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THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

21 South Fruit Street Suite 14
Concord, New Hampshire 03301

Roger A. Sevigny
Commissioner

Alexander K. Feldvebel
Deputy Commissioner

February 19, 2014

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the New Hampshire Insurance Department (NHID) to enter into a contract in the amount of $96,275.00 with Manatt, Phelps & Phillips, LLP, New York, New York. (Vendor # 225912), for the provision of legal research to explore regulatory models for oversight of provider payment practices and safe harbors relative to anti-trust for activities related to efforts to inform policymakers and others regarding options for payment reform that improve care and reduce medical costs. This agreement is to be effective upon Governor & Council approval through June 30, 2014. 100% Federal Funds.

The funding is available in account titled Rate Review Grant as follows.

	FY2014
02-24-24-240010-59780000-046-500464 Consultants	$96,275

EXPLANATION

The New Hampshire Insurance Department has received a federal grant to improve the health insurance premium rate review process and transparency related to health insurance premiums and medical care costs in New Hampshire. Under the grant, the Insurance Department will evaluate opportunities to influence provider payment reform through the rate review process, in order to best serve the people of New Hampshire.

The major deliverables for Manatt include:

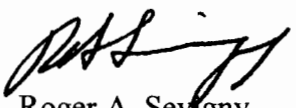
1. Identify key payment reform models and analyze the general federal and state regulatory issues that each model raises.
2. Perform legal and regulatory analysis of provider payment models to identify regulatory issues, including the level of insurance risk providers can bear; antitrust concerns; self-dealing laws; and cross-border issues.
3. Generate a written report and presentation to the New Hampshire Insurance Department by June 30, 2014.
4. Work set out in the response to the RFP (attached)

After reviewing the bid responses, the Commissioner selected the Manatt's proposal as the most responsive to the Request for Proposals (RFP). The Request for Proposals was posted on the Department's website December 23, 2013 and sent to past bidders for Department contract work and companies doing work in this field. Four bids were received. Bids were evaluated by Department staff familiar with the project goals using a scoring system included in the RFP.

The department respectfully requests that the Governor and Council authorize funding for this consulting work. Your consideration of the request is appreciated.

In the event Federal Funds become no longer available, General Funds will not be requested to support this program.

Respectfully submitted,



Roger A. Sevigny

RFP 2013 RRG-17 PROPOSALS EVALUATIONS

Evaluation Committee members: Tyler Brannen, Alain Couture, Martha McLeod, Jennifer Patterson

Evaluation process: Every member reviewed and independently evaluated the bids.
On February 7, 2014, the Evaluation Committee members met, and as a group assigned points to each bid per the "Specific comparative scoring process" described in each RFP.
All members agreed with the points assigned to each category for each bid depicted in the table below.

RFP/VENDOR	CONTRACTOR SKILL (25% or points)	CONTRACTOR EXPERIENCE & QUALIFICATIONS (25% or points)	PLAN OF WORK (25% or points)	Bid Price- BUDGET AMOUNT	COST (25% or points)	TOTAL SCORE (100% or Points)	Score without $$$	NOTES
RFP 2013-RRG-17 Legal Barriers To Payment Reform								
Manatt	22.00%	22.00%	22.50%	$96,275	25.00%	91.50%	66.50%	Winning Bid
UMASS	21.00%	21.50%	22.50%	$130,200	18.49%	83.49%	65.00%	
Public Consulting Group, Inc.	18.00%	15.50%	15.50%	$155,000	15.53%	64.53%	49.00%	
Freedman HealthCare, LLC	19.50%	18.50%	19.00%	$325,000	7.41%	64.41%	57.00%	

Print Form

FORM NUMBER P-37 (version 1/09)

Subject:

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Insurance Department	1.2 State Agency Address 21 South Fruit St. Suite 14, Concord, NH 03301
1.3 Contractor Name Manatt, Phelps & Phillips, LLP	1.4 Contractor Address 7 Times Square, New York, NY 10036
1.5 Contractor Phone Number 212-790-4500 / 1.6 Account Number	1.7 Completion Date June 30, 2014 / 1.8 Price Limitation $96,275.00
1.9 Contracting Officer for State Agency Alexander Feldvebel	1.10 State Agency Telephone Number 603.271.7973 x248
1.11 Contractor Signature	1.12 Name and Title of Contractor Signatory Melinda Dutton, Partner

1.13 Acknowledgement: State of New York, County of New York

On February 14, 2014, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

Marianella Santiago

[Seal]

MARIANELLA SANTIAGO
NOTARY PUBLIC-STATE OF NEW YORK
No. 01SA4991173
Qualified in Bronx County
My Commission Expires January 27, 2018

1.13.2 Name and Title of Notary or Justice of the Peace

Marianella Santiago

1.14 State Agency Signature Alexander K. Feldvebel	1.15 Name and Title of State Agency Signatory Alexander Feldvebel, Deputy Commissioner

1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)*

By: Director, On:

1.17 Approval by the Attorney General (Form, Substance and Execution)

By: J Christopher Meyerhoff, Asst Attorney General On: 3/26/14

1.18 Approval by the Governor and Executive Council

By: On:

2. EMPLOYMENT OF CONTRACTOR/SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT A which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.
3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, this Agreement, and all obligations of the parties hereunder, shall not become effective until the date the Governor and Executive Council approve this Agreement ("Effective Date").
3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.
Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds, and in no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to terminate this Agreement immediately upon giving the Contractor notice of such termination. The State shall not be required to transfer funds from any other account to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.
5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT B which is incorporated herein by reference.
5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.
5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.
5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.
6.1 In connection with the performance of the Services, the Contractor shall comply with all statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal opportunity laws. In addition, the Contractor shall comply with all applicable copyright laws.
6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.
6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.
7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.
7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.
7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

Contractor Initials MJD
Date 2/14/14

8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely remedied, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 treat the Agreement as breached and pursue any of its remedies at law or in equity, or both.

9. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

9.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

9.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

9.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

10. TERMINATION. In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT A.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS. The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written consent of the N.H. Department of Administrative Services. None of the Services shall be subcontracted by the Contractor without the prior written consent of the State.

13. INDEMNIFICATION. The Contractor shall defend, indemnify and hold harmless the State, its officers and employees, from and against any and all losses suffered by the State, its officers and employees, and any and all claims, liabilities or penalties asserted against the State, its officers and employees, by or on behalf of any person, on account of, based or resulting from, arising out of (or which may be claimed to arise out of) the acts or omissions of the Contractor. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $250,000 per claim and $2,000,000 per occurrence; and

14.1.2 fire and extended coverage insurance covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than fifteen (15) days prior to the expiration date of each of the insurance policies. The certificate(s) of insurance and any renewals thereof shall be

Contractor Initials
Date 2/14/14

attached and are incorporated herein by reference. Each certificate(s) of insurance shall contain a clause requiring the insurer to endeavor to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than ten (10) days prior written notice of cancellation or modification of the policy.

15. WORKERS' COMPENSATION.
15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation").*
15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. WAIVER OF BREACH. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

17. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

18. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire.

19. CONSTRUCTION OF AGREEMENT AND TERMS. This Agreement shall be construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional provisions set forth in the attached EXHIBIT C are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire Agreement and understanding between the parties, and supersedes all prior Agreements and understandings relating hereto.

