Access Plans USA, Inc.
Form 10-K/A
October 27, 2008

Table of Contents

U.S. SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
Form 10-K/A
(Amendment No. 1)

þ ANNUAL REPORT UNDER SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2007

OR

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

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 WEST 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, a non-accelerated filer, or a smaller reporting company. See the definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act. (Check one):

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

Indicate by check mark whether 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, 2007 (the last business day of our most recent second fiscal quarter), was $28,494,972 based on the closing sale price on that date.

As of March 31, 2008, 20,269,145 shares of the issuer s common stock, $.01 par value, were outstanding.

ACCESS PLANS USA, INC.
FORM 10-K/A
For the Fiscal Year Ended December 31, 2007

TABLE OF CONTENTS

Throughout this report the first personal plural pronoun in the nominative case form we and its objective case form us , its possessive and the intensive case forms our and ourselves and its reflexive form ourselves refer collectively to Access Plans USA, Inc. and its subsidiaries, and its and their executive officers and directors.

Table of Contents

EXPLANATORY NOTE

On May 22, 2008, we received a comment letter from the Securities and Exchange Commission (SEC) regarding certain matters set forth in our 2007 Annual Report on Form 10-K filed on April 2, 2008. In connection with the disposition of the matters set forth in the SEC s comment letter we agreed to:

1. Restate our statement of cash flows for the year ended December 31, 2007 to include the change in both commissions advanced to agents and unearned advanced commissions received from insurance carriers as operating activities. Previously, we had considered that these receipts and payments had more than one class of cash flows and had characterized these items as investing and financing activities, respectively. Note 2 to the financial statements provides a tabular summary of this restatement and we have updated the applicable amounts set forth in Item 6 Selected Financial Data and Item 7 Liquidity and Capital Resources. Additionally, our independent registered public accountants have amended their report to reflect this restatement.

2. Deleted an inadvertent disclosure of a financial measure that did not conform with generally accepted accounting principles from certain commentary set forth in Item 7. (Management s Discussion and Analysis of Financial Condition, Results of Operations, Liquidity and Capital Resources).

3. Deleted the inadvertent use of the word significant in our discussion of controls and procedures set forth in Item 9A (Controls and Procedures, Information Technology General Controls).

4. Disclosure of additional information regarding the magnitude of the provision for litigation related matters that we recorded and reported at December 31, 2007.

5. Inclusion, as an Exhibit, the preferability letter we obtained from our independent registered public accountants in connection with the change in our annual goodwill impairment testing date from December 31 to September 30 of each year.

6. Amended Exhibits 31.1 and 31.2 to correct the prior omission of certain parenthetical information.

Additionally, we have enhanced the formatting of certain tabular presenations.

Table of Contents

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING INFORMATION

Certain statements under the captions Item 1. 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 should or other variations th 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 Item 1A. Risk Factors 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.

Table of Contents

PART I

ITEM 1. BUSINESS

We at Access Plans USA, Inc. develop and distribute quality affordable consumer-driven healthcare 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 healthcare. They include health insurance plans and non-insurance healthcare discount programs that provide solutions for the millions of Americans who need access to affordable healthcare.

The current organization of our business, including our new Insurance Marketing Division, is a result of our January 30, 2007 merger with Insurance Capital Management USA, Inc. (ICM) and our October 1, 2007 acquisition of Protective Marketing Enterprises, Inc. (PME). To 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. in 2007. Operations are organized under three business divisions:

Consumer Plan Division. Our Consumer Plan Division develops and markets non-insurance healthcare discount programs and association memberships that include defined benefit insurance features. These programs are distributed through multiple distribution channels. The division operates through our wholly-owned subsidiaries, The Capella Group, Inc. (Capella) and PME. PME also owns and manages a proprietary customer healthcare advocacy department and proprietary networks of dental and vision providers that provide services at negotiated rates to members of our discount medical plans and to members of other plans that have contracted with us on a wholesale basis for access to our networks. Before 2007, the division was referred to as our consumer healthcare savings segment.

Insurance Marketing Division. Our Insurance Marketing Division markets individual health insurance products and related benefit plans, including specialty insurance products, primarily through a broad network of independent agents. We support our distribution channels with web-based technology, incentive programs and back-office support. The division operates as Insuraco USA LLC (Insuraco).

Regional Healthcare Division. Our Regional Healthcare Division 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. It also owns and manages a proprietary network of medical providers. The division operates as Foresight TPA (Foresight) and was previously referred to as the Employer and Group Healthcare Services segment. Foresight TPA is the assumed name of Access HealthSource, Inc.

For the year ended December 31, 2007 we recorded a net loss of $13,155,000. Beginning in 2007, we adopted an end-of-third-quarter schedule for our annual assessment of the carrying value of goodwill. This assessment resulted in a third quarter non-cash goodwill valuation charge of $8.0 million, comprised of a $4.6 million charge in the Insurance Marketing Division, primarily due to lower than previously projected future sales in the senior market, and a $3.4 million charge in the Consumer Plan Division resulting from a re-evaluation of the discounted value of expected future earnings on certain programs. The 2007 loss also reflects second quarter 2007 charges, aggregating to $5.4 million for the write-down of the Regional Healthcare Division s goodwill balance, resulting from the loss of certain key customers, and other company-wide charges relating to unsuccessful marketing initiatives and legal expenses related to our activities in prior years. Additionally, in 2007, we began incurring substantial non-cash intangible asset amortization charges relating to the acquisition of the Insurance Marketing Division, and to a lesser extent, PME.

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 our directors and officers and all amendments to those 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 Code of Conduct, the charters for our Audit Committee, the Compensation Committee, and the Corporate Governance and Nominating Committee, and a hyperlink to our SEC filings.

Table of Contents

Healthcare Industry Challenges and Market Opportunity

Our market is directly impacted by the widely recognized challenges of the healthcare industry.

The uninsured. It is estimated that 15.8% of all people in America, or 47 million individuals, were without health insurance coverage in 2006, an increase of 2.2 million people compared to 2005. [Source: U.S. Census Bureau Statistics published by the U.S. Department of Commerce.] Among the uninsured are 8.5% of people with annual income over $75,000. [Source: U.S. Census Bureau and Center on Budget and Policy Priorities, August 2007.]

The percentage of people working full-time without health insurance in 2006 was 17.9%, an increase from 17.2% in 2005. [Source: U.S. Census Bureau Statistics published by U.S. Department of Commerce.] Nationally, healthcare expenditures totaled $2.1 trillion in 2006, up from $1.4 trillion in 2000. [Source: Centers for Medicare and Medicaid Services.] Costs of healthcare (in doctors offices and hospitals) for self paying uninsured patients are often far higher than the amount an insured and his or her insurance company would pay for the same healthcare services. The growing number of uninsured people have special needs for accessing affordable healthcare.

The insured and underinsured. In 2006, 59.7% 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 2007.] 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, 2007.] Between 2006 and 2007, premiums for employer-sponsored health insurance rose 6.1%, a rate that exceeds the overall inflation rate by about 3.5 percentage points and the increase in workers earnings by almost 2.5 percentage points. 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%. [Source: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, Annual Salary, 2007.] 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 $58 and $273, respectively, in 2007. The average cost of family coverage is now $12,106 per year, including worker contributions of $3,281. Not surprisingly, employers are looking for alternatives. Since 2000, the percentage of firms offering health benefits has dropped by nine percentage points. The cost of health insurance remains the main reason cited by firms for not offering health benefits. [Source: Employer Health Benefits 2007 Summary of Findings, published by the Kaiser Family Foundation].

Over-utilization, increasing regulation and legislation. Over-utilization of the healthcare system is one of the factors behind increasing cost trends. American citizens are utilizing healthcare services at an ever-increasing rate. Behind this phenomenon is the fact that insurance plans and 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 $1,000 for

individuals and $2,000 for families and the maximum amount that can be contributed is $2,700 for individuals and $5,450 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

Table of Contents

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. Since the higher deductible health insurance policies generally provide lower premium amounts, there is 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. In 2006, 60% of employers with between three and 199 workers provided health insurance, down from 68% five years earlier. [Source: U.S. Government Accountability Office Study, March 2007]. There were also over 11.5 million firms with fewer than 100 employees (with a total of 63.0 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 increases, the market for our non-insurance healthcare savings programs and economically priced small group insurance products increases.

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 healthcare expenses for senior Americans, the gaps in coverage provide a significant market for supplemental plans.

Our Solutions

The current state of our nation s healthcare industry provides significant market opportunities for our company. We have implemented a number of solutions to assist consumers in saving money and navigating the healthcare system.

Access Plans is focused on developing and distributing products and services that meet the full range of healthcare product needs of consumers, including individuals, families, small businesses, and, in some locations, larger public and private employers. These products range from prescription discount cards and medical discount programs, through defined benefit plans, major medical insurance and high-deductible major medical insurance plans. As the healthcare system and consumer needs change, we adjust our products and services.

We distribute these products through a number of channels, including licensed insurance agents for insured products, telephonic marketing, Internet marketing and network marketing by face-to-face representatives for discount medical programs.

Through our Consumer Plan Division and our Insurance Marketing Division, we provide programs that 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. For certain products, our Consumer Plan Division also provides patient advocacy services.

Our Regional Healthcare 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 healthcare plans, including large public and private employers. Our benefit program management services successfully reduce costs and provide access to affordable healthcare 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 Plan Division membership programs are offered through our own commissioned sales force (see Network Marketing below) under the trade names of USA Healthcare Savings and Care Entrée[tm].

Table of Contents

These programs are also offered through other distribution channels under the trade name HealthCard Now and through the trade names of our private label resellers. Our healthcare savings programs are not managed care.

For years, insurance companies have been successful by obtaining healthcare for their insureds at much lower prices than that obtainable by the self-insured or uninsured person. These benefits were provided through the use of preferred provider organizations (PPOs), where doctors, hospitals and other providers agreed to provide services to participants in the PPO at rates lower than those offered to the general public. In our Consumer Plan Division programs, we have contracted with some of these same PPOs to provide the same negotiated rates to our program members and thereby allow our members to receive services at a discount compared to what members of the general public not participating in a PPO would pay. In addition, through our acquisition of PME, we now own and manage our own networks of dental and vision providers that contract directly with us, agreeing to offer discounted rates to our 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 choose 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. For instance, in reviewing nearly 600,000 medical bills that were actually sent to us for repricing between September 2004 and December 2007, we identified the ten most commonly reported procedures. In analyzing the average full billed price for each such procedure and comparing it to the repriced amount, we were able to determine the average savings for our members for those most common procedures as follows:

CPT	CPT Code Description	Avg.* Price	Avg.* Repriced Amount	Avg.* Savings	% Discount
99213	Office/Outpatient Visit, Est	$ 83.80	$ 55.11	$ 28.69	34.24%
36415	Routine Venipuncture	$ 20.60	$ 6.88	$ 13.72	66.62%
99214	Office/Outpatient Visit, Est	$ 123.38	$ 82.98	$ 40.39	32.74%
80061	Lipid Panel	$ 81.30	$ 21.93	$ 59.37	73.03%
85025	Complete CBC w/Auto Diff WBC	$ 31.39	$ 12.72	$ 18.67	59.49%
80053	Comprehensive Metabolic Panel	$ 55.93	$ 15.95	$ 39.98	71.49%
99212	Office/Outpatient Visit, Est	$ 61.61	$ 39.80	$ 21.80	35.39%
84443	Assay Thyroid Stim Hormone	$ 83.58	$ 25.36	$ 58.22	69.66%
99203	Office/Outpatient Visit, New	$ 140.42	$ 97.87	$ 42.55	30.30%
83036	Glycated Hemoglobin Test	$ 65.99	$ 19.15	$ 46.84	70.98%

* Avg. Price reflects the retail rates providers charge the uninsured; Avg. Repriced Amount reflects our consumer plan discount rate; and Avg. Savings reflects the average savings by our consumer plan members. Current Procedural Terminology (CPT®) is a registered trademark of the American Medical Association.

