

# Arizona Physicians IPA, Inc.

Financial Statements as of and for the Years  
Ended December 31, 2013 and 2012,  
Supplemental Schedules as of and for the Year  
Ended December 31, 2013, and  
Independent Auditors' Report



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## INDEPENDENT AUDITORS' REPORT

To the Audit Committee of  
Arizona Physicians IPA, Inc.  
3141 North 3rd Avenue  
Phoenix, AZ 85013

We have audited the accompanying financial statements of Arizona Physicians IPA, Inc. (the "Company"), which comprise the balance sheets as of December 31, 2013 and 2012, and the related statement of operations, comprehensive income, changes in stockholder's equity and accumulated other comprehensive income, and cash flows for the years then ended, and the related notes to the 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 accounting principles generally accepted in the United States of America; this includes 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 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 audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the 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 Company'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 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 financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2013 and 2012, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

## Report on Supplemental Schedules

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information in Exhibit I, although not a part of the basic financial statements, is required by the Arizona Health Care Cost Containment System who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

*Deloitte & Touche LLP*

April 29, 2014

## ARIZONA PHYSICIANS IPA, INC.

### BALANCE SHEETS

AS OF DECEMBER 31, 2013 AND 2012

(In thousands, except share and per share data)

	2013	2012
<b>ASSETS</b>		
CURRENT ASSETS:		
Cash and cash equivalents	\$ 72,752	\$ 25,580
Short-term investments	8,152	10,624
Receivables from contract programs	65,268	55,529
Investment receivables	1,464	1,513
Other receivables — net of allowances of \$432 and \$2,577 in 2013 and 2012, respectively	1,652	2,261
Related-party receivable — net	513	3,999
Current income taxes receivable	-	394
Current deferred taxes — net	642	1,749
Total current assets	150,443	101,649
LONG-TERM INVESTMENTS	173,054	171,134
TOTAL	<u>\$ 323,497</u>	<u>\$ 272,783</u>
<b>LIABILITIES AND STOCKHOLDER'S EQUITY</b>		
CURRENT LIABILITIES:		
Medical services payable	\$ 170,360	\$ 147,002
Payables to contract programs	21,469	42,361
Accounts payable and accrued expenses	13,383	11,192
Current income taxes payable	8,533	90
Total current liabilities	213,745	200,645
LONG-TERM DEFERRED INCOME TAXES — NET	680	3,432
Total liabilities	214,425	204,077
CONTINGENCIES (Note 7)		
STOCKHOLDER'S EQUITY:		
Common stock, \$0.01 par value — 1,000,000 shares authorized; two shares issued and outstanding	-	-
Additional paid-in capital	79,266	52,266
Retained earnings	28,680	11,122
Accumulated other comprehensive income	1,126	5,318
Total stockholder's equity	109,072	68,706
TOTAL	<u>\$ 323,497</u>	<u>\$ 272,783</u>

See notes to financial statements.

## ARIZONA PHYSICIANS IPA, INC.

### STATEMENTS OF OPERATIONS FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012 (In thousands)

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	2013	2012
REVENUES:		
Capitation and risk-sharing settlements	\$1,283,611	\$1,161,065
Delivery supplemental premiums	47,135	42,967
Investment income — net	<u>5,951</u>	<u>7,454</u>
Total revenues	<u>1,336,697</u>	<u>1,211,486</u>
MEDICAL SERVICES EXPENSES:		
Hospital inpatient services	284,091	294,947
Medical compensation	331,328	289,561
Other medical services (Note 3)	584,091	543,824
Recoveries from AHCCCS	<u>(44,153)</u>	<u>(39,340)</u>
Total medical services expenses	1,155,357	1,088,992
ADMINISTRATIVE EXPENSES	135,363	118,268
PREMIUM TAXES	<u>18,155</u>	<u>16,970</u>
Total expenses	<u>1,308,875</u>	<u>1,224,230</u>
INCOME (LOSS) BEFORE INCOME TAXES	27,822	(12,744)
PROVISION FOR INCOME TAXES	<u>10,264</u>	<u>(5,893)</u>
NET INCOME (LOSS)	<u>\$ 17,558</u>	<u>\$ (6,851)</u>

See notes to financial statements.

## ARIZONA PHYSICIANS IPA, INC.

### STATEMENTS OF COMPREHENSIVE INCOME FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012 (In thousands)

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	2013	2012
NET INCOME (LOSS)	<u>\$ 17,558</u>	<u>\$ (6,851)</u>
OTHER COMPREHENSIVE INCOME:		
Gross unrealized holding (losses) gains on investment securities during the period	(6,367)	2,160
Income tax effect	<u>2,750</u>	<u>(854)</u>
Total unrealized (losses) gains — net of tax	<u>(3,617)</u>	<u>1,306</u>
Gross reclassification adjustment for net realized gains included in net earnings	(946)	(1,897)
Income tax effect	<u>371</u>	<u>750</u>
Total reclassification adjustment — net of tax	<u>(575)</u>	<u>(1,147)</u>
Other comprehensive (loss) income	<u>(4,192)</u>	<u>159</u>
COMPREHENSIVE INCOME (LOSS)	<u>\$ 13,366</u>	<u>\$ (6,692)</u>

See notes to financial statements.

## ARIZONA PHYSICIANS IPA, INC.

### STATEMENTS OF CHANGES IN STOCKHOLDER'S EQUITY AND ACCUMULATED OTHER COMPREHENSIVE INCOME FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012 (In thousands, except share data)

	Common Stock		Additional Paid In Capital	Retained Earnings	Accumulated Other Comprehensive Income	Total Shareholder's Equity
	Shares	Amount				
BALANCE — January 1, 2012	2	\$ -	\$ 52,266	\$ 27,973	\$ 5,159	\$ 85,398
Comprehensive loss:						
Net loss	-	-	-	(6,851)	-	(6,851)
Change in net unrealized gains on investments available-for-sale — net of tax effects and reclassification adjustments	-	-	-	-	1,306	1,306
Reclassification adjustments for net realized gains included in net loss — net of tax effects	-	-	-	-	(1,147)	(1,147)
Total comprehensive loss						(6,692)
Dividend paid	-	-	-	(10,000)	-	(10,000)
BALANCE — December 31, 2012	2	-	52,266	11,122	5,318	68,706
Comprehensive income:						
Net income	-	-	-	17,558	-	17,558
Change in net unrealized gains on investments available-for-sale — net of tax effects and reclassification adjustments	-	-	-	-	(3,617)	(3,617)
Reclassification adjustments for net realized gains included in net income — net of tax effects	-	-	-	-	(575)	(575)
Total comprehensive income						13,366
Infusions	-	-	27,000	-	-	27,000
BALANCE — December 31, 2013	<u>2</u>	<u>\$ -</u>	<u>\$ 79,266</u>	<u>\$ 28,680</u>	<u>\$ 1,126</u>	<u>\$ 109,072</u>

See notes to financial statements.