Contractor Initials
Date 2/14/14

Agreement with Manatt, Phelps & Phillips, LLP
Legal Barriers to Payment Reform – Cycle II Rate Review

Exhibit A

Scope of Services

The consultant's primary responsibility will be to

1. Identify key payment reform models and analyze the general federal and state regulatory issues that each model raises.
2. Perform legal and regulatory analysis of provider payment models to identify regulatory issues, including the level of insurance risk providers can bear; antitrust concerns; self-dealing laws; and cross-border issues.
3. Generate a written report and presentation to the New Hampshire Insurance Department by June 30, 2014.
4. Work set out in the response to the RFP (attached)

State of New Hampshire
Legal Barriers to Payment Reform
2013-RRG-17

Manatt Response

JANUARY 27, 2014

Manatt Health Solutions
A division of Manatt, Phelps & Phillips, LLP
7 Times Square
New York, NY 10036

manatt

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APPENDICES:

I. UNDERSTANDING OF PROJECT

The American healthcare system is undergoing a significant shift in how health care providers are compensated by public and private payers: from fee-for-service to new payment models that are tied to performance, quality, and value. From 2011 to 2013, the total number of accountable care organizations (ACOs)—provider organizations that bear some of the risk for the cost or quality of patient care—has increased more than tenfold, including more than a dozen ACO and FQHC initiatives in New Hampshire.[1]

Today providers and payers are embracing a range of models to replace fee-for-service reimbursement. These include pay-for-reporting and pay-for-performance in which providers receive incentive payments for reporting certain quality measures and achieving certain levels on them; patient-centered medical homes, in which providers receive a capitated amount to manage primary care, in addition to normal fee-for-service payments; bundled or global payments that make a single payment to a group of providers for an episode of care, sometimes including risk-adjustment or quality bonuses; and ACOs, where providers take financial risk for the total cost and quality of care of a defined population. In 2011, 12% of total provider payments in New Hampshire were made using a reimbursement structure other than fee-for-service, and half of payments to New Hampshire hospitals were based on fee schedules that included performance incentives.[2]

New Hampshire is asking the same questions as other states about what types of payment reform are most promising for controlling costs and improving quality of care. How can New Hampshire encourage the shift to risk- and quality-based purchasing across the various market segments, including public programs (Medicare and Medicaid), commercial insurance markets (individual and group, inside and outside the new Marketplace), and the self-insured market? New Hampshire has more control over some markets than others. Medicare is an important market, but the state's role is primarily limited to deciding how much, if any, it wants to align with federal ACO and other payment reform strategies. The state's role as a purchaser in the Medicaid program offers substantially more opportunity, as does the state's role as the regulator of the commercial insurance market, including the Marketplace to the extent the state takes on plan management functions. Almost 80% of the insurance market is controlled by three carriers with one of those carriers having more than 40% of the entire market and being the sole carrier participating in the new exchange Marketplace in 2014. Furthermore, almost two-thirds of New Hampshire residents are covered by employer-sponsored coverage, many of them in self-insured plans in which the state's role is limited by ERISA.

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[1] *See* Matthew Peterson, et al., Ctr. for Accountable Care Intelligence, Leavitt Partners, *Growth and Dispersion of Accountable Care Organizations* 6 (2013); Michael G. Grenier et al., Univ. of Mass. Med. School, *New Hampshire's Health Insurance Market and Provider Payment System* 8 (2013).

[2] *See* Grenier., *supra* note 1, at 54.

Market segmentation creates many challenges, especially for ambitious forms of payment reform, such as ACOs, that are more effective with alignment across market segments. To the extent that such alignment is constrained by federal law, there are new opportunities for multi-payer initiatives through programs such as State Innovation Models (SIM) grants and various waiver programs, including State Innovation waivers under section 1332 of the ACA starting in 2017. Effective payment reform strategies require a sophisticated understanding of state market dynamics and federal programs to find the most appropriate mix, as illustrated by leading reform states. For example, Maryland, which has had a hospital rate-setting program for three decades, is currently proposing to leverage its unique Medicare waiver to move to a new payment system that would shift virtually all hospital revenue into global payments that make hospitals accountable for controlling costs and improving quality.[3] Similarly, Massachusetts is using its Medicaid and Connector experience to set statewide targets for healthcare spending growth and is encouraging the development of accountable care organizations and other risk-bearing provider arrangements.[4] New York recently adopted accountable care organization regulations that permit third-party administrators of self-insured health plans to enter into capitated payment arrangements with provider organizations.

Faced with this new risk-based terrain—driven in different ways by private payers, state Medicaid agencies, and the Medicare program—the state insurance regulator's role is challenging.[5] A principal concern of insurance regulators is ensuring the solvency of entities that bear insurance risk. In a world where providers are bearing more risk, policymakers need to evaluate how regulatory controls should adapt. Regulators also need to look beyond solvency—to understand what limits existing rules may place on provider payment reform and what steps the state can take to encourage reform.

The June 2013 study, *New Hampshire's Health Insurance Market and Provider Payment System: An Analysis of Stakeholder Views*, commissioned by the New Hampshire Insurance Department (NHID), identified several roles NHID could play in facilitating provider payment reform in New Hampshire. Specifically, stakeholders see two principal roles for the NHID: first, a "convening role," in which the NHID identifies best practices for payment models across payers and encourages their implementation; second, as a regulator that would directly intervene into the contractual relationships between payers and providers, where appropriate.[6]

Building on these recommendations, NHID now seeks a contractor to analyze models of provider payment reform and assess what role NHID should play in the ongoing transformation. In particular, NHID seeks an analysis of the legal barriers and opportunities for each of the

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[3] *See* Ctr. for Medicare & Medicaid Innovation, Maryland All-Payer Model, http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/ (last visited 1/21/14).
[4] *See* Robert E. Mechanic, et al., *The New Era of Payment Reform, Spending Targets and Cost Containment in Massachusetts*, 31 Health Aff. 2334 (2012).
[5] *See* John E. McDonough, *Tracking the Demise of State Hospital Rate Setting*, 16 Health Aff. 142 (1997).
[6] *See* Grenier, *supra* note 1, at 57.

payment reform models under consideration, including promotion of payment options that align payment policies across market segments, such as a Maryland-style rate-setting approach.

As part of an analysis of the full continuum of payment reform models, NHID seeks advice on several discrete issues that may inhibit or encourage reform.

- First, as more risk is taken by providers, the NHID seeks identification of those situations, if any, where it would be appropriate for NHID to set regulatory standards for provider risk-bearing. Regulating the solvency of entities that bear insurance risk is a key function of the NHID. The NHID can promote provider reimbursement reform by clarifying what type of risk-bearing arrangements implicate insurance regulation and what regulatory approach should be taken in those cases. For example, NHID could adopt an approach similar to the Massachusetts certification process for providers that bear "downside" risk under alternative payment contracts.[7]

- Second, NHID seeks advice on how it might adapt its regulation of third-party administrators (TPAs) to facilitate better alignment between the self-insured group market and other payers in the state. This research could also involve evaluating whether existing regulations of TPAs are creating adverse incentives that impede payment reforms that could promote cost control or quality improvement.

- Third, ACOs and other forms of payment reform could raise antitrust concerns, as well as implicate anti-kickback, self-referral, and other provider self-dealing regulations. The Medicare ACO programs include waivers from some otherwise applicable standards in these areas, and New Hampshire should consider what state laws may be implicated and what, if any accommodations are appropriate. For example, NHID seeks advice on whether the state action doctrine would immunize payers from antitrust liability and, if so, what type of state action would be necessary to invoke the immunity.

Manatt has analyzed these issues for many states and is in a unique position to assist New Hampshire in this initiative. Manatt has developed accountable care, care management, and risk-based contracting programs for health plans and providers across the country. Manatt is also a thought leader on payment reform, writing white papers on the subject for foundations and serving as a consultant to the Centers for Medicare & Medicaid Services (CMS). As detailed in our qualifications section, Manatt has provided detailed analyses in New York and California on how state payment reform initiatives do and do not align with federal ACO

As a subcontractor to CMS's Innovation Center, Manatt routinely provides advice to sixteen states on provider payment reform through CMS's State Innovation Models program. An example of one presentation, **"State Laws Affecting Multi-Payer Payment & Delivery System Reform"** is attached as Appendix A

[7] *See* Grenier, *supra* note 1, at 57.

strategies, and has done work in Oregon on aligning the state's unique Medicaid purchasing strategy with state purchasing and commercial market practices.

Manatt proposes to leverage its experience counseling states, providers, insurers, and others to analyze New Hampshire's options for adapting its regulatory approach to best promote effective payment reforms.

II. PROJECT APPROACH

NHID is seeking legal and policy research to explore regulatory models for promotion and oversight of provider payment practices, to identify models with the best chance for success in improving care and reducing costs across market segments, and to identify legal strategies and safe harbors that can encourage the appropriate adoption of the most promising payment models. Immediately after contract execution, Manatt will schedule a telephonic kick-off meeting with NHID to review goals for the project, gain an understanding of the NHID's perspective on payment reform, and discuss expected deliverables.

After the kick-off meeting, Manatt will organize its work under four tasks:

- **Task 1:** ***Identify Key Payment Reform Models.*** Manatt will draw from prior engagements and expertise to describe the continuum of provider payment models, with an analysis of the general federal and state regulatory issues that each model raises. We anticipate having a webinar with NHID to discuss the models and general legal issues, with the goal of clarifying particular legal and regulatory issues for deeper analysis in Task 2.
- **Task 2:** ***Perform Legal and Regulatory Analysis of Provider Payment Models.*** We will conduct research into each model to identify regulatory issues, including the level of insurance risk providers can bear; antitrust concerns; self-dealing laws; cross-border issues; and other issues identified in the course of the research.
- **Task 3:** ***Develop Draft Report.*** We will provide an outline of the draft report and write the report for NHID review.
- **Task 4:** ***Incorporate NHID Feedback and Develop Final Report***. Manatt will incorporate NHID revisions and prepare the final report, which the NHID can distribute to stakeholders. We will also prepare a summary PowerPoint presentation and travel onsite to present our findings to NHID staff.

