The Affiliated Physicians & Employers Master Trust

Statutory Financial Statements

December 31, 2016 and 2015

With Independent Auditors' Report

withum
AUDIT TAX ADVISORY

The Affiliated Physicians & Employers Master Trust
December 31, 2016 and 2015

TABLE OF CONTENTS

withum
AUDIT TAX ADVISORY

INDEPENDENT AUDITORS' REPORT

To the Board of Trustees,
The Affiliated Physicians & Employers Master Trust:

We have audited the accompanying statutory financial statements of The Affiliated Physicians & Employers Master Trust, which compromise the statements of admitted assets, liabilities and surplus - statutory basis as of December 31, 2016 and 2015, and the statements of revenue and expenses - statutory basis, capital and surplus - statutory basis, and cash flows - statutory basis for the years then ended, and the related notes to statutory financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Statements of Statutory Accounting Principles as promulgated by the National Association of Insurance Commissioners subject to conflicting practices prescribed or permitted by the State of New Jersey Department of Banking and Insurance ("NJDOBI"). Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these statutory financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the statutory financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the statutory financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the statutory financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the statutory financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the statutory financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the statutory financial statements referred to above present fairly, in all material respects, the statements of admitted assets, liabilities and surplus - statutory basis as of December 31, 2016 and 2015, and the statements of revenue and expenses - statutory basis, capital and surplus - statutory basis, and cash flows - statutory basis for the years then ended in accordance with Statements of Statutory Accounting Principles as promulgated by the National Association of Insurance Commissioners subject to conflicting practices prescribed or permitted by NJDOBI described in Note 2.

Basis of Accounting

We draw attention to Note 2 of the statutory financial statements, which describes the basis of accounting. As described in Note 2 to the statutory financial statements, the financial statements are prepared by The Affiliated Physicians & Employers Master Trust in accordance with Statements of Statutory Accounting Principles as promulgated by the National Association of Insurance Commissioners subject to conflicting practices prescribed or permitted by NJDOBI, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to meet the requirements of NJDOBI. Our opinion is not modified with respect to this matter.

Withum Smith + Brown, PC

May 15, 2017

The Affiliated Physicians & Employers Master Trust
Statements of Admitted Assets, Liabilities and Surplus - Statutory Basis
December 31, 2016 and 2015

	2016	2015
Admitted Assets		
Cash and cash equivalents	$ 28,755,222	$ 23,539,820
Statutory deposit - cash account	201,214	200,869
Total cash, cash equivalents and short-term investments	28,956,436	23,740,689
Subscriber receivables	2,020,373	1,070,058
Investment in captive	700,000	700,000
Reinsurance receivables	2,230,877	4,609,054
Other receivables	1,479,051	426,545
	$ 35,386,737	$ 30,546,346
Liabilities and Surplus		
Liabilities		
Accounts payable and accrued expenses	$ 1,007,804	$ 1,836,168
Medical claims reserve	15,380,578	12,027,013
Deferred health care fees	4,278,011	2,253,833
Total liabilities	20,666,393	16,117,014
Surplus		
Unassigned surplus	14,720,344	13,206,936
Special surplus	--	1,222,396
Total surplus	14,720,344	14,429,332
	$ 35,386,737	$ 30,546,346

The Notes to Statutory Financial Statements are an integral part of these statements.

The Affiliated Physicians & Employers Master Trust
Statements of Revenue and Expenses - Statutory Basis
Years Ended December 31, 2016 and 2015

	2016	2015
Revenues		
Health care fees, net of reinsurance	$ 127,118,977	$ 111,691,965
Expenses		
Medical claims benefits	83,024,381	67,013,335
Prescription benefits	22,261,273	20,713,434
Professional fees	1,023,796	606,353
Administrative fees	10,770,786	9,111,420
Broker commissions	6,664,974	5,717,347
Affordable Care Act assessment fees	2,020,052	763,694
Miscellaneous expenses	1,393,257	471,639
	127,158,519	104,397,222
Underwriting (loss) gain	(39,542)	7,294,743
Other income		
Investment income	23,324	11,491
Net (loss) income	$ (16,218)	$ 7,306,234

The Notes to Statutory Financial Statements are an integral part of these statements.