## ARIZONA PHYSICIANS IPA, INC.

### STATEMENTS OF CASH FLOWS FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012 (In thousands)

	2013	2012
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net income (loss)	\$ 17,558	\$ (6,851)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:		
Amortization of investment premium — net	1,151	970
Deferred income taxes	1,102	(139)
Gains on sale of investments — net	(946)	(1,897)
Changes in operating assets and liabilities:		
Receivables from contract programs	3,560	19,039
Investment income receivable	49	285
Other receivables	609	979
Current income taxes	8,837	(163)
Medical services payable	24,933	15,089
Accounts payable and accrued expenses	752	3,171
Payables to contract programs	(22,465)	(5,976)
Related party receivable (payable) — net	<u>3,486</u>	<u>(14,872)</u>
Net cash provided by operating activities	<u>38,626</u>	<u>9,635</u>
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of investments available-for-sale	(60,582)	(59,700)
Proceeds from maturities/sales of investments available-for-sale	<u>53,987</u>	<u>53,528</u>
Net cash used in investing activities	<u>(6,595)</u>	<u>(6,172)</u>
CASH FLOWS FROM FINANCING ACTIVITIES:		
Capital infusions received (Dividend paid)	27,000	(10,000)
Checks outstanding	1,112	(5,628)
AHCCCS funds administered	(17,080)	-
Customer funds administered	<u>4,109</u>	<u>(5,035)</u>
Net cash provided by (used in) financing activities	<u>15,141</u>	<u>(20,663)</u>
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	47,172	(17,200)
CASH AND CASH EQUIVALENTS — Beginning of the year	<u>25,580</u>	<u>42,780</u>
CASH AND CASH EQUIVALENTS — End of year	<u>\$ 72,752</u>	<u>\$ 25,580</u>
SUPPLEMENTAL CASH FLOW DISCLOSURE — Cash paid (received) for income taxes	<u>\$ 324</u>	<u>\$ (5,591)</u>

See notes to financial statements.



## ARIZONA PHYSICIANS IPA, INC.

### NOTES TO FINANCIAL STATEMENTS AS OF AND FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012 (In thousands)

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#### 1. ORGANIZATIONAL STRUCTURE AND OPERATION

**Organization** — Arizona Physicians IPA, Inc. (the “Company” or “APIPA”) was incorporated on September 19, 1995. Effective December 31, 2012, the Company is a wholly owned, for-profit subsidiary of United HealthCare, Inc. (“UHC”), which is a wholly owned subsidiary of United HealthCare Services, Inc. (“UHS”), a Minnesota corporation. UHS provides management services to managed care companies and is a wholly owned subsidiary of UnitedHealth Group Incorporated (“UHG”). UHG is a publicly held company trading on the New York Stock Exchange. Prior to December 31, 2012, the Company was a wholly owned, for-profit subsidiary of UnitedHealthcare of Arizona, Inc. (“UHC of AZ”), which is also a wholly owned subsidiary of UHS (see Note 10).

**Operation** — The majority of the Company’s premium revenues result from its contract with the Arizona Health Care Cost Containment System (“AHCCCS”). Under this contract, the Company provides health care benefits to Medicaid enrollees and Children’s Rehabilitative Services (“CRS”) members. The contract has been approved by AHCCCS and expires on September 30, 2016, with capitation rates up for renewal annually. The Company’s other operations are through contracts with the Arizona Department of Economic Security Division for Developmental Disabilities (“DES/DDD”) and the Centers for Medicare and Medicaid Services (“CMS”) for its Medicare Advantage health plan.

#### 2. BASIS OF PRESENTATION, USE OF ESTIMATES AND SIGNIFICANT ACCOUNTING POLICIES

**Basis of Presentation** — The Company has prepared the financial statements according to United States of America (U.S.) Generally Accepted Accounting Principles (GAAP).

**Use of Estimates** — These financial statements include certain amounts based on the Company’s best estimates and judgments. The Company’s most significant estimates related to medical services expenses, estimates of receivables, medical services payable, payable to AHCCCS, valuation of certain investments, and estimates and judgments related to income taxes. These estimates require the application of complex assumptions and judgments, often because they involve matters that are inherently uncertain, and will likely change in subsequent periods. The impact of any changes in estimates is included in earnings in the period in which the estimate is adjusted.

**Cash, Cash Equivalents, and Investments** — Cash and cash equivalents are highly liquid investments with original maturity of three months or less. The fair value of cash and cash equivalents approximates their carrying value because of the short maturity of the instruments.

Cash and cash equivalents primarily represent the Company’s share of an investment pool sponsored and administered by UHS. The investment pool consists principally of investments with original maturities of less than one year, with the average life of the individual investments being less than 60 days. The Company’s share of the pool represents an undivided ownership interest in the pool and is immediately convertible to cash at no cost or penalty. The participants within the pool have an individual fund number to track those investments owned by the Company. In addition, the Company is listed as a participant in the executed custodial agreement between UHS and the custodian whereby the

Company's share in the investment pool is segregated and separately maintained. The pool is primarily invested in government obligations, commercial paper, certificates of deposit, and short-term agency notes and is recorded at cost or amortized cost. Interest income from the pool accrues daily to participating members based upon ownership percentage.

The Company had checks outstanding of \$8,766 and \$7,654 at December 31, 2013 and 2012, respectively, which were classified in accounts payable and accrued expenses in the balance sheets. The change in this balance has been reflected as checks outstanding within financing activities in the statements of cash flows. The outstanding checks are related to zero balance accounts. The Company does not net checks outstanding with deposits in other accounts.

Investments with maturities of less than one year are classified as short-term. All other investments are classified as available-for-sale and reported at fair value based on quoted market prices, where available.

The Company excludes unrealized gains and losses on investments in available-for-sale securities from earnings, and reports them as other comprehensive income (loss) and, net of income tax effects, as a separate component of stockholder's equity. To calculate realized gains and losses on the sale of investments, the Company specifically identifies the cost of each investment sold.

The Company evaluates an investment for impairment by considering the length of time and extent to which market value has been less than cost or amortized cost, the financial condition and near-term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer, and the Company's intent to sell the security or the likelihood that it will be required to sell the security before recovery of the entire amortized cost.

- For debt securities, if the Company intends to either sell, or determines that it will be more likely than not required to sell a security before recovery of the entire amortized cost basis or maturity of the security, the Company recognizes the entire impairment in investment income. If the Company does not intend to sell the debt security, and it determines that it will not be more likely than not required to sell the security, but it does not expect to recover the entire amortized cost basis, the impairment is bifurcated into the amount attributed to the credit loss, which is recognized in earnings, and all other causes, which are recognized in other comprehensive income (loss).

New information and the passage of time can change these judgments. The Company manages its investment portfolio to limit its exposure to any one issuer or market sector, and largely limits its investments to U.S. government and agency securities; state and municipal securities; mortgage-backed securities; and corporate debt obligations, substantially all of which are investment grade quality. Securities downgraded below policy minimums after purchase will be disposed of in accordance with the investment policy.

Long-term investments include U.S. agency and non-U.S. agency mortgage backed securities, which are valued using the retrospective adjustment methodology. Prepayment assumptions for the determination of the amortized cost of mortgage backed securities are based on a three month constant prepayment rate history obtained from external data source vendors. The Company's investment policy limits investments in non-agency residential mortgage-backed securities, including home equity and sub-prime mortgages, to 10% of total cash and invested assets and total investments in mortgage backed securities to 30% of total cash and invested assets.

Investment income earned and due as of the reporting date, in addition to investment income earned but not paid or collected until subsequent periods, is reported as investment receivables in the balance sheets. The Company evaluates the collectability of the amounts due and amounts determined to be uncollectible are written off in the period in which the determination is made.

Investment Income — net includes investment income collected during the period, as well as the change in investment income due and accrued on the Company's holdings. Amortization of premium or discount on bonds and certain external investment management costs are also included in investment income — net.

**Revenues** — Capitation and risk-sharing settlements and delivery supplemental premiums are contractual. Capitation revenues are generally paid in advance of the coverage period in which benefits are to be provided and are earned and recognized during the applicable coverage period regardless of whether services are incurred. The majority of net premium income recorded is based on capitated rates, which are monthly premiums paid for each member enrolled.

Effective October 1, 2013, AHCCCS withholds 1% of gross prospective capitation from all Medicaid contractors in Arizona to be redistributed based upon each contractor's performance on selected Quality Management Performance Measures as determined by AHCCCS. At December 31, 2013, the Company has accrued \$1,619 for withheld revenues it expects to collect for this program as receivables from contract programs in the balance sheets.

