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Established 1886
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March 16, 2018

RECEIVED
MAR 16 2018
MAURA S. DOYLE, CLERK
OF THE SUPREME JUDICIAL COURT
FOR SUFFOLK COUNTY

BY HAND

Maura S. Doyle, Clerk
Supreme Judicial Court for Suffolk County
John Adams Courthouse, 1st Floor
One Pemberton Square, Suite 1300
Boston, Massachusetts 02108-1707

Re: Commissioner of Insurance, Plaintiff v.
Minuteman Health, Inc., Defendant – No. SJ-2017-0288

Dear Ms. Doyle:

Enclosed please find for filing the original of:

1. Verified Complaint Requesting Appointment of Liquidator;
2. Proposed Order of Notice of Hearing (which is also on the enclosed disk);
3. Proposed Order of Liquidation (which is also on the enclosed disk); and
4. Certificate of Service.

Thank you for your cooperation.

Very truly yours,

J. David Leslie
Special Assistant Attorney General

JDL:dlc
Enclosures

cc: Christopher M. Joyce
Service List

160 Federal Street
Boston, MA 02110-1700
TEL 617 542 2300
FAX 617 542 7437

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS:

SUPREME JUDICIAL COURT
FOR SUFFOLK COUNTY
NO. SJ-2017-0288

COMMISSIONER OF INSURANCE, PLAINTIFF,	)
v.	)
MINUTEMAN HEALTH, INC., DEFENDANT.	)

VERIFIED COMPLAINT REQUESTING APPOINTMENT OF LIQUIDATOR

Gary D. Anderson, Commissioner of Insurance for the Commonwealth of Massachusetts (the "Commissioner"), as Receiver (the "Receiver") of Minuteman Health, Inc. ("MHI" or the "Company"), institutes this action, by and through Maura Healey, the Attorney General, seeking an order appointing the Commissioner as Liquidator of MHI pursuant to G.L. c. 176G, §§ 20 and 20A (the statutes applicable to health maintenance organizations), and G.L. c. 175, §§ 6 and 180C (the statutes applicable to insurers), and granting appropriate relief to protect MHI's creditors and the public (the "Liquidation Order").

For the convenience of the Court in having all critical factual information in one document and of persons interested in this Verified Complaint but not in possession of a copy of

the Receiver's August 2, 2017 Verified Complaint and Request for Appointment of Receiver ("Rehabilitation Complaint"), the Statement of Facts ¶¶ 5-6 and 8-11 below generally recapitulate important contextual facts concerning MHI's organization and historical operations as originally set forth in similar paragraphs of the Rehabilitation Complaint.

SUBJECT MATTER JURISDICTION

1. The Supreme Judicial Court has exclusive and original jurisdiction over this matter pursuant to G.L. c. 175, §§ 6 and 180C, and G.L. c. 176G, § 20. See G.L. c. 175, § 180C ("the pertinent provisions of [G.L. c. 175, §§ 6 and 180B] shall apply," which section includes "making application to the supreme judicial court").

PARTIES

2. The plaintiff is the duly qualified Commissioner of Insurance of the Commonwealth of Massachusetts. Pursuant to G.L. c. 175, § 3A, he is charged with the administration and enforcement of the insurance laws of the Commonwealth, including G.L. c. 176G, which governs the organization, operation, and oversight of health maintenance organizations ("HMO").

3. The Commissioner appears by and through the Attorney General, who is charged with representing officials of the Commonwealth and the public interest in the administration of

public charities pursuant to G.L. c. 12, §§ 3, et seq., and the common law. The Attorney General's Office has asserted that MHI is a public charity.

4. The defendant MHI is a nonprofit corporation organized and existing under the laws of Massachusetts and operating as an HMO. MHI's statutory offices are located at 38 Chauncy Street, 6th Floor, Boston, Massachusetts 02111.

STATEMENT OF FACTS

5. MHI is authorized to do business as an HMO in the Commonwealth of Massachusetts and the State of New Hampshire. New Hampshire is a "reciprocal state" as defined in G.L. c. 175, § 180A.

6. MHI functions as a qualified nonprofit health insurance issuer under the Consumer Operated and Oriented Plan ("CO-OP") program of the Patient Protection and Affordable Care Act ("Affordable Care Act"). See P.L. 111-148, § 1322 [42 U.S.C. § 18042]. MHI offered so-called "narrow network" coverage designed to provide members access to a comparatively limited number of health care providers as a means of controlling the overall growth in health care costs. MHI offered health plans to groups and individuals both on and off of the Affordable Care Act exchange at premium levels that were lower than average in the markets in which the Company did business. The Company's health plans were effective for a

twelve-month term. Approximately 91% of MHI's members in 2017 purchased individual insurance plans, 7% small group plans and 2% large group plans. The individual insurance plans had a January 1 anniversary date, while the small and large group plans had anniversary dates throughout the year. Of MHI's total members as of December 31, 2017 (30,988), 75% were in New Hampshire and 25% in Massachusetts.

7. MHI did not participate in 2018 open enrollment and therefore wrote no 2018 individual business. Pursuant to the Court's order of October 19, 2017, MHI's in-force group business was cancelled as of December 31, 2017 (11:59 PM Eastern Time). Consequently, as of January 1, 2018, MHI had no insurance business in-force.

8. MHI commenced insurance operations on January 1, 2014. MHI's initial capital was provided by start-up and solvency loans from the United States, administered by the United States Department of Health & Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS"). The start-up and solvency loan agreements provided for the incremental disbursement of up to $156.4 million upon the attainment of milestones, subject to a filed business plan, and at the discretion of CMS. Notably, to request solvency distributions subsequent to the initial installment, the Company needed to certify that the requested amount "[was]

sufficient and necessary to maintain the additional risk based capital ["RBC"] reserve requirement imposed under this Agreement of 500% RBC."[1] Infused with the initial tranches of capital from CMS, the Company's surplus (the difference between total assets and liabilities) as of year-end 2013 - that is, immediately before beginning insurance operations - totaled $29.8 million.

9. At the end of its first year of operation, 2014, the Company reported 1,700 members, negative net income of $20.2 million, and surplus of $9.3 million. In the Company's 2015 annual statement, reporting results for its second year of operation, MHI advised that membership had grown to 13,726 at year end, that it had negative net income for the year of $51.6 million, and that (due to the contribution of additional capital by CMS) its surplus had increased to $11.4 million. The Company's 2015 results were significantly impacted by its

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[1] The RBC system consists of two parts: (1) a formula used to set a regulatory minimum capital level for each insurer based on the insurer's mix of assets, liabilities, and risk; and (2) a definition of "financial impairment" and remedies for state insurance regulators in the event an insurer meets the definition of impairment. There are essentially four levels: (1) Company Action Level (RBC ratio between 200% and 150%); (2) Regulatory Action Level (RBC ratio between 150% and 100%); (3) Authorized Control Level (RBC ratio between 100% and 70%); and (4) Mandatory Control Level (RBC ratio of 70% or lower). See 211 C.M.R. § 25.01.