In addition to our tasks described above, we also envision periodic phone calls with NHID to check in on progress, resolve issues and answer questions. A detailed description of each task in our approach follows.

Task 1: Identify Key Payment Reform Models

Task 1 will begin with creating a description of the variety of provider payment reform models currently being considered in the United States, for both private and public payers. Manatt is a national leader in provider payment reform. We produce high-level thought leadership on these issues in foundation-supported reports and other vehicles, but also work closely with state regulators, insurers, hospitals, and other health care providers to implement payment reform. Our past payment reform implementation work combines legal and policy analysis, and

we will tap this reservoir of experience to develop a continuum of payment reform models for New Hampshire.

CMS has become a leader in developing, testing, and promulgating new payment models, and a key element of this task will be cataloguing the payment models CMS is testing and promoting. These include penalties and incentives for thirty-day readmissions, hospital-acquired infections, and other quality measures, Medicare shared savings programs, and value-based purchasing. Manatt is uniquely suited to perform this analysis efficiently and intelligently, because we have been intimately involved in the dissemination of these new models. For foundations and CMS, we have written white papers analyzing these payment reforms.[8]

States, healthcare systems, health plans, and other organizations are on the front lines in implementing CMS models and conducting further experiments in provider payment reform. Manatt has been engaged by a wide variety of these organizations and will leverage these experiences to provide operational and legal insights from experts who have built new payment systems.

As previously mentioned, as a subcontractor to CMS's Innovation Center, Manatt provides legal advice on adopting provider payment reform to sixteen states through CMS's State Innovation Models program. As consultant to a patient-centered medical home, Community Care of North Carolina, Manatt developed a new payment model to encourage community pharmacists to play a large role in medication management. When CMS began the Medicare Shared Savings Program (MSSP), Aetna hired Manatt to partner with it to develop ACOs for Aetna's provider clients. We have also developed ACOs for individual health systems across the country.

Manatt has worked with provider organizations in Maryland and Oregon and is familiar with developments in these two trend-setting states, among many others. The Maryland Health Services Cost Review Commission (HSCRC) sets hospital rates for all payers, including Medicare and Medicaid. Our understanding of the unique Maryland regulatory framework to establish all-payer pricing will help inform this project. Oregon also has been on the leading edge in evaluating how to regulate innovative provider reimbursement models. In 2011, Oregon considered regulating provider risk sharing under concierge medicine. More recently Oregon has considered how to determine the reasonableness and adequacy of capital and surplus for coordinated care organizations (CCOs), and how to align health reform implementation across CCOs and other payers and market segments. Another key point of comparison will be the cost-containment and provider integration reforms in Massachusetts and how they align with

[8] For a more complete description, see Part IV of this proposal. *See, e.g.*, Deborah Bachrach, et al., Manatt, Phelps & Phillips, LLP, *High-Performance Health Care for Vulnerable Populations: A Policy Framework for Promoting Accountable Care in Medicaid* (2012), for the Commonwealth Fund; William S. Bernstein, et al., *Accountable Care Organizations in California: Programmatic and Legal Considerations* (2011), for the California HealthCare Foundation; Jonah P.B. Frohlich, et al., Manatt Health Solutions, *Implementing National Health Reform in California: Payment and Delivery System Changes* (2011), for the California HealthCare Foundation.

various models New Hampshire might consider. This analysis will examine the complicated issues that arise for payers, providers, and regulators when communities and health systems span a geographic boundary.

These prior engagements highlight the important translational work Manatt can do for New Hampshire—identifying promising models in Medicare, Medicaid, and state reforms; determining what legal and policy constraints and opportunities exist; and helping stakeholders operationalize their vision.

The schematic Manatt will produce for NHID will discuss the policy and operational differences among pay for performance, shared savings, patient-center centered medical homes, bundled or global payments, and other models along this continuum. We will analyze which reforms could leverage the state's existing all-payer claims database and which can integrate with the state's growing Medicaid managed care sector. We will also discuss the role of health information exchange in successful provider payment reforms. The analysis will also address whether the limited competition in the state's insurance market—the only insurer in the Marketplace also dominates the non-Marketplace market—should play a role in how the state approaches payment reform.

As part of our webinar presentation of this continuum of reform models, we will discuss the key state and federal legal and regulatory concerns and opportunities across the models and will facilitate a discussion to clarify the particular legal and regulatory issues that need further analysis in Task 2.

Task 2: Perform Legal and Regulatory Analysis of Provider Payment Models

Building on the continuum developed in Task 1, Manatt will prepare an analysis of the opportunities that are presented by provider payment reform and the legal barriers that may impede progress. The focus is on understanding what the NHID could do as a regulator to facilitate development of provider payment reform. Manatt is uniquely situated to develop this analysis given our experience. The following describes key areas of research, although the focus will be customized based on the direction we receive from NHID in Task 1. Part IV of this proposal identifies recent engagements in which Manatt has provided legal advice on these issues.

- ***Provider risk-bearing***. Many models of provider payment reform involve providers bearing more risk for containing costs and improving quality of patient care. Provider risk sharing has historically been done through arrangements in which a licensed insurer bears the insurance risk, but evolving models are testing the type of risk that providers might bear—for example, in a contract with a self-insured employer. Manatt's analysis will explore the challenging issues raised for the NHID with the new risk-sharing models, many of which are more finely calibrated than the 1990s-style capitation model.

Although it often will make sense for risk-bearing provider entities to become fully-licensed insurers, there may be alternatives, such as the Massachusetts' certification process for providers taking downside risk or Oregon's registration system for concierge medicine. In addition, various models are evolving with public programs, that may be helpful to examine. In Medicare, for instance, providers that are put at risk under their Medical Advantage contracts must, in some circumstances, maintain stop-loss coverage.

- ***Regulating third-party administrators***. The growth of health care reform—and the pervasive regulation of insured group health plans—may drive more employers, including smaller employers, to consider self-insuring their group health plans. Manatt worked with the NHID on this issue in our 2012 work on stop loss insurance. One regulatory lever is that third-party administrators (TPAs) of self-insured health plans are generally subject to state regulation, with important ERISA limitations. Manatt will consider the range of issues with TPA regulation, including the role of TPAs under rate-setting models. We also will look at whether existing New Hampshire TPA regulations may be creating adverse incentives for payment reform. For example, in some circumstances, TPA regulation could impede payment reform because of uncertainty about the regulatory consequences of using payment systems other than fee-for-service.

- ***Antitrust implications***. Some new payment models involve prices being set by providers or payers acting in concert. This could be viewed as inhibiting competition under federal and state antitrust laws. Federal antitrust law recognizes a "state action" immunity, which immunizes state officials who as a matter of public policy instruct competitors to act in a way that would otherwise violate antitrust law. Critically, the competitors who act subject to the state policy are also immune from federal antitrust claims. Furthermore, the U.S. Justice Department and Federal Trade Commission have adopted a safe harbor for ACOs under the federal antitrust laws. Manatt's analysis will determine which payment reforms implicate state or federal antitrust laws, whether the model can fit in the existing ACO safe harbor, and whether safe harbors under state law or additional state action would be helpful to facilitate payment reforms.

- ***Physician self-referral laws***. Payment reforms generally include integration of health care providers that may increase the risk of self-referrals. The federal physician self-referral law (the "Stark law") prohibits, in the context of Medicare, certain types of physician referrals of patients to facilities in which the physician has an ownership interest. Under the Affordable Care Act, the Centers for Medicare & Medicaid Services and the HHS Office of Inspector General have waived certain applications of the Stark law to Medicare ACOs. New Hampshire has a self-referral law that applies to all health care providers and patients, not just those participating in Medicare, but the New Hampshire law does not prohibit self-referrals. It only require that the health care providers give each patient a disclosure when making a self-referral. N.H. Rev. Stat. Ann.

§§ 125:25-a, 25-b. Manatt's analysis will indicate when a particular payment reform model implicate these laws and what steps NHID and policymakers could take to facilitate these reforms, while preserving the goals of the self-referral laws. These could include structuring payment models to avoid self-referral concerns or adapting the state self-referral law to better accommodate certain types of integrated care delivery models.