CMS deploys a risk adjustment model that apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk-adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, and physician treatment settings. The Company and health care providers collect, capture, and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS, which result in changes to its Medicare revenues. The Company recognizes such changes when the amounts become determinable and supportable and collectability is reasonably assured. The estimated risk adjusted payments due to the Company at December 31, 2013 and 2012, were \$4,869 and \$7,674 respectively, and are recorded as receivables from contract programs in the balance sheets. The Company recognized \$563 and \$694 for changes in prior year Medicare risk factor estimates during the years ended December 31, 2013 and 2012, respectively, which is recorded as capitation and risk-sharing settlements within the statements of operations.

AHCCCS also applies a risk adjustment using a national episodic/diagnostic risk adjustment model for the existing risk groups. The estimated risk adjustment payment due to the Company at December 31, 2013 and 2012 were \$607 and \$0, respectively, and are recorded as receivables from contract programs in the balance sheets.

Delivery supplemental premium payments are per delivery and intended by AHCCCS to cover the cost of maternity care. Such premiums are recognized in the month that the delivery occurs. Total premiums of \$47,135 and \$42,967 for 2013 and 2012, respectively, are recorded in the delivery supplemental premiums in the statements of operations and receivables from contract programs in the accompanying balance sheets.

**Medical Services Expenses and Medical Services Payables** — Medical services expenses and medical services payable include estimates of the Company's obligations for medical care services that have been rendered on behalf of insured consumers, but for which claims have either not yet been received or processed, and for liabilities for physician, hospital and other medical cost disputes. The Company develops estimates for medical services expenses incurred but not reported using an actuarial process that is consistently applied, centrally controlled and automated. The actuarial models consider factors such as historical submission and payment data, cost trends, customer and product mix, seasonality, utilization of health care services, contracted service rates, and other relevant factors. The Company estimates liabilities for physician, hospital and other medical services payable disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. Each period, the Company re-examines previously established medical services payable estimates based on actual claim submissions and other changes in facts and circumstances. As the medical services payable estimates recorded in prior periods develop, the Company adjusts the amount of the estimates and includes the changes in estimates in medical services expenses in the period in which the change is identified.

The Company contracts with hospitals, physicians, and other providers of health care under capitated or discounted fee for service arrangements, including a hospital per diem to provide medical care services to enrollees. Some of these contracts are with related parties (see Note 10). Capitated providers are at risk for the cost of medical care services provided to the Company's enrollees; however, the Company is ultimately responsible for the provision of services to its enrollees should the capitated provider be unable to provide the contracted services.

The Company has agreements with certain medical providers that provide for the establishment of a pool into which the Company places funds based on the performance of the provider as defined in the contract. The Company manages the disbursement of funds from this account as well as reviews the utilization and designated quality scores based on members assigned to the provider. Any surpluses and/or deficits in the pool are shared by the Company and the provider based upon specific contracts and the liability is included within medical services payable on the balance sheets.

**AHCCCS Reinsurance** — Reinsurance is a stop-loss program provided by AHCCCS for the partial reimbursement of covered medical services and those costs incurred beyond an annual deductible per member. AHCCCS provides regular reinsurance so long as the member incurred an inpatient stay, catastrophic reinsurance for those members receiving certain drugs or diagnosed with specific disorders, transplant reinsurance and other reinsurance. Recoveries from AHCCCS are recorded at estimated amounts due to the Company pursuant to the AHCCCS and DES/DDD contracts. Both contracts require the respective agencies to reimburse the Company 75% (85% for catastrophic cases) of qualified health care costs in excess of a recovery deductible. The deductibles applied are \$50 for DES/DDD, \$25 for Acute, and \$75 for CRS. For cases where qualified medical out-of-pocket expense exceeds \$650, the Company is reimbursed for 100% of the expense.

The Company estimated recoveries from AHCCCS of \$18,346 and \$26,069 in receivables from contract programs in the balance sheets as of December 31, 2013 and 2012, respectively. Recoveries from AHCCCS of \$44,153 for 2013 and \$39,340 for 2012 have been offset against medical services expenses in the statements of operations.

**Medicare Part D Pharmacy Benefits** — The Company serves as a plan sponsor offering Medicare Part D prescription drug insurance coverage under contracts with CMS. Under the Medicare Part D program, there are seven separate elements of payment received by the Company during the plan year. These payment elements are as follows:

- *CMS Premium.* CMS pays a fixed monthly premium per member to the Company for the entire plan year.
- *Member Premium.* Additionally, certain members pay a fixed monthly premium to the Company for the entire plan year.
- *Low-Income Premium Subsidy.* For qualifying low-income members, CMS pays some or all of the member's monthly premiums to the Company on the member's behalf.
- *Catastrophic Reinsurance Subsidy.* CMS pays the Company a monthly cost reimbursement estimate to fund the CMS obligation to pay approximately 80% of the costs incurred by individual members in excess of the individual annual out-of-pocket maximum. A settlement is made with CMS, based on actual cost experience, after the end of the plan year.
- *Low-Income Member Cost Sharing Subsidy.* For qualifying low-income members, CMS pays on the member's behalf some or all of a member's cost sharing amounts, such as deductibles and coinsurance. The cost sharing subsidy is funded by CMS through monthly payments to the Company. The Company administers and pays for the subsidized portion of the claims on behalf of CMS, and a settlement payment is made between CMS and the Company, based on actual claims and premium experience, after the end of the plan year.
- *CMS Risk-Share.* Premiums from CMS are subject to risk corridor provisions that compare costs targeted in the Company's annual bids by product and region to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances of more than 5% above or below the original bid submitted by the Company may result in CMS making additional payments to the Company, or require the Company to refund to CMS a portion of the premiums received. The Company estimates and recognizes an adjustment to premium revenues related to the risk corridor payment settlement based upon pharmacy claims experience to date. The estimate of the settlement associated with these risk corridor provisions requires the Company to consider factors that may not be certain, including estimates of eligible pharmacy costs and member eligibility status differences with CMS. The Company records risk-share adjustments to capitation and risk-sharing settlements in the statements of operations and payables to contract programs or receivables from contract programs in the balance sheets.
- *Drug Discount.* Beginning in 2011, Health Reform Legislation mandated a consumer discount of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. This discount is funded by CMS and pharmaceutical manufacturers, while the Company administers the application of these funds. Amounts received are not reflected as capitation and risk-sharing settlements, but rather are accounted for as deposits. The Company records a payable when amounts are received from CMS, and a receivable when the Company bills the pharmaceutical manufacturers. Related cash flows are presented as customer funds administered within financing activities in the statements of cash flows.

The CMS Premium, the Member Premium, and the Low-Income Premium Subsidy represent payments for the Company's insurance risk coverage under the Medicare Part D program and are therefore recorded as capitation and risk-sharing settlements in the statements of operations. Premium revenues

are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. The Company records premium payments received in advance of the applicable service period in payables to contract programs in the balance sheets.

The Company's Medicare Part D program business is subject to a retrospective rating feature related to Part D premiums. The Company has estimated accrued retrospective premiums related to certain Part D premiums based on guidelines determined by CMS. The formula is tiered and based on bid medical loss ratio. The amount of Part D premium subject to retrospective rating was \$33,155 and \$28,630 for the years ended December 31, 2013 and 2012, respectively, representing 2.5% and 2.4% of total revenues excluding investment income as of December 31, 2013 and 2012, respectively.

The Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidy ("Subsidies") represent cost reimbursements under the Medicare Part D program. The Company is fully reimbursed by CMS for costs incurred for these contract elements and, accordingly, there is no insurance risk to the Company. Amounts received for these Subsidies are not reflected as capitation and risk-sharing settlements but rather are accounted for as deposits, with related amounts recorded in receivables from or payables to contract programs in the balance sheets. The Company recorded \$3,516 and \$7,625 in receivables from contract programs as of December 31, 2013 and 2012, respectively, for cost reimbursements under the Medicare Part D program for the catastrophic reinsurance and low-income member cost sharing subsidies. Related cash flows are presented as customer funds administered within financing activities in the statements of cash flows.