"risk adjustment" payment obligations pursuant to regulations promulgated by HHS and start-up costs.[2]

10. MHI continued to incur large losses in 2016 and in November advised the Commissioner that the Company would be reporting negative net worth by year-end if CMS did not exercise its discretion to contribute further capital pursuant to the loan agreement. As a result, the Commissioner called for a targeted examination of the Company and prepared contingency plans. As it developed, however, CMS did release $28.7 million to MHI during December 2016.

11. The December funding from CMS was expected at the time to be sufficient to return the Company's surplus, as of December 31, 2016, to the 500% RBC ratio required by the loan agreement with CMS. This did not prove to be the case. Substantial increases in the estimate of MHI's obligations to pay risk adjustment in 2017 for the prior year required MHI to post larger-than-expected reserves. Consequently, MHI ultimately reported negative net income of $39 million for 2016, a reduction in surplus to $5.1 million, and an RBC ratio

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[2] Risk adjustment is an Affordable Care Act mechanism intended to assess health insurers that draw members who are healthier than average and compensate health insurers who draw members that are sicker than average. The intent is to encourage carriers to compete through efficiency, cost, and service rather than ability to draw healthier members. MHI's management had asserted that the negative impact of risk adjustment was approximately $100 million through 2016.

of 142% when it filed its 2016 annual statement on March 16, 2017.

12. Due to MHI's consistent and substantial adverse financial results each year since it began operations combined with its expressed need for additional capital in order to remain viable over time, the Commissioner issued an Administrative Supervision Order pursuant to G.L. c. 175J, § 3(E) on February 2, 2017.[3] As the Company's financial statements for the period ending December 31, 2016 were prepared after the Administrative Supervision Order was issued, the Commissioner's independent consulting actuaries (Lewis & Ellis, Inc.) reviewed the principal reserves recorded by MHI as of December 31, 2016 for its unpaid claim liability, risk adjustment payable in 2017, and premium deficiency for 2017 business (the estimated difference between the applicable premium rates and the expected claims and expenses related to that business).[4] MHI's total recorded reserves as of December 31, 2016 for its unpaid claim liability, risk

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[3] On February 7, 2017, the Company consented to the Administrative Supervision Order.

[4] The premium rates for Affordable Care Act business are required to be set well before the beginning of the open enrollment period. Participating insurers are then required to issue and renew eligible business with those rates. To the extent that the assumptions used in setting those premium rates are thereafter deemed inadequate, an insurer is required to establish a reserve for that premium deficiency.

adjustment payable in 2017, and premium deficiency for its 2017 business fell within the range estimated by its independent consulting actuaries, Milliman, Inc., and Lewis & Ellis. Thereafter, KPMG, MHI's independent auditors, reviewed its 2016 financial statements prepared in accordance with statutory accounting practices prescribed or permitted by the Massachusetts Division of Insurance (the accounting method applicable to HMOs). KPMG issued its audit opinion, dated September 1, 2017, that the 2016 MHI financial statements "present fairly, in all material respects, the admitted assets, liabilities, and surplus of Minuteman Health, Inc. as of December 31, 2016 and 2015, and the results of its operations and its cash flow for the years ended, in accordance with statutory accounting practices…".[5]

13. After the Order of Rehabilitation for MHI was entered on August 2, 2017, the Receiver re-engaged Lewis & Ellis, to review the adequacy of MHI's reserves, as of June 30, 2017, for unpaid claim liabilities, risk adjustment payable in 2017, and premium deficiency for its 2017 business. MHI recorded reserves for those three liabilities, as of June 30, 2017, in a total amount higher than Lewis & Ellis' best estimate. The

[5] KPMG's September 1, 2017 audit opinion contained a note advising of "substantial doubt about the Company's ability to continue as a going concern."

reported surplus at June 30, 2017 was $1,496. The results of MHI's operations in the second half of 2017 (particularly in December) were significantly worse than those revised estimates.

14. Attached as Exhibit A are MHI's statement of operations and balance sheet for the period ending December 31, 2017, which report negative net income of $40.4 million for 2017 and ending surplus of negative $8.3 million.[6] (At the Receiver's request, Lewis & Ellis calculated an estimate of MHI's unpaid claim liabilities as of December 31, 2017 and its report is attached as Exhibit B.)

15. MHI's RBC ratio as of December 31, 2017 is a negative number, its liabilities exceed its assets, and it cannot pay

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[6] The negative $8.3 million surplus is a $13.4 million reduction from the $5.1 million reported in MHI's 2016 annual statement. This difference is the net result of: i) negative net income of $40.4 million; ii) a $1.05 million favorable adjustment to estimated employee expenses accrued in the 2016 annual statement; iii) a $1.02 million favorable change in non-admitted assets; and iv) positive surplus impact due to reclassification of the $24.9 million start-up loan made to MHI by CMS. As explained in ¶ 5 of the Receiver's October 6, 2017 "Report and Recommendation on the Continuing Necessity for the Injunctions in the Order of Rehabilitation", the terms of the $24.9 million start-up loan provide for that obligation to be subordinated to MHI's claim-related obligations and "Basic Operating Expenses". As of June 30, 2017, the Company reclassified $11.9 million of that liability (i.e. reduced the liability for borrowed money and added a write-in for special surplus) to facilitate an increase in the premium deficiency reserve. The remaining balance of the start-up loan was reclassified as of December 31, 2017, but was inadequate to fully cushion the impact of MHI's losses.

all its obligations in the normal course of business. MHI is therefore insolvent within the meaning of G.L. c. 175, §§ 6 and 180C and G.L. c. 176G, § 20A.

16. The principal driver of the $40.4 million of negative net income in 2017 was worse-than-expected experience (including lower premium, higher expenses, and greater losses) which accounts for nearly $22 million of the adverse result. In addition: the actual risk adjustment payable by MHI in 2017 was approximately $6 million higher than the amount estimated and recorded as of December 31, 2016; the Company lost approximately $1.6 million when CMS stopped making cost sharing reduction payments in October of 2017; and, MHI incurred approximately $2 million in costs associated with the rehabilitation staffing plan approved by the Court on September 7, 2017. Finally, because MHI has no on-going business its financial statements cannot be prepared on a going concern basis, requiring that the total estimated expenses to run off MHI be fully accrued as of December 31, 2017. An additional $9.1 million was accrued for that purpose.

