Exhibit E

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

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.

Exhibit F

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

NEW MEXICO HEALTH CONNECTIONS, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	:	No. 1:16-cv-00878-JB/WPL

DECLARATION OF KEN LALIME

I, KENNETH R. LALIME, being over 18 years of age and of sound mind, declare under penalty of perjury that the following statements are true and correct:

1. I make this declaration based on my personal knowledge.

2. I was the CEO of HealthyCT from January 1, 2013 until December 15, 2016. HealthyCT was a not-for-profit health insurance carrier in Connecticut established under the CO-OP Program in the Affordable Care Act. HealthyCT sought to improve its enrollees' health by partnering with primary care physicians in patient-centered medical homes to improve care management and coordination.

3. The risk adjustment program administered by the United States Department of Health and Human Services ("HHS") contributed to the demise of HealthyCT. In the summer of 2016, HHS assessed a risk adjustment penalty of over $13M against HealthyCT. We were unable to predict the magnitude of this penalty in advance, even though HealthyCT used nationally recognized actuarial consultants to develop its pricing. Soon after the assessment of this risk adjustment charge, the Connecticut Insurance Department determined that

HealthyCT lacked adequate reserves and placed the company under supervision, eventually leading to HealthyCT being shut down.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Dated: April 17, 2018

Kenneth R. Lalime

Exhibit G

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

NEW MEXICO HEALTH CONNECTIONS, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	No. 1:16-cv-00878-JB/WPL

DECLARATION OF PETER BEILENSON

I, DR. PETER BEILENSON, being over 18 years of age and of sound mind, declare under penalty of perjury that the following statements are true and correct:

1. I make this declaration based on my personal knowledge.

2. I was the CEO of Evergreen Health Cooperative, Inc. ("Evergreen"), which I co-founded, from 2012 to August 2017. Evergreen was a not-for-profit health insurance carrier in Maryland that was established under the CO-OP Program in the Affordable Care Act.

3. Evergreen combined health insurance and primary care physician services, seeking to deliver more patient-centered medical management that would improve the quality of medical care while reducing its costs. Evergreen attracted tens of thousands of members.

4. The risk adjustment program administered by the United States Department of Health and Human Services ("HHS") destroyed Evergreen. In the summer of 2016, HHS assessed Evergreen a risk adjustment penalty equal to 28.2% of its premium revenue for calendar year 2015. Evergreen was unable to predict this massive risk adjustment penalty, which ultimately caused Evergreen to financially fail. This is despite the fact that Evergreen was

a profitable company prior to its risk adjustment assessment and that Evergreen used nationally recognized actuarial consultants to advise on the setting of premiums and reserves.

5. Since Evergreen has departed the Maryland market, CareFirst (the Blue Cross/Blue Shield plan in Maryland) has become a virtual monopoly in the State's individual insurance market and it has raised premiums substantially. In my opinion, HHS's risk adjustment program is responsible for dramatically curtailing competition and raising premiums in the State of Maryland.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Dated: April 18, 2018

Dr. Peter Beilenson

Exhibit H

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

NEW MEXICO HEALTH CONNECTIONS, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	:	No. 1:16-cv-00878-JB/WPL

DECLARATION OF KATHRYN A. HOWELL

I, Kathryn A. Howell, being over 18 years of age and of sound mind, declare under penalty of perjury that the following statements are true and correct:

1. My name is Kathryn Howell. I am the Acting President of CareConnect Insurance Company, Inc. ("CareConnect"), domiciled in New York. Prior to January 1, 2018, I served as the SVP, Chief Legal Officer of CareConnect.

2. CareConnect, New York State's first provider owned commercial insurance company, was founded in 2013 by the Northwell Health System, formerly North Shore-LIJ Health System. CareConnect presented an innovative approach to health insurance. Built on customer service and powered by integration into Northwell Health's health care delivery system, CareConnect offered members access to a broad range of plans on and off New

York's marketplace with the goal of providing access to quality care at an affordable price. (CareConnect's rates on Long Island for its best-selling gold metal tier, were approximately 10% below its competitors, other than Health Republic, a New York based co-op, in 2015-2016.)

3. CareConnect grew rapidly from approximately 11,000 members at the end of 2014 to 118,000 at its peak in 2017, due partially to the collapse of Health Republic at the end of 2015, but also due to positive consumer response.

4. Then in 2015, CareConnect was required to pay approximately $13 million in small group risk adjuster liability. This amount equaled approximately 31% of its total small group direct written premium. In 2016, the CareConnect small group risk adjuster liability grew to approximately $112 million, 44% of total small group direct written premium. And, currently, for 2017, we are estimating that CareConnect will owe approximately $113 million in small group risk adjuster liability, before the New York Department of Financial Services application of a 30% reduction pursuant to emergency regulation, which equates to 35% of its 2017 direct small group written premium. The New York regulation was issued by the Superintendent in anticipation that "the federal risk adjustment program will adversely impact the small group health insurance market in this State in 2017 to such a degree as to require a remedy." 11 NYCRR 361.9(b)(1).

5. The magnitude of these losses required CareConnect to deviate from its business plan and increase its rates. Although losses amounted to between approximately one-third and close to one-half of its total small group premium in 2015 and 2016, year-over-year rate increases in that amount are not feasible from a commercial viability or regulatory stand-point. As a result, CareConnect's small group rates were increased 20% on average in 2017 and were set to increase an additional 18% on average for 2018 had CareConnect not ultimately withdrawn from

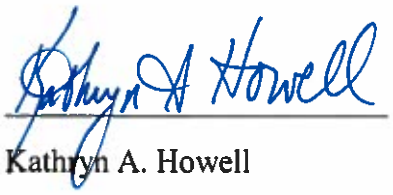
the market (as further described below). This size rate increase left CareConnect with substantial losses while still negatively impacting consumers.

6. CareConnect did not increase its premium rates for 2016 to adequately account for risk adjustment liabilities, as it did not anticipate the magnitude of risk adjustment payments when setting rates in 2015 for the upcoming year. In fact, when 2016 rates were developed in May 2015, CareConnect had 21,000 members and anticipated a combined individual and small group risk adjustment liability of approximately $5 pmpm. By December 2016 CareConnect had 110,000 members, and a combined risk adjustment liability of $159 pmpm.

7. Eventually, due largely to the severity of its small group risk adjuster losses, CareConnect ceased writing new small and large group business on December 1, 2017 and new individual business on and off the New York State of Health ("Exchange") on January 1, 2018, causing consumers to have fewer and largely more expensive commercial options for comparable small group coverage on Long Island.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Dated: April 23, 2018



Kathryn A. Howell