* 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 find the discounted amount. On average, we

believe that our members save 10% to 50% on services from these other providers. Through our proprietary Access Dental Network, our members receive average savings of 34% on routine and most major dental care, and through our proprietary Access Vision Network, members receive discounts of 15% to 60% on exams, prescription eyeglasses, and other purchases and services.

Table of Contents

Our membership programs encompass 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. Some aspects of our programs are not available in all states. In most states, memberships in our USA Healthcare Savings, Care Entréetm and HealthCard Now programs range in price from $9.95 to $99.95 per month per family depending on the selected options, plus a one-time enrollment fee of up to $30.00. 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.

Technology and Member Services

We have made substantial investments in our proprietary technology and management information systems. We currently operate on two proprietary platforms. The first, the Provident system, is a proprietary platform that we developed for Capella. The second, the Affinity system is operated under a license that we acquired with our acquisition of PME. Employees of PME that we hired after our acquisition were responsible for the design and implementation of the Affinity system. These systems are used in most aspects of our Consumer Plan business, including:

maintaining member eligibility and demographic information,

maintaining representative information including network reporting,

paying commissions,

maintaining a database of all providers and providing provider locator services,

re-pricing and payment of medical bills,

drafting member accounts on a monthly basis, and

tracking 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 network 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 third quarter of 2006, we entered into a one-year agreement with Lifeguard Emergency Travel, Inc. (Lifeguard). Under this agreement, Lifeguard provided certain member support services, claims administration, and fulfillment services for our members in our Consumer Plan Division. On October 1, 2007, we acquired PME. Headquartered in the Dallas area, PME offers, as a wholesaler, discount medical service products, provides back office support through its use of various operating systems, maintains a customer service facility, and develops products from both its proprietary and third party provider networks. After our acquisition of PME in October 2007, we transitioned most of our member services functions to our own member services call center. We are now able to provide, on an in-house-basis, primary and secondary customer support, enrollment and billing functions, fulfillment services, claims administration, provider location services, a concierge service that allows us to interact with providers on behalf of our members, and an advocacy function that allows us to negotiate for preferred rates for our members that receive services from out-of-network providers.

Sales and Marketing Channels

Products in our Consumer Plan Division are currently offered through two distribution channels:

Private Label and Co-Branded Sales. We enter into agreements with third-party marketers to sell our Consumer Plan products under a private label name or under a co-branding arrangement using our selected retail name. These marketers either pay for the product on a wholesale basis and sell it for an approved retail price, or sell the product under our pricing schedule and receive a sales commission from us. These third-party

Table of Contents

marketers use various distribution channels which can include: direct mail, outbound telemarketing, Internet, direct response television, direct response radio, cross-sell/upsell and alternate media.

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

Network Marketing. Our USA Healthcare Savings and Care Entrée[tm] programs are distributed by independent commission-based contractors referred to as independent marketing representatives (IMRs). Our independent representatives become marketing representatives by paying an enrollment fee (currently $99.95) and an annual renewal fee (currently $49.95) and signing a standard representative agreement. These IMRs are not required to be licensed insurance agents. IMRs are generally paid a 20% commission on the membership fees of each member they enroll for the life of that member s enrollment (subject to the representative continuing to meet certain commission qualifications). IMRs may also recruit other representatives and earn override commissions on sales made by those representatives. We pay up to 35% in override commissions through seven upper levels (or upline) of the marketing representatives. In the first month of the membership sale, no override commissions are paid to the representative s upline.

The total regular or ongoing commission 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 55% of qualified membership sales.

Our Insurance Marketing Division

The revenue of our Insurance Marketing Division is primarily from earned sales commissions paid by the insurance companies this Division 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.

Our strategy is to:

continue to develop products for consumers to provide healthcare savings and/or insurance protection to families and individuals,

continue to use technology and innovative marketing and agent-support programs to attract new agents to sell insurance products that are available to us,

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, and

expand the number of insurance carriers that we represent.

Our three principal insurance markets are:

Major medical/individual health insurance,

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

Senior health insurance, managed care, life insurance and annuity

Distribution Channels and Operating Divisions

Our insurance marketing operations are largely focused on our America s Healthcare/Rx Plan (AHCP) agency. AHCP distributes major medical and short-term medical products to small business owners, self-employed and other individuals and families through approximately 2,100 independent agents. In addition, we also operate Adult Care Plans/Rx America (ACP) which distributes supplemental medical, life and managed care products to senior Americans through approximately 2,900 independent agents.

Table of Contents

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

Insurance Company	Products	Insurance Marketing Division Revenue (Dollars in Thousands) 2007
Guarantee Trust Life	Proprietary Major Medical and HSA-qualified High Deductible plans	$ 5,124
Central Reserve Life Insurance Company	Medicare Supplement; Final Expense Life Insurance	4,393
Golden Rule Insurance Company	Major Medical and HSA-qualified High Deductible plans	3,464
Continental General Insurance Company	Proprietary Major Medical; Proprietary HSA-qualified High Deductible plans	1,861
World Insurance Company	Proprietary Major Medical; HSA-qualified High Deductible plans	1,733
Companion Life Insurance Company	Proprietary Mini-Medical plan	1,496
Empire Fire and Marine	Proprietary Major Medical; Proprietary HSA-qualified High Deductible plans	746
The Wellpoint Family of Companies	Senior Managed Care, Medicare Advantage products and Medicare Advantage Medical Savings Accounts (MSAs)	435
Other Carriers		331
		$ 19,583

Products for Consumers

Insurance Marketing 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. Insurance Marketing 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 contributed to their HSA, which amounts may then be used to pay for qualifying uninsured medical expenses. The Insurance Marketing Division markets high deductible insurance plans that qualify for the HSA benefits.

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

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;

Table of Contents

available to all or most individuals, regardless of their health conditions;

operate on an indemnity basis in most cases, reimbursing the member for certain incurred healthcare costs; and

in some instances allowing 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.

Senior Health Insurance, Managed Care, Life Insurance and Annuity. Senior health insurance, managed care, life insurance and annuity include 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, almost doubled between 1966 and 2005, growing to 35.6 million from 19 million.

Medicare Advantage Plans. Our Medicare Advantage Plans 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.

Developments in the Medicare Supplemental Insurance or MediGap markets have led to declining revenues and earnings in that part of our business. There are 12 standardized Medicare Supplemental insurance plans A through L also called Medigap plans. Each plan has different benefits, but within each standardized Medicare Supplemental insurance plan, benefits are identical from one carrier to the next. Therefore, competition in this market has centered on premium cost to the insured, resulting in thinner margins and lower compensation to selling agents and intermediaries. While we still have nearly 14,000 such policies in force, issuance of new policies has rapidly declined

during 2007. Accordingly, we have decided to not emphasize this part of our business, while continuing to service in-force policies.

Insurance Marketing s Services For Agents and Agencies

Insurance Marketing provides sales and marketing services to its national network of independent agents and agencies 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

Table of Contents

and that fit well within the suite of products that are sold by insurance agents and their agencies. Insurance Marketing has relationships with numerous well established, highly-rated insurance companies.

Multiple Carriers for Specific Product Lines. Insurance Marketing 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 Insurance Marketing s marketing channels based on ongoing changes in carriers product, pricing and marketing plans.

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

real-time rate quoting;

agent recruiting, licensing, and contracting;

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, Insurance Marketing 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. We provide a comprehensive portfolio of incentives that attract agents, including annual conventions and sales contests. By leveraging Insurance Marketing s sales management and marketing expertise, insurance companies can focus on the administration of their products, while Insurance Marketing 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. Insurance Marketing 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, Insurance Marketing trains its independent agents in market conduct standards, regulatory compliance requirements, and sales techniques. Insurance Marketing 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. Insurance Marketing delivers important news and updates to its

Table of Contents

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 Healthcare Division

We offer full third-party administration services through our wholly-owned subsidiary that does business as Foresight TPA. Through Foresight, 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 Foresight s services we offer a suite of healthcare service products. Also through Foresight, we provide individuals and employee groups with access to preferred provider networks, medical escrow accounts and full third-party administration capabilities to adjudicate and pay medical claims.

Foresight 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. Foresight s utilization review services are licensed by the Texas Department of Insurance as a utilization review agent. Advantage Care Network is a proprietary 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 healthcare 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, Foresight 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.

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, Foresight successfully completed an SAS 70 Type I examination by independent registered public accountants.

We believe that certain former employees and business practices of Foresight are currently under investigation by the U.S. Department of Justice (the DOJ). In 2007, there was considerable adverse publicity in the El Paso community about the investigation. For more information about this investigation, see Item 3. Legal Proceedings, below. We believe that this investigation and the resulting publicity contributed to the loss of two key clients of Foresight in 2007 that had a material adverse effect on the business and operations of Foresight.

Reliance on key customers.

During 2007, insurance commissions on sales of policies for two carriers amounted to 12.6% and 10.8% of our total revenue. Additionally, a material portion of Regional Healthcare s revenues have historically been derived from Foresight s contractual relationships with a few key governmental entities.

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, The Amacore Group, Inc., New Benefits, Inc., CAREington International, Coverdell, International Association of Businesses, and Family Care. We also compete with all types of network marketing companies throughout the U.S. for new representatives. Our other competitors

Table of Contents

include large retailers, financial institutions, insurance companies, preferred provider organization networks, and other organizations that 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 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. Foresight 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 (PPO) 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;

the ability to effectively market the product on the Internet,

compensation plans for representatives;

the ability to hire and retain employees;

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

Table of Contents

responsiveness to customer needs;

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

the ability to finance promotions and commission advance programs for the recruiting of members and representatives.

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;

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

our competitors will 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 effect 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 Multiple 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 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.

Table of Contents

In our Regional Healthcare Division, we intend to minimize the loss in revenue from El Paso governmental clients for our third-party administration services by expanding the service area of Foresight beyond the metropolitan area of El Paso, Texas and expand into sales to commercial clients.

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

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. Foresight offers a full-service TPA function, including 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 of our Consumer Plan Division. Our discount medical plans are not insurance and 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 these 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 20 states have enacted legislation or adopted regulations that specifically address the operation and marketing of discount medical programs like ours. These laws vary in scope and operation. Some of these laws apply to discounts on all

Table of Contents

healthcare purchases, others regulate only prescription discounts, while others exclude prescription discounts but regulate other services. Furthermore, some of these laws 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. There is a risk that compliance with the legislation and/or regulations could have material adverse effects 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 Healthcare 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 and will continue to be 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 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 legislation and 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, independent marketing 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 Insurance Marketing to carefully monitor state and federal legislative and regulatory activity as it affects their insurance products and services. We believe 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

Table of Contents

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,

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, 2007, we had marketing representatives for our Consumer Plan Division in 42 states. 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

Table of Contents

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 defense costs, 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.

Healthcare Regulation and Reform. Government regulation and reform of the healthcare industry may also affect the manner in which Insurance Marketing 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 healthcare 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 own re-pricing software systems are considered HIPAA compliant and we believe that those used by our third party service providers are also 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. We expect 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. We 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

Table of Contents

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 healthcare 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.

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

Employees

As of December 31, 2007, we had 124 full-time employees in the following departments:

Department	Number of Employees
Customer Services and Claims Administration	71
Sales and Marketing	20
Executive and Administration	13
Finance and Accounting	13
Information Services	7

The total number of our employees after we completed the merger with ICM in January 2007 and our acquisition of PME in October 2007 increased to 124. 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.

Table of Contents

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 negative ther 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 THE YEARS OF 2007, 2006 AND 2005 WE INCURRED LOSSES FROM OPERATIONS AND THESE LOSSES MAY CONTINUE.

