percentage of commissions as a percent of revenue. The decrease from 2005 to 2006 was offset by an increase in consulting and other marketing costs of $469,000 related to various sales and new product initiatives. The decrease from 2004 to 2005 was partially offset by $125,000 of personnel severance costs incurred in 2005.

General and Administrative Expenses. The decreases in general and administrative expenses from 2005 to 2006 and from 2004 to 2005 are primarily related to cost reductions measures that included reductions in staffing that began in 2005. The decrease from 2005 to 2006 was offset by fourth quarter 2006 restructuring costs of $214,000 related to our outsourcing initiative.

Employer and Group Healthcare Services. The operating results for our Employer and Group Healthcare Services segment were as follows:

Dollars in Thousands	**For the Twelve Months Ended December 31,**						
	2006	**Dollar Change**	**Percent Change**	**2005**	**Dollar Change**	**Percent Change**	**2004**
Revenues	$ 7,409	$ (1,128)	(13.2)%	$ 8,537	$ 4,458	109.3%	$ 4,079
Operating expenses:							
Cost of operations	4,933	(337)	(6.4)%	5,270	2,594	96.9%	2,676
Sales and marketing	659	(103)	(13.5)%	762	375		