Pharmacy benefit costs and administrative costs under the contract are expensed as incurred, and are recognized in medical services expenses and administrative expenses, respectively, in the statements of operations.

The Company has settlements with CMS based on whether the ultimate per member per month ("PMPM") benefit costs of any Medicare Part D program regional plan varies more than 5% above or below the level estimated in the original bid submitted by the Company and approved by CMS in 2013 and 2012. The estimated risk share adjustment of \$1,883 and \$940 in 2013 and 2012, respectively, is recorded as payables to contract programs in the balance sheets and a decrease to capitation and risk-sharing settlements in the statements of operations. The final 2013 risk-share amount is expected to be settled during the second half of 2014 and is subject to the reconciliation process with CMS.

Total premium revenues from CMS related to the Medicare Part D program and all other Medicare-related programs were approximately 29.7% and 3.5% of capitation and risk-sharing settlements reported in the statements of operations for the years ended December 31, 2013 and 2012, respectively.

As of January 1, 2014, certain changes were made to the Medicare Part D coverage by CMS, including: (in whole dollars)

- The initial coverage limit decreased to \$2,850 from \$2,970 in 2013.
- The catastrophic coverage begins at \$6,455 as compared to \$6,734 in 2013.
- The annual out-of-pocket maximum decreased to \$4,550 from \$4,750 in 2013.
- The discounts on prescription drugs within the coverage gap of 52.5% is consistent with 2013 for brand name drugs and has been increased to 28% from 21% in 2013 for generic drugs.

**Medicaid Risk Sharing** — Due to the uncertainty regarding actual utilization and medical cost experience, AHCCCS limits the financial risk to the Company through risk share reconciliations. The Company has yearly risk-sharing agreements with AHCCCS to cover medical expenses in excess of certain limits established by the contract depending upon product. The CRS reconciliation is tiered beginning at 3%, recouping or (repaying) different percentages of the excess in intervals up to losses of 6% and up to profits of 9%. For the prior period coverage capitated groups the risk band is 2%. For the newly eligible adult group, part of the most recent contract, the prospective and prior period coverage capitation will be limited to 1% due to a lack of historical experience. Receivables or payables and the corresponding revenues or contra-revenues are recorded depending on the surplus or deficit of revenues over medical and certain administrative expenses for the period and are calculated in accordance with the contract.

The Company estimated risk-sharing payables of \$19,517 and \$42,994 and risk-sharing receivables of \$352 and \$2,775 recorded as payables to contract programs and receivables from contract programs as of December 31, 2013 and 2012, respectively. The change in estimated risk share of \$7,444 and (\$33,089) in 2013 and 2012, respectively, is recorded as an increase (decrease) to capitation and risk-sharing settlements in the statements of operations. In 2013, the final reconciliation and settlement for the Medicaid contract year ending October 31, 2011 was received and the Company recorded a favorable change in the estimated risk share payables as recorded at December 31, 2012 of \$10,261. The primary driver behind the favorable retroactivity is due to a change to clarification in the underlying administrative expense component within the Company's estimated calculation. The clarification also contributed to retroactivity related to contract years ending 2012 and 2013, which have not yet been reconciled with AHCCCS. The favorable retroactivity is included in capitation and risk-sharing settlements in the statements of operations for the year ended December 31, 2013.

**Loss Adjustment Expenses** — Loss adjustment expenses are costs that are expected to be incurred in connection with the adjustment and recording of health claims. Management believes the amount of the liability for unpaid claims adjustment expenses as of December 31, 2013, is adequate to cover the Company's cost for the adjustment of unpaid claims; however, actual expenses may differ from those established estimates. It is the responsibility of UHS to pay loss adjustment expenses in the event the Company ceases operations. As of December 31, 2013 and 2012, the loss adjustment expenses included in the accompanying balance sheets in the accounts payable and accrued expenses line item is \$3,047 and \$3,202, respectively.

**Administration of AHCCCS Funds** — The Company has two contracts with AHCCCS which became effective during 2013 to administer funds from AHCCCS to specific provider populations and are accounted for as deposits. The funds transferred during 2013 are reported as AHCCCS funds administered under cash flows from financing on the statements of cash flows.

*Primary Care Physician Enhancement Payments* — Effective for calendar years 2013 and 2014 the Patient Protection and Affordable Care Act (ACA) has mandated that certain physicians practicing primary care ("PCPs") are eligible to receive increased payments for specified primary care services provided to Medicaid eligible individuals. This is to encourage PCPs to serve the Medicaid population in advance of the Medicaid expansion in 2014.

The state has elected to administer the additional PCP funds through non-risk reconciled payments for enhanced rates model. Under this model, the state's capitation rate is not inclusive of the enhanced rate. The Company is reimbursed at agreed upon intervals for all of the enhanced payment amounts in the determined period. There is no risk to the Company because any excess or shortfall is 100% remitted or received back from the state. The Company recorded a receivable from AHCCCS in receivables from contract programs of \$17,408 in the balance sheets of as of December 31, 2013.

*Rural Hospital Enhancement Payments* — Effective October 1, 2013, the Company entered into an agreement with AHCCCS in which it will pass through supplemental inpatient reimbursement payments to qualifying rural hospitals as determined by AHCCCS. AHCCCS remits payment and informs the Company of the amount to be paid to each provider. The Company then makes the prescribed payments to the providers specified within 15 days of the receipt of funds. There is no risk to the Company as a result of this program. At December 31, 2013 the Company has not received or paid cash related to this program, and as a result there is nothing recorded on the balance sheets.

**Income Taxes** — The Company's operations are included in the consolidated federal income tax return of UHG. Federal and state income taxes are paid to, or refunded by, UHG pursuant to the terms of a tax sharing agreement ("TSA"), under which taxes approximate the amount that would have been computed on a separate company basis. Under the terms of the TSA, the Company's share based compensation related tax benefits are reimbursed to UHG upon realization (see Note 18).

**Premium Deficiency Reserve** — The Company assesses the profitability of its contract for providing health care services to its members when current operating results or forecasts indicate possible future losses. The Company compares anticipated premiums to health care related costs, including estimated payments for physicians and hospitals, commissions, and costs of collecting premiums and processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. The Company has no amounts recorded for premium deficiency reserves as of December 31, 2013 and 2012.

**Concentration of Business and Credit Risk** — Future contract awards are contingent upon the continuation of the AHCCCS, DES/DDD, and CRS programs by the State of Arizona and the continuation of the CMS Medicare Advantage program and the Company's ability and desire to retain its status as a contractor under the programs. For the years ended December 31, 2013 and 2012, substantially all of the Company's total revenues and receivables were from these programs.

Premiums from the Acute and Medicare contracts of \$751,273 and \$381,723, respectively; representing 56% and 29% of total revenues excluding investment income for the year ended December 31, 2013. All other contracts represent less than 10% of total revenues excluding investment income.

Concentration of credit risk with respect to receivables is limited due to the fact that AHCCCS, DES/DDD, and CMS are governmental agencies.

**Recently Adopted Accounting Standards** — In February 2013, the Financial Accounting Standards Board (FASB) issued Accounting Standards Updated (ASU) No. 2013-02, "Comprehensive Income (Topic 220): Reporting of Amounts Reclassified Out of Accumulated Other Comprehensive Income" (ASU 2013-02). ASU 2013-02 requires companies to report the effect of significant reclassifications out of accumulated other comprehensive income, by component, either on the face of the financial statements or in the notes to the financial statements and is intended to help entities improve the transparency of changes in other comprehensive income. ASU 2013-02 does not amend any existing requirements for reporting net income or other comprehensive income in the financial statements. ASU 2013-02 became effective for the Company's fiscal year 2013 and the new disclosures have been included with the Company's investment disclosures in Note 8 of Notes to the Financial Statements.

ASU No. 2011-06, "Other Expenses (Topic 720): Fees Paid to the Federal Government by Health Insurers (a consensus of the FASB Emerging Issues Task Force)" (ASU 2011-06) addresses the recognition and classification of an entity's share of the annual health insurance industry assessment (the industry fee) mandated by Health Reform Legislation. The industry fee is levied on health insurers for each calendar year beginning on or after January 1, 2014, and is not deductible for income tax purposes. The amount of the industry fee for each health insurer is based on a ratio of the insurer's net health



insurance premiums written for the previous calendar year compared to the U.S. health insurance industry total net premiums. In accordance with the amendments in ASU 2011-06 on January 1, 2014, the liability for the industry fee payable in 2014 will be estimated and recorded in full within the Company's 2014 financial statements, with a corresponding deferred cost which will be amortized to expense using the straight-line method of allocation over the calendar year it is payable.

The Company has determined that there have been no other recently adopted or issued accounting standards that had or will have a material impact on its financial statements.

### 3. OTHER AMOUNTS

Other medical services expenses included in the statements of operations for the years ended December 31, 2013 and 2012, consist of the following:

	2013	2012
Pharmacy	\$ 167,943	\$ 151,793
Outpatient facility	108,186	104,776
Emergency	69,669	66,096
Nursing facility and home health care	76,482	66,586
Laboratory, x-ray, and medical imaging	39,183	40,498
Dental	37,941	34,248
Durable medical equipment	33,887	30,089
Transportation	23,755	25,720
Other	12,059	11,986
Prior period coverage outpatient retroactivity	3,318	4,263
Physical therapy	8,748	7,769
CRS behavioral health	<u>2,920</u>	<u>-</u>
Total	<u>\$ 584,091</u>	<u>\$ 543,824</u>

### 4. PLEDGES/ASSIGNMENTS AND GUARANTEES

The Company has no pledges, assignments, collateralized assets, or guaranteed liabilities not disclosed in the balance sheets as of December 31, 2013 and 2012.

### 5. PERFORMANCE BONDS

Pursuant to its contracts with AHCCCS, the Company is required annually to provide performance bonds, in an acceptable form, to guarantee performance of the Company's obligations under certain contracts. To satisfy this requirement, the Company maintained surety bonds in 2013 and 2012 in the amounts of \$121,714 and \$92,800, respectively, which are included in long-term investments in the balance sheets. The bonds are unsecured and require no Company assets to secure the obligations.

## 6. MEDICAL SERVICES PAYABLE ANALYSIS

Changes in estimates related to prior years' incurred claims are included in medical services expenses in the current year in the statements of operations. Stop loss recoveries are included in receivables from contract programs in the accompanying balance sheets and claim overpayment receivables are included in other receivables in the accompanying balance sheets. The following tables disclose paid claims, incurred claims, and the balance in the unpaid claim reserve for the years ended December 31, 2013 and 2012:

	<b>2013</b>		
	<b>Current Year Incurred Claims</b>	<b>Prior Years' Incurred Claims</b>	<b>Total</b>
Beginning year medical services payable	\$ -	\$ (147,002)	\$ (147,002)
Paid claims — net of stop loss recoveries, pharmacy rebates and claim overpayments collected	1,028,604	98,443	1,127,047
End of year medical services payable	<u>165,967</u>	<u>4,393</u>	<u>170,360</u>
Incurred claims excluding stop loss recoveries, pharmacy rebate and claim overpayment receivables as presented below	1,194,571	(44,166)	1,150,405
Beginning stop loss recoveries, pharmacy rebate and claim overpayment receivables	-	34,834	34,834
End of year stop loss recoveries, pharmacy rebate and claim overpayment receivables	<u>(28,335)</u>	<u>(1,547)</u>	<u>(29,882)</u>
Total incurred claims	<u>\$ 1,166,236</u>	<u>\$ (10,879)</u>	<u>\$ 1,155,357</u>
	<b>2012</b>		
	<b>Current Year Incurred Claims</b>	<b>Prior Years' Incurred Claims</b>	<b>Total</b>
Beginning year medical services payable	\$ -	\$ (131,913)	\$ (131,913)
Paid claims — net of stop loss recoveries and claim overpayment collected	972,052	88,818	1,060,870
End of year medical services payable	<u>144,187</u>	<u>2,815</u>	<u>147,002</u>
Incurred claims excluding stop loss recoveries and claim overpayment receivables as presented below	1,116,239	(40,280)	1,075,959
Beginning stop loss recoveries	-	40,243	40,243
End of year stop loss recoveries and claim overpayment receivables	<u>(23,275)</u>	<u>(3,935)</u>	<u>(27,210)</u>
Total incurred claims	<u>\$ 1,092,964</u>	<u>\$ (3,972)</u>	<u>\$ 1,088,992</u>

In 2013 the table above includes pharmacy rebates as they are a component of total medical services expenses and the change in receivables are a direct adjustment to incurred expenses. The beginning balance of stop loss recoveries, pharmacy rebates, and claim overpayment receivables has been modified in the 2013 table to include the pharmacy rebate estimates as of December 31, 2012.

The liability for medical services payable net of stop loss recoveries and claim overpayment receivables as of December 31, 2012 was \$112,168. As of December 31, 2013, \$98,443 has been paid for incurred claims attributable to insured events of prior years. The medical services payable remaining for prior years excluding the effect of stop loss recoveries and claim overpayment receivables of \$1,547 are now \$4,393 as a result of re-estimation of unpaid claims. Therefore, there has been \$10,879 of favorable prior year development since December 31, 2012 to December 31, 2013. The primary drivers consist of favorable development as a result of a change in the provision for adverse deviations in experience of \$7,261 and by favorable development of \$3,615 in retroactivity for inpatient, outpatient, physician, and pharmacy claims. At December 31, 2012, the Company recorded \$3,972 of favorable development primarily driven by \$6,745 as a result of a change in the provision for adverse deviations in experience. This was partially offset by unfavorable development of \$2,283 related to capitation and risk share reserves, and \$183 of unfavorable retroactivity for inpatient, outpatient, physician, vision, dental, and pharmacy claims. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

## **7. CONTINGENT LIABILITIES AND GOVERNMENT REGULATIONS**

Because of the nature of its businesses, the Company is frequently made party to a variety of legal actions and regulatory inquiries, including class actions and suits brought by members, care providers, consumer advocacy organizations, customers and regulators, relating to the Company's businesses, including management and administration of health benefit plans and other services.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred. Although the outcomes of any such legal actions cannot be predicted, in the opinion of management, the resolution of any currently pending or threatened actions will not have a material adverse effect on the accompanying balance sheets or statements of operations of the Company.

The Company's business is regulated at the federal, state, and local levels. The laws and rules governing the Company's business and interpretations of those laws and rules are subject to frequent change. Broad latitude is given to the agencies administering those regulations. Further, the Company must obtain and maintain regulatory approvals to market and sell many of its products.

The Company has been, or is currently involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments and other governmental authorities. Certain of the Company's businesses have been reviewed or are currently under review, including for, among other things, compliance with coding and other requirements under the Medicare risk-adjustment model.

**Risk Adjustment Data Validation (RADV) Audit** — CMS adjusts capitation payments to Medicare Advantage plans and Medicare Part D plans according to the predicted health status of each beneficiary as supported by data from health care providers. The Company collects claim and encounter data from providers, who the Company generally relies on to appropriately code their claim submissions and document their medical records. CMS then determines the risk score and payment amount for each enrolled member based on the health care data submitted and member demographic information.