- ***Cross-border issues***. New Hampshire has traditionally had a strong regulatory interest in cross border issues, including the extra-territorial implications of group insurance laws when an employer is based in one state and has employees in another. Similar issues can arise with cross border use of providers – for example, when New Hampshire residents see providers in Massachusetts and vice-versa. Attempts to create uniform incentives to improve cost and quality across payers could be limited by the effect of New Hampshire's geographic and economic interactions with its neighbors, including the potential development of a single-payer healthcare system in Vermont. Manatt's analysis will look at these issues based on the direction given by the NHID in Task 1.

The output of these various analyses and any others than are identified will be included in the final report, as described below.

Task 3: Develop Draft Report

Manatt will develop a draft report, in Microsoft Word, that will concisely summarize the payment models considered, highlight the opportunities associated with each model, incorporate the legal analysis of the barriers, and describe state policy options for moving forward that support both the opportunities for improving quality and reducing cost with each payment reform while also recommending appropriate state oversight of such reform. The report will not propose a single solution for the state, but rather present a balanced analysis of options based on our research and legal analysis.

Before drafting this report, we will draft an outline for review by the NHID. We anticipate that the outline will provide additional details on the report structure which go beyond the sample table of contents provided below:

I. Introduction
    a. Section will contain a brief overview of payment reform and the purpose for the NHID conducting research
II. Payment Reform Models
    a. Section will contain a description on the payment reform models contemplated in the legal analysis, which will include both TPA and provider-risk sharing models, as well as a standard reimbursement model
III. Legal Analysis Impacting Reform Implementation

a. Section will contain an overview of New Hampshire law and relevant federal law as identified and discussed in Task 2.
b. Section will also contain opportunities for and barriers against enactment of identified payment reform models (e.g. including state action antitrust immunity opportunities)

IV. Considerations and Next Steps
a. Section will contain considerations that New Hampshire stakeholders (policymakers, regulators, provider and carriers) can weigh against the various models for reform and address high-level next steps.

We will discuss the more detailed outline during one of our check in calls, and incorporate NHID feedback. We will then start writing the report. We will provide a draft report to the NHID for review by May 23rd.

Task 4: Incorporate NHID Feedback and Develop Final Report/Summary PPT Presentation
In this task we will incorporate NHID edits to the draft report. Since the NHID intends to publish the report, we anticipate that there will be two rounds of revisions. We will work with the NHID to identify specific timelines for the revisions, but anticipate that all revisions will be done by June 23rd, which will provide Manatt one week to incorporate edits and go through a final quality assurance and editing process prior to turning around the final report for distribution by Monday, June 30th.

The Manatt team anticipates coming on site and presenting, via a PowerPoint presentation, the summary report findings prior to June 30th and at the point where NHID finds it most helpful. We will work with the NHID well in advance of the onsite to secure the date and time that works best for the NHID.

III. MANATT OVERVIEW AND PROJECT TEAM

About Manatt

Manatt Health Solutions (Manatt) is an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, one of the nation's premier law and consulting firms. Relied upon for our significant strategic and operational expertise, Manatt is deeply engaged in implementing the far-reaching requirements of the ACA. Manatt's command of federal law (statute, regulation, and sub-regulatory guidance) and our sophisticated understanding of the law's impact on insurance markets, enable us to effectively work with state agency officials to implement policies in compliance with federal requirements and aligned with state policy goals. Manatt's experience spans all segments of the health care sector; our clients include state governments and quasi-governmental entities, health insurers (commercial and public), providers, foundations and consumer advocacy organizations. This 360-degree perspective allows Manatt to design solutions and produce recommendations rooted in the practical realities of public policy goals, business imperatives, legal requirements, and program implementation needs.

Project Team Members
Joel Ario will be the Project Director and Sharon Woda will be the Project Manager. Michael Kolber, Esq., will lead the regulatory and legal analysis with Robert Belfort, Esq. providing oversight and supervision. Manatt also possesses a deep bench of over 60 health law attorneys and health policy consultants that will be available for consultation when their special expertise or skills are required. The most relevant subject-matter experts are identified here.

Joel Ario, Managing Director
Joel Ario, a managing director at Manatt Health Solutions, has 30 years of experience helping to shape and implement public policy, including two decades devoted to leading health insurance reform efforts at the state and federal government levels. He provides strategic consulting and policy analysis to assist state governments, health plans, hospitals, foundations, and other stakeholders in preparing for the implications of healthcare reform, with a particular emphasis on planning for and implementing the new exchange-based marketplaces.

Mr. Ario previously served as Director of the Office of Health Insurance Exchanges at the U.S. Department of Health & Human Services (HHS), where he worked closely with states and other stakeholders in leading HHS efforts to develop the regulatory framework for exchanges, including the rights and responsibilities of the states in establishing exchanges and preserving their authority over the private insurance marketplace.

Prior to his federal service, Mr. Ario was Pennsylvania Insurance Commissioner from 2007 to 2010 and Oregon Insurance Commissioner from 2000 to 2007. Mr. Ario served on the Executive Committee of the National Association of Insurance Commissioners (NAIC) for a decade and was an NAIC officer from 2003 to 2005.

Mr. Ario has reviewed various forms of provider risk sharing both as an Insurance Commissioner and more recently as an advisor to a provider-based integrated delivery system. He serves as an advisor to the Robert Wood Johnson Foundation in support of its State Health Reform Assistance Network, and is a member of the Leavitt Partners Future Panel. His publications include "Post Election, the Affordable Care Act Leaves the Intensive Care Unit for Good," (with Larry Jacobs, Health Affairs Entry Point, Dec. 2012) and "Public Exchanges Dominate the Headlines, but Will Private Exchanges Really Shape the Future?" (Manatt Healthcare Newsletter, June 2013). His ten years as an Insurance Commissioner also entailed deep and sustained involvement with state legislatures in two states over insurance regulatory matters.

Harvard Law School, J.D., cum laude, 1981.
Harvard Divinity School, M.Div., cum laude, 1978.
Saint Olaf College, B.A., American Political Experience, 1975. Phi Beta Kappa.

Sharon Woda, Director

Sharon Woda is a director with Manatt Health Solutions (MHS), an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP. She advises public sector clients on how to implement new healthcare programs and works with payers, providers, and other health care stakeholders to understand the associated business opportunities and implications of healthcare reform.

Ms. Woda has led multi-stakeholder engagements to help states plan for and implement new insurance marketplaces. She is skilled at managing complex, fast-paced, multidimensional projects that require a deep understanding of healthcare policy and regulations, coupled with the ability to evaluate options and recognize the operational implications. Ms. Woda served as project manager performing market reform work for a state Department of Insurance, which required knowledge of ACA-related statutes and regulations across various stakeholder groups, including providers. Her role included assessing implications of these regulations across stakeholders, writing policy papers to inform legislative staff on the options available, and making recommendations to the Department of Insurance. Ms. Woda also has worked with several large hospital organizations looking to start up health insurance companies and develop care coordination models. As part of this analysis, Ms. Woda analyzed payment reform models for implementation, and addressed the pros and cons of the various models. Finally, Ms. Woda has played a lead role on the development of several policy papers related to the ACA which

addressed the role of Navigators in the state marketplace and essential health benefits selections and comparisons.

Prior to joining MHS, Ms. Woda was a managing consultant with The Lewin Group, a healthcare policy research and consulting firm, where she spearheaded a strategy for the Centers for Medicare & Medicaid Services (CMS) to implement new provider network criteria for Medicare Advantage plans and worked with numerous Blue Cross Blue Shield companies and state organizations to assess plan surplus levels and community benefit programs and to make recommendations to states and plans regarding the level of "appropriate" surplus and giving. As part of her efforts with BCBS plans, Ms. Woda investigated cross-border issuers related to plan surplus and community giving. Prior to Lewin, Ms. Woda worked at United HealthCare to develop customized networks.

The Wharton School, University of Pennsylvania, M.B.A., healthcare management concentration, 2001.
University of Florida, B.S., Health Sciences, 1996.

Robert Belfort, Partner

Robert Belfort is a partner in the healthcare practice of Manatt, Phelps & Phillips, LLP and has over 20 years of experience representing healthcare organizations on regulatory compliance and transactional matters. Mr. Belfort has extensive experience advising a wide variety of healthcare clients, including hospitals, medical groups, health insurers, managed care organizations, accountable care organizations, mental health providers, pharmacy chains, information technology vendors and healthcare industry trade associations.