During the years ended December 31, 2007, 2006 and 2005 we incurred losses from continuing operations of $13,155,000, $6,814,000 and $13,229,000, respectively and net losses of $13,155,000, $7,724,000 and $13,371,000, respectively. As part of those operating losses and net losses, we incurred goodwill impairment charges of $12,069,000, $6,440,000 including tax considerations of $426,000, and $12,900,000 in 2007, 2006 and 2005, respectively. In 2007, we recorded goodwill impairment charges of $4,092,000 for Foresight due to the loss of significant contracts, $3,377,000 for Capella due to the failure of certain new product and marketing initiatives to achieve expected results, and $4,600,000 for the Insurance Marketing Division due to significant declines in sales of Medicare supplemental policies. In 2006, we recorded goodwill impairment charges of $4,066,000 including tax considerations of $426,000 for Foresight and $2,800,000 for Capella. In 2005, we recorded a goodwill impairment charge of $12,900,000 related to Capella. The operating losses before goodwill impairment charges in 2007 and 2005 were primarily attributable to the continuing costs associated with our medical savings program. There is no assurance that losses from our medical savings program will not continue or that our other operations will become or continue to be profitable in 2008 or thereafter.

WE MAY BE UNABLE TO OBTAIN ADDITIONAL CAPITAL ON A TIMELY BASIS OR ON ACCEPTABLE TERMS TO FUND OUR WORKING CAPITAL REQUIREMENTS.

As a result of our decline in revenues, our merger with ICM, our acquisition of PME, and certain marketing and sales initiatives, we have used significant amounts of cash in our operations and in financing and investing activities. As of December 31, 2007, we had a balance of $2.7 million of unrestricted cash. In 2007, cash used in investing and financing activities was $1.4 million and $.9 million, respectively, while our operating activities provided $1.7 million

in cash. This resulted in a decrease of $.5 million in our cash and cash equivalents during 2007.

We expect that we will need significant additional cash resources to operate and execute our business plan in the future, particularly with respect to our agent advance commission programs that are critical to the success of our Insurance Marketing Division. Our future capital requirements will depend on many factors, including our ability to maintain our existing cost structure and return on sales, fund obligations for additional

Table of Contents

capital and execute our business and strategic plans as currently conceived. If these resources are insufficient to satisfy our cash requirements, we may seek to sell additional equity or debt securities or obtain a credit facility. The sale of additional equity securities may result in additional dilution to our stockholders. Additional indebtedness could result in debt service obligations and lender imposed operating and financing covenants that restrict our operations. In addition, financing might be unavailable in amounts or on terms acceptable to us, if at all.

OUR SUBSIDIARY, FORESIGHT, 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.

Foresight 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. Foresight s primary market is governmental entities in the metropolitan area of El Paso, Texas, including cities and school districts. There are a limited number of these types of entities within that metropolitan area. During the second and third quarters of 2007, we announced several adverse events related to the loss of two major customers and possible loss or non-renewal of another major customer beyond contract expirations in 2007. As of June 30, 2007, we re-evaluated the carrying value of goodwill related to Foresight and determined that an impairment charge of $4,092,000 that reduced the carrying value of the goodwill to zero for the loss of these contracts was appropriate. There is no assurance that Foresight will obtain renewal or extension on its remaining contracts. The loss of any of these remaining contractual relationships will adversely affect 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 HAVE IDENTIFIED MATERIAL WEAKNESSES IN OUR INTERNAL CONTROLS, THAT COULD AFFECT OUR ABILITY TO ENSURE TIMELY AND RELIABLE FINANCIAL REPORTS.

Our processing and recording of commission revenues earned and commission expenses payable to agents are key determinants of material revenues and expenses reported in our financial statements. This processing and recording of commission revenue and expense, together with the accurate and timely disbursement of commission payments to certain agents, is dependent upon our timely receipt of complete and accurate information about such commissions from the insurance carriers whose policies we sell. While we have established multiple compensating manual processes designed to partially mitigate these weaknesses, we nevertheless have insufficient control procedures in place to fully assure that commission information received from those insurance carriers is complete, accurate or received in a timely manner. Additionally, some information is processed for us by outside third party service bureaus or administrators. Some of those third party service bureaus or administrators have not had their controls evaluated by independent registered accountants and they have not received SAS 70 reports on their controls. We have performed limited reviews of their controls and have preliminarily determined that they have insufficient information technology general controls. Additionally, we determined that we had numerous weaknesses in our own internal information technology controls in these areas. Our failure to receive and process such commission information in a timely, complete and accurate fashion or to process it accurately could adversely impact our ability to pay commissions to our agents in a timely and accurate manner or to state revenues or expenses in our financial statements in a materially correct manner.

WE RELY ON OUR INSURANCE CARRIER PARTNERS TO ACCURATELY AND REGULARLY PREPARE COMMISSION REPORTS, AND IF THESE REPORTS ARE INACCURATE OR NOT SENT TO US IN A TIMELY MANNER, OUR RESULTS OF OPERATIONS COULD SUFFER.

Our Insurance Marketing Division generates revenues primarily from the receipt of commissions paid to us by insurance companies based upon the insurance policies sold to consumers through agents with which we have contracted. These revenues are in the form of first year and renewal commissions that vary by company and product.

In calculating the amount of commission earned by us and in accounting for commission paid to us by insurance companies, we rely on data not under our control, including data provided to us by the

Table of Contents

insurance company and premium collection and payment service providers engaged by the insurance company to calculate and pay commissions. The data that we receive may fluctuate as the insurance company or its collection and payment service providers make adjustments to their reports of policies sold. We have implemented our own processes to evaluate the data that we receive to help confirm that it is consistent with the number and types of policies that we believe have been sold. However, it is difficult for us to independently determine whether carriers are reporting all commissions due to us, primarily because the majority of our members terminate their policies by discontinuing their premium payments to the carrier instead of informing us of the cancellation. Because we cannot always rely on the accuracy or timeliness of the data that we receive from the insurance company or its payment service providers, our financial reports are subject to adjustment and we may not collect and recognize revenue that we are entitled, both of which would harm our business, operating results and financial condition.

The same data from insurance carriers or their payment service providers is used to calculate the balances of advanced commissions owed by us to the insurance carrier or owed to us by agents. Because we cannot always rely on the accuracy or timeliness of the data that we receive from the insurance company or its payment service, our calculation of these balances may fluctuate and resulting adjustments may adversely affect our business, operating results and financial condition.

Our processing and recording of commission revenues earned and commission expenses payable to agents are key determinants of material revenues and expenses reported in our financial statements. This processing and recording of commission revenue and expense, together with the accurate and timely disbursement of commission payments to agents, is dependent upon our timely receipt of complete and accurate information about such commissions from the insurance carriers whose policies we sell. Our failure to receive such commission information in a timely, complete and accurate fashion could adversely impact our ability to pay commissions in a timely and accurate manner or to state revenues or expenses in our financial statements in a materially correct manner.

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 USA Healthcare Savings and Care Entrée^{tm} medical savings programs. Our independent marketing representatives typically offer and sell theseprograms 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 programs. Also, our ability to attract and retain marketing representatives could be negatively affected by adverse publicity relating to our programs 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 CONSUMER PLAN DIVISION 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 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

Table of Contents

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 Consumer Plan Division products 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 TWO KEY PREFERRED PROVIDER ORGANIZATIONS AND THE LOSS OF OR A CHANGE IN OUR RELATIONSHIPS WITH THESE PROVIDERS 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 have obtained savings on medical services through our Care Entrée^{tm} program. PME has utilized the Galaxy Health Network (Galaxy) preferred provider organization. The loss of PHCS or Galaxy as a preferred provider organization or a disruption of our members access to PHCS or Galaxy could affect our ability to retain our members and could, therefore, adversely affect our business. While we currently enjoy a good relationship with Galaxy, 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

Table of Contents

trends or changing industry requirements. Increased competition may result in price reductions, reduced gross margins, 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 AND RELATED PRIVATE PARTY LITIGATION MAY ADVERSELY AFFECT OUR FINANCIAL POSITION AND LIMIT OUR OPERATIONS.

In recent years, several states have enacted laws and regulations that govern discount medical program organizations (DMPOs). The laws vary in scope, ranging from registration to a comprehensive licensing process with oversight over all aspects of the program, including the manner by which discount medical programs are sold, the price at which they are sold, the relationship of the DMPO licenses or registrations for both subsidiaries in our Consumer Plan Division. We hold these licenses in every jurisdiction where such a license or registration is required to be held and where the respective subsidiary conducts business. Because these laws and regulations are relatively new, we do not know the full extent of how they will affect our business or whether or not we will be able to maintain all necessary licenses. 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 adverse 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 market memberships in associations that have been formed to provide various consumer benefits to their members. These associations may include in their benefit packages insurance products that are issued under group or blanket policies covering the association s members. Most states allow these memberships to be sold under certain circumstances without a licensed insurance agent making each sale. If a state were to determine that our sales of these memberships do not comply with their regulations, our ability to continue selling such memberships would be affected and we might be subject to fines and penalties and may have to issue refunds or provide restitution to the associations and their members.

The business practices and compensation arrangements of the insurance intermediary industry, including our practices and arrangements, are subject to uncertainty due to investigations by various government authorities and related private litigation. The legislatures of various states may adopt new laws addressing contingent commission arrangements, including laws prohibiting such arrangements, and addressing disclosures of these arrangements to insureds. Various state departments of insurance may also adopt new regulations addressing these matters. While it is not possible to predict the outcome of the government inquiries and investigations into the insurance industry s commission payment practices or the response by the market and government regulators, any material decrease in our profit-sharing contingent commissions is likely to have an adverse effect on our results from operations.

OUR FAILURE TO PROTECT OUR MEMBERS AND CUSTOMERS DATA COULD ADVERSLY AFFECT OUR FINANCIAL POSITION AND OPERATIONS BY DAMAGING OUR REPUTATION, HARMING OUR BUSINESS AND CAUSING US TO EXPEND CAPITAL AND OTHER RESOURCES TO PROTECT AGAINST FUTURE SECURITY BREACHES.

Certain of our services are based upon the collection, distribution, and protection of sensitive private data. Unauthorized users might access that data, and human error or technological failures might cause the wrongful

dissemination of that data. If we experience a security breach, the integrity of certain of our services may be affected and such a breach could violate certain of our marketing partner agreements, which could give our marketing partners the right to terminate such agreements with us. We have incurred, and may incur in the

Table of Contents

future, significant costs to protect against the threat of a security breach. We may also incur significant costs to solve problems that may be caused by future breaches or to prevent such breaches. Any breach or perceived breach could subject us to legal claims from our marketing partners or customers and/or regulatory or law enforcement entities under laws that govern the protection of non-public personal information. Moreover, any public perception that we have engaged in the unauthorized release of, or have failed to adequately protect, private information could adversely affect our ability to attract and retain members and customers. In addition, unauthorized third parties might alter information in our databases that could adversely affect both our ability to market our services and the credibility of our information.

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.

Table of Contents

THE ADVERTISING AND PROMOTIONAL ACTIVITIES OF OUR INDEPENDENT MARKETING REPRESENTATIVES AND PRIVATE-LABEL CUSTOMERS ARE SUBJECT TO AND MAY VIOLATE FEDERAL AND STATE REGULATION CAUSING US TO BE SUBJECT TO THE IMPOSITION OF CIVIL PENALTIES, FINES, INJUNCTIONS AND LOSS OF STATE LICENSES.

The Federal Trade Commission (FTC) and most states regulate advertising, product claims, and other consumer matters, including advertising of our healthcare savings products. All advertising, promotional and solicitation materials used by our independent marketing representatives and private label customers must be approved by us prior to use. We are currently under investigation by the Texas Attorney General as a result of the activities of one of our private label customers, with whom we have terminated our relationship. While we have not been the target of FTC enforcement action for the advertising of, or product claims related to, our healthcare savings products, there can be no assurance that the FTC will not question our advertising or other operations in the future. In addition, there can be no assurance that a state, in addition to Texas, will not interpret our product claims presumptively valid under federal law as illegal under that state s regulations, or that future FTC regulations or decisions will not restrict the permissible scope of the claimed savings. We are subject to the risk of claims by our independent marketing representatives and private label customers and members of our Care Entree[tm] programs and those under private label arrangements may file actions on their own behalf, as a class or otherwise, and may file complaints with the FTC or state or local consumer affairs offices. These agencies may take action on their own initiative against us for alleged advertising or product claim violations. These actions may include consent decrees and the refund of amounts paid by the complaining members, refunds to an entire class of independent marketing representatives, private label customers or members, or other damages, as well as changes in our method of doing business. A complaint because of a practice of one independent marketing representative or private label customer, whether or not that practice was authorized by us, could result in an order affecting some or all of our independent marketing representatives and private label customers in the particular state, and an order in one state could influence courts or government agencies in other states considering similar matters. Proceedings resulting from these complaints may result in significant defense costs, settlement payments or judgments and could have a material adverse effect on our operations.

