

# WILLIS 2015 MANAGED CARE E&O MARKET REVIEW/ 2016 MARKET FORECAST

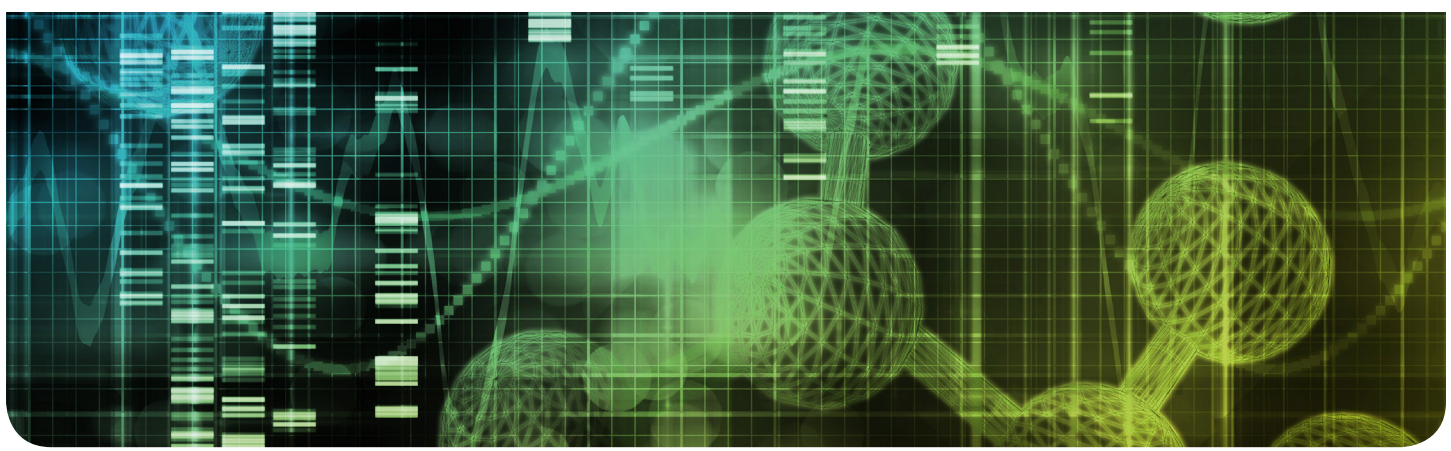
Willis

## A BRAVE NEW WORLD WELCOME TO THE CYBER CIRCUS

Is Cyber/Network Security and Privacy (NSP) coverage disappearing from managed care E&O policy forms? The Anthem, Premera, CareFirst and now Excellus cyber breaches have the Managed Care E&O insurance industry concerned, especially about the Blues plans. These breaches came on the heels of other health care industry breaches and were followed by additional government breaches. Government breach activity is one of the most perplexing problems for MCOs. All plans have multiple connections to the federal government, especially HHS/CMS which are required by law, regulation, business and practical considerations. However, the U.S. Department of Health and Human Services/CMS has, itself, been hacked multiple times over the last few years. This trend is expected to increase. Since the government doesn't pay for its failures, if the breach of an MCO is through access to or from information obtained from a breach of a government system, the MCO must have coverage that will protect it. MCOs have personal information, financial information and health information in large quantities and there are multiple access portals. This makes them a target. With the "hacks" on exchanges, HHS and CMS, access to these entities is even more vulnerable.

How are the managed care E&O markets responding to a risk they don't typically underwrite? Will a sliver of coverage continue to be included in the managed care E&O forms? Willis is immersed in the industry and has been following the information available related to these breaches. We represent numerous health care and managed care clients in claims related to breaches and breach coverage. Willis has many recognized thought and industry leaders in matters related to network privacy and security coverage, E&O coverage and breach response in health care. We have also interviewed all of the major markets for managed care E&O coverage in detail regarding how each intends to respond to this environment. Each carrier has a different approach to providing, or not providing, coverage.

- ACE has taken the most aggressive approach by adding a TOTAL cyber exclusion to all primary and excess managed care E&O policies. ACE has also notified us that they will not follow in the excess any primary policy that includes NSP coverage. It may make an exception for a long-term insured.<sup>1</sup>
- AIG continues to provide third-party privacy liability but includes no first-party coverage or coverage for HIPAA fines and penalties.
- Allied World/Darwin has indicated it will consider limited NSP coverage on an application-by-application basis, although AWAC is unlikely to agree to first-party coverage and will sublimit any third-party coverage if extended by endorsement.
- Berkshire Hathaway Specialty will evaluate and underwrite each potential insured for third-party coverage and make a decision on coverage, terms, limits, sub-limits and retentions based on the individual situation. BHS may be willing to consider terms/language where the "type" of breach is segregated (e.g., HIPAA/HITECH non-cyber breaches, wide scale data breach by cyber attack).
- IronShore has not changed its coverage position. It continues to provide third-party privacy liability coverage as well as coverage for HIPAA fines and penalties. This coverage is not subject to a sublimit but is generally required to be excess to any standalone "cyber" coverage. Ironshore also offers \$250,000 in first-party "Private Information Protection Event" coverage.
- OneBeacon's Network Security and Privacy Liability Endorsement is no longer available for new placements. OneBeacon will continue to offer the endorsement on renewals with limits up to \$5M. Coverage is subject to the satisfactory completion of the questionnaire included in the application. OneBeacon will continue to provide third-party privacy liability in the policy form and will utilize the "Other Insurance" endorsement to schedule the standalone cyber coverage as primary. It will recognize SIR erosion on an account-by-account basis.