Mr. Belfort's practice focuses on the following areas:

- Managed Care and Accountable Care. He counsels health insurers and other managed care organizations on compliance with Affordable Care Act standards, Medicaid managed care requirements, Medicare Part C and Part D rules, HIPAA portability and nondiscrimination mandates, and state insurance licensing and market conduct laws. He also advises both insurers and providers on establishing accountable care organizations and other value-based contracting arrangements. He drafts and negotiates the full range of managed care and accountable care contracts, including provider participation agreements as well as specialty carve-out and PBM arrangements.

- HIPAA/Privacy. He assists clients in managing health information within the parameters established by HIPAA and state confidentiality laws. He conducts internal gap analyses, drafts privacy policies and advises on the development of other privacy safeguards and also helps clients respond to complaints and privacy breaches. He also works with regional health information organizations and other multi-stakeholder entities to develop patient consent and other data-sharing policies and practices.

- Fraud and Abuse. He advises clients on structuring transactions and conducting day-to-day business operations to ensure compliance with the Anti-Kickback Statute, the Stark law, Medicare and Medicaid participation and billing requirements, professional licensing rules, and corporate practice of medicine and fee-splitting restrictions. He also performs risk assessments, develops compliance programs, conducts internal investigations and represents clients in government investigations and audits.

New York University School of Law, J.D., 1988. Order of the Coif; Root-Tilden Scholar; American Jurisprudence Award in Torts; Benjamin F. Butler Award.
Oberlin College, B.A., Economics and Government, magna cum laude, 1981.

Michael Kolber, Associate

Michael Kolber is an associate within the healthcare practice of Manatt, Phelps & Phillips, LLP, who focuses his practice on regulatory and transactional matters in the healthcare industry. Mr. Kolber counsels health systems, managed care plans, pharmaceutical manufacturers, technology firms, and other stakeholders on complex regulatory and compliance issues affecting their business. His practice focuses on implementation of the Affordable Care Act, especially the establishment of health insurance Exchanges and the transformation of the commercial health insurance market. He also advises clients on Medicare and Medicaid managed care and employee benefits (ERISA) issues.

Prior to joining Manatt, Mr. Kolber was an attorney in the Centers for Medicare and Medicaid Services Division in the Office of the General Counsel of the U.S. Department of Health and Human Services (HHS). He served as the lead legal advisor to federal policymakers on central elements of health reform and provided counsel on the formation of health benefit exchanges and risk adjustment, reinsurance and risk corridor programs. He also advised HHS on defining the essential health benefits package, operating the Pre-Existing Condition Insurance Plan program, and awarding loans to Consumer Oriented and Operated Plans (CO-OPs). Mr. Kolber previously served as a law clerk for Judge Amalya L. Kearse of the U.S. Court of Appeals for the Second Circuit.

Harvard Law School, J.D., magna cum laude, 2009. Supervising Editor, Harvard Law Review.
Yale University, B.A. with distinction in History, 2002.

Manatt Subject Matter Experts

William Bernstein, Chair, Healthcare Division

Mr. Bernstein is a member of Manatt, Phelps & Phillips, LLP's Executive Committee, is Chairman of the Healthcare Division, and is Administrative Partner of the New York office. Mr. Bernstein's law and consulting practice concentrates on advising clients in the healthcare

industry, including provider organizations, payor organizations, emerging companies and financial institutions. His practice also emphasizes strategic, business, transactional and regulatory matters.

Mr. Bernstein has advised governmental, provider and insurance clients on the legal structures associated with developing risk bearing organizations, new payment models and care delivery models, including serving as a key advisor to the States, including North Carolina and Missouri and as an advisor to leading State affiliated organizations, including Community Care of North Carolina and the New York eHealth Collaborative. Mr. Bernstein also serves as the Project Director for the Manatt technical assistance team supporting the CMMI State Innovation Model program.

Mr. Bernstein writes and speaks frequently on health reform related topics. He has also co-authored several articles on these subjects, including Accountable Care Organizations in California (California Health Care Foundation); Considerations for the Development of Accountable Care Organizations in New York State (NY Healthcare Foundation) ; High-Performance Health Care for Vulnerable Populations: A Policy Framework for Promoting Accountable Care in Medicaid (Commonwealth Foundation) , Integrating Physical and Behavioral Health: Strategies for Overcoming Legal Barriers to Health Information Exchange (Robert Wood Johnson Foundation)

Mr. Bernstein has served as a law clerk to the Honorable Raymond J. Pettine, United States District Judge for the District of Rhode Island (1983), and as a staff member in the Office of Secretary Joseph A. Califano Jr., the United States Department of Health, Education and Welfare (1979).

New York University School of Law, J.D., 1982.
Brown University, M.A., American History, 1979.
Brown University, B.A., 1978; Magna cum laude, Phi Beta Kappa.

Jon Glaudemans, Managing Director

Jon Glaudemans has more than 25 years of senior leadership experience in managed care, policy issues management, public affairs, communications and health insurance. His areas of focus include insurance regulation, payer-provider market dynamics, provider payment policy, e-health, health plan administration, health disparities and quality improvement initiatives across a variety of care settings.

Prior to joining Manatt, Mr. Glaudemans was Chief Advocacy and Communications Officer at Ascension Health, the nation's largest not-for-profit healthcare system, with over 120 hospitals in more than 20 states. In this role, he led the development and execution of an integrated advocacy, government affairs and communications strategy, enhancing Ascension Health's

ability to drive the transformation of healthcare, with a primary emphasis on providing access to vulnerable populations.

Mr. Glaudemans spent five years as the Senior Vice President/Chief Operating Officer at Avalere Health, LLC, a Washington-based advisory group. In this role, he oversaw a broad array of health policy and business strategy engagements for private, nonprofit and government sector clients, and helped create and manage the firm's quantitative analytics practice. In addition, he supervised a number of practice areas, including payment reform, budget scoring, health IT, Medicaid, reimbursement, long-term care, evidence-based medicine and external communications, as well as the firm's operating functions of human resources, finances, and IT.

In 2001, Mr. Glaudemans was asked to serve as Co-Transition Coordinator for the incoming Administrator for the Centers for Medicare and Medicaid Services. Prior to that position, Mr. Glaudemans spent a decade at Aetna, where his roles included General Manager of Aetna U.S. Healthcare's Mid-Atlantic Region. In that role, he was responsible for all healthcare sales, services, network, quality, and utilization management activities for a 1,500,000 member health plan. Mr. Glaudemans began his career at the the U.S. Office of Management and Budget (OMB), where he was intimately involved in Medicare budget, regulatory and legislative initiatives, including the development and implementation of the PPS and RB-RVS payment systems.

Princeton University, Woodrow Wilson School, M.P.A., Economics, 1983.
Massachusetts Institute of Technology, B.S., Political Science, 1980.

Martin Thompson, Partner

Martin Thompson's practice focuses on the healthcare industry, including multi-hospital systems and other healthcare providers, as well as other businesses. He is the author of the first book ever published on the subject of applying antitrust law to the healthcare industry (Antitrust and the Health Care Provider, Aspen Systems, 1979), and has focused his practice on antitrust matters within the healthcare industry for over 30 years. He was also the co-author of the chapter on antitrust exemptions and immunities for the American Bar Association's book titled Antitrust Health Care Enforcement and Analysis.

Mr. Thompson has been antitrust counsel in on engagements with multiple states, advising on state action as a mechanism for avoiding antitrust proscriptions to payment reform. He has worked with a variety of ACOs and healthcare networks on navigating antitrust issues. He was also the principal draftsman of California's antitrust exemption statute for healthcare networks.

He has served in leadership roles in the American Bar Association Antitrust and Healthcare sections, the American Health Lawyers Association, the National Health Lawyers Association, and the California Society for Healthcare Attorneys.

He has been a frequent speaker on antitrust topics at healthcare seminars and has authored numerous articles and contributed to books on this topic. He has guided numerous healthcare mergers through agency processes and litigated cases concerning these subjects.

University of California Berkeley Boalt Hall School of Law J.D., 1973; Order of the Coif.; Associate Editor, California Law Review.
University of California Davis, A.B., 1970, with highest honors, Phi Beta Kappa.