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 were 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 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 OUR RELIANCE ON OUR MANAGEMENT INFORMATION SYSTEM MAY OCCUR AND COULD ADVERSELY AFFECT OUR CLIENT RELATIONSHIPS.

We manage certain information related to our Consumer Plan Division membership on an administrative proprietary information system. Because it is a proprietary system, 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

Table of Contents

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 RECORDED GOODWILL ASSOCIATED WITH OUR ACQUISITIONS OF CAPELLA, ICM AND PME MAY BECOME IMPAIRED AND REQUIRE A SUBSTANTIAL WRITE-DOWN AND THE RECOGNITION OF AN IMPAIRMENT EXPENSE.

In connection with our acquisitions of Capella, Foresight, ICM and PME, we recorded goodwill that had a net aggregate asset value of $5,489,000 at December 31, 2007. This carrying value has been reduced through impairment charges of $12,069,000 in 2007, $6,440,000 in 2006, and $12,900,000 in 2005. 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.

WE MAY FIND IT DIFFICULT TO INTEGRATE ICM S AND PME S BUSINESSES 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, Insurance Marketing s business is relatively 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 ICM s operations. There can be no assurance that this will occur. Similarly, we believe that PME s marketing and distribution of dental and vision network access and non-insurance medical discount programs will complement and fit well with our Consumer Plan Division. We will not achieve the anticipated benefits of that acquisition unless we successfully integrate the PME operations. 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

Table of Contents

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. We are also dependent upon third-party data processing and administrative service providers for the processing of commission revenue and expense for our Insurance Marketing Division. As a result of these outsourcing arrangements, we may lose direct control over 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. Although we are transitioning the services provided to us by Lifeguard to systems that we now own or manage as a result of our acquisition of PME, we will remain dependent on Lifeguard for certain services until that transition is complete and for the accurate completion of the transition.

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 our Insurance Marketing Division has strategic relationships, more than 85% of Insurance Marketing s 2007 revenue and 95% of ICM s 2006 and 2005 revenue 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.

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 our Insurance Marketing Division has active distribution and marketing relationships, more than 80% of Insurance Marketing s revenues

Table of Contents

are 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 MARKETPLACE 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 our 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 offer 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.

ON AUGUST 19, 2007, PETER W. NAUERT, OUR CHIEF EXECUTIVE OFFICER, ON WHOM WE WERE HIGHLY DEPENDENT, PASSED AWAY AND THE CONSEQUENCES OF THE LOSS OF HIS SERVICES ARE CURRENTLY INDETERMINABLE.

We were highly dependent upon Peter W. Nauert, the Company s Chief Executive Officer and Chairman. Mr. Nauert s management skills, reputation and contacts within the insurance industry were key elements of our business plans. Mr. Nauert passed away August 19, 2007 after a brief illness. The ultimate effect and consequences of the loss of Mr. Nauert s services are not currently determinable. The loss of Mr. Nauert s management skills, reputation and

insurance industry contacts may adversely affect the growth and success we expect to obtain from our merger with ICM.

Table of Contents

ITEM 1B. UNRESOLVED STAFF COMMENTS

We do not have any pending unresolved comments with 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 West 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 and 4,941 square feet for a call center from the same unaffiliated third party under a separate lease that expires November 30, 2011.

Foresight occupies 16,780 square feet at 7430 Remcon Circle, Building C, El Paso, Texas, 79912. These offices are occupied under a lease agreement with an unaffiliated third party that expires May 31, 2011. This property was owned by an affiliated party through January 2007. Terms of this lease were at competitive market rates within the local area and were consistent with those of an arms-length arrangement. Total payments of $169,000 were paid to the affiliated party under this agreement in 2006.

We assumed an existing lease in our acquisition of PME for 5,169 square feet at 14651 Dallas Parkway, Dallas, Texas 75240. These offices are occupied under a lease agreement with an unrelated third party that expires June 1, 2008.

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	1-2 Years	3-5 Years	More than 5 Years
Total operating leases on real property	$ 2,226	$ 647	$ 1,201	$ 378	$

ITEM 3. LEGAL PROCEEDINGS

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

Zermeno v Precis, Inc. 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., 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 under case number BC 300788.

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 under Section 445 of the California Health and Safety Code. That Section governs medical referral services. The plaintiffs also sought relief under Section 17200 of the Business and Professions Code, California s Unfair Competition Law.

On December 21, 2007, we received a verdict in our favor. The plaintiffs have indicated that they plan to appeal. A negative result in this case would have a material affect our financial condition and would limit our ability (and that of other healthcare discount programs) to do business in California.

We believe that we have complied with all applicable statues and regulations in the state of California. Although we believe the Plaintiffs claims are without merit, we cannot provide any assurance regarding the outcome or results of this litigation.

Table of Contents

State of Texas v The Capella Group, Inc. et al. The State of Texas filed a lawsuit against Capella and Equal Access Health, Inc. (including various names under which Equal Access Health, Inc. does business) on April 28, 2005. Equal Access Health was 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[tm], directly and through at least one other party that formerly resold the services of Care Entrée[tm] s 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. 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.

Investigation of Access HealthSource, Inc.(Foresight) and National Center for Employment of the Disabled, Inc. In June 2004, we acquired Foresight and its subsidiaries from National Center for Employment of the Disabled, Inc. (now known as Ready One Industries, NCED). Robert E. Jones, the Chief Executive Officer of NCED was elected to and served on our Board of Directors until his March 2006 resignation. Frank Apodaca served as the President and Chief Executive Officer of Foresight from our acquisition until his employment termination on September 3. 2007 after having been placed on administrative leave. Mr. Apodaca also previously served as Chief Administrative Officer and a member of the Board of Directors of NCED. He also served as our President from June 10, 2004 to January 30, 2007. Until July 2006, his employment agreement with us allowed him to spend up to 20% of his time on matters related to NCED s operations. NCED has been one of our significant shareholders as a result of shares it received from our acquisition of Foresight.

While we believe that there is no investigation of current employees of Foresight or of its current business practices, there is an ongoing federal investigation of Mr. Apodaca and of past business activities of Foresight that has been well publicized in the El Paso, Texas area. The investigation involves several elected public officials and over 20 companies that do business with local government entities in the El Paso area. We believe that the investigation involves, among other things, allegations of corruption relating to contract procurement by Mr. Apodaca and Foresight and other companies from these local governmental entities. We can offer no assurance as to the outcome of the investigation. In addition to the negative financial effect from the loss of business, we have suffered and may continue to suffer as a result of the investigation and the adverse publicity surrounding the investigation. Our financial condition and the results of our operations will be materially affected should the investigation result in formal allegations of wrongdoing by Foresight. We may become obligated to pay fines or restitution and our ability to operate Foresight under licenses may be restricted or terminated. In addition, the publicity and financial effect resulting from the investigation may affect our other divisions reputation and ability to attract business, and secure financing.

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, 126th District Court, 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. We, our subsidiaries, the estate of Mr. Nauert and Mr. Smith intends 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. We have been named as a defendant in this action as a successor-in-interest to ICM.

Table of Contents

In connection with our merger with ICM, Mr. Nauert and the Peter W. Nauert Revocable Trust agreed to fully indemnify ICM and us against any losses resulting from this matter. Although we can provide no assurance, we believe that the ultimate outcome of these claims and lawsuits will not have a material adverse effect on our consolidated financial condition, results of operation, or liquidity.

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

We held our annual meeting of shareholders on July 31, 2007. 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 20,269,145 shares of our common stock outstanding as of the record date for the meeting, 15,355,017 were represented and voted at the meeting. At the meeting, the following directors were elected: Andrew A. Boemi, Russell Cleveland, Kenneth S. George, J. French Hill, Peter W. Nauert, Kent H. Webb, M.D., and Nicholas J. Zaffiris. The only other matter voted upon at the meeting was the ratification of the engagement of Hein & Associates LLP to audit our financial results for the year ended December 31, 2008. The vote result for the engagement of Hein & Associates LLP was as follows:

	Votes			
Item	**For**	**Against**	**Abstained**	**Total**
Ratification of Hein & Associates, LLP	15,139,443	190,708	24,866	15,355,017

PART II

ITEM 5. MARKET FOR THE REGISTRANT S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

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). 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.

	Closing Sale Price Common Stock	
Quarter Ended	**High**	**Low**
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
March 30, 2007	$ 2.35	$ 2.30
June 29, 2007	$ 1.90	$ 1.73
September 28, 2007	$ 1.48	$ 1.02

December 31, 2007	$ 1.44	$ 0.85

On March 27, 2008, the closing sale price of the common stock as quoted on the Nasdaq Capital Market was $0.90. On March 27, 2008, there were 254 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,

Table of Contents

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, 2007, 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	575,000	$	2.03	904,500
2002 IMR stock option plan				
1999 stock option plan	742,000		1.89	603,294
	1,317,500		1.95	1,507,974

(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.

Table of Contents

Unregistered Securities Sold During Preceding Three Years

Insurance Capital Management USA Inc.

On January 30, 2007, we completed our merger with ICM. Under the terms of the merger, the shareholders of ICM received our common stock shares based on the adjusted earnings before income taxes, depreciation and amortization (adjusted EBITDA) of ICM and its subsidiary companies. On January 30, 2007, the ICM shareholders were issued 4,498,529 common stock shares. Furthermore, on May 31, 2007, the ICM shareholders were issued an additional 2,257,853 common stock shares as a result of the acquired ICM companies achieving adjusted EBITDA (earnings before income taxes, depreciation and amortization) of $1,250,000 over the four consecutive calendar quarters ended on December 31, 2006. These shares were sold pursuant to Rule 506 of Regulation D promulgated under the Securities Act of 1933, as amended, without payment of sales commissions or other remuneration.