17. A significant portion of the 2017 loss resulting from adverse experience was reported in December of 2017.[7] Reporting of adverse experience was concentrated in December due, in large part, to the inadequacy of the Company's historical methodology for calculating its unpaid claim liability as described below. While this methodology problem was identified in mid-January 2018, it is likely that the reserve for unpaid claim liability was deficient throughout 2017 with the scope of that deficiency only emerging in December for the following reasons. To the extent that a claim had no dollar value assigned to it or had been rejected for an administrative reason, the claim was not considered in establishing the unpaid claim liability. MHI's contracts to pay health care providers for medical services to its members frequently set the reimbursement rate as a function of the Medicare reimbursement rate for that particular medical service. Medicare reimbursement rates were changed last fall and it took several months for the necessary adjustments to be made by MHI's claim administrator. During this period claims

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[7] The Statement of Operations attached as Exhibit A shows a net loss of approximately $21.3 million reported for the month ended December 31, 2017. Approximately $12.2 million of that loss reflects adverse experience as described in ¶ 17. The remaining $9.1 million represents the additional expense accrual to run off MHI (this was in addition to $9.9 million otherwise accrued as of December 31, 2017 for the expense of administering the 2017 business).

were "pended" awaiting application of the proper reimbursement rate. Pursuant to the historical reserving methodology, no liability was ascribed to those claims in October and November which were then fully paid in early December. Since the reserve for unpaid claim liabilities as of November 30, 2017 had not reflected those claims, the December payments for the "pended" claims flowed through directly and generated a substantial net loss for the month. Also, several large claims previously rejected for administrative reasons were resubmitted in December. Since they had not been reflected in the reserve for unpaid claim liabilities as of November 30, 2017, this also directly increased the net loss for December.

18. As of February 28, 2018, MHI had approximately $49.7 million of cash and invested assets and the Lewis & Ellis-reviewed reserve for unpaid claim liabilities was $6.0 million. The reserve for runoff expenses was $13.4 million ($19.0 million accrued as of December 31, 2017 less paid expenses in January and February). (An estimated $1.9 million of the remaining runoff expense reserve is projected to fall to priority class 7 (all other claims) if the proposed Liquidation Order enters.) Therefore, after applying the creditor priorities set forth at G.L. c. 175, § 180F and G.L. c. 176G, §20, it appears there are adequate assets to pay in full expected expenses of administration (priority class 1) and

claims of policyholders, beneficiaries and insureds arising from insurance policies and contracts (priority classes 2 and 3). The estimated amount remaining to pay lower priority claims would be approximately $32.2 million.

19. For the reasons described in ¶ 18 above and in order to avoid unnecessary member and health care provider disruption, the Commissioner requests authority to continue to pay policy-related claims in the normal course of business. All creditors with claims in priorities below policy-related (priority classes 4 through 7) would be required to submit a proof of claim by the date and in the form approved by the Court.

20. Based on the developments described above, the Commissioner believes that MHI, a company which is the subject of a rehabilitation proceeding under G.L. c. 175, § 180B and G.L. c. 176G, §§ 20 and 20A, is insolvent, and that it is therefore appropriate to enter an order of liquidation for MHI pursuant to G.L. c. 175, §§ 6 and 180C and G.L. c. 176G, §§ 20 and 20A. He requests that this Court appoint the Commissioner, and his successors in office, as Liquidator of MHI in order to liquidate the business of MHI and protect the interests of creditors and the public.

21. The Commissioner requests, pursuant to G.L. c. 175, §§ 179 and 180C and G.L. c. 176G, § 20, that as Liquidator he

be authorized to employ special counsel. In accordance with G.L. c. 175, §§ 179 and 180C, the Commissioner seeks authorization to fix the compensation of said special counsel, and to pay said compensation and all other necessary expenses of conducting the proceeding, out of the funds or assets of MHI.

22. Upon entry of the order appointing the Liquidator herein requested, the commencement or continuation of litigation or other proceedings against MHI in courts and fora other than this Court is possible. Such litigation or other proceedings, and the time and expense involved in defending such litigation or proceedings, could interfere with the receivership proceeding in this Court and the orderly winding up of MHI's business. Litigation or other proceedings against MHI, its directors, employees, and agents or the Commissioner, as Liquidator, conducted outside of a proceeding in this Court, could materially hinder the discharge of the Liquidator's responsibilities under G.L. c. 175 and G.L. c. 176G, and frustrate the purpose and policies of the Commonwealth as expressed in G.L. c. 175, § 180C and G.L. c. 176G, § 20. Since such actions or proceedings would interfere with the liquidation proceedings, they should be enjoined to the full extent of the Court's jurisdiction.

23. The Commissioner, as Liquidator, may find it necessary or desirable to institute or defend litigation or other proceedings in jurisdictions outside Massachusetts, or to take other action requiring legal attention in jurisdictions outside Massachusetts, to protect MHI and its interests or otherwise to discharge the Liquidator's responsibilities under G.L. c. 175 and G.L. c. 176G. Accordingly, the Commissioner, as Liquidator, may need to employ attorneys, or to continue the employment of attorneys previously employed by MHI, as special or local counsel to represent the interests of MHI or the Commissioner, as Liquidator, in the proper defense, prosecution or other disposition of litigation, other proceedings, and other legal matters, all upon such terms and conditions as the Commissioner, as Liquidator, considers necessary in accordance with G.L. c. 175 and G.L. c. 176G, and to pay for such services out of the funds or assets of MHI.

24. Pursuant to G.L. c. 175, § 180C and G.L. c. 176G, § 20, the Commissioner, in order to perform his duties as Liquidator, may delegate such authority to and to pay such appropriate personnel and vendors as he deems reasonably necessary to carry out the operations of MHI in liquidation, subject to compliance with the provisions of G.L. c. 175 and G.L. c. 176G, the supervision of the Commissioner, as Liquidator, and subject to further orders of this Court.

25. As MHI has no in-force policies, it has no policyholders within the definition of G.L. c. 175, § 180D. Accordingly, the Commissioner, as Liquidator, will not give notice of his appointment to policyholders pursuant to G.L. c. 175, § 180D. See In re Liquidation of Amer. Mut. Liab. Ins. Co., 440 Mass. 796, 800-804 (2004) (policyholders to whom notice is due under § 180D, are those "with in-force policies at the time of the appointment of the receiver.")

26. A proposed Injunction and Order Appointing Liquidator accompanies this Verified Complaint and is consistent with the authority set forth in G.L. c. 175 and G.L. c. 176G.