CMS and the Office of Inspector General for Health and Human Services periodically perform RADV audits of selected Medicare health plans to validate the coding practices of and supporting documentation maintained by health care providers. Such audits have in the past resulted and could in the future result in retrospective adjustments to payments made to the Company, fines, corrective action plans or other adverse action by CMS.

In February 2012, CMS announced a final RADV audit and payment adjustment methodology and that it will conduct RADV audits beginning with the 2011 payment year. These audits involve a review of medical records maintained by care providers and may result in retrospective adjustments to payments made to health plans. CMS has not communicated how the final payment adjustment under its methodology will be implemented.

Health Reform Legislation and the related federal and state regulations will continue to impact how the Company does business and could restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, increase the Company's medical and administrative costs, expose the Company to an increased risk of liability (including increasing our liability in federal and state courts for coverage determinations and contract interpretation), or put the Company at risk for loss of business. In addition, the Company's results of operations, financial condition and cash flows could be materially adversely affected by such changes. The Health Reform Legislation may create new or expand existing opportunities for business growth, but due to its complexity, the impact of the Health Reform Legislation remains difficult to predict and is not yet fully known.

## 8. INVESTMENTS

A summary of investments by major security type is as follows:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
<b>December 31, 2013</b>				
Debt securities — available-for-sale:				
U.S. government and agency obligations	\$ 15,042	\$ -	\$ (280)	\$ 14,762
State and municipal obligations	84,748	2,928	(791)	86,885
Corporate obligations	46,727	638	(287)	47,078
U.S. agency mortgage-backed securities	23,783	139	(649)	23,273
Non-U.S. agency mortgage-backed securities	<u>9,053</u>	<u>268</u>	<u>(113)</u>	<u>9,208</u>
Total debt securities — available-for-sale	<u>179,353</u>	<u>3,973</u>	<u>(2,120)</u>	<u>181,206</u>
Total investments	<u>\$179,353</u>	<u>\$ 3,973</u>	<u>\$ (2,120)</u>	<u>\$181,206</u>
<b>December 31, 2012</b>				
Debt securities — available-for-sale:				
U.S. government and agency obligations	\$ 17,381	\$ 433	\$ (26)	\$ 17,788
State and municipal obligations	82,168	5,546	(40)	87,674
Corporate obligations	48,645	1,596	(8)	50,233
U.S. agency mortgage-backed securities	15,091	466	-	15,557
Non-U.S. agency mortgage-backed securities	<u>9,677</u>	<u>835</u>	<u>(6)</u>	<u>10,506</u>
Total debt securities — available-for-sale	<u>172,962</u>	<u>8,876</u>	<u>(80)</u>	<u>181,758</u>
Total investments	<u>\$172,962</u>	<u>\$ 8,876</u>	<u>\$ (80)</u>	<u>\$181,758</u>

The fair value of the Company's mortgage-backed securities by credit rating (when multiple credit ratings are available for an individual security, the average of the available ratings is used) and origination as of December 31, 2013, were as follows:

	AAA	Non- Investment Grade	Total Fair Value
2013	\$ 470	\$ -	\$ 470
2012	2,511	-	2,511
2011	528	-	528
2007	1,105	-	1,105
2006	2,829	-	2,829
2005	1,765	-	1,765
U.S. agency mortgage-backed securities	<u>23,273</u>	<u>-</u>	<u>23,273</u>
Total	<u>\$ 32,481</u>	<u>\$ -</u>	<u>\$ 32,481</u>

The amortized cost and fair value of available-for-sale debt securities as of December 31, 2013, by contractual maturity, were as follows:

	<b>2013</b>	
	<b>Amortized Cost</b>	<b>Fair Value</b>
Due in one year or less	\$ 8,031	\$ 8,151
Due after one year through five years	51,639	52,721
Due after five years through ten years	60,422	61,720
Due after ten years	26,425	26,133
U.S. agency mortgage-backed securities	23,783	23,273
Non-U.S. agency mortgage-backed securities	<u>9,053</u>	<u>9,208</u>
 Total debt securities — available-for-sale	 <u>\$ 179,353</u>	 <u>\$ 181,206</u>

The fair value of available-for-sale investments with gross unrealized losses by major security type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	<u>Less than 12 Months</u>		<u>12 Months or Greater</u>		<u>Total</u>	
	<u>Fair Value</u>	<u>Gross Unrealized Losses</u>	<u>Fair Value</u>	<u>Gross Unrealized Losses</u>	<u>Fair Value</u>	<u>Gross Unrealized Losses</u>
<b>December 31, 2013</b>						
Debt securities — available-for-sale:						
U.S. government and agency obligations	\$14,512	\$ (253)	\$ 250	\$ (27)	\$14,762	\$ (280)
State and municipal obligations	23,069	(678)	2,106	(113)	25,175	(791)
Corporate obligations	18,986	(287)	-	-	18,986	(287)
U.S. agency mortgage-backed securities	18,745	(649)	-	-	18,745	(649)
U.S. non-agency mortgage-backed securities	<u>2,564</u>	<u>(62)</u>	<u>1,617</u>	<u>(51)</u>	<u>4,181</u>	<u>(113)</u>
Total debt securities — available-for-sale	<u>\$77,876</u>	<u>\$(1,929)</u>	<u>\$3,973</u>	<u>\$(191)</u>	<u>\$81,849</u>	<u>\$(2,120)</u>
 <b>December 31, 2012</b>						
Debt securities — available-for-sale:						
U.S. government and agency obligations	\$ 2,136	\$ (26)	\$ -	\$ -	\$ 2,136	\$ (26)
State and municipal obligations	6,386	(40)	-	-	6,386	(40)
Corporate obligations	4,035	(8)	-	-	4,035	(8)
U.S. non-agency mortgage-backed securities	<u>1,670</u>	<u>(6)</u>	<u>-</u>	<u>-</u>	<u>1,670</u>	<u>(6)</u>
Total debt securities — available-for-sale	<u>\$14,227</u>	<u>\$ (80)</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$14,227</u>	<u>\$ (80)</u>

The unrealized losses from all securities as of December 31, 2012, were generated from approximately 108 positions out of a total of approximately 280 positions. The Company believes that it will collect all principal and interest due on its investments that have an amortized cost in excess of fair value. The unrealized losses on investments were primarily caused by interest rate increases and not by unfavorable changes in the credit ratings associated with these securities. The Company evaluates impairment at each reporting period for each of the securities whereby the fair value of the investment is less than its amortized cost. The contractual cash flows of the U.S. government and agency obligations are either guaranteed by the U.S. government or an agency of the U.S. government. It is expected that the securities would not be settled at a price less than the cost of the investment, and the Company does not intend to sell the investment until the unrealized loss is fully recovered. The Company evaluated the underlying credit quality and credit ratings of the issuers, noting whether a significant deterioration since purchase or other factors that may indicate an other-than temporary impairment (“OTTI”), such as the length of time and extent to which fair value has been less than cost, the financial condition, and near

term prospects of the issuer as well as specific events or circumstances that may influence the operations of the issuer and the Company's intent to sell the investment. As of December 31, 2013, the Company did not have the intent to sell any of the securities in an unrealized loss position.

Net realized gains included in investment income on the statements of operations were from the following sources:

	<b>Years Ended December 31,</b>	
	<b>2013</b>	<b>2012</b>
Total OTTI	<u>\$ -</u>	<u>\$ (12)</u>
Net OTTI recognized in earnings	<u>-</u>	<u>(12)</u>
Gross realized losses from sales	(85)	1,909
Gross realized gains from sales	<u>1,031</u>	<u>-</u>
Net realized gains (included in investment income — net on the statements of operations)	<u>946</u>	<u>1,897</u>
Income tax effect (included in provision for income taxes on the statement of operations)	<u>(371)</u>	<u>(750)</u>
Realized gains, net of taxes	<u>\$ 575</u>	<u>\$ 1,147</u>

## 9. FAIR VALUE

Certain assets and liabilities are measured at fair value in the consolidated financial statements, or have fair values disclosed in the Notes to the Financial Statements. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. In instances in which the inputs used to measure fair value fall into different levels of the fair value hierarchy, the fair value measurement is categorized in its entirety based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular item to the fair value measurement in its entirety requires judgment, including the consideration of inputs specific to the asset or liability.