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, 2007, 2006, 2005, and the balance sheet data as of December 31, 2007 and 2006 have been derived from our consolidated financial statements included elsewhere in this report. Data for the statement of operations and cash flow data presented below for the two years ended on December 31, 2004 and 2003 were derived from previous audited financial statements. (1) (2) (3)

Dollars in Thousands	**2007 (1)**	**2006**	**2005**	**2004 (2)**	**2003**
Commissions and service revenues	$ 39,922	$ 21,974	$ 30,028	$ 37,413	$ 40,224
Interest income on advances	551				
Interest income-other	201	406	232	27	
Total revenues (3)	40,674	22,380	30,260	37,440	40,224
Operating expenses: (3)					
Commissions	18,027	3,686	6,015	10,731	14,599
Cost of operations	10,428	10,173	13,138	14,492	10,509
Sales and marketing	4,268	1,776	1,471	627	613
General and administrative	8,260	6,345	8,272	9,408	5,508
Depreciation and amortization	1,135	774	1,498	2,311	2,040
Interest expense	233	50	72	84	153
Impairment charge for goodwill	12,069	6,440	12,900	2,000	
Total operating expenses	54,420	29,244	43,366	39,653	33,422
Net (loss) income before taxes	(13,746)	(6,864)	(13,106)	(2,213)	6,802
Provision for income taxes (benefit) expense	(591)	(50)	123	(556)	2,524

(Loss) income from continuing operations	(13,155)	(6,814)	(13,229)	(1,657)	4,278
Gain on sale of operations, net of taxes			300		
Loss from discontinued operations, net of taxes		(910)	(442)	(299)	(189)
Net (loss) earnings	$ (13,155)	$ (7,724)	$ (13,371)	$ (1,956)	$ 4,089
(Loss) earnings per share:					
Basic					
Continuing operations	$ (0.69)	$ (0.51)	$ (1.06)	$ (0.14)	$ 0.36
Discontinued operations	$ (0.00)	$ (0.07)	$ (0.01)	$ (0.03)	$ (0.02)
Diluted(4)					
Continuing operations	$ (0.69)	$ (0.51)	$ (1.06)	$ (0.14)	$ 0.36
Discontinued operations	$ (0.00)	$ (0.07)	$ (0.01)	$ (0.03)	$ (0.02)
Weighted average shares outstanding					
Basic	18,983,843	13,486,562	12,432,591	11,921,946	11,848,789
Diluted	18,983,843	13,486,562	12,432,591	11,921,946	11,924,214

Table of Contents

Dollars in Thousands	2007	2006	2005	2004	2003
Cash Flows Data:					
Net cash provided by operating activities	$ 1,435	$ 725	$ 514	$ 1,759	$ 7,819
Net cash used in investing activities	(617)	(3,263)	(1,822)	(2,595)	(945)
Net cash used in financing activities	(1,339)	(241)	(964)	(1,969)	(1,398)

Dollars in Thousands	December 31, 2007	2006
Balance Sheet Data:		
Cash and cash equivalents	$ 2,711	$ 3,232
Unrestricted short-term investments		200
Restricted short-term investments	1,231	1,420
Current assets	10,614	6,800
Working capital	1,076	3,996
Total assets	20,818	16,244
Current liabilities	9,538	2,804
Total liabilities	9,561	2,852
Stockholder s equity	11,257	13,392

(1) Operating results for the Insurance Marketing Division are included only from February 2007 forward, after the completion on January 30, 2007 of the acquisition of Insurance Capital Management USA, Inc. (ICM). ICM s assets and liabilities acquired were initially valued, in the aggregate net amount of $10,540,000, based upon the market value of the common stock issued as consideration in the acquisition. Of those amounts we allocated $10,087,000 to goodwill and $3,700,000 to other intangible assets. Operating results for the Consumer Plan Division include the operating results of Protective Marketing Enterprises, Inc. (PME) from the date of its acquisition on October 1, 2007. PME was acquired, and became one of our wholly-owned subsidiaries, for a cash consideration of $1,098,000.

(2) We acquired Foresight 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.

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

(4) For the years ended December 31, 2007, 2006 and 2005 and outstanding stock options of 31,369, 43,575, 25,375 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

We develop and distribute quality affordable consumer driven healthcare 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 healthcare. These products and plans include health insurance plans and non-insurance healthcare 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.

The current organization of our business, including our new Insurance Marketing Division, is a result of our January 30, 2007 merger with Insurance Capital Management USA, Inc. (ICM). As a result of this merger, and to properly reflect our broadened mission of providing access to affordable healthcare for all Americans, we

Table of Contents

changed our name from Precis, Inc. to Access Plans USA, Inc. Beginning in 2007, our operations are organized under three business divisions, Consumer Plans, Insurance Marketing and Regional Healthcare:

Consumer Plan Division. 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. 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 comparable savings for our 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.

These programs are sold primarily through 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. We refer to these programs and membership sales as wholesale programs or private-label programs. Each of the private-label programs can bundle our services to fit the needs of their consumers.

We also sell consumer healthcare discount programs through Independent Marketing Representatives (IMRs), primarily under the USA Healthcare Savings and Care Entrée TM brands. Our 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 member s enrollment. IMRs may also recruit other representatives and earn override commissions on sales made by those recruited representatives. In the first month of a membership sale, no override commissions are paid to the representative s upline. The total regular or ongoing commission payout, including overrides on monthly membership sales after the enrollment month and our contribution to the bonus pools, is up to 55% of qualified membership sales.

Insurance Marketing Division. Operating results for the Insurance Marketing Division are only for the 11 months following completion of our merger with ICM on January 30, 2007. However, ICM s 2006 results prior to acquisition are discussed below for comparative purposes.

Revenue. We generate most of our revenue in this segment from commissions paid to us by health insurance carriers whose health insurance policies we have sold. Commission and fee revenue represented 97% of our total revenue in this segment for the year ended December 31, 2007. The remainder of our revenue is primarily attributable to interest earned on commissions advanced to agents. Our commission revenue has grown principally as a result of recruitment of a growing number of agents and the resulting penetration of the individual, family and small business health insurance markets, driving a corresponding growth in the number of policies in force. We estimate that as of December 31, 2007 we had approximately 31,500 policies in force compared to an estimated 30,000 policies in force at December 31, 2006.

Policyholder Acquisition. An important factor in our revenue growth is the growth of our policyholder base. Our strategy for growing the number of policies in force and, therefore, revenue is to:

- continue to recruit new agents and retain the current agents selling our products and services and also continue to provide increasingly valuable services to insurance agents and their agencies;

continue to use technology and innovative marketing and agent-support programs to attract new agents to sell products that are available to us;

continue to develop products for consumers to provide healthcare savings and/or insurance protection to families and individuals;

Table of Contents

enhance the product portfolio we distribute by adding new products developed on our current product platform;

expand into new states where we are not currently marketing to any significant degree; and

expand the number of insurance carriers we represent.

Regional Healthcare Division. For governments and other large, self-funded employers seeking to reduce their costs for providing 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 Foresight, 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 Foresight, 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. Foresight 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 2007 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.

Critical Accounting Policies

Basis of Presentation. The consolidated financial statements have been prepared in accordance with generally accepted accounting principles and include the accounts of our wholly-owned subsidiaries, Capella, Insuraco, and Foresight. All significant inter-company accounts and transactions have been eliminated. Certain reclassifications have been made to prior period financial statements to conform to the current presentation of the financial statements.

Restatement. On May 22, 2008, we received a comment letter from the Securities and Exchange Commission (SEC) regarding the presentation, in our statement of cash flows, of the change in both commission advances paid by us to agents and unearned commissions advances received from insurance carriers. Previously, we considered these receipts and payments had more than one class of cash flows and had characterized these items as investing and financing activities, respectively. In connection with the disposition of this matter, we have characterized both the change in commissions advances paid by us to agents and the

39

Table of Contents

change in unearned commission advances received from insurance carriers as operating activities. A summary of this restatement is set forth below:

	Year Ended December 31, 2007		
Dollars in Thousands	**Previously Reported**	**Restated Amount**	**Effect of Change**
Net cash provided by (used in):			
Operating activities	$ 1,823	$ 1,435	(388)
Investing activities	(1,442)	(617)	825
Financing activities	(902)	(1,339)	(437)
Net decrease in cash and cash equivalents	(521)	(521)	
Cash and cash equivalents, beginning of year	3,232	3,232	
Cash and cash equivalents, end of year	$ 2,711	$ 2,711	$

Use of Estimates. The preparation of financial statements in conformity with generally accepted accounting principles requires us to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Certain significant estimates are required in the evaluation of goodwill and intangible assets for impairment as well as allowances for doubtful recoveries of advanced agent commissions and accounts and notes receivable. Actual results could differ from those estimates and the differences could be material.

Fair Value of Financial Instruments. The recorded amounts of short-term investments, accounts receivable, income taxes receivable, notes receivable, accounts payable, accrued liabilities, income taxes payable, capital lease obligations and debt approximate fair value because of the short-term maturity of these items.

Recently Issued Accounting Standards. In December 2007, the FASB issued SFAS No. 141R (FAS 141R), *Business Combinations*, which revises FAS 141 and changes multiple aspects of the accounting for business combinations. Under the guidance in FAS 141R, the acquisition method must be used, which requires the acquirer to recognize most identifiable assets acquired, liabilities assumed, and non-controlling interests in the acquiree at their full fair value on the acquisition date. Goodwill is to be recognized as the excess of the consideration transferred plus the fair value of the non-controlling interest over the fair values of the identifiable net assets acquired. Subsequent changes in the fair value of contingent consideration classified as a liability are to be recognized in earnings, while contingent consideration classified as equity is not to be re-measured. Costs such as transaction costs are to be excluded from acquisition accounting, generally leading to recognizing expense, and, additionally, restructuring costs that do not meet certain criteria at acquisition date are to be subsequently recognized as post-acquisition costs. FAS 141R is effective for business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2008. The Company is currently evaluating the impact that this issuance will have on its financial position and results of operation.

In September 2006, the Financial Accounting Standards Board (FASB) issued Statement of Financial Accounting Standards (SFAS) No. 157, *Fair Value Measurements*, that provides enhanced guidance for using fair value measurements in financial reporting. While the standard does not expand the use of fair value in any new circumstance, it has applicability to several current accounting standards that require or permit entities to measure assets and liabilities at fair value. This standard defines fair value, establishes a framework for measuring fair value in U.S. Generally Accepted Accounting Principles (GAAP) and expands disclosures about fair value measurements.

Application of this standard is required beginning in 2008.

In February 2007, the FASB issued SFAS No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities Including an Amendment of FASB Statement No. 115*, that is effective for fiscal years beginning after November 15, 2007. This statement permits an entity to choose to measure many financial instruments and certain other items at fair value on specified election dates. This election, which may be

applied on an instrument by instrument basis, is typically irrevocable once elected. Subsequent unrealized gains and losses on items for which the fair value option has been elected will be reported in earnings.

Management is currently assessing the potential impact, if any, the application of these standards could have on our financial statements.

In fiscal year 2007, we adopted Securities and Exchange Commission Staff Accounting Bulletin (SAB) No. 108, *Considering the Effects of Prior Year Misstatements when Quantifying Current Year Misstatements*. SAB No. 108 requires companies to quantify misstatements using both a balance sheet (iron curtain) and an income statement (rollover) approach to evaluate whether either approach results in an error that is material in light of relevant quantitative and qualitative factors, and provides for a one-time cumulative effect transition adjustment. The adoption of SAB No. 108 did not have an impact on our financial statements.

Revenue Recognition. Revenue recognition varies based on source.

Consumer Plan Division Revenues. We recognize Consumer Plan program membership revenues, other than initial enrollment fees, ratably over the membership month. Membership revenues are reduced by the 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 of those amounts, 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 creditworthiness 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.

Insurance Marketing Division Revenues. The revenue of our Insurance Marketing Division is primarily from sales commissions due from the insurance companies we represent. These sales commissions are generally a percentage of the commissionable insurance premium and other related amounts charged and collected by the insurance companies. Commission income and policy fees, other than enrollment fees, and corresponding commission expense payable to agents, are generally recognized at their gross amount, as earned on a monthly basis, until such time as the underlying policyholder contract is terminated. Advanced commissions received are recorded as unearned commission revenue and are recognized in income as earned. Initial enrollment fees are deferred and amortized over the estimated lives of the respective policies. The estimated weighted-average life for the policies sold ranges from 18 to 48 months, and is based upon our historical policyholder contract termination experience.

Our commission revenue generally represents a percentage of the insurance premium a policyholder pays to his or her insurance carrier and, to a lesser extent, additional incentive payments that insurance carriers pay us for achieving sales volume thresholds or other objectives. Commission rates vary by carrier and by the type of plan purchased by a policyholder. Commission rates also may vary based upon the amount of time that the policy has been active, with commission rates for individual and family policies typically being higher in the first 12 months of the policy. Individuals, families and small businesses purchasing health insurance through us typically pay their premiums on a

monthly basis. Insurance carriers typically pay us our commissions monthly, after they receive the premium payment from the member. We continue to receive the commission payment from the relevant insurance carrier until the health insurance policy is cancelled or we otherwise do not remain the agent on the policy. As a result, the majority of our revenue is recurring in nature and grows in correlation with the growth we experience in our policies in force. Commission income and policy fees, other

Table of Contents

than initial enrollment fees, and corresponding commission expense payable to agents who sell policies on our behalf, are generally recognized at their gross amount, as earned on a monthly basis, until such time as the underlying policyholder contract is terminated.