Anne Karl, Associate

Anne Karl focuses her practice on a variety of regulatory and transactional matters in the healthcare industry for providers, Medicaid managed care plans, and commercial health insurers. She advises providers, payers, and policymakers on a wide array of payment and delivery system reform issues, including issues specific to Accountable Care Organizations, the Medicare Shared Savings Program, and other innovative payment models. Ms. Karl also assists providers and Medicaid managed care plans in negotiating, drafting, and securing regulatory approval for agreements, with a particular expertise in those incorporating innovative value-based purchasing strategies. She conducts research and policy analysis on a wide range of Medicaid payment issues, including pay-for-performance incentive payments and supplemental payments, and she has experience analyzing Medicaid waiver programs. Additionally, Ms. Karl assists commercial health insurers with a wide range of regulatory issues, including analyzing federal healthcare reform requirements pertaining to commercial plans.

Prior to joining Manatt, Ms. Karl served as a law clerk to the Honorable José A. Cabranes, U.S. Court of Appeals for the Second Circuit.

Yale Law School, J.D., 2009.
Dartmouth College, A.B., Economics and Environmental Studies, summa cum laude, 2006.

IV. MANATT QUALIFICATIONS AND REFERENCES

Experience Related to Payment Reform
Provider payment reform is a central focus of Manatt's practice. William Bernstein and Jon Glaudemans, whose biographies are provided in part III of this proposal, devote a considerable portion of their practices to developing provider payment reforms. They is supported by Joel Ario and the attorneys described in part III who provide legal advice on insurance law, antitrust, physician self-referral, employee benefits, and Affordable Care Act issues. As described in the previous section, Manatt is familiar with the New Hampshire insurance laws, based on our prior work for the NHID and other engagements in New Hampshire.

The following are select additional provider payment reform engagements:

- As a subcontractor to the CMS Innovation Center (through the National Opinion Research Center at the University of Chicago), Manatt provides legal counseling to states in designing and testing new payment and service delivery models. As part of the CMS Innovation Center State Innovation Model (SIM) initiative, Manatt has analyzed the legal barriers and opportunities associated with provider payment reform. In a series of presentations to state healthcare leaders, Manatt describes the implications for provider payment reform under state insurance laws, fraud and abuse laws, antitrust laws, and laws relating to corporate practice of medicine, healthcare governance, and data privacy and security. In addition to this legal advice, Manatt's multiple roles include working with the Center for Healthcare Strategies to develop a Demonstration Readiness Review (DRR) tool to be used in approving state demonstrations, providing assistance and advice to the states on policy, regulatory analysis and payment reform, and assisting NORC and other subcontractors in supporting the newly-formed CMMI team charged with getting the SIM program off the ground. A recent presentation Manatt prepared for states through the SIM initiative on payment reform issues is in the appendix to this report.

- In a report funded by the New York State Health Foundation, "Considerations for Development of Accountable Care Organizations in New York State," Manatt provides a framework for state policymakers to encourage the growth of innovative provider payment mechanisms. The report examines state and federal fraud and abuse, antitrust, insurance, corporate practice of medicine and fee splitting laws. Manatt also points out the role of health information exchange in facilitating accountable care. The report asks the state to assess the role ACOs should play in controlling runaway medical expenses and improving the quality of healthcare, as well as the need to reevaluate New York's existing healthcare regulatory structure. This report is available in the appendix to this proposal. A copy of the report can also be accessed here:

http://nyshealthfoundation.org/uploads/resources/development-accountable-care-oraganizations-june-2011.pdf

- For the California HealthCare Foundation, Manatt prepared the report, "Accountable Care Organizations in California: Programmatic and Legal Considerations." This report examines state and federal laws that impact the development of ACOs, including healthcare governance requirements, HMO regulations, state and federal antitrust and fraud and abuse laws, including physician self-referral laws, corporate practice of medicine laws, and data security and privacy concerns. This report is also available in the appendix to this proposal. A copy of the report can also be accessed here: http://www.chcf.org/publications/2011/07/aco-programmatic-legal-considerations

- The Oregon Health Policy Board retained Manatt to develop regulatory options for implementing Governor Kitzhaber's directive to align the state's ACA implementation and health reform efforts across all market segments to ensure that Triple Aim goals were being consistently pursued. The work culminated in a PowerPoint presentation to the Policy Board that recommended alignment across state purchasing, the Marketplace and the commercial market with Oregon's unique Medicaid Coordinated Care Organization (CCO) approach, which emphasizes primary care and global budgeting based on a sustainable rate of growth in health care spending. Other recommendations included development of a measurement framework, built on the state's all payers all claims database, to assess the effectiveness of payment reforms; and enhanced transparency in insurance rate review to educate consumers and strengthen carrier accountability for quality improvement and cost containment.

- A provider-sponsored, integrated delivery system retained Manatt to advise it on how it could best achieve its goals for moving away from fee for service contracts with self-insured employers in a state where insurance regulation appeared to preclude many innovative payment reform models without an insurance license. The project involved analyzing a continuum of payment reform options, first in terms of how those arrangements are more calibrated than prior capitation models, and second in terms of what risk is transferred in each model and how insurance regulatory concerns might be addressed. The project looked at how regulator responses to provider risk sharing; how providing a safe harbor for fee for service (FFS) clashed with broader goals of moving to value-based purchasing; and how direct contracting with employer groups differs from risk sharing in public programs, where the government is the ultimate risk bearer.

- Manatt worked with Community Care of North Carolina (CCNC), the patient centered medical home (PCMH) Medicaid delivery system in North Carolina, to develop an innovative new care delivery and payment model that integrates community pharmacy-provided cognitive medication management strategies into existing patient-centered care teams, e.g. medical homes and neighborhoods, while incentivizing the pharmacist to address gaps in care. The payment model is comprised of: (1) a PMPM for all

members of a pharmacy's attributed population (subject to patient opt in) for augmented dispensing and care coordination services; (2) a scaled PMPM for core encounter-based services which is inclusive of a P4P component; and (3) enhanced encounter-based payments for moderate and complex medication optimization services, with an opportunity to build in shared risk elements over time.

- Manatt supported the Association of American Medical Colleges, which convened 19 academic medical centers in a collaboration to develop responses to CMS's request for applications for the Bundled Payment Initiative. Manatt's involvement included drafting the clinical, technical and finance approach to bundled payment; developing code for episode logic; and supporting participant Workgroups. Manatt also prepared a template participation contract for use between the Academic Medical Centers and participating hospitals, physicians and other providers, including gain-sharing and governance provisions.

- Manatt also is helping the Washington State Healthcare Authority in developing and refining its comprehensive State Healthcare Innovation Plan for submission to CMS as part of the agency's SIM initiative. Manatt analyzed the state's current systems for administering and delivering physical and behavioral health services. We also developed and delivered options to the state for improving the integration of physical and behavioral health.

- After Manatt's support in developing a successful CMS Innovation Center application through which Maimonides Medical Center and the Brooklyn Care Coordination Consortium were awarded $15 million to implement a project to improve the care of 7,500 adults with serious mental illness in southwest Brooklyn, Maimonides recently turned to Manatt to guide the implementation of the clinical and financial model for the Brooklyn Care Coordination Consortium. Manatt is working with the project partners – acute care providers, behavioral health and managed care organizations – to create a pilot project to test a financial model that measures and reimburses, recognizing the total cost of care. The model will allow the Consortium to assume risk for targeted Medicaid and Medicare beneficiaries and share in any savings that are attributed to the population. Manatt is managing the development of the financial model with assistance from an actuary and input from the project team.

References

Oregon Health Policy Board
Bruce Goldberg, Director
Oregon Department of Human Services
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New York State Health Foundation
David Sandman, Senior Vice President
1385 Broadway, 23rd floor
New York, New York
(212) 584-7690
sandman@nyshealth.org

Maimonides Medical Center
David Cohen, Executive Vice President, Clinical Integration
4802 10th Ave
Brooklyn, NY 11219
(718) 283-6392
dcohen@maimonidesmed.org

Additional provider-based delivery system client reference available upon request.

Legal and Regulatory Research Qualifications
As a national law and consulting firm, with a focus on healthcare law and policy, Manatt has all required resources, talent, and experience to perform the tasks described in this proposal at the highest level. From offices in New York, Washington, D.C., and California, Manatt attorneys and health policy consultants perform legal and policy analysis for state agencies, health plans, health care providers, and others. The following list of select prior engagements demonstrates Manatt's skills in the particular areas identified in the NHID's request for proposals. In addition to these past engagements, the biographies in part III of this proposal demonstrate Manatt's expertise in the following areas: insurance laws and the legislative process (Robert Belfort, Joel Ario, Michael Kolber, Sharon Woda); health care provider laws, including self-referral laws (Robert Belfort); and antitrust law, including state action immunity (Martin Thompson).