The Affiliated Physicians & Employers Master Trust
Statements of Capital and Surplus - Statutory Basis
Years Ended December 31, 2016 and 2015

	Unassigned Surplus	Special Surplus	Total
Balance at December 31, 2014	$ 5,928,902	$ 1,007,795	$ 6,936,697
Net income	7,306,234	--	7,306,234
Change in non-admitted assets	186,401	--	186,401
Reversal of Section 9010 Affordable Care Act Assessment - 2015	1,007,795	(1,007,795)	--
Section 9010 Affordable Care Act Assessment - 2016	(1,222,396)	1,222,396	--
Balance at December 31, 2015	13,206,936	1,222,396	14,429,332
Net loss	(16,218)	--	(16,218)
Change in non-admitted assets	307,230	--	307,230
Reversal of Section 9010 Affordable Care Act Assessment - 2016	1,222,396	(1,222,396)	--
Balance at December 31, 2016	$ 14,720,344	$ --	$ 14,720,344

The Notes to Statutory Financial Statements are an integral part of these statements.

The Affiliated Physicians & Employers Master Trust
Statements of Cash Flows - Statutory Basis
Years Ended December 31, 2016 and 2015

	2016	2015
Cash flows from operating activities		
Health care fees collected, net of reinsurance	$ 128,192,839	$ 115,253,679
Net investment income	23,324	11,491
Claims payments	(100,364,090)	(85,914,881)
Expenses and other deductions	(22,636,326)	(18,016,135)
Net cash provided by operating activities	5,215,747	11,334,154
Cash and cash equivalents		
Beginning of year	23,740,689	12,406,535
End of year	$ 28,956,436	$ 23,740,689

The Notes to Statutory Financial Statements are an integral part of these statements.

1. DESCRIPTION OF PLAN

The following brief description of The Affiliated Physicians & Employers Master Trust (the "Plan") is provided for information purposes only. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

General

The Plan was adopted and became effective January 1, 2004. The Plan is a multiple employer welfare arrangement ("MEWA"), qualifying under relevant sections of the Internal Revenue Code, whereby multiple employers join together to self-insure the welfare benefits of their employees. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended.

Under New Jersey statute, each participating employer may be, but is not required to be, a member of an association, having a minimum of 100 or more persons, organized and maintained in good faith for purposes other than that of obtaining insurance. The association must have been in active existence for more than one year and have a constitution or bylaws that provide that the association holds regular meetings (not less than annually) to further the purposes of the members, to collect dues or solicit contributions from members and the members have voting privileges and representation on the governing board and committees. At least one or more of the employer's members must be domiciled in New Jersey or have its principal headquarters or administrative offices located in New Jersey.

Benefits

The Plan is designed to provide medical, dental and prescription drug benefits to covered employees (subscribers) of participating employers of The Affiliated Physicians Multiple Employer Trust ("the Plan"). Any employee of a covered employer is eligible to participate in the Plan on the first day of the month following 30 days of employment, provided that the employee works a minimum of 24 hours per week. In addition, the employee may elect to cover qualified dependents under the Plan's provisions.

The Plan will pay benefits only for the expenses incurred while coverage is in full force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if expenses were incurred as a result of an accident, injury or disease that occurred, began or existed while coverage was in force. In the event that the Plan is unable to pay its obligations, enrolled participants of the Plan shall be required to contribute, on a pro rata earned contribution basis, the funds necessary to meet any unfilled obligations.

Contributions

Contributions, in the form of health care and dental fees, are made by the employer on a monthly basis. Health care and dental fee amounts are determined annually by the Plan's actuary and are calculated based upon four elected coverages: employee only, employee plus spouse, employee plus children or family. The participating employers determine individual eligibility and the amount, if any, that employees are responsible for making to the employer for coverage under the Plan. Subscriber receivables are amounts due to the Plan from employers for benefits provided to covered employees under the Plan.

Eligibility

The eligibility of employers and employees shall be determined in accordance with the provisions of each individual group trust agreement and the Plan.

2. SUMMARY OF ACCOUNTING POLICIES

Basis of Accounting

The accompanying statutory financial statements of the Plan have been prepared in accordance with Statements of Statutory Accounting Principles as promulgated by the National Association of Insurance Commissioners ("NAIC") subject to conflicting practices prescribed or permitted by the State of New Jersey Department of Banking and Insurance ("NJDOBI"). There are no material differences in the accounting practices followed by the Plan from those designated by the NAIC. However, the practices designated by the NAIC, vary in certain respects from accounting principles generally accepted in the United States of America ("GAAP").

The significant differences from GAAP include the following: a) certain assets are designated as "non-admitted" assets; b) errors from prior years, if applicable, are corrected in the current year financial statements as an adjustment to surplus in the aggregate write-ins for gains and losses in surplus; c) loss reserves are reported net of reinsurance ceded; d) policy acquisition costs are expensed in the year incurred and not amortized over the life of the policy; and e) the assessment entities that issue health insurance under the Affordable Care Act (see section *9010 Affordable Care Act Assessment* to follow). New Jersey Statute 17B:27C-6 authorized the NJDOBI to establish regulations governing the management and reporting of a MEWA which became effective in 2004.