In some cases, we may receive an advance payment of commissions from the carrier, representing our expected commission on future premiums not yet collected or earned. These advances are subject to repayment back to the carrier in the event that the policy lapses before the advanced commissions are collected and earned. These advanced commissions are reflected on our balance sheet as unearned commissions. Similarly, we or the carrier may advance commissions to brokers and agents who sell for us. These advances are subject to repayment back to us or to the carrier in the event that the policy lapses before the advanced commissions are collected and earned. These commissions advanced to agents are reflected on our balance sheet as advanced agent commissions. Collection of the commissions advanced may be accomplished by withholding amounts due to the agents, plus accumulated interest, from future commissions on the policy upon which the advance was made, commissions on other policies sold by the agent or, in certain cases, commissions due to agents managing the agent to whom advances were made. Advanced agent commissions are reviewed on a quarterly basis to determine if any advanced agent commissions will likely be uncollectible. An allowance is provided for any advanced agent commission balance where recovery is considered doubtful. This allowance for uncollectible advances is based upon review of the aging of outstanding balances and estimates of future commissions expected to be due to the agents to whom advances are outstanding and the agents responsible for their management. Any bad debt is written off when determined uncollectible.

We recognize commission revenue when the commission is earned, based upon premiums collected and earned on the underlying policies in force. These revenues are based upon amounts reported to us by a carrier, which occurs through our receipt of a cash payment and a commission statement. Incentive payments from carriers are recognized when we receive notice from the carrier that they have been earned and are generally reported to us in a more irregular pattern than premium commissions. As a result, our revenue for a particular quarter could be higher or lower than expectations due to the timing of the reporting of commission override payments.

Revenue attributable to individual and family major medical policies for the 11 months ended December 31, 2007 represented approximately 74% of our total revenue in the Insurance Marketing Division. Additionally, revenue attributable to Medicare supplemental policies for the eleven months ended December 31, 2007 represented approximately 23% of our total revenues in the Insurance Marketing Division. In addition to the revenue we derive from commissions on the sale of health insurance products, we derive revenue from interest charged to agents on their outstanding advanced commissions and for the sale of leads to those agents.

Regional Healthcare Division (Foresight) Revenues. The principal sources of revenues of our Regional Healthcare Division, Foresight (formerly Access HealthSource, Inc.), 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. Commission expense varies based upon source.

Consumer Plan. Commissions on Consumer Plan Division revenues are accrued in the month in which a member has enrolled in the program. These commissions are only paid to our independent marketing representatives in the month following our receipt of the related membership fees by us. In 2007, we began issuing advances of commissions on certain Consumer Plan programs to increase sales representative recruitment.

Insurance Marketing. Commission expenses for the Insurance Marketing Division consist primarily of commissions payable to agents and are generally recognized at their gross amount, as earned on a monthly basis, until such time as the underlying policyholder contract is terminated. Advances of commissions up to one year are paid to agents in the Insurance Marketing Division based on certain insurance policy premium commissions. Collection of the commissions advanced may be accomplished by withholding amounts due to

Table of Contents

the agents for future commissions on the policy upon which the advance was made, commissions on other policies sold by the agent or, in certain cases, commissions due to agents managing the agent to whom advances were made. We periodically assess the collectibility of the amounts outstanding for commission advances and record an estimated allowance for uncollectible amounts. This allowance for uncollectible advances is based upon review of the aging of outstanding balances and estimates of future commissions expected to be due to the agents to whom advances are outstanding and the agents responsible for their management.

Acquisition Costs. Certain policy acquisition costs, including lead expenses for sales of major medical policies, are capitalized and amortized over the estimated lives of the respective policies. The estimated weighted-average life for the policies sold ranges from 18 to 48 months, and is based upon our historical policyholder contract termination experience.

Advanced Agent Commissions. Our Insurance Marketing Division advances agent commissions for certain insurance programs. Collection of the commissions advanced (plus accrued interest) is accomplished by withholding amounts due to the agents for future commissions on the policy upon which the advance was made, commissions on other policies sold by the agent or, in certain cases, commissions due to agents managing the agent to whom advances were made. Advanced agent commissions are reviewed on a quarterly basis to determine if any advanced agent commissions will likely be uncollectible. An allowance is provided for the estimated advanced agent commission balance for which recovery is considered doubtful. This allowance for uncollectible advances requires judgment and is based upon review of the aging of outstanding balances and estimates of future commissions expected to be due to the agents to whom advances are outstanding and the agents responsible for their management. Any bad debt is written off when determined uncollectible.

Accounts Receivable. Accounts receivable generally represent commissions and fees due from insurance carriers and plan sponsors. Accounts receivable are reviewed on a monthly basis to determine if any receivables will be potentially uncollectible. An allowance is provided for any accounts receivable balance where recovery is considered to be doubtful. Any bad debt is written off when determined uncollectible.

Acquisitions. On January 30, 2007, we completed our merger with ICM. Under the terms of the merger, the shareholders of ICM received 6,756,382 shares of our common stock. The assets and liabilities acquired were initially valued, in the aggregate net amount of $10,540,000, based upon the market value of the common stock issued as the merger consideration in the acquisition. Judgment was required in the allocation of value to the acquired assets and liabilities, based upon their fair values, especially with regard to the allocation of $10,087,000 to goodwill and $3,700,000 to other intangible assets. These other intangible assets represent the estimated value, at the date of their acquisition, of policies in force (Customer Contracts) of $1,800,000 and certain agent relationships (Agent Relationships) of $1,900,000. These assets are being amortized on a straight-line basis over three years and eight years, respectively. Goodwill is deemed to have an infinite life and is subject to an annual, or more frequent, analysis for possible impairment (discussed below).

On October 1, 2007, we completed our acquisition of PME. PME offers, as a wholesaler, discount medical service products, provides back office support through its use of various operating systems, maintains a customer service facility, and develops products from both its proprietary networks of dental and vision providers contracted and third-party provider networks. The $1,098,000 purchase price of PME was cash consideration paid to PME s parent, Protective Life Corporation. Judgment was required in the allocation of value to the acquired assets and liabilities, based upon their fair values, especially with regard to the allocation of $1,073,000 to other intangible assets. The other intangible assets included memberships in force (Customer Contracts) having an estimated value of $482,000 and dental and vision provider network contracts (Network Contracts) having an estimated value of $591,000. These assets are being amortized on a straight-line basis over four years and eight years, respectively.

43

Table of Contents

The changes in the carrying amount of the Company s intangible assets for the years ended December 31, 2007, 2006 and 2005 are as follows:

Dollars in Thousands	Goodwill & Trademark	Customer Contracts	Agent Relationships	Total
Intangible assets, balance as of January 1, 2005	$ 21,381	$ 1,400	$	$ 22,781
Goodwill acquired in Foresight acquisition	4,591			4,591
Amortization of intangibles		(140)		(140)
Goodwill impairment charge	(12,900)			(12,900)
Intangible assets, balance as of December 31, 2005	13,072	1,260		14,332
Goodwill impairment charge	(6,440)			(6,440)
Tax impact on goodwill impairment charge	(426)			(426)
Reclassification of customer contract	1,260	(1,260)		
Acquisition of trademark	5			5
Intangible assets, balance as of December 31, 2006	7,471			7,471
Allocation of ICM goodwill	10,087			10,087
Allocation of ICM contracts and relationships assets		1,800	1,900	3,700
Allocation of PME contracts and relationships assets		482	591	1,073
Amortization of intangibles		(578)	(235)	(813)
Goodwill impairment charges	(12,069)			(12,069)
Intangible assets, balance as of December 31, 2007	$ 5,489	$ 1,704	$ 2,256	$ 9,449

At September 30, 2007, we performed our annual assessment of the carrying value of goodwill, as mentioned above. Previously, we had performed this assessment as of the end of our fiscal year (December 31). However, we determined that it was preferable to perform the annual assessment as of September 30 of this and subsequent years, to allow us to incorporate into that analysis, and give most timely effect to, the budgets and forecasts for the coming year that we develop during our fourth quarter budgeting process. Additionally, performing the assessment of goodwill for impairment as of September 30 of each year will reduce the burden on us and our professional advisors during the period immediately following our fiscal year-end, when we prepare our audited year-end financial statements and evaluation of our internal controls over financial reporting pursuant to Sarbanes-Oxley Section 404.

As the result of those annual (and in some cases, interim) assessments of goodwill impairment, we have recorded impairment charges as follows:

Dollars in Thousands	Capella	Foresight	ICM	Total
Goodwill originally recorded	$ 19,077	$ 7,764	$ 10,089	$ 36,930
Other goodwill adjustments		(32)		(32)
2005 impairment charges	(12,900)			(12,900)
2006 impairment charges	(2,800)	(3,640)		(6,440)
2007 impairment charges	(3,377)	(4,092)	(4,600)	(12,069)

Net goodwill balance at December 31, 2007	$	$	$ 5,489	$ 5,489

Impairment charges were recorded related to Capella s goodwill in 2005 due to the continuing declines in the number of members and related revenues to a lower level than previously predicted and pending litigation and regulatory activity that was announced in the second quarter of that year. Impairment charges were again recorded in 2006 and 2007 related to Capella s goodwill due to continuing decline in members and revenues and the failure of certain new product and marketing initiatives to achieve expected results. In 2007 and 2006, we recorded goodwill impairment charges for Foresight due to the loss of significant contracts. In 2007 we

recorded impairment charges for Insurance Marketing due to significant declines in sales of Medicare supplemental policies.

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 engaged an independent valuation consultant to assist management with our estimate of the fair values of Foresight and Capella using discounted cash flow projections and other valuation methodologies in evaluating and measuring a potential goodwill impairment charges. 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 the Audit Committee of our Board of Directors. These impairments are discussed in more detail in the Notes to Consolidated Financial Statements.

Stock Option Expense and Option-Pricing Model. Recognized compensation expense for stock options granted to employees includes: (a) compensation cost for all share-based payments previously granted, but not yet vested, based on the grant date fair value estimated in accordance with the original provisions of SFAS No. 123, *Accounting for Stock-Based Compensation*, and (b) compensation cost for all share-based payments currently granted based on the grant date fair value estimated in accordance with the provisions of SFAS No. 123(R), *Share-Based Payment*. The binomial lattice option-pricing model is used to estimate the option fair values. The option-pricing model requires a number of assumptions, of which the most significant are expected stock price volatility, the expected pre-vesting forfeiture rate and the risk-free interest rate. Expected volatility was calculated based upon actual historical stock price movements over the most recent period ended December 31, 2007 equal to the expected option term. Expected pre-vesting forfeitures were estimated based on actual historical pre-vesting forfeitures over the most recent period ended December 31, 2007 for the expected option term. The risk-free interest rate was based on the interest rate of zero-coupon United States Treasury securities over the expected option term.

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. As of December 31, 2007, we evaluated the probability of recognizing the benefit of deferred tax assets through the reduction of taxes otherwise payable in the future. We determined that a valuation allowance to fully offset deferred tax assets remained appropriate as of December 31, 2007.

On July 14, 2006, the FASB issued Interpretation No. 48 (FIN 48), *Accounting for Uncertainty in Income Taxes*, an Interpretation of SFAS No. 109, *Accounting for Income Taxes*. FIN 48 prescribes guidance to address inconsistencies among entities with the measurement and recognition in accounting for income tax positions for financial statement purposes. Specifically, FIN 48 addresses the timing of the recognition of income tax benefits. FIN 48 requires the financial statement recognition of an income tax benefit when the company determines that it is more-likely-than-not that the tax position will be ultimately sustained. We adopted the provisions of FIN 48 Accounting for Uncertainty in Income Taxes (FIN 48) on January 1, 2007 and it had no material effect on our financial statements. We have analyzed all filing positions in federal and state tax jurisdictions where we are required to file income tax returns. Our major tax jurisdictions include the federal jurisdiction and the state of Texas. Tax years open to examination include 2003 through 2006 for the federal return. A federal audit for 2004 has been completed with no change to our tax liability. The Texas audit of Capella for the years 2002 through 2005 has been concluded with no material change to our tax provision. We have elected to recognize penalties and interest related to tax liabilities as a component of income tax expense and income taxes payable.