STATEMENT OF CLAIMS

27. The allegations contained in Paragraphs 1 through 26 of this Verified Complaint Requesting Appointment of Liquidator are reasserted as if set forth herein.

28. The foregoing allegations demonstrate that MHI is insolvent and should be liquidated. Therefore, grounds exist under G.L. c. 175, § 180C and G.L. c. 176G, §§ 20 and 20A, for the granting of the injunctive relief requested and for the appointment of the Commissioner as Liquidator for the purposes of liquidation of MHI.

RELIEF REQUESTED

WHEREFORE, the Commissioner prays that this Court:

(1) Set a date for a hearing on this petition pursuant to G.L. c. 175, §§ 6 and 180C, and issue an order of notice in the form submitted herewith;

(2) After notice to creditors and others pursuant to the Court's Order of Notice and hearing, find that MHI is insolvent within the meaning of G.L. c. 175, §§ 6 and 180C and G.L. c. 176G, § 20A; vacate the Injunction and Order Appointing Rehabilitator; issue an order in the form submitted herewith directing the liquidation of MHI and appointing the Commissioner and his successors in office as the Liquidator of MHI pursuant to G.L. c. 175, §§ 6 and 180C and G.L. c. 176G, §§ 20 and 20A, authorizing the Commissioner as Liquidator to pay MHI's policy-level claims in the normal course of business, ordering MHI's creditors with claims below the policy-level to submit their claims by August 31, 2018 in the form attached hereto as Exhibit C, and directing the Liquidator to take possession of the property and effects of MHI, to settle its affairs and to distribute its assets subject to such rules and orders as this Court or a Justice thereof may prescribe; and

(3) Grant such other relief as may be appropriate.

Respectfully submitted,

GARY D. ANDERSON
COMMISSIONER OF INSURANCE
By his attorney,
MAURA HEALY
ATTORNEY GENERAL

J. David Leslie BBO # 294820
dleslie@rackemann.com
Eric A. Smith BBO # 546244
esmith@rackemann.com
Special Assistant Attorneys General
Rackemann, Sawyer & Brewster, P.C.
160 Federal Street
Boston, Massachusetts 02110
(617) 542-2300

Dated March 14, 2018

VERIFICATION

I, Gary D. Anderson, state that I am the duly qualified Commissioner of Insurance of the Commonwealth of Massachusetts, and that I have read the allegations set forth in the Verified Complaint Requesting Appointment of Liquidator, and that they are true to the best of my knowledge, information, and belief.

Gary D. Anderson
Commissioner of Insurance

March 16, 2018

Exhibit A

Minuteman Health, Inc.
Balance Sheet (unaudited)
December 31, 2017

ASSETS

Current Assets		
Bonds	$	41,873,564
Cash		19,706,521
Cash Equivalents		2,339,206
Short Term Investments		2,010,551
Cash and Short Term Investments		24,056,278
Subtotal: Cash and invested assets		65,929,842
Investment income due and accrued		240,226
Uncollected premiums and agents balances		544,257
Amounts recoverable from reinsurers		1,458,942
Amounts receivable relating to uninsured plans		15,797
Prepaid Expenses		141,740
Other Assets		1,752,730
TOTAL ASSETS ADMITTED	**$**	**70,083,534**

LIABILITIES AND SURPLUS

LIABILITIES		
Claims unpaid	$	17,758,124
General expenses due or accrued		18,970,278
Risk Adjustment Liability		41,331,615
Other Liabilities		361,967
TOTAL LIABILITIES		**78,421,984**
SURPLUS		
Surplus note		129,016,095
Aggregate write-in for other-than-special surplus funds		24,904,495
Unrealized Gain/Loss		669
Retained earnings		(162,259,709)
TOTAL SURPLUS		(8,338,450)
TOTAL LIABILITIES AND SURPLUS	**$**	**70,083,534**

Exhibit A

Minuteman Health, Inc.
Statement of Operations (Unaudited)

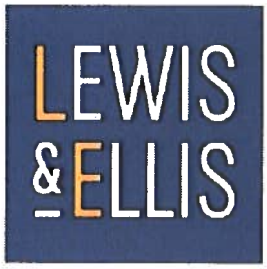
For the month ended December 31, 2017[1]		For the year ended December 31, 2017[1]
	REVENUES	
	Premiums	
$ 9,597,945	Net Premiums	$ 133,847,602
(2,962,346)	Risk Adjustment	(41,331,474)
8,415	Risk Corridor Current Year	19,726
-	Prior Year Risk Adjustment	(6,053,003)
6,644,014	**Total Premiums**	**86,482,851**
7,181	Other Revenue	75,938
6,651,195	**TOTAL REVENUE**	**86,558,789**
	EXPENSES	
	Medical Expenses	
17,235,185	Claims Expense	106,162,460
-	Reinsurance Recoveries	(2,228,461)
174,521	Health Care Quality Improvement	2,150,104
17,409,706	**Total Medical Expenses**	**106,084,103**
	Administrative Expenses	
490,760	Commission	3,282,883
317,110	Distribution Expense	4,271,304
374,030	Claims Adjudication Expense	2,506,821
370,199	Provider Network Expense	4,301,967
1,788,378	Salaries and Related Expense	9,551,687
3,348,887	Administration and Claim TPA	7,897,790
1,708,215	Legal and Consulting[2]	4,920,816
7,522	CMS and Risk Adjustment Expense	1,377,498
1,836,485	Rent, Insurance and Other Administration	5,066,967
10,241,586	**Total Administrative Expenses**	**43,177,733**
480,881	Assessments and Taxes	2,490,994
-	Premium Deficiency Reserve (PDR)[3]	(23,708,112)
28,132,173	**TOTAL EXPENSES**	**128,044,718**
193,372	Investment Income	1,116,515
$ (21,287,606)	**NET INCOME/(LOSS)**	**$ (40,369,414)**

[1] Because MHI has no on-going business its financial statements cannot be prepared on a going concern basis. Estimated additional administrative expenses to fully run off MHI ($9.1 million) were therefore accrued as of December 31, 2017 and are reflected in the particular categories described.

[2] MHI incurred $324,195 in legal/consulting expenses associated with the rehabilitation in 2017. As of December 31, 2017, $760,000 was accrued for Receiver-related legal/consulting expenses for the remainder of the run off proceeding.

[3] As of December 31, 2016, MHI accrued a PDR for 2017 operations. This PDR was fully drawn down during 2017 to offset losses.

Exhibit B



ACTUARIAL MEMORANDUM ON

Estimate of Minuteman Health, Inc., Claims Unpaid as of December 31, 2017

FOR THE MASSACHUSETTS COMMISSIONER OF INSURANCE, AS RECEIVER OF MINUTEMAN HEALTH, INC.