- Travelers has not changed its cyber coverage position. It continues to provide third-party privacy liability coverage as well as coverage for HIPAA fines and penalties at the same limits as its other policy limits. BCS is still limited to Blues plans but, at least at this time, it will continue to include third-party liability for limited privacy breaches in the E&O form, though it is moving towards restricting that or eliminating it if possible.

#### **What about the stand alone Cyber/Network Security and Privacy (NSP) coverage: Who's in and who's out?**

Some stand alone cyber carriers are no longer writing cyber coverage for managed care organizations. Others are very cautious. New carriers, such as Travelers, have jumped in. Retentions and limits management and the use of exclusions are common. Coverage terms vary widely. Allied World and Beazley have both been leaders in writing MCO Cyber coverage but have taken a new direction. Neither carrier is writing coverage for Blue plans.

#### **So what does all this mean for managed care organizations and hybrid MCOs/alternative delivery models which are concerned about the marketplace?**

- A detailed discussion of the current managed care E&O and cyber insurance programs and how coverage will be affected is important. This includes the details of what is and is not covered by any E&O or stand alone NSP policy, the exposure and risks for any given entity and the underwriting and rating process. There must be a discussion of the adequacy of current cyber limits. Willis analytical tools can be used to help MCOs make decisions on what limits to carry and what programs are the most cost effective.
- Negotiate MCO E&O and cyber renewal terms early.
- Dovetail the MCO E&O and cyber policies to obtain the most cost efficient program.

## **2015 INDUSTRY HIGHLIGHTS**

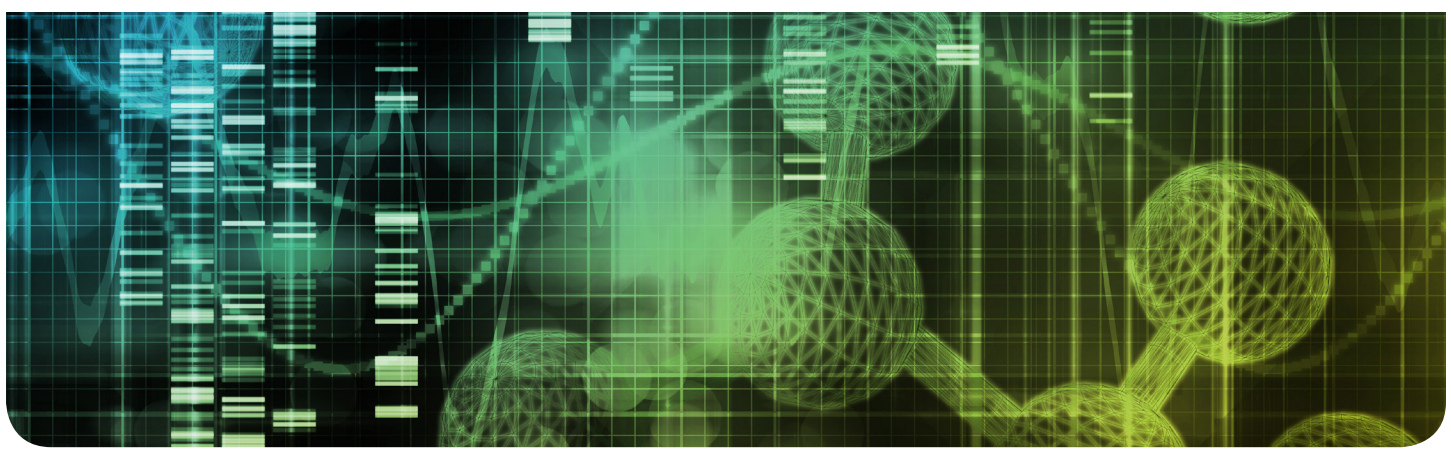
### **MERGERS AND ACQUISITIONS**

We have seen a flurry of managed care organizations considering M&A, including the top five managed care entities – Aetna, Anthem, CIGNA, Humana and United. Add to that the Blue Shield CA/Care 1st acquisition and the Centene/HealthNet acquisition and we are left wondering who will be still standing. These all follow the acquisitions nationwide of many smaller plans by larger regional/national plans and pharmacy benefit management companies by larger plans. While many of these deals face stiff regulatory scrutiny at the federal and state level, as well as potential competitor, provider and member lawsuits, the trend of consolidation is continuing. What about providers who are acquiring managed care organizations? What concerns does M&A create for MCOs when they are the buyers? How can brokers assist their clients with the due diligence process?

### **WILL EXCHANGES SURVIVE?**

The *King v. Burwell* ruling has pumped new life into the federal exchanges. In June, the U.S. Supreme Court affirmed that tax subsidies are legal for health insurance offered on the federal exchange. The decision continues to provide security to more than 10 million people who would have potentially lost their insurance. Of the over 10 million currently with exchange products, a statistical majority of which did not previously have coverage, over 300,000 have already ceased paying for coverage in 2015. Over 80% of those with exchange premiums receive federal tax subsidies for the premiums, but very few receive assistance with paying for high deductibles and co-payments. However, the *King* decision removes uncertainty that the insurance industry and health plans will continue to maintain their revenues generated by this business segment. Employers will also be affected. Those required by the Affordable Care Act (ACA) will be obligated to comply with the mandate. There is still significant resistance to compliance with the individual mandate, and the rising costs of the premiums and the impact of high deductibles is adversely impacting the industry. There are between 15-20 million additional uninsured persons in the country even with the substantial number of persons who now qualify for the expanded Medicaid program in many states.





The *King* ruling is good news for the federal exchange operating in most states but does not provide incentives for the states to create or continue their exchanges. State exchanges face uphill battles in many locations because of budget constraints and technological/bureaