Questions & Answers -- Minuteman Health, Inc. Rehabilitation
Updated October 27, 2017

Minuteman Health, Inc., ("MHI") was placed in rehabilitation by an *Order of Rehabilitation* entered by the Supreme Judicial Court for Suffolk County on August 2, 2017. The Order of Rehabilitation appointed Gary D. Anderson, the Massachusetts Commissioner of Insurance for the Commonwealth of Massachusetts, as Receiver of MHI. The Receiver has provided MHI members with notice of the rehabilitation and his appointment; the notice described the reasons for the proceeding, noting that MHI's latest financial reports showed it to be solvent and with adequate funds to pay all insurance claims in the normal course of business, and describing anticipated effects on members' coverage.

Since the *Order of Rehabilitation* was entered, additional financial information about MHI has become available. This information shows that MHI has adequate funds to pay all insurance claims in the normal course of business, but it also shows that the capital "cushion" is reduced. Considering the financial risks associated with continuing to provide coverage after December 31, 2017 and the benefits of accelerating the wind-up of MHI's operations, the Receiver decided to seek authority to terminate all coverage as of that date. The Court granted the Receiver such authority by its *Order Authorizing Receiver to Terminate Group Insurance Coverage as of December 31, 2017 and Approving Plan to Ameliorate Impact on Members' Cost-Sharing Payments During 2017*, dated October 19, 2017.

Why did the Commissioner seek the Order of Rehabilitation?

The Commissioner sought the *Order of Rehabilitation* because MHI's capital – provided by $154 million in loans from the United States – was significantly diminished and additional federal funds were not available. MHI had experienced adverse results for some time, primarily due to significant start-up costs and risk adjustment obligations. When MHI's risk adjustment obligations announced in June of 2017 were much higher than what was estimated, MHI's surplus was reduced to a level where the Commissioner determined that it was necessary (with the assent of MHI's Board of Directors) to seek an order of rehabilitation.

What does rehabilitation mean for MHI?

Since the *Order of Rehabilitation* entered, the Commissioner (as Receiver) has been in control of MHI with its officers and employees reporting to him. Reporting arrangements have been put in place so that operations can proceed efficiently while affording the Receiver information and control over substantive decisions. The rehabilitation will continue until MHI's operations are "run off" and its business can be closed in an orderly manner. The Massachusetts Division of Insurance has considerable experience with insurer runoffs and is coordinating closely with both federal officials and the New Hampshire Insurance Department.

Does the Receiver believe MHI's insurance obligations can be paid in full?

Yes. MHI's capital is "thin". However, approximately $25 million of MHI's liabilities are for a loan from the United States which is subordinated to MHI's insurance claim obligations. The United States' loan, therefore, functions as a "cushion". Recent financial reports suggest that this "cushion" is eroding somewhat faster than initially anticipated but that it will still be sufficient to make full payment to members and their health care providers on all policy-related claims. Moving now to terminate all business effective December 31, 2017 will help to maintain adequacy of the "cushion".

Does MHI's rehabilitation impact a member's ability to receive health care?

No. In rehabilitation, members in both individual and group plans will have coverage through December 31, 2017 and should continue to receive needed care according to the benefits in their MHI policy.

To avoid a lapse in coverage, individual plan members must select new insurance during the open enrollment period beginning November 1, 2017 for coverage beginning January 1, 2018 and employers should examine all available options to secure coverage with another health insurer that would begin by January 1, 2018.

Does MHI's rehabilitation impact providers rendering health care services or getting paid?

No. Providers will be paid in accordance with their existing contracts for any care provided to an MHI member while coverage is in effect through December 31, 2017. Providers are therefore expected to continue providing the same quality health care to MHI members.

What was the Receiver's initial plan with regard to MHI's in-force policies?

One of the Receiver's principal objectives in the rehabilitation is to minimize impacts on MHI members and their health care providers so that members receive uninterrupted delivery of health care services and their health care providers are paid promptly for their services. When the *Order of Rehabilitation* was entered, the Receiver believed this objective could be accomplished by ceasing the issuance of new coverage while continuing to administer all of MHI current policies in the ordinary course and through their normal termination dates.

With regard to individual policies and many calendar-year group policies (approximately 93% of MHI's business), this meant continuing coverage through the end of the policy period on December 31, 2017. With regard to other group policies (approximately 7% of MHI's business), this meant continuing coverage through the day before the group policies' anniversary date.

Why did the Receiver decide it was necessary to terminate group coverage effective December 31, 2017?

In recent weeks, MHI has prepared additional financial reports. While these continue to show that MHI has adequate funds to pay all insurance claims in the normal course of business, they also show that the capital "cushion" is eroding somewhat faster than initially anticipated. Because MHI is expected to continue experiencing losses throughout the rehabilitation, the longer this process continues the thinner that "cushion" will get. To reduce risk to MHI, its members, and their health care providers, the Receiver deems it prudent to cease providing all coverage at the end of calendar year 2017.