- Manatt worked with the New Hampshire Insurance Department to develop options for regulating stop-loss insurance in the small group market. The project included interviews with New Hampshire insurers and brokers and a range of national experts on stop-loss insurance; a review of various state laws and regulations addressing stop-loss; an assessment of how existing New Hampshire regulations setting minimum attachment points for stop-loss appeared to be impacting the marketplace and what changes might be expected in 2014; a review of the ERISA-related issues and the current NAIC debate over whether to amend the group's model law on stop-loss; and development of four options for how stop-loss could be regulated to address the market dynamics associated with ACA implementation.

- In anticipation of CMS' review of new Medicare Shared Savings Program (MSSP) applicants, Aetna retained Manatt's healthcare team to assist its clients and prospective clients with the preparation and submission of their applications to become part of the MSSP (ACO) program. Manatt's work included interpreting policy and procedural issues raised by the final MSSP rule, monitoring subregulatory guidance when issued, and reviewing and commenting on MSSP applications. Four Aetna partners received notice in December 2012 that they had been accepted into the program for the January 1, 2013, start date. Manatt continues to work with these partners to prepare for implementation. In 2013 Manatt developed applications for participation in the program in collaboration with six providers and developed an MSSP ACO toolkit for Aetna staff and clients.

- Manatt advised Montefiore Medical Center, a New York City-based 1,500-bed hospital for the Albert Einstein College of Medicine and one of the 50 largest employers in New York State, in creating a pioneer healthcare organization characterized by a payment and care delivery model (aka Accountable Care Organization) and a related business unit for New York Medicaid and private health insurers. Our role included all legal and regulatory analysis, advising on strategy, evaluating regulatory issues, providing counsel on governance and potential antitrust concerns, assisting in the design of features to welcome and include other providers, as well as drafting contracts and legal documents, including handling all contracts with state regulators and participating in contracts with all federal regulators. We also assisted Montefiore in its successful bid to receive a pioneer contract for this new healthcare organization model with Medicare, which was significant because Montefiore was one of 32 organizations selected in the nation by the Centers for Medicare and Medicaid Services (CMS) and developed the first business model of this kind in New York State.

- Manatt worked with the Department of Insurance in North Carolina to provide regulatory and research analysis of ACA options that would serve as the foundation for development of the state's health insurance Marketplace (prior to the state electing a FFM model). The Manatt team, with support from Oliver Wyman and Mercer actuaries, supported the overall work of the Department in planning for the Marketplace and specifically: (1) facilitating a collaborative process with targeted stakeholders and the Department to develop Marketplace-related market reform policies; (2) identifying areas requiring legislative action or other immediate-implementation steps; and (3) producing issue briefs outlining critical considerations and recommendations that help drive decision-making.

- Manatt regularly advises one of the nation's largest not-for-profit hospital systems on its financial relationships with physicians, including compliance with the Stark Law. Our work includes, among other things, reviewing innovative compensation arrangements

with employed physicians, developing physician contracts for various types of service arrangements, and structuring "captive professional corporation" arrangements.

References

New Hampshire Insurance Department
Michael Wilkey
Director Life, Accident & Health
21 South Fruit St, Suite 14
Concord, NH 03301
(603) 271-2261

Aetna
Rachael Lines
Counsel
Hartford, CT
(860) 273-2273
LinesRI@aetna.com

North Carolina Department of Insurance
Louis Bello
Chief Deputy Commissioner
430 N. Salisbury Street
Raleigh, NC 27603-5926
(919)733-0433
Louis.Belo@ncdoi.gov

V. PROJECT TIMELINE AND BUDGET

Timeline

For the above-described activities, Manatt has developed a project timeline whereby most of the effort is completed within a 12-week timeline and allows for ample time for NHID review and consideration. This timeline starts on March 3rd and ends with a draft report being submitted for review the week of May 19th. We anticipate some work will continue through June 30th, which will primarily involve incorporating edits to the report and preparing and presenting a PowerPoint document to the NHID. The start date is based on NHID expectation that all state approvals will be done by late February. The timeline for each task is illustrated below:

Key Tasks and Activities	March 3rd & 10th	March 17th & 24th	March 31st & April 7th	April 14th & 21st	April 28th & May 5th	May 12th & May 19th	May 26th & June 2nd	June 9th & 16th	June 23rd & June 30th
Project Kick Off/Teleconference	**Upon Contract Approval**								
Task1 Identify Key Payment Reform Models									
Draw from prior work and NHID direction to describe range of models for discussion									
Develop PPT Presentation on Continuum of Models for Consideration									
Present Continuum in webinar			**By April 4th**						
Task 2: Perform Legal and & Regulatory Analysis									
New Hampshire and Federal Specific Laws/Regulations re: Provider Risk Sharing, Provider Self-Dealing, Kick Backs, Referrals; Anti-Trust									
TPA/ERISA Research									
Task 3: Develop Draft Report									
Develop and Share Outline with NHID									
Develop Report for NHID Review						**By May 23rd**			
Task 4: NHID Edits; Final PPT & Report									
Incorporate Round 1 Edits									

Key Tasks and Activities	March 3rd & 10th	March 17th & 24th	March 31st & April 7th	April 14th & 21st	April 28th & May 5th	May 12th & May 19th	May 26th & June 2nd	June 9th & 16th	June 23rd & June 30th
Incorporate Round 2 Edits									
Prepare PPT for NHID Onsite									
Come Onsite and Present to NHID Staff re: Final Report									**By June 30th**

Budget

We estimate project costs for the contract term not to exceed $96,275. For the 12-week scope, we estimate professional costs of $95,000, which is inclusive of all core team and subject matter expert time dedicated to this report and exclusive of travel expenses for the presentation of payment reform models and the final report. Project costs were derived from a project team commitment applying the hourly rates and travel expenses reflected below.

Project Team Members Hourly Rate

Project Team Members	*Hourly Rate*
Core Team (Joel Ario; Sharon Woda; Michael Kolber; Robert Belfort; Manatt Analyst)	$230-$690
Subject Matter Experts (William Bernstein; Jon Glaudemans; Martin Thompson; Anne Karl)	$465-$710

Manatt will bill for actual travel expenses. We estimate a same-day trip travel cost of $425 per individual as noted below. For the 12-week project scope, we assumed one trips of three core project team members to Concord for the presentation of preliminary and final findings totaling $1,275.

Expense Items Itemized (Per Person, per trip)	*Expense*
Roundtrip Airfare	$300
Ground Transportation	$75
Meals and Incidentals	$50
Total	$425

The figures described in this section are estimates based on our best understanding of the proposed scope and described activities. Manatt is available for additional discussion on these estimates with the NHID.

VI. CONTRACT EXCEPTIONS

Manatt has reviewed Form P-37, the general conditions as required by the State of New Hampshire purchasing policies and the Department of Administrative Services. We would like to propose an addendum to the term noted at 9.2 to reflect "*Contractor will retain ownership of its pre-existing intellectual property which it has independently developed.*"

We would also like to propose that the following language be added to the contract, which is consistent with existing language we have with the University System of New Hampshire to provide other consulting services:

"Under this agreement, Contractor represents the New Hampshire Insurance Department ("NHID") only and no other agency or instrumentality of the State of New Hampshire. Contractor represents other clients in legal matters involving the State of New Hampshire. Specifically, Contractor represents Sirius XM Radio Inc. ("Sirius") in connection with state and local regulatory matters, including in a multi-state investigation on marketing practices. Contractor also represents Seedco Financial Services ("Seedco") in connection with New Markets Tax Credit financing transactions, including in a transaction for a biomass power plant in Berlin, New Hampshire. NHID acknowledges that these matters are unrelated to Contractor's work for NHID and do not present conflicts. NHID consents to Contractor continuing to represent Sirius and Seedco and other clients involving the State of New Hampshire in matters unrelated to this agreement, while Contractor represents NHID under this agreement."

We understand that any change in contract language will have to be approved by the New Hampshire Attorney General department and are available for further discussion.

Agreement with Manatt, Phelps & Phillips, LLP Legal Barriers to Payment Reform – Cycle II Rate Review

Exhibit B

Contract Price, Price Limitations and Payment

The services will be billed at the hourly rates set forth in the Contractors Proposal, dated January 27, 2014. Including any out-of-pocket expenses for travel, the total reimbursable amount shall not exceed the total contract price of $96,275. The services and out-of-pocket expenses shall be billed at least monthly and the invoice for the services shall identify the person or persons providing the service. Payment shall be made within 30 days of the date the invoiced is received.