The Plan had filed its registration with the NJDOBI and became registered in 2006.

Estimates
The preparation of financial statements in conformity with the statutory basis of accounting requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. The primary estimate made by management includes the establishment of claims reserves. Actual results could differ from those estimates.

Health Care Fees and Deferred Health Care Fees
Health care fees are recorded as revenue when earned. Deferred health care fees are recognized for amounts paid in advance by individual employers for covered benefits, prior to the effective date of the policy or for which services have not yet been provided. The Plan has a policy to evaluate whether or not to refund health care fees if the surplus is at least 30 percent above its company action level risk based capital. There were no health care fee refunds for the years ended December 31, 2016 and 2015.

Cash and Cash Equivalents
For purposes of the statements of cash flows - statutory basis, the Plan considers short-term investments with an initial maturity at time of acquisition of one year or less to be cash equivalents.

Concentration of Credit Risk
The Plan maintains cash balances at one financial institution in excess of amounts insured by the Federal Deposit Insurance Corporation. Management monitors the soundness of this institution in an effort to minimize collection risk.

Reserve for Incurred But Not Reported Claims
Claims are recorded on the accrual basis of accounting, including a reserve for incurred but not reported claims ("IBNR"). The IBNR is estimated by the Plan's actuarial consultant in accordance with accepted actuarial principles using prior claims experience, current enrollment, health service costs, health service utilization statistics and other related information. Such estimate is reported in the accompanying statements of admitted assets, liabilities and surplus - statutory basis at present value.

Non-Admitted Assets
Non-admitted assets consisted of the following at December 31:

	2016	2015
Uncollected subscriber receivables	$ 268,595	$ 575,825

Section 9010 Affordable Care Act Assessment
The Affordable Care Act (the "ACA") imposes an assessment on entities that issue health insurance for each calendar year beginning on or after January 1, 2014. Pursuant to Section 9010 of the ACA, a reporting entity's portion of the assessment is paid no later than September 30 of the applicable calendar year (the "fee year") beginning in 2014. The amount of the assessment for the reporting entity is based on the ratio of the amount of an entity's subject net health premiums written for any United States health risk during the preceding calendar year (the "data year") to the aggregate amount of subject net health premiums written by all subject United States health insurance providers during the preceding calendar year. A reporting entity's portion of the annual assessment becomes payable to the United States Treasury once the reporting entity provides health insurance (in the fee year) for any subject United States health risk for each calendar year beginning on or after January 1, 2014.

In accordance with Statement of Statutory Accounting Principles ("SSAP") No. 106, *Affordable Care Act Section 9010 Assessment*, the liability related to the assessment is to be estimated and recorded in full once the entity provides qualifying health insurance (typically January 1) in the applicable calendar year in which the assessment is paid (fee year) with a corresponding recording of administrative expense.

Liability recognition of the fee is not required in the data year. In the data year, the reporting entity is required to reclassify from unassigned surplus to special surplus an amount equal to its estimated subsequent fee year assessment. On January 1 of the fee year, the prior year segregation in special surplus is reversed and the full current fee year assessment liability is accrued.

3. REINSURANCE PROVISIONS

The Plan entered into an insurance agreement for aggregate excess loss and individual excess loss which covers medical benefits. Under the terms of the policy with Everest Reinsurance Company for the year ended December 31, 2016, the Plan has an aggregate deductible of the greater of $106,587,295 or 85 percent of the first Monthly Aggregate Deductible amount times twelve, and a per member deductible of $200,000. The Plan will receive reimbursement for all claims, in any fiscal year, over the deductible, with a maximum annual benefit under the Plan of $5,000,000, after reaching an aggregating specific deductible of $1,200,000. Under the terms of the policy with American Alternative Insurance Corporation, for the year ended December 31, 2015, the Plan has an aggregate deductible of the greater of $106,616,560 or 100 percent of the first Monthly Aggregate Deductible amount times twelve, and a per member deductible of $200,000. The Plan will receive reimbursement for all claims, in any fiscal year, over the deductible, with a maximum annual benefit under the Plan of $5,000,000 after reaching an aggregating specific deductible of $1,000,000.

For the years ending December 31, 2016 and 2015, total premiums paid for stop-loss coverage amounted to $6,418,895 and $4,922,459, respectively. Net recoveries under the stop-loss policy, which are included as a reduction in claim payments amounted to $3,573,086 and $6,360,688 for the years ending December 31, 2016 and 2015, respectively.