MARCH 8, 2018

LEWIS & ELLIS

MR. DAVID DILLON, FSA, MAAA
MR. ARI LOIBEN, MS

Exhibit B

Table of Contents

Executive Summary

On August 2, 2017, Gary D. Anderson, the Massachusetts Commissioner of Insurance ("Commissioner"), was appointed Receiver of Minuteman Health, Inc. ("MHI"). The Commissioner, as Receiver, retained Lewis & Ellis, Inc. ("L&E") to perform actuarial services regarding MHI.

L&E was asked to independently calculate an estimate for MHI's Claims Unpaid (or "Incurred But Not Reported" or "IBNR") provision for the 12/31/2017 financial statement.

Conclusions:

- L&E estimates MHI's Claims Unpaid provision for 12/31/2017 to be $17,758,124.
  - The above estimate is a retrospective estimate based on updated claims information through 2/27/2018.
  - The above estimate does not require the addition of an explicit margin for adverse deviation.

- Approximately 66%, or $11,788,461, of the $17,758,124, has been paid as of 2/27/2018.
  - Therefore, L&E expects an additional $5,969,663 of claims to ultimately be paid.

David Dillon, FSA, MAAA
Vice President & Principal
Lewis & Ellis, Inc.

Ari T. Loiben, MS
Statistician & Actuarial Associate
Lewis & Ellis, Inc.

Purpose & Scope

On August 2, 2017, Gary D. Anderson, the Massachusetts Commissioner of Insurance, was appointed Receiver of Minuteman Health, Inc. ("MHI"). The Commissioner, as Receiver, retained Lewis & Ellis, Inc. ("L&E") to perform actuarial services regarding MHI.

L&E was asked to independently calculate an estimate for MHI's Claims Unpaid provision for the 12/31/2017 financial statement.

This report is solely for the use of the Receiver as part of the receivership process but may be filed with the court supervising the proceeding.

Limits on Distribution and Utilization

This report has been prepared for the use of the Receiver regarding the receivership of Minuteman Health, Inc. The data and information presented is not appropriate for any other purpose.

L&E is aware that this report may be distributed to other parties; however, Lewis & Ellis, Inc. requires that any user of this report must possess a certain level of expertise in actuarial science and/or health insurance so as not to misinterpret the data presented. Any distribution of this report should be made in its entirety. Any third party with access to this report acknowledges, as a condition of receipt, that L&E does not make any representations or warranties as to the accuracy or completeness of the material. Any third party with access to these materials cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

Confidentiality of Review & Reliances

L&E recognizes that in the performance of its work hereunder, L&E had access to records and information considered confidential by the Commonwealth as defined in M.G.L. c. 66A, M.G.L. c. 175, § 4, M.G.L. c. 176G, § 10 and M.G.L. c. 4, § 7(26) or any other law or regulation applicable thereto.

L&E took steps to comply with all laws and regulations relating to confidentiality and privacy (including but not limited to the confidentiality and privacy of MHI). This included taking reasonable steps to ensure the physical security of such data under its control.

L&E has agreed to not discuss information or findings with persons other than those specifically designated by the Receiver.

L&E will promptly notify the Receiver of any inquiries, requests or demands concerning any confidential information, including any subpoenas issued thereof.

Analysis of Claims Unpaid

For its independent review and estimation, L&E performed the following:

1) Reviewed MHI's actuarial reports and exhibits;

2) Obtained claim triangles, premium, and membership through February 27, 2017;

3) Performed a retrospective calculation of the December 31, 2017 Claims Unpaid estimates as of February 27, 2017.

Independent Calculation of Claims Unpaid

L&E calculated an independent retrospective estimate for the 12/31/2017 reserve based on claims, premium, and membership information through February 27, 2018.

The analysis was performed separating by MHI's business into three layers. The layers were defined by the aggregate claim amounts over the last twenty-four months for each claimant.

Layer 1 contained all claimants with less than $100,000 in total claims. Layer 2 contained claimants with aggregate claims between $100,000 - $500,000. Layer 3 contained claimants with aggregate claims more than $500,000.

As of 2/27/2018, Layer 2 contained 112 members and Layer 3 contained 11 members. The more than 30,000 other members were included in Layer 1.

Layer 1

L&E loaded historical claim lag reports from inception through February 27, 2018, into the L&E claim lag model to independently calculate completion factors. L&E's estimate for the IBNR was based on a claim development method which was supplemented by a per member per month (PMPM) method.

Layer 2

L&E summed the aggregate unpaid and pended (or "pending") amounts as of February 27, 2017. Unpaid amounts were defined as claims with a status of paid while having no paid date. These were added to the actual claims paid as of 2/27/2018 for claims incurred prior to 1/1/2018.

Pended claims were further categorized into two groups:

- Group 1 – claims with a non-zero allowed amount; and
- Group 2 – claims with a zero-dollar allowed amount.

For those in Group 1, the allowed amount was reduced by 13%. This was to reflect that ultimate paid claims tend to be less than the original amount after adjudication. This 0.87 factor was developed based on a review of recent claim transactions and discussions with MHI.

For Group 2, the charge amounts were reduced by 60%. This 0.40 factor was based on an internal MHI historical analysis of pended claims with no associated allowed amounts.

Layer 3

Like Layer 2, pended claims were further categorized into two groups:

- Group 1 – claims with a non-zero allowed amount; and
- Group 2 – claims with a zero-dollar allowed amount.

For those in Group 1, rather than utilize a 0.87 factor for each claimant like that was used for Layer 2, the pended amounts were adjusted on a case by case basis for each claimant. These ranged from 0.82 to 0.87 for three claimants. The claims for the other eight claimants were not reduced.

These factors (or lack thereof) was developed based on a review of recent claim transactions and discussions with MHI.

For those in Group 2, claims were reduced by the same 0.40 factor that was used for Layer 2.

Aggregate Claims Unpaid

L&E's aggregate final IBNR estimate across all three layers is $17,758,124.