The fair value hierarchy is summarized as follows:

*Level 1* — Quoted prices (unadjusted) for identical assets/liabilities in active markets.

*Level 2* — Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets/liabilities in non active markets (e.g., few transactions, limited information, non current prices, high variability over time, etc.);
- Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, implied volatilities, credit spreads); and

- Inputs that are corroborated by other observable market data.

*Level 3* — Unobservable inputs that cannot be corroborated by observable market data.

Non-financial assets and liabilities, or financial assets and liabilities that are measured at fair value on a nonrecurring basis, are subject to fair value adjustments only in certain circumstances, such as when the Company records an impairment. There were no significant fair value adjustments for these assets and liabilities recorded during the years ended December 31, 2013 and 2012.

The following table presents a summary of the fair value measurements by level for assets and liabilities measured at fair value on a recurring basis:

	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total Fair and Carrying Value
<b>December 31, 2013</b>				
Cash and cash equivalents	<u>\$ 72,752</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 72,752</u>
Debt securities — available-for-sale:				
U.S. government and agency obligations	14,762	-	-	14,762
State and municipal obligations	-	86,885	-	86,885
Corporate obligations	-	47,078	-	47,078
U.S. agency mortgage-backed securities	-	23,273	-	23,273
Non-U.S. agency mortgage-backed securities	<u>-</u>	<u>9,208</u>	<u>-</u>	<u>9,208</u>
Total debt securities — available-for-sale	<u>14,762</u>	<u>166,444</u>	<u>-</u>	<u>181,206</u>
Total cash, cash equivalents, and investments at fair value	<u>\$ 87,514</u>	<u>\$ 166,444</u>	<u>\$ -</u>	<u>\$ 253,958</u>
<b>December 31, 2012</b>				
Cash and cash equivalents	<u>\$ 25,580</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 25,580</u>
Debt securities — available-for-sale:				
U.S. government and agency obligations	17,788	-	-	17,788
State and municipal obligations	-	87,674	-	87,674
Corporate obligations	-	50,233	-	50,233
U.S. agency mortgage-backed securities	-	15,557	-	15,557
Non-U.S. agency mortgage-backed securities	<u>-</u>	<u>10,506</u>	<u>-</u>	<u>10,506</u>
Total debt securities — available-for-sale	<u>17,788</u>	<u>163,970</u>	<u>-</u>	<u>181,758</u>
Total cash, cash equivalents, and investments at fair value	<u>\$ 43,368</u>	<u>\$ 163,970</u>	<u>\$ -</u>	<u>\$ 207,338</u>

Transfers between levels, if any, are recorded as of the beginning of the reporting period in which the transfer occurs. There were no transfers between Levels 1, 2 or 3 of any financial assets or liabilities during 2013 or 2012.

The Company does not have financial assets with a fair value hierarchy of Level 3.



The following methods and assumptions were used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument:

*Cash and Cash Equivalents* — The carrying value of cash and cash equivalents approximates fair value, as maturities are less than three months. Fair values of cash equivalent instruments that do not trade on a regular basis in active markets are classified as Level 2.

*Debt Securities* — Fair values of debt and equity securities are based on quoted market prices, where available. The Company obtains one price for each security, primarily from a third-party pricing service (pricing service), which generally uses quoted or other observable inputs for the determination of fair value. The pricing service normally derives the security prices through recently reported trades for identical or similar securities and, if necessary, makes adjustments through the reporting date based upon available observable market information. For securities not actively traded, the pricing service may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, benchmark yields, credit spreads, default rates, prepayment speeds and non-binding broker quotes.

As the Company is responsible for the determination of fair value, it performs quarterly analyses on the prices received from the pricing service to determine whether the prices are reasonable estimates of fair value. Specifically, the Company compares the prices received from the pricing service to prices reported by a secondary pricing source such as its custodian, its investment consultant, and third-party investment advisors. Additionally, the Company compares changes in the reported market values and returns to relevant market indices to test the reasonableness of the reported prices. The Company's internal price verification procedures, and review of fair value methodology documentation provided by independent pricing services, have not historically resulted in adjustment to the prices obtained from the pricing service.

Fair values of debt securities that do not trade on a regular basis in active markets, but are priced using other observable inputs, are classified as Level 2.

Fair value estimates for Level 1 and Level 2 equity securities are based on quoted market prices for actively traded equity security and/or other market data for the same or comparable instruments and transactions in establishing the prices.

The carrying amounts reported in the balance sheets for cash and cash equivalents, other receivables and accounts payable and accrued expenses approximate fair value because of their short-term nature.

## **10. RELATED-PARTY TRANSACTIONS**

Effective July 1, 2012, the Company entered into a revised Management Agreement (“Agreement”) with UHS. This Agreement has been approved by AHCCCS. UHS will continue to provide management services to the Company under a revised fee structure that is changing from a percent of capitation revenue to a direct charge based on UHS's expenses for services or use of assets provided to the Company. Management fees under this arrangement totaled \$118,646 and \$104,670 in 2013 and 2012, respectively. Direct expenses not included in the Agreement, such as broker commissions and premium taxes are paid by UHS on behalf of the Company. UHS is reimbursed by the Company for these direct expenses.

The Company expensed as medical services expenses and administrative expenses \$16,744 and \$8,859 in capitation fees and administrative services to related parties during 2013 and 2012, respectively. Under the Agreement, effective for July 1, 2012, UHS provides or arranges for services on behalf of the Company using a pass-through of charges incurred by UHS on a PMPM basis (where the charge incurred by UHS is on a PMPM basis) or using another allocation methodology consistent with the Agreement. These services include, but are not limited to, integrated personal health management solutions, such as disease management, treatment decision support and wellness services, including a 24-hour call-in service, access to a network of transplant providers and discount program services. OptumHealth Care Solutions, Inc. provides chiropractic, speech therapy, physical therapy and occupational therapy services. Dental Benefit Providers, Inc. provides dental care assistance. The Company entered into a new agreement with United Behavioral Health effective January 1, 2012 to provide mental health services. The Company entered into a new agreement with INSPIRIS, Inc. effective January 1, 2013 to provide Health Home Assessments. Spectera, Inc. provides administrative services related to vision benefit management and claims processing. As of October 31, 2011, the administrative services agreement with Spectera, Inc., was discontinued and was replaced by Nationwide, a non-related party.

The capitation expenses, administrative services, and access fees paid to related parties, that are included as medical services expenses and administrative expenses in the accompanying statements of operations for the years ended December 31, 2013 and 2012, are shown below:

	<b>2013</b>	<b>2012</b>
Dental Benefit Providers, Inc.	\$ 8,880	\$ 5,847
United HealthCare Services, Inc.	5,528	1,942
United Behavioral Health	917	839
INSPIRIS, Inc.	1,026	-
OptumHealth Care Solutions, Inc.	393	217
Spectera, Inc.	<u>-</u>	<u>14</u>
<b>Total</b>	<b><u>\$ 16,744</u></b>	<b><u>\$ 8,859</u></b>

The Company contracts with OptumRx, Inc. to provide administrative services related to pharmacy management and pharmacy claims processing for its enrollees. Fees related to these agreements, which are calculated on a per-claim basis, of \$6,102 and \$4,963 in 2013 and 2012, respectively, are included in administrative expenses in the accompanying statements of operations. Additionally, OptumRx collects rebates on certain pharmaceutical products based on member utilization. Rebate receivables of \$10,029 and \$7,619 as of December 31, 2013 and 2012, respectively, are included as related-party receivable — net on the balance sheets.