4. MEDICAL CLAIMS RESERVE

Medical claims benefits reflect actual claims expenses for services provided to enrollees and provisions for incurred but not reported claims. The Plan's management and actuary estimate the amount of the provision for incurred but not reported claims using actuarial methodologies based upon historical costs and utilization, payment trends with respect to timing and a statistical analysis of claims development patterns. The estimates for incurred but not reported claims are made on an accrual basis and adjusted in future periods as required. While the ultimate settlement of these claims expenses may differ from the estimated medical claims reserve, management believes that the reserve is adequate to satisfy its ultimate claim liability.

This liability is subject to the impact of future changes in claim severity, frequency and other factors which may be outside of the Plan's control. Despite the variability inherent in such estimates, management believes that the liability for unpaid claims is adequate and includes a buffer for adverse claim developments. However, the Plan's actual future experience may not conform to the assumptions inherent in the determination of this liability. Accordingly, the ultimate settlement of these claims expenses may vary significantly from the amounts included in the accompanying statutory financial statements.

The breakdown of the reserve components are as follows:

	2016	2015
Medical	$ 13,936,287	$ 11,262,104
Pharmacy	1,358,259	711,909
Dental	86,032	53,000
	$ 15,380,578	$ 12,027,013

Claims payable represents the benefit obligations of the Plan as follows:

Claims incurred but not reported	$ 15,380,578	$ 12,027,013

Changes in benefit obligations consisted of the following:

Claims payable as of January 1, 2015	$ 9,384,715
Change in reserve	2,642,298
Claims payable as of December 31, 2015	12,027,013
Change in reserve	3,353,565
Claims payable as of December 31, 2016	$ 15,380,578

Claims incurred during the year consisted of the following:

	2016	2015
Claims paid, net of stop loss recoveries	$ 101,932,089	$ 85,084,471
Change in claims payable	3,353,565	2,642,298
	$ 105,285,654	$ 87,726,769

5. INCOME TAXES

The Plan is a qualified trust under the Internal Revenue Code (the "Code"). In accordance with the Code, the Plan is only subject to income tax on investment income earned. The Plan has no significant items which would result in a deferred tax asset or liability.

The Plan follows the accounting pronouncement dealing with uncertain tax positions. The Plan had no unrecognized tax benefits at December 31, 2016 and 2015. The Plan had no income tax related penalties or interest in these financial statements.

6. STATUTORY DEPOSIT AND LOSS RESERVE

The Plan is required under New Jersey statute to deposit and continuously maintain with a financial institution licensed in the State, cash or securities having an admitted asset value of not less than $200,000. The deposit is for the benefit and protection of all covered members of the Plan. Furthermore, the Plan is required to maintain a cash reserve for unpaid losses in an amount established by a qualified actuary as being adequate to provide for all incurred losses including unpaid claims. For each of the years December 31, 2016 and 2015, the Plan has satisfied these requirements.

7. RELATED PARTIES

The Plan has entered into an Administrative Services Agreement with QualCare Alliance Networks, Inc. ("QANI"), a trustee of the Plan, whereby QANI, through its subsidiaries, provides certain management services and third party administrative functions on behalf of the Plan. Fees for these services aggregated $10,478,213 and $8,914,593 during the years ended December 31, 2016 and 2015, respectively, and are included in administrative fees on the statements of revenue and expenses - statutory basis.

8. PLAN TERMINATION

Should the Plan terminate at some future time, the net assets of the Plan will be allocated based upon Plan provisions.

9. INVESTMENT IN CAPTIVE

Qualcare Captive Insurance Company ("QCIC") and APEMT Cell Captive ("APEMT") entered into a participation agreement related to the reinsurance coverage of the Plan. APEMT receives a return for any favorable loss experience of the program through participating in the profit and is responsible for any loss in the separate account held by QCIC. The investment in captive balance as of each of the years December 31, 2016 and 2015 amounted to $700,000. The net loss of APEMT for the year ending December 31, 2015 was $350,279 and is included in health care fees, net of reinsurance and accounts payable and accrued expenses in the accompanying statutory financial statements. The captive was terminated effective December 31, 2015. Accordingly, there was no net income or loss recorded for the year ending December 31, 2016. The Plan is awaiting instruction from the State of New Jersey on the necessary filing requirements to officially terminate the captive and withdraw its $700,000 investment.

10. SECTION 9010 AFFORDABLE CARE ACT ASSESSMENT

The Consolidated Appropriations Act of 2016, Title II § 201, Moratorium on Annual Fee on Health Insurance Providers, suspends collection of the health insurance provider fee for the 2017 calendar year. Thus no reclassification of unassigned surplus to special surplus is reflected for the year ended December 31, 2016.

11. SUBSEQUENT EVENTS

The Plan has evaluated all subsequent events through May 15, 2017, the date the statutory financial statements were available to be issued. Based on this evaluation, the Plan has no subsequent events which require disclosure in, or adjustment to, the statutory financial statements.