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 their estimated useful lives or the lease term, whichever is shorter. Ordinary maintenance and

Table of Contents

repairs are charged to expense as incurred. Expenditures that extend the physical or economic life of property and equipment are capitalized.

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.

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

Summary Results of Operations

We incurred a net loss for 2007 of $13,155,000, compared to net losses of $7,724,000 in 2006 and $13,371,000 in 2005. These losses arose primarily from goodwill impairment charges of $12,069,000, $6,440,000 and $12,900,000 in 2007, 2006 and 2005, respectively. 2007 results were also adversely impacted by exceptionally high legal and litigation settlement costs of $1,120,000, amortization of intangible assets of $813,000 and charges taken on unsuccessful marketing initiatives of $696,000. Additionally, we recorded a net income tax benefit of $559,000 primarily as the result of reversal of liabilities previously thought to be owed on state income taxes for certain prior years.

During 2007, we completed two significant acquisitions, merging with Insurance Capital Management (ICM) in January in a stock transaction and acquiring Protective Marketing Inc. (PME) in October in a cash transaction. The merger with ICM created our Insurance Marketing Division, described below, that provides wholesale distribution of a broad range of health insurance products through national networks of independent agents. During the 11 months for which its results are included in our operations, the Insurance Marketing Division contributed revenues of $20,134,000 and a pre-tax loss of $4,371,000, net of a goodwill impairment charge of $4,600,000 and amortization of acquired intangible assets of $768,000. The acquisition of PME significantly increased the number of members that we serve with our consumer healthcare discount programs and provided us with a new customer service and administrative platform for those programs. During the three months for which its results are included in our operations, this acquired operation contributed revenues of $1,316,000 and pre-tax earnings of $95,000, net of amortization of acquired intangible assets of $46,000. Unfortunately, our existing Consumer Plan operations continued to suffer from attrition in membership, with corresponding declines in revenues and pre-tax earnings (exclusive of goodwill impairment charges). Also, our Regional Healthcare Division in El Paso continued to suffer the negative impact, in declining revenue and earnings, of the loss of certain significant contracts and the expenses resulting from a federal investigation of the El Paso operation and its former CEO. Additional membership and revenue reductions are anticipated to occur in that division during 2008. To date, expense reductions have been less than the corresponding revenue declines, in part due to the re-branding of the division as Foresight TPA and commencement of marketing campaigns, led by Michael Puestow, the division s new Chief Executive Officer hired during August 2007, targeting the generation of new sources of revenue for 2008. On a consolidated basis, we achieved revenue of $40,674,000, up $18,294,000 or 82% from 2006, and posted a net loss of $13,155,000 that included goodwill impairment charges of $12,069,000.

Table of Contents

Consumer Plan Division. The operating results for our Consumer Plan Division segment were as follows:

Dollars in Thousands	**For the Twelve Months Ended December 31,**						
	2007	**Dollar Change**	**Percent Change**	**2006**	**Dollar Change**	**Percent Change**	**2005**
Service revenues	$ 13,700	$ (783)	(5.4%)	$ 14,483	$ (6,677)	(31.6%)	$ 21,160
Interest income-other	104	(186)	(64.1%)	290	208	253.7%	82
Total revenues	13,804	(969)	(6.6%)	14,773	(6,469)	(30.5%)	21,242
Operating expenses:							
Commissions	3,606	(52)	(1.4%)	3,658	(2,190)	(37.4%)	5,848
Cost of operations	5,677	437	8.3%	5,240	(2,595)	(33.1%)	7,835
Sales and marketing	846	(271)	(24.3%)	1,117	489	77.9%	628
General and administrative	3,432	(639)	(15.7%)	4,071	(806)	(16.5%)	4,877
Depreciation and amortization	236	(415)	(63.7%)	651	(789)	(54.8%)	1,440
Interest expense	26	(24)	(48.0%)	50	3	6.4%	47
Goodwill impairment	3,377	577	20.6%	2,800	(10,100)	(78.3%)	12,900
Total expenses	17,200	(387)	(2.2%)	17,587	(15,988)	(47.6%)	33,575
Loss before taxes	$ (3,396)	$ (582)	20.7%	$ (2,814)	$ 9,519	(77.2%)	$ (12,333)
Percent of revenue:							
Total revenues	100.0%			100.0%			100.0%
Operating expenses:							
Commissions	26.1%			24.8%			27.5%
Cost of operations	41.1%			35.5%			36.9%
Sales and marketing	6.1%			7.6%			3.0%
General and administrative	24.9%			27.6%			23.0%
Depreciation and amortization	1.7%			4.4%			6.8%
Interest expense	0.2%			0.3%			0.2%
Goodwill impairment	24.5%			19.0%			60.7%
Total expenses	124.6%			119.2%			158.1%
Earnings (loss) before taxes	(24.6%)			(19.2%)			(58.1%)

Table of Contents

Capella-Selected Metrics

Dollars in Thousands (except monthly averages)	2007 4th Qtr	2007 3rd Qtr	2007 2nd Qtr	2007 1st Qtr	2007 Year	2006 Year	2005 Year
Members newly enrolled	4,811	6,771	7,483	6,461	25,526		
Members at end of period	25,680	27,902	28,965	30,649	25,680	31,826	37,952
Percent Change	(8.0%)	(3.7%)	(5.5%)	19.3%	(19.3%)	(16.1%)	(8.9%)
Service revenues	$ 2,940	$ 3,119	$ 3,221	$ 3,104	$ 12,384	$ 14,483	$ 21,160
Commissions paid	$ 721	$ 810	$ 822	$ 702	$ 3,055	$ 3,658	$ 5,848
Sales and Marketing	$ 147	$ 216	$ 276	$ 205	$ 844	$ 1,117	$ 628
Average monthly revenue per member, net of commissions, sales and marketing costs	$ 25.78	$ 24.54	$ 23.74	$ 26.00	$ 24.59	$ 23.19	$ 27.24

PME-Selected Metrics

Dollars in Thousands (except monthly averages)	2007 4th Qtr
Retail member count	14,057
Wholesale member count	49,019
Total PME member count	63,076
Revenues Retail	$ 1,175
Revenues Wholesale	$ 141
Average monthly revenue per Retail member	$ 27.86
Average monthly revenue per Wholesale member	$ 0.96

This division primarily markets, on a national basis, medical discount cards and other membership programs that provide healthcare related services and benefits. The division posted a loss before taxes of $3,396,000 for 2007 as compared to operating losses of $2,814,000 in 2006 and $12,333,000 in 2005. These losses arose primarily from goodwill impairment charges of $3,377,000, $2,800,000 and $12,900,000 in 2007, 2006 and 2005, respectively. 2007 results for this division were also adversely impacted by exceptionally high legal and litigation settlement costs of $583,000 and charges taken on unsuccessful marketing initiatives of $522,000. Excluding those items, our 2007 income before taxes was $1,086,000. Membership count for our Capella members (our legacy consumer plans) totaled 25,680 at December 31, 2007, down 19.3% from December 31, 2006, compared to a decline of 16.1% during 2006. Although this trend translated into lower quarterly and annual revenue as reflected above, relative to the respective prior year periods, the execution of various cost control initiatives resulted in the pre-tax earnings, exclusive of goodwill impairment charges, exceptionally high legal and litigation settlement and charges taken on unsuccessful marketing initiatives.

During the latter part of the year, the Consumer Plan Division refocused its efforts toward integrating and leveraging the PME operation, which we acquired effective October 1, 2007. PME membership count at December 31, 2007 consisted of 14,057 retail plan customers (with an average revenue per member per month of $27.86, slightly higher than the division s 25,680 Capella members) and an additional 49,019 wholesale customers (which have average revenue of less than $1.00 per member per month) who have purchased access to the PME proprietary dental and vision networks. Prior to our acquisition of PME, its former parent company had announced the winding down of its

operations and put its consumer plan resellers on notice that they would no longer support the consumer plans. Concurrent with our acquisition of PME, we rescinded that notice and have been actively engaging those resellers, and other potential resellers of PME s plans, in discussions regarding resumed and expanded marketing of those plans. Additionally, PME has a portfolio of proprietary products, discount card services and marketing expertise that we believe will complement and create cross-selling opportunities for our consumer medical discount products and managed care services. We

Table of Contents

also plan to reduce operating costs and enhance our consumer plan customer service and other administrative capabilities by vertically integrating PME s product development and administrative functions into our existing operations.

While the Capella membership count totaled 25,680 at December 31, 2007, down 19.3% from December 31, 2006 (compared to a decline of 16.1% during 2006), the majority of that decline in member count came from memberships sold through our network marketing sales channel, where the decline in membership was 28.8% for 2007 and 31.0% for 2006. Currently, the majority of our new member enrollments come from private label resellers, rather than network marketing independent marketing representatives. While member counts have also declined in that channel, they declined only by 22.8% during 2007 and increased by 11.0% during 2006. However, our margins are substantially less on memberships sold through that channel as compared to memberships sold through network marketing. In spite of the decline, from 2006 to 2007, in revenue attributable to memberships sold through network marketing, commissions expense, which relates almost entirely to that channel, only declined by 1.4%. Commencing with the merger with ICM in January 2007, revenues of $2,044,000, and associated costs for their consumer healthcare discount products were included in our 2007 results. Those products accounted for 2,229 of the members reflected above as of December 31, 2007. The average revenue on those products is substantially higher than our other consumer plans, but so are their costs, resulting in very limited margins. This reduced the decline in division revenues that otherwise would have occurred during 2007, but contributed to an increase in the cost of operations as well as the increase in commission expense as a percentage of revenue. Additionally, costs incurred for new product development efforts and conversions to new administrative platforms contributed to the increase in the cost of operations. Therefore, costs of operations in this division increased by 8.3% from 2006 to 2007 compared to a 33.1% decrease in those expenses from 2005 to 2006.

Sales and marketing expenses decreased 24.3% from 2006 to 2007, compared to a 77.7% increase from 2005 to 2006, primarily due to elimination of marketing consultants and contractors formerly used, prior to the ICM merger.

General and administrative expenses continued to decline, by 15.7% from 2006 to 2007 and by 16.5% from 2005 to 2006. This resulted primarily from cost containment measures, responding to declining revenues.

Depreciation and amortization expense declined by 63.7% from 2006 to 2007 and by 54.8% from 2005 to 2006 primarily due to outsourcing of certain administrative and customer support functions at the end of 2006.

Table of Contents

Insurance Marketing Division. The operating results for our Insurance Marketing Division segment were as follows:

Dollars in Thousands		**Eleven months ended December 31, 2007**
Service revenues	$	19,583
Interest income on advances		551
Interest income-other		
Total revenues		20,134
Operating expenses:		
Commissions		14,412
Cost of operations		512
Sales and marketing		2,936
General and administrative		1,048
Depreciation and amortization		789
Interest expense		208
Goodwill impairment		4,600
Total expenses		24,505
Earnings (loss) before taxes	$	(4,371)
Percent of revenue:		
Total revenues		100.0%
Operating expenses:		
Commissions		71.6%
Cost of operations		2.5%
Sales and marketing		14.6%
General and administrative		5.2%
Depreciation and amortization		3.9%
Interest expense		1.0%
Goodwill impairment		22.8%
Total expenses		121.7%
Earnings (loss) before taxes		(21.7%)

Table of Contents

Insurance Marketing-Summary of Selected Metrics

Dollars in Thousands	2007				
	4th Qtr	3rd Qtr	2nd Qtr	1st Qtr (1)	Year (2)
Major Medical Submitted annualized premiums	$ 17,094	$ 15,993	$ 14,143	$ 16,923	$ 64,153
Major Medical Issued annualized premiums	$ 13,120	$ 12,269	$ 10,314	$ 10,524	$ 46,227
Medicare Issued Annualized premiums	$ 1,215	$ 914	$ 666	$ 1,127	$ 3,922
New issued policies Major Medical and Medicare	4,443	4,506	3,625	4,754	17,328
Policies in-force at end of period:					
Major Medical AHCP	16,449	15,317	14,353	13,665	16,449
Medicare Supplement ACP	12,873	13,305	13,549	14,107	12,873
Total Insurance Marketing Policies in-force (1)	29,322	28,622	27,902	27,772	29,322
Percent change	2.4%	2.6%	0.5%	n/a	n/a
Commission revenues	$ 5,456	$ 5,520	$ 5,275	$ 3,332	$ 19,583
Commission expense	$ 4,113	$ 4,091	$ 3,697	$ 2,511	$ 14,412
Sales & Marketing	$ 648	$ 751	$ 914	$ 623	$ 2,936
Revenue, net of commission expense	$ 1,343	$ 1,429	$ 1,578	$ 821	$ 5,171
Average monthly revenue per policy, net of commission expense	$ 14.21	$ 15.52	$ 17.53	$ 13.68	

(1) 2 months activity
(2) 11 months ended December 31, 2007, except for premiums and policies issued

Operating results for the Insurance Marketing Division are included only for the 11 months ended December 31, 2007 forward, after the completion on January 30, 2007 of the acquisition of ICM. However, ICM s 2006 results prior to acquisition are discussed below for comparative purposes.