In addition to these prudential concerns, the Receiver's decision was also informed by MHI's cost structure and mix of business. Specifically, 93% of MHI members are covered under policies which will terminate on December 31, 2017. If MHI continued to administer group business in 2018, however, its internal costs (staff, overhead, and administrative costs) and external costs (vendor expenses) would not reduce proportionally. These costs, coupled with MHI's reduced capital "cushion", increase the risk that the company will run out of capital and make it more likely that MHI will need to be liquidated. In a liquidation proceeding, the Receiver would take

all actions necessary so that members and providers would be paid in full but the probability of disruption and delay would increase. The Receiver did not believe it was appropriate to expose group members and their health care providers to the risk of a sudden interruption of coverage in 2018 while continuing operations at a disproportionately higher per-member cost. Rather, the Receiver believed it was important that group policyholders be given sufficient notice to change to another insurer to allow for better continuity of coverage.

How does this impact my current policy?

All MHI policies will terminate on December 31, 2017 at 11:59 PM (ET). There will be no interruption of coverage prior to December 31, 2017 and your policy will continue in ordinary operation until that date. To avoid a loss of coverage after December 31, 2017, group policyholders will need to obtain replacement group coverage from another insurer. Individual policyholders will need to select a new insurer during open enrollment which begins November 1, 2017.

Does this impact group insurance members' cost-sharing payments?

MHI's group policies provide for cost-sharing including deductibles and maximum out-of-pocket payments ("MOOP"). These cost-sharing "accumulators" were established at a level intended to apply to a twelve-month coverage period. However, termination of the group coverage on December 31, 2017 will mean that MHI actually provides certain members with coverage for less than twelve months. Recognizing that this could impose financial hardships on those impacted MHI members, the Receiver sought authority from the Court to establish an amelioration plan that will pro-rate a group member's cost-sharing contributions and issue refunds as appropriate. The Court approved the Amelioration Plan on October 19, 2017.

What is the Amelioration Plan and how will it affect group members?

Under the Amelioration Plan, MHI will pro-rate a group member's annual "accumulators" (deductibles and MOOPs) and, if the member has made payments in excess of the pro-rated amount, issue a refund for the difference. **Neither members nor their employers need to take any action. MHI will perform the calculations and make any refund payments due.**

For deductibles, MHI will pro-rate each potentially applicable deductible (e.g. individual in-network, individual out-of-network, family in-network, and family out-of-network), compare the member's payments in the policy period prior to December 31, 2017, and refund any excess payments to the member as promptly as possible. If a member's payments satisfy more than one pro-rated deductible (e.g. individual vs. family), MHI will issue a refund based on whichever "accumulator" produces the greater payment to the group member.

For MOOPs, MHI will follow the same procedure as for deductibles -- MHI will pro-rate the non-deductible portion of each potentially applicable "accumulator", compare the member's non-deductible cost-sharing payments in the policy period prior to December 31, 2017, apply a "greater of" approach to individual and family MOOPs, and refund any excess payments as promptly as possible.

Do members or their health care providers need to do anything different regarding claim issues?

Members and their health care providers should continue to contact MHI at 855-644-1776 regarding claims issues. Health care providers should deal with health care service issues (like pre-authorization) just as they did in the past. Claims should be submitted as they were in the past and claim administration questions should be raised in the same way. Payments will be processed promptly and remitted in the same manner as previously.

How does this impact MHI's New Hampshire members?

MHI's Massachusetts and New Hampshire members will be treated the same. So too, New Hampshire health care providers will be treated the same as Massachusetts providers. The Massachusetts and New Hampshire insurance departments have worked closely together and with the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services to develop and implement an integrated regulatory plan. This coordination is intended to facilitate equivalent treatment for MHI members regardless of their state.

How can employers procure replacement group coverage for 2018?

Employers with Small Group Policies -- In order to avoid a lapse in group coverage, small group employers can shop and enroll in three ways:

1. Contact a licensed agent or broker.
2. Contact a health insurer directly for enrollment options.
3. Shop for small group plans on the Marketplace
    - Employers in Massachusetts can visit the State Marketplace at: www.mahealthconnector.org/business/employers
    - Employers in New Hampshire can visit the SHOP Marketplace on the federal Marketplace at: www.healthcare.gov/small-business

Employers with Large Group Policies -- In order to avoid a lapse in group coverage, large group employers can shop and enroll in two ways:

1. Contact a licensed agent or broker.
2. Contact a health insurer directly for additional enrollment options.

How can individuals obtain coverage for 2018?

In order to avoid a lapse in coverage for January 1, 2018, individual MHI members must shop and enroll with a new health insurer during the open enrollment period starting on November 1, 2017. There are three ways to shop and enroll in a new plan:

1. Contact a licensed agent or broker.
2. Contact a health insurer directly for enrollment options.
3. Visit the online Marketplace

- Massachusetts residents can visit the State Marketplace at: www.mahealthconnector.org
- New Hampshire residents can visit the federal Marketplace at: www.healthcare.gov

Who should I contact about questions?

Members with questions about their coverage or the Amelioration Plan described above should continue to contact MHI member services at 855-644-1776 or at members@minutemanhealth.org. Updates will also be posted on www.MinutemanHealth.org.
Members and their health care providers should continue to contact MHI at 855-644-1776 regarding claims issues.

MHI's Massachusetts members and health care providers with questions about MHI's receivership can call Tracey McMillan at 617-521-7347 or email her at: Tracey.T.McMillan@state.ma.us and New Hampshire members can call the New Hampshire Insurance Department Consumer Services Division at 1-800-852-3416 or email at: consumerservices@ins.nh.gov.