The Company contracts with OptumRx, Inc. to provide personal health products catalogues showing the health care products and benefit credits needed to redeem the respective products. OptumRx, Inc. will mail the appropriate personal health products catalogues to the Company's members and manage the personal health products credit balance. OptumRx, Inc. also distributes personal health products to individual members based upon the terms of the agreement. Fees related to this agreement in 2013 and 2012, which are calculated on a PMPM basis of \$5,847 and \$6,931 are included in the other medical services expenses in the accompanying statements of operations.

The Company holds a \$50,000 subordinated revolving credit agreement with UHG, at an interest rate of London InterBank Offered Rate, plus a margin of 0.50%. The credit agreement is for a one-year term and automatically renews annually, unless terminated by either party. The agreement was renewed effective June 1, 2012. No amounts were outstanding under the line of credit as of December 31, 2013 and 2012.

The remaining related-party receivable — net, as reflected in the accompanying balance sheets, represents costs incurred in the ordinary course of business by, or on behalf of, the Company.

#### **11. STOCKHOLDER'S EQUITY**

As a result of the change in net unrealized gains and losses on investments available-for-sale, the Company had accumulated other comprehensive income of \$1,126 and \$5,318 as of December 31, 2013 and 2012, respectively.

The Company paid a dividend of \$10,000 on November 27, 2012 to its former parent, UHC of AZ, which was approved by AHCCCS and recorded as a reduction to retained earnings.

The Company received an infusion of \$12,000 on January 11, 2013 and an infusion of \$15,000 on March 28, 2013 from its parent, UHC. This was recorded as an increase to additional paid-in capital.

Effective December 31, 2012, the Company changed its ownership, moving from a direct subsidiary of UHC of AZ to a direct subsidiary of UHC. This internal ownership reorganization was approved by AHCCCS on November 7, 2012. The reorganization will not have an impact on the financial statements of the Company. On February 20, 2013 all previously held common stock was canceled and two shares of \$0.01 par value common stock were issued to UHC.

#### **12. COMPLIANCE WITH FINANCIAL VIABILITY STANDARDS AND PERFORMANCE GUIDELINES**

For the contract year ended September 30, 2013, the Company was in compliance with the Financial Viability Standards and Performance Guidelines. Performance against these standards and guidelines for the contract year ending September 30, 2014 is being monitored by the Company on a quarterly basis.

#### **13. DRUG REBATES/DISCOUNTS**

The Company received and accrued \$20,911 and \$17,756 in pharmacy rebates in 2013 and 2012, respectively. The pharmacy rebates are included as a reduction in other medical services in the statements of operations (see Note 10).

#### **14. INTEREST ON LATE CLAIMS**

The Company paid \$25 and \$29 in interest on late claims for all members in 2013 and 2012, respectively. The interest on late claims is included in hospital inpatient services in the statements of operations.

#### **15. ACCRUED SANCTIONS**

The Company accrued a liability of \$604 and \$200 for AHCCCS sanctions as of December 31, 2013 and 2012, respectively. The sanctions are included in accounts payable and accrued expenses in the accompanying balance sheets.

## 16. PROVIDER INCENTIVES

The Company does not currently offer any provider incentives.

## 17. NON-COVERED SERVICES

The Company performed a review of claims with dates of service in 2013. Areas of focus included non-covered outpatient rehabilitation services, chiropractic services and dental services for adults. Small amounts of services were identified as having been provided to adults for outpatient rehabilitation services and chiropractic services. The results showed that \$2 of chiropractic services and \$9 of physical therapy services were paid for in 2013 for all members under contract.

## 18. INCOME TAXES

The Company's operations are included in the consolidated federal income tax return of UHG. Federal income taxes are paid to or refunded by UHG pursuant to the terms of a TSA, approved by the Board of Directors, under which taxes approximate the amount that would have been computed on a separate company basis. The Company receives a benefit at the federal rate in the current year for net losses incurred in that year to the extent losses can be utilized in the consolidated federal income tax return of UHG.

The components of the provision for income taxes for the years ended December 31, are as follows:

	2013	2012
Current provision:		
Federal	\$ 7,432	\$ (4,849)
State and local	<u>1,728</u>	<u>(905)</u>
Total current provision	<u>9,160</u>	<u>(5,754)</u>
Deferred provision:		
Federal	902	(114)
State and local	<u>202</u>	<u>(25)</u>
Total deferred provision	<u>1,104</u>	<u>(139)</u>
Total provision for income taxes	<u>\$ 10,264</u>	<u>\$ (5,893)</u>

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes for the years ended December 31, is as follows:

	2013	2012
Tax provision at the U.S. federal statutory rate	\$ 9,738	\$ (4,460)
State income taxes — net of federal benefit	1,254	(605)
Tax-exempt investment income	(781)	(837)
Other — net	<u>53</u>	<u>9</u>
Provision for income taxes	<u>\$ 10,264</u>	<u>\$ (5,893)</u>

Current federal and state income taxes receivable was \$0 and \$394 as of December 31, 2013 and 2012, respectively, and current federal and state income taxes payable was \$8,533 and \$90 as of December 31, 2013 and 2012, respectively.

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities, based on enacted tax rates and laws. The deferred income tax provision or benefit generally reflects the net change in deferred income tax assets and liabilities during the year. The current income tax provision reflects the tax consequence of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

The components of deferred income tax assets and liabilities as of December 31, 2013 and 2012, are as follows:

	2013	2012
Deferred income tax assets:		
Bad debt reserve	\$ 170	\$ 1,019
Unpaid losses and loss adjustment expense	<u>639</u>	<u>831</u>
Total deferred income tax assets	<u>809</u>	<u>1,850</u>
Deferred income tax liabilities:		
Prepaid expenses	(64)	-
Investments	(56)	(56)
Unrealized gain	<u>(727)</u>	<u>(3,477)</u>
Total deferred income tax liabilities	<u>(847)</u>	<u>(3,533)</u>
Net deferred income tax liabilities	<u>\$ (38)</u>	<u>\$ (1,683)</u>

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. There were no valuation allowances as of December 31, 2013 or 2012.

UHG currently files income tax returns in the United States federal jurisdiction, various states, and foreign jurisdictions. The U.S. IRS has completed exams on UHG's consolidated income tax returns for fiscal years 2012 and prior. UHG's 2013 tax return is under advance review by the IRS under its Compliance Assurance Program ("CAP"). With the exception of a few states, UHG is no longer subject to income tax examinations prior to 2008 in major state and foreign jurisdictions. The Company does not believe any adjustments that may result from these examinations will be material to the Company.

The Company has not included a reconciliation of the beginning and ending amount of unrecognized tax benefits as it does not have any uncertain tax positions as of December 31, 2013 or 2012.

Federal and state income taxes paid, net of refunds, in 2013 was \$324, and federal and income taxes received, net of refunds, in 2012 was \$5,591.

**19. RETIREMENT PLANS, DEFERRED COMPENSATION, POSTEMPLOYMENT BENEFITS AND COMPENSATED ABSENCES, AND OTHER POSTRETIREMENT BENEFIT PLANS**

The Company has no retirement plan, deferred compensation, and other benefit plans, since all personnel are employees of UHS, which provides services to the Company under the terms of a management agreement (see Note 10).

**20. SUBSEQUENT EVENTS**

In preparing these financial statements, management has evaluated and disclosed all material subsequent events up to April 29, 2014, the date that the financial statements were available to be issued.

The Company declared a \$25,000 dividend on March 20, 2014, paid on March 21, 2014.

There are no other events subsequent to December 31, 2013, that require disclosure.

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