The revenue of our Insurance Marketing Division is primarily from sales commissions paid by the insurance companies it represents; these sales commissions are generally a percentage of premium revenue. Substantially all of our revenues in the Insurance Marketing Division are derived from commissions on premiums paid by policyholders for major medical or Medicare supplemental health insurance policies. Our processing and recording of commission revenues earned and commission expenses payable to agents are key determinants of material revenues and expenses reported in our financial statements. This processing and recording of commission revenue and expense, together with the accurate and timely disbursement of commission payments to agents, is dependent upon our timely receipt of complete and accurate information about such commissions from the insurance carriers whose policies we sell. Our failure to receive this commission information in a timely, complete and accurate fashion could adversely impact our ability to pay commissions in a timely and accurate manner or to state revenues or expenses in our financial statements in a materially correct manner.

During the 11 months since our merger with ICM, the Insurance Marketing Division has experienced growth in the sale of major medical insurance policies (approximately 26.0% over the 11 months), but a decline in the sale of Medicare supplemental policies (approximately 20.0% over that same period). The growth in major medical policy sales arose from our continuing recruitment of agents as well as the development of additional products, some with

new carriers such as Guarantee Trust Life and Golden Rule Insurance Company. As the table above reflects, although there are seasonal fluctuations in the trend, the volume of new policies sold has trended upward over the last three years. This is reflected in the increases in New issued policies and the growth in the number of Policies in-force at the end of the successive periods. A leading indicator of policies issued, and therefore, policies in force and commission revenue, is the annualized premium for applications submitted on new policies for each period. Growth in the annualized premium for applications submitted typically foreshadows growth in the annualized premium of policies issued and, therefore, growth in the number, premiums and commissions to us on policies in force. Since policies, once issued, tend to stay in-force for a period of up to 18 to 48 months, policy issuance in excess of

Table of Contents

policy lapses grows the number of policies in force. If all other things (including commission rate and average premium) are equal, this tends to have a positive effect on future commission revenue (and expense) for several subsequent quarters.

Unfortunately, developments in the Medicare Supplemental Insurance or MediGap markets have led to declining revenues and earnings in that part of our business. There are 12 standardized Medicare Supplemental insurance plans A through L also called Medigap plans. Each plan has different benefits. Within each standardized Medicare Supplemental insurance plan, benefits are identical from one carrier to the next. Therefore, competition in this market has focused on premium cost to the insured, resulting in thinner margins and lower compensation to selling agents and intermediaries. While we still have nearly 14,000 of these policies in force, issuance of new policies has rapidly declined during 2007. As a result, commission revenue for these products has declined throughout 2007. Accordingly, we have decided to not emphasize this part of our business, while continuing to service in-force policies. In the third quarter of 2007, in conjunction with our annual assessment of possible impairment of goodwill and other intangible assets, we determined that these deteriorating sales prospects for Medicare Supplemental policies indicated a decline in the future earnings projections for ACP, our subsidiary within which that business operates. Accordingly, we recorded an impairment expense of $4,600,000 within our Insurance Marketing Division.

As discussed in Item 1. Business, above, we serve as an intermediary between the health insurance carriers (several of whom we represent) and the agents who ultimately sell the carriers policies. We provide the agents with access to multiple carriers, web-based technology, leads for new prospective customers, advances of up to 12 months of future commissions and home office support. The revenue of our Insurance Marketing Division is primarily from sales commissions due from the insurance companies we represent. These sales commissions are generally a percentage of the commissionable insurance premium and other related amounts charged and collected by the insurance companies. Commission income and policy fees, other than enrollment fees, and corresponding commission expense payable to agents, are generally recognized at their gross amount, as earned on a monthly basis, until such time as the underlying policyholder contract is terminated. Advanced commissions received are recorded as unearned commission revenue and are recognized in income as earned. Initial enrollment fees are deferred and amortized over the estimated lives of the respective policies. The estimated weighted average life for the policies sold ranges from 18 to 48 months, and is based upon our historical policyholder contract termination experience.

As reflected in the table appearing under Item 1. Business Distribution Channels and Operating Divisions, above, we represent over eight health insurance carriers. The gross and net amounts of commissions that we receive on premiums for policies vary significantly among those carriers. Therefore, the net commission revenue, or margin, that we receive will also vary between carriers and their products. Additionally, some of those carriers directly advance commissions to our agents on our behalf. As a result, the cost and capital requirements for our commission advancing activities can vary significantly between the various insurance products sold.

As of December 31, 2007, our agents were obligated to us and the carriers in the aggregate amount of $5,332,000 (net of the allowance discussed below) for future commissions that had been advanced to them. In turn, as of December 31, 2007 we were obligated to the carriers in the aggregate amount of $4,221,000 for future commissions that had been advanced to us and our agents by the carriers. Additionally, as of December 31, 2007, we were obligated to lenders in the aggregate amount of $1,255,000 for amounts borrowed, primarily to finance the advances to agents that were not in turn advanced to us or the agents by the carriers. Collection of the commissions advanced may be accomplished by withholding amounts due to the agents, plus accumulated interest, from future commissions on the policy upon which the advance was made, commissions on other policies sold by the agent or, in certain cases, commissions due to agents managing the agent to whom advances were made. Advanced agent commissions are reviewed periodically to determine if any advanced agent commissions will likely be uncollectible. An allowance is provided for any advanced agent commission balance where recovery is considered doubtful. The aggregate amount of those allowances as of December 31, 2007 was $400,000. During the eleven months ended December 31, 2007, we

provided $308,000 of that allowance through a charge to operations. This allowance for uncollectible advances required judgment and is based upon review of the aging of outstanding balances and estimates of future commissions

Table of Contents

expected to be due to the agents to whom advances are outstanding and the agents responsible for their management. Any bad debt is written off when determined uncollectible.

Costs of operations consist primarily of charges from a third party service organization for administration of our insured products. These costs approximate 9% of net commission revenue. Sales and marketing expenses consist primarily of personnel costs for support of our agents, as well as costs for agent recruitment, advertising, promotion and conventions. During 2007, these expenses declined from 76% of net revenue in the first quarter to 48% of net commission revenue in the fourth quarter due to the elimination of certain new product and channel development initiatives.

Regional Healthcare Division. The operating results for our Regional Healthcare Division segment were as follows:

Dollars in Thousands	**For the Twelve Months Ended December 31,**						
	2007	**Dollar Change**	**Percent Change**	**2006**	**Dollar Change**	**Percent Change**	**2005**
Service revenues	$ 6,603	$ (806)	(10.9%)	$ 7,409	(1,128)	(13.2%)	$ 8,537
Interest income-other	97	(18)	(15.7%)	115	(21)	(15.4%)	136
Total revenues	6,700	(824)	(11.0%)	7,524	(1,149)	(13.2%)	8,673
Operating expenses:							
Cost of operations	4,213	(720)	(14.6%)	4,933	(337)	(6.4%)	5,270
Sales and marketing	485	(174)	(26.4%)	659	(103)	(13.5%)	762
General and administrative	1,372	964	236.3%	408	(294)	(41.9%)	702
Depreciation and amortization	103	(2)	(1.9%)	105	47	81.0%	58
Interest expense					(26)	(100.0%)	26
Goodwill impairment	4,092	452	12.4%	3,640	3,640		
Total expenses	10,265	520	5.3%	9,745	2,927	42.9%	6,818
Earnings (loss) before taxes	$ (3,565)	$ (1,344)	60.5%	$ (2,221)	$ (4,076)	(219.7%)	$ 1,855
Percent of revenue:							
Total revenues	100.0%			100.0%			100.0%
Operating expenses:							
Cost of operations	62.9%			65.6%			60.8%
Sales and marketing	7.2%			8.8%			8.8%
General and administrative	20.5%			5.4%			8.1%
Depreciation and amortization	1.5%			1.4%			0.7%
Interest expense	0.0%			0.0%			0.3%
Goodwill impairment	61.1%			48.4%			0.0%
Total ex penses	153.2%			129.6%			78.7%

Earnings (loss) before taxes	(53.2%)	(29.6%)	21.3%

Regional Healthcare-Summary of Selected Metrics

Dollars in Thousands	**2007**					**2006**	**2005**
	4th Qtr	**3rd Qtr**	**2nd Qtr**	**1st Qtr**	**Year**	**Year**	**Year**
Covered employees	25,612	28,215	29,666	31,005	25,612	31,277	30,295
Percent Change	(9.2%)	(4.9%)	(4.3%)	(1.1%)	(18.1%)	3.2%	
Service revenues	$ 1,593	$ 1,594	$ 1,680	$ 1,736	$ 6,603	$ 7,409	$ 8,537
Average monthly revenue per member	$ 19.73	$ 18.36	$ 18.46	$ 18.66	$ 21.48	$ 20.06	

Table of Contents

Service Revenues. The primary element of our Regional Healthcare Division segment is Foresight that we acquired in June 2004, through which we offer full third-party administration services. Through Foresight, 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. Foresight helps us offer a more complete suite of healthcare service products. Also through Foresight, we provide individuals and employee groups access to preferred provider networks, medical escrow accounts and full third-party administration capabilities to adjudicate and pay medical claims.

Member count at December 31, 2007 totaled 25,612, an 18.1% decline from a year ago, resulting in a 10.9% decrease in revenue to $6,603,000 for 2007 compared to $7,409,000 in 2006 (and $8,537,000 in 2005). Those declines resulted from the loss of three major customers, two in the latter part of 2005 and another in June of 2006. Primarily as a result of the previously disclosed notice of termination of two additional major contracts during 2007, additional membership and revenue reductions are anticipated to occur during 2008. To date, expense reductions have been less than the corresponding revenue declines, primarily due to exceptionally high legal costs relating to the previously disclosed federal investigation of the El Paso operation and its former CEO. Those legal costs resulted in an increase from 2006 to 2007 of $511,000 in legal fees reflected in general and administrative expenses. As a consequence, earnings before taxes and excluding the effect of goodwill impairment charges has decreased from $1,855,000 in 2005 to $1,419,000 in 2006 and $527,000 in 2007, decreases year-to-year of 24% and 63%, respectively. Furthermore, in the second quarter of 2007, upon the loss of the third major customer in June 2007 discussed above, we conducted an assessment of possible impairment of goodwill in this division. We determined that the deteriorating revenue prospects resulting from the loss of these major contracts indicated a decline in the future earnings projections for our Regional Healthcare Division. Accordingly, we recorded an impairment charge of $4,092,000. This follows a similar impairment charge of $3,640,000 in 2006, following the loss of two major contracts that year.

Corporate and Other. The operating costs for our corporate and other activities were as follows:

Dollars in Thousands	**For the Twelve Months Ended December 31,**						
	2007	**Dollar Change**	**Percent Change**	**2006**	**Dollar Change**	**Percent Change**	**2005**
Service revenues	$ 36	$ (46)	(56.1%)	$ 82			