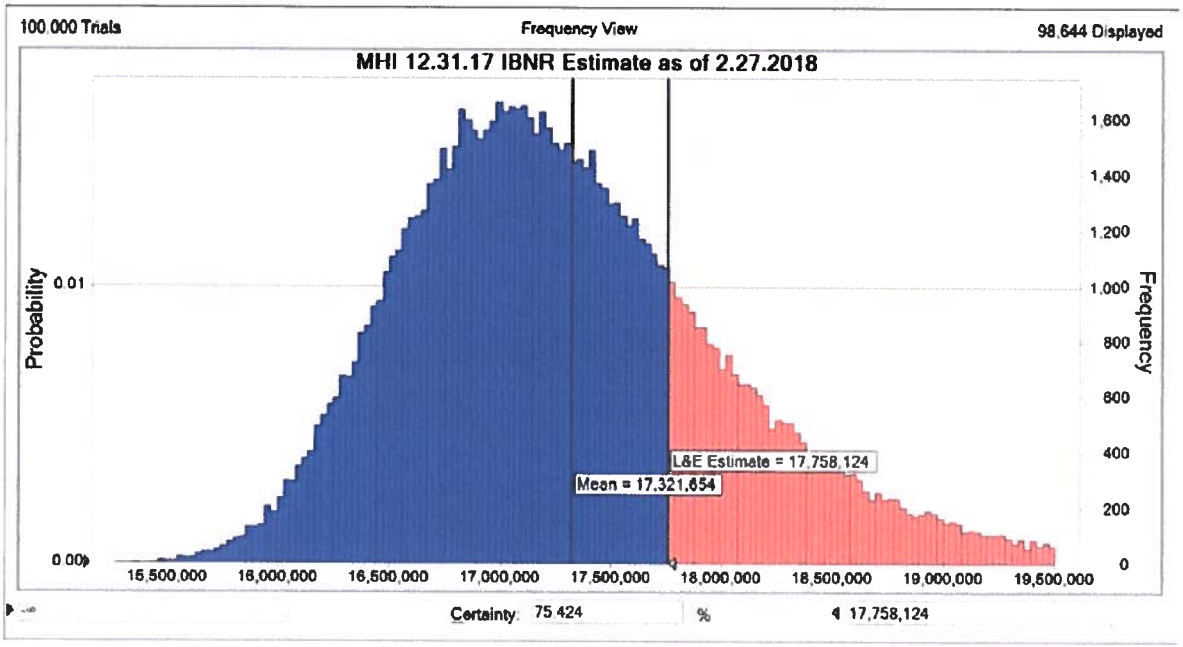
Layer	Claims Paid Thru 2/27/2018	IBNR	12/31/2017 Retrospective IBNR
Layer 1	$7,456,649	$3,169,836	$10,626,485
Layer 2	$3,368,263	$413,715	$3,781,978
Layer 3	$963,549	$2,386,112	$3,349,661
Total*	$11,788,461	$5,969,663	$17,758,124

$11,788,461 of the total 17,758,124 reserve estimate (≈66%) has been paid as of 2/27/2018.

Generally accepted actuarial principles requires that a Claims Unpaid provision include a margin for adverse deviation. This provision should account for the fact that an IBNR estimate should be adequate under moderately adverse conditions.

L&E generally considers a "best estimate" IBNR to be equal to the ultimate realized IBNR approximately 50% of the time. L&E considers a "moderately adverse" IBNR one that is ultimately sufficient 75-80% of the time.

L&E simulated 100,000 IBNR scenarios based on the inherent volatility of claims to develop a range for the ultimate IBNR for 12/31/2017. That is, L&E developed a range for each input assumption e.g. lag factors and pending claim factors based on MHI's claim history. After producing 100,000 simulated IBNR results, it appears that L&E's IBNR estimate of $17,758,124 appears to satisfy moderately adverse conditions since that IBNR level is expected to be sufficient 75.4% of the time. Therefore, no additional explicit margin was included.



ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[1], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[2], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary

The responsible actuary is:

- David M. Dillon, FSA, MAAA, MS, Vice President & Principal at Lewis & Ellis, Inc.

The actuary is available to provide supplementary information and explanation.

Identification of Actuarial Documents

The date of this document is March 9, 2018. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is February 27, 2018.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Receiver but may be filed with the court supervising the proceeding. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from MHI. L&E is not aware of anything that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Receiver with the rehabilitation of MHI pursuant to the Order of Rehabilitation entered by the supervising court on August 2, 2017.
- The responsible actuary identified above is qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- L&E is not aware of any subsequent events that may have a material effect on the findings.

Actuarial Findings

The actuarial findings of the report can be found in the body of this report.

[1] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.
[2] These organizations adopted identical Codes of Professional Conduct effective January 1, 2001.

Methods, Procedures, Assumptions, and Data

The methods, procedures, assumptions and data used by the actuary can be found in the body of this report.

Assumptions or Methods Prescribed by Law

This report was prepared as prescribed by applicable law, statues, regulations and other legally binding authority.

Responsibility for Assumptions and Methods

The actuary does not disclaim responsibility for material assumptions or methods.

Deviation from the Guidance of an ASOP

The actuary does not believe that material deviations from the guidance set forth in an applicable ASOP have been made.

Exhibit C

PROOF OF CLAIM

MINUTEMAN HEALTH, INC. ("MHI")

The deadline for filing a Proof of Claim is **August 31, 2018**

IF YOUR CLAIM ARISES FROM AN MHI INSURANCE CONTRACT OR A PROVIDER HOLD HARMLESS OBLIGATION AND YOU SUBMIT IT TO MHI IN THE ORDINARY COURSE OF BUSINESS ON OR BEFORE **AUGUST 31, 2018**, THIS FORM NEED NOT BE COMPLETED.

***

IF YOU DO NOT SUBMIT A CLAIM BY THE FILING DEADLINE, YOU MAY NOT RECEIVE ANY PAYMENTS FROM MHI.

ADDITIONAL INSTRUCTIONS ARE ON THE REVERSE SIDE OF THIS FORM. PLEASE PRINT OR TYPE.

1. Description of Claim(s). Provide a detailed description of the basis for your claim(s) against MHI. Include reference to any policy or member number(s), contract or agreement, claim or docket numbers, or amounts paid:

   _____

   _____

   _____

   _____

   (If you have multiple claims or require additional space, you may attached additional pages as required.)

2. Amount of the claim. If the amount of the claim will increase, state the known amount and then add that the amount is "subject to increase." If you do not know the amount, state "unknown": $_____.

3. Type of security. If your claim is secured, state the type and amount of such security. If none, state "none": _____.

4. Offsets/Reductions. Payments made by MHI that reduce the claim. If none, state "none": $_____.

5. Priority. Right of priority to payment or other specific right asserted by the claimant. _____.

6. Attach copies of any documents that provide support for the claim.

Under penalties of law, I state that the facts set forth in this Proof of Claim are true to the best of my knowledge, that the sum claimed is justly owed, and that there is no known setoff, counterclaim or defense to the claim.

Your Name and Address:

_____

_____

_____

_____

Name and Address of your Attorney:

_____

_____

_____

_____

Signature: _____

Date: _____

MAIL THIS FORM TO:

J. David Leslie, Esq.
Rackemann, Sawyer & Brewster PC
160 Federal Street
Boston, MA 02110

(To be completed by the Liquidator)

The Liquidator of MHI acknowledges receipt of this Proof of Claim.