Agreement with Manatt, Phelps & Phillips, LLP Legal Barriers to Payment Reform- Cycle II Rate Review

Exhibit C

Special Provisions

The following provision is incorporated at the end of paragraph 9.2 of the Agreement, as if printed on Form P-37:

Contractor will retain ownership of its pre-existing intellectual property which it has independently developed.

The following provision is incorporated into the Agreement as a new paragraph, as if printed on Form P-37:

25. ***CONFLICTS.*** *Under this Agreement, Contractor represents the New Hampshire Insurance Department ("NHID") only and no other agency or instrumentality of the State. Contractor represents other clients in legal matters involving the State. Specifically, Contractor represents Sirius XM Radio Inc. ("Sirius") in connection with state and local regulatory matters, including in a multi-state investigation on marketing practices. Contractor also represents Seedco Financial Services ("Seedco") in connection with New Markets Tax Credit financing transactions, including in a transaction for a biomass power plant in Berlin, New Hampshire. NHID acknowledges that these matters are unrelated to Contractor's work for NHID and do not present conflicts. The Department consents to the Contractor continuing to represent Sirius and Seedco and other clients involving the State in matters unrelated to NHID while Contractor represents the Department under this agreement.*

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that Manatt, Phelps & Phillips, LLP is a California registered limited liability partnership registered on March 7, 2014. I further certify that all fees required by the Secretary of State's office have been received and that a withdrawal notice has not been filed.

In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 7th day of March, A.D. 2014

William M. Gardner
Secretary of State

LIMITED LIABILITY PARTNERSHIP CERTIFICATION OF AUTHORITY

I, Melinda Dutton, hereby certify that I am an Equity Partner of Manatt, Phelps & Phillips, LLP, a California LLP.

I certify that I am authorized to bind the company pursuant to provision in the LLP Operating Agreement. I understand that the State of New Hampshire will rely on this Certificate as evidence that I have full authority to bind the company.

Dated: February 14, 2014

Attest:

Melinda Dutton
Equity Partner

manatt
manatt | phelps | phillips

William T. Quicksilver
Chief Executive Officer and Managing Partner
Manatt, Phelps & Phillips, LLP
Direct Dial: (310) 312-4210
E-mail: wquicksilver@manatt.com

March 12, 2014

RECEIVED BY
NH INSURANCE DEPT
MAR 13 2014

Martha McLeod
Rate Review Project Manager
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, New Hampshire 03301

Re: Confirmation of Authority to Bind Limited Liability Partnership

Dear Sir or Madam:

As the Chief Executive Officer and Managing Partner of Manatt, Phelps & Phillips, LLP, a California limited liability partnership (the "Firm"), I hereby confirm that Melinda Dutton is an Equity Partner of the Firm and is authorized to bind the Firm to contracts for the engagement of the Firm. I understand that the State of New Hampshire will rely on this Confirmation as evidence of Melinda Dutton's authority to so bind the Firm.

Sincerely,

William T. Quicksilver

WTQ: lsf

311621047.1
3/12/14

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 2/13/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Meghan McDonough
The Rubin Group Inc 111 John Street Suite 1900 New York NY 10038	PHONE (A/C, No, Ext): (212) 791-4300 FAX (A/C, No): (212) 791-0456 E-MAIL ADDRESS: mmcdonough@therubingroup.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Great Northern Insurance Co.	20303
INSURER B: Federal Insurance Company	20281
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
MANATT PHELPS & PHILLIPS
11355 WEST OLYMPIC BLVD
LOS ANGELES CA 90064

COVERAGES **CERTIFICATE NUMBER:** 13-14 GL,Auto,Umb **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY [X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [ ] POLICY [ ] PRO-JECT [X] LOC	X		3581-49-86 PRODS/COMPL OPS INCL IN GENERAL AGGREGATE	5/1/2013	5/1/2014	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 2,000,000 $ 2,000,000 $ 10,000 $ 2,000,000 $ 2,000,000 $ Included
B	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [X] HIRED AUTOS [X] NON-OWNED AUTOS			73522080	5/1/2013	5/1/2014	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
B	[X] UMBRELLA LIAB [ ] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [X] RETENTION $ 10,000			7983-26-33	5/1/2013	5/1/2014	EACH OCCURRENCE AGGREGATE	$ 25,000,000 $ 25,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] N / A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					WC STATU-TORY LIMITS [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
New Hampshire Insurance Department is included as Additional Insured respecting claims arising out of the operations of the Named Insured.

CERTIFICATE HOLDER

New Hampshire Insurance Department
Attn: Alexander Feldvebel
21 South Fruit Street
Suite 14
Concord, NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Meghan McDonough/LUIS

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 2/13/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Meghan McDonough
The Rubin Group Inc 111 John Street Suite 1900 New York NY 10038	PHONE (A/C, No, Ext): (212) 791-4300 FAX (A/C, No): (212) 791-0456 E-MAIL ADDRESS: mmcdonough@therubingroup.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Nautilus Insurance Company	17370
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED

Manatt Phelps & Phillips
11355 West Olympic Blvd
Los Angeles CA 90064

COVERAGES **CERTIFICATE NUMBER: 13-14 Prof Liab** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	☐ CLAIMS-MADE ☐ OCCUR						MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$
	☐ POLICY ☐ PRO-JECT ☐ LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ WC STATU-TORY LIMITS ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability			LDUSA1300205	8/1/2013	8/1/2014	Per Claim	$20,000,000
							Aggregate	$20,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
Evidence of Insurance

CERTIFICATE HOLDER

New Hampshire Insurance Department
Attn: Alexander Feldvebel
21 South Fruit Street
Suite 14
Concord, NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Beatrice Bowen/BEA1

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 3/28/2014

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IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Katrine Minasyan
HUB International Insurance Services Inc. License Number 0757776 PO Box 20005 Encino CA 91416-0005	PHONE (A/C, No, Ext): (818) 257-7400 FAX (A/C, No): (818) 257-7450 E-MAIL ADDRESS: katrine.minasyan@hubinternational.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A: Hartford Accident and Indemnity — 22357
INSURED MANATT, PHELPS & PHILLIPS, LLP 11355 W OLYMPIC BLVD LOS ANGELES CA 90064-1614	INSURER B:
	INSURER C:
	INSURER D:
	INSURER E:
	INSURER F:

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	☐ ☐ CLAIMS-MADE ☐ OCCUR						MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$
	☐ POLICY ☐ PRO-JECT ☐ LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			72WEJX8445	4/1/2014	4/1/2015	X WC STATU-TORY LIMITS ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER

New Hampshire Insurance Department
Attn: Alexander Feldvebel
21 South Fruit Street
Suite 14
Concord, NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

J Pfaffenberger/JPF

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STANDARD EXHIBIT I

The Contractor identified as "Manatt, Phelps & Phillips, LLP" in Section A of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 and those parts of the HITECH Act applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the New Hampshire Insurance Department.

BUSINESS ASSOCIATE AGREEMENT

(1) **Definitions**.

a. "Breach" shall have the same meaning as the term "Breach" in Title XXX, Subtitle D. Sec. 13400.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.501.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH Act.

(2) Use and Disclosure of Protected Health Information.

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, the Business Associate shall not, and shall ensure that its directors, officers, employees and agents, do not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HITECH Act, Subtitle D, Part 1, Sec. 13402 of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) **Obligations and Activities of Business Associate.**

a. Business Associate shall report to the designated Privacy Officer of Covered Entity, in writing, any use or disclosure of PHI in violation of the Agreement, including any security incident involving Covered Entity data, in accordance with the HITECH Act, Subtitle D, Part 1, Sec. 13402.

b. The Business Associate shall comply with all sections of the Privacy and Security Rule as set forth in, the HITECH Act, Subtitle D, Part 1, Sec. 13401 and Sec.13404.

c. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

d. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section (3)b and (3)k herein. The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard provision #13 of this Agreement for the purpose of use and disclosure of protected health information.

e. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

f. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

g. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

h. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

i. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

j. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

k. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to standard provision #10 of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, and the HITECH Act as amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the

changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

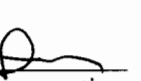
c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule and the HITECH Act.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section 3 k, the defense and indemnification provisions of section 3 d and standard contract provision #13, shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

NH Insurance Dept The State	Manatt, Phelps & Phillips, LLP Name of the Contractor
Alexander K Feldbebel Signature of Authorized Representative	 Signature of Authorized Representative
Alexander Feldbebel Name of Authorized Representative	Melinda Dutton Name of Authorized Representative
Deputy Commissioner Title of Authorized Representative	Partner Title of Authorized Representative
2/19/14 Date	2/14/14 Date