Date Received: _____

Proof of Claim No.: _____

Exhibit C

[To be printed on the reverse side of the Proof of Claim Form]

NOTICE OF LIQUIDATION

By Order of the Massachusetts Supreme Judicial Court for Suffolk County, dated _____ (the "Liquidation Order"), the Massachusetts Commissioner of Insurance was appointed Liquidator of Minuteman Health, Inc. ("MHI"). The Liquidation Order directs, among other things, that the Liquidator settle MHI's affairs and distribute its assets and that creditors of MHI file claims on or before August 31, 2018.

IF YOU BELIEVE THAT YOU ARE PRESENTLY OWED MONIES BY MHI, OR MAY BE OWED MONIES AT ANY TIME IN THE FUTURE, YOU MUST SUBMIT YOUR CLAIM ON OR BEFORE AUGUST 31, 2018 OR YOUR CLAIM AGAINST MHI MAY BE BARRED.

IF YOUR CLAIM ARISES FROM AN MHI INSURANCE CONTRACT OR A PROVIDER HOLD HARMLESS OBLIGATION AND YOU SUBMIT IT TO MHI IN THE ORDINARY COURSE OF BUSINESS ON OR BEFORE AUGUST 31, 2018, THIS FORM NEED NOT BE COMPLETED.

INSTRUCTIONS FOR COMPLETION OF PROOF OF CLAIM FORM

If you believe that you have a claim now, or may have a claim in the future, against MHI for any reason, you must file a Proof of Claim form in order to preserve your claim. (There is a time-limited exception for claims arising out of MHI policies or health care provider member hold harmless requirements which may be submitted in the ordinary course of business until August 31, 2018.) If you wish to preserve your rights as to any claim that might be filed in the future, describe the claim as "unreported claim."

- You must print your name and address in the space provided and sign and date the Proof of Claim form. If you have an attorney, include his or her contact information.
- Your Proof of Claim must be postmarked on or before August 31, 2018 and mailed to the following address:

  J. David Leslie, Esq.
  Rackemann, Sawyer & Brewster PC
  160 Federal Street
  Boston, MA 02110

- Priority rights are governed by statute (Mass. Gen. Laws c. 175, § 180F, and c 176G, § 20). If you do not assert a right of priority or do not know the priority class that applies to your claim(s), write "none".
- You may be requested to submit supporting documentation to facilitate the Liquidator's determination of your claim(s).
- If you need more information or have any questions, you may mail your inquiry to the above address or contact Stuart Leslie at sleslie@rackemann.com or (617) 951-1130.
- If you file a Proof of Claim and your address changes, you are required to notify the Liquidator of such change.

After you file your Proof of Claim, the Liquidator will acknowledge receipt. If you do not receive an acknowledgement within three weeks, please call (617) 951-1130.

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS:

SUPREME JUDICIAL COURT
FOR SUFFOLK COUNTY
NO. SJ-2017-0288

COMMISSIONER OF INSURANCE,
PLAINTIFF,

v.

MINUTEMAN HEALTH, INC.,
DEFENDANT.

[PROPOSED]

ORDER OF NOTICE OF HEARING

The Commissioner of Insurance, as Receiver of Minuteman Health, Inc. ("MHI"), having filed a Verified Complaint Requesting Appointment of Liquidator ("Complaint") and proposed order directing the liquidation of MHI, appointing him as Liquidator of MHI, and entering permanent injunctions, it is ORDERED:

1. That said Complaint be and it hereby is set down for hearing before Justice Lowy of this Court to be held in Boston on _____, 2018 at _____ in the Oliver Wendell Holmes, Jr., Courtroom, John Adams Courthouse, One Pemberton Square, Boston, Massachusetts.

2. That the Receiver give notice of said hearing by causing a copy of the attached notice to be sent by U.S. mail,

first class postage prepaid to the last known address reflected in the company's electronic records of:

(a) The New Hampshire Insurance Commissioner;

(b) The United States Department of Justice and Department of Health & Human Services, Centers for Medicare and Medicaid Services;

(c) The former directors of MHI as of August 2, 2017 (the date of the Rehabilitation Order);

(d) All MHI vendors (including health care providers) receiving payments from the company from January 1, 2017 to February 28, 2018 as shown on its electronic payment records;

(e) All former MHI members with claims open as of February 28, 2018 or with coverage effective on or after January 1, 2017 as shown on its electronic membership and claim records;

(f) All former MHI group policyholders with policies in force at any time between January 1, 2017 and December 31, 2017 as shown on its electronic membership and claim records; and,

(g) All other potential creditors to whom MHI made payment from January 1, 2017 through February 28, 2018 as reflected in MHI's accounts payable system.

3. That the Receiver also give notice of said hearing by posting an electronic copy of the notice as well as the Verified

Complaint and related pleadings on the website of the Massachusetts Division of Insurance and by causing a copy of the attached notice to be published once a week for two successive weeks in one newspaper of general circulation in Boston, Massachusetts and Concord, New Hampshire, the capital cities of the two states where MHI was authorized to do business.

4. That any interested person appear at said hearing and show cause, if any they have, why the prayers of said Complaint should not be allowed. Any person intending to object to the Verified Complaint shall file that written objection with the Court at least five days prior to the hearing, and shall simultaneously provide a copy to counsel for the Receiver, J. David Leslie, Rackemann, Sawyer & Brewster, P.C., 160 Federal Street, Boston, Massachusetts 02110.

By the Court, (Lowy, J.)

_____
Clerk

Entered: _____ __, 2018

NOTICE

Insurance Commissioner's Verified Complaint Requesting Appointment of Liquidator for Minuteman Health, Inc. ("MHI")

Notice is hereby given that a hearing will be held on _____, 2018 at _____, before Justice Lowy of the Supreme Judicial Court for Suffolk County, Massachusetts, in the Oliver Wendell Holmes, Jr., Courtroom, John Adams Courthouse, One Pemberton Square, Boston, Massachusetts, to consider and act upon the Verified Complaint Requesting Appointment of Liquidator brought by the Commissioner of Insurance of the Commonwealth of Massachusetts. (An electronic copy of this notice as well as the Verified Complaint, related pleadings, and a Q&A document have been posted on Massachusetts Division of Insurance website at https://www.mass.gov/lists/receiverships.)

The Verified Complaint seeks to have the Court order the liquidation of MHI and appoint the Commissioner of Insurance, and his successors in office, as Liquidator of MHI to liquidate the company pursuant to G.L. c. 175, §§ 6 and 180C and G.L. c. 176G, § 20 and 20A. It also requests the Court's approval to continue paying member and health care provider claims in full and without interruption, as well as seeks to terminate the prior proceedings pursuant to which the Commissioner of Insurance has acted as Receiver of MHI since August 2, 2017.

Any person intending to object to the Verified Complaint shall file that written objection with the Court at least five days prior to the hearing, and shall simultaneously provide a copy to counsel for the Receiver, J. David Leslie, Rackemann, Sawyer & Brewster, P.C., 160 Federal Street, Boston, Massachusetts 02110.

By the Court, (Lowy, J.)

_____
Clerk

Entered: _____ __, 2018

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS:

SUPREME JUDICIAL COURT
FOR SUFFOLK COUNTY
NO. SJ-2017-0288

COMMISSIONER OF INSURANCE, PLAINTIFF,	)
v.	)
MINUTEMAN HEALTH, INC., DEFENDANT.	)

[PROPOSED]

ORDER OF LIQUIDATION

This matter came before the Court, Lowy, J., upon a verified complaint requesting appointment of liquidator ("Complaint"). Upon consideration thereof, and after hearing, it is ORDERED, ADJUDGED AND DECREED, UNTIL FURTHER ORDER OF THIS COURT, that:

(1) Minuteman Health, Inc. ("MHI"), is insolvent within the meaning of G.L. c. 175, §§ 6 and 180C and G.L. c. 176G, § 20A.

(2) The proceedings initiated under G.L. c. 175, § 180B and G.L. c. 176G, §§ 20 and 20A ("Rehabilitation") are hereby terminated and the Injunction and Order Appointing Rehabilitator entered on August 2, 2017 is vacated.

(3) Gary D. Anderson, as the Commissioner of Insurance of the Commonwealth of Massachusetts, and his successors in office (the "Commissioner"), is hereby appointed as permanent receiver of MHI ("Liquidator") for the purposes of liquidation pursuant to G.L. c. 175, §§ 6 and 180C and G.L. c. 176G, §§ 20 and 20A.

(4) The Commissioner, as Liquidator, is directed to take possession of all property and effects of MHI, to settle its affairs, to distribute its assets, and to otherwise proceed forthwith to liquidate the business of MHI under the general supervision of the Court.

(5) Pursuant to G.L. c. 175, §§ 179, 180B, and 180C and G.L. c. 176G, § 20, the Commissioner, as Liquidator, is authorized to employ special counsel (including special counsel in other jurisdictions) and consultants and vendors as he deems necessary and to fix and pay the compensation of such special counsel, consultants, and vendors and all other necessary expenses of conducting this proceeding out of the funds or assets of MHI as appropriate.

(6) Pursuant to G.L. c. 175, § 180F and G.L. c. 176G, § 20, all claims against MHI shall be filed on or before August 31, 2018. With the exception of claims described in ¶¶ (7) and (8) below, all claims must be submitted in the form attached to the Complaint as Exhibit C ("Proof of Claim").

(7) The Commissioner, as Liquidator, is authorized to pay the claims of policyholders, beneficiaries, insureds, members, and members' beneficiaries arising from and within the coverage of and not in excess of the applicable limits of insurance policies and contracts issued by MHI, or health care providers assigned such claims ("Policyholder-Level Claims") without the submission of a Proof of Claim so long as such Policyholder-Level Claims are tendered to MHI in the ordinary course of business on or before August 31, 2018.

(8) The Commissioner, as Liquidator, is authorized to pay the claims of any provider who is obligated by statute or agreement to hold members harmless from liability for services provided pursuant to and covered by a health maintenance contract ("Hold Harmless Claims") without the submission of a Proof of Claim so long as such Hold Harmless Claims are tendered to MHI in the ordinary course of business on or before August 31, 2018.

(9) To the full extent of the jurisdiction of the Court and the comity to which orders of the Court are entitled, all persons are hereby enjoined and restrained from: (a) instituting or continuing to prosecute any suit, action, arbitration, or other proceeding against MHI, its officers, directors, employees or agents, or against the Commissioner as Liquidator; and (b) from executing or issuing or causing the execution or issuance

of any writ, process, summons, attachment, subpoena, replevin, execution, or other proceeding for the purpose of impounding or taking possession of or interfering with any property owned by or in the possession of MHI, or owned and in the possession of any of its directors officers, employees or agents, or owned by it and in the possession of the Commissioner as Liquidator.

(10) Any bank, savings and loan association, or other financial institution or legal entity is prohibited from disposing of, allowing to be withdrawn, or concealing in any manner property or assets of MHI, except under the express authorization of the Liquidator or by the further order of this Court.

(11) The actual, reasonable, and necessary costs of preserving or recovering the assets of MHI and the costs of goods or services provided to MHI or the receiver during the period of Rehabilitation shall be treated as "expenses of administration" pursuant to G.L. c. 175, §§ 180C and 180F and G.L. c. 176G, § 20.

(12) The amounts recoverable by the Liquidator from any reinsurer of MHI shall not be reduced as a result of this liquidation proceeding, and each such reinsurer of MHI is hereby enjoined and restrained from terminating, canceling, failing to extend or renew, reducing, or changing coverage under any reinsurance policy or contract with MHI without first obtaining

leave of this Court. The Liquidator may, in his discretion, commute any contract with a reinsurer or reinsurers.

(13) The Commissioner, as Liquidator, is authorized to take such other actions as he deems appropriate to effectuate the purposes of this order.

(14) The Court retains jurisdiction to issue such further orders as may be appropriate.

So ORDERED,

By the Court (Lowy, J.)

_____
Clerk

Entered: _____ __, 2018

CERTIFICATE OF SERVICE

I, J. David Leslie, Special Assistant Attorney General, hereby certify that I served the Verified Complaint Requesting Appointment of Liquidator; Proposed Order of Notice of Hearing; and a Proposed Order of Liquidation on all counsel by first class mail to:

Daniel J. Hammond, Esq.
Assistant Attorney General
Commonwealth of Massachusetts
Administrative Law Division
Government Bureau, 20th Floor
One Ashburton Place
Boston, MA 02108

Susan E. Brown
President and Chief Operating Officer
Minuteman Health, Inc.
38 Chauncy Street
Boston, MA 02111

Stephen M. Weiner, Esq.
Elissa Flynn-Poppey, Esq.
Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C.
One Financial Center
Boston, MA 02111

Thomas O. Bean, Esq.
Verrill Dana, LLP
One Boston Place, Suite 1600
Boston, MA 02108

J. David Leslie
Special Assistant Attorney General
Rackemann, Sawyer & Brewster
160 Federal Street
Boston, MA 02110-1700
617-951-1131
dleslie@rackemann.com

Dated: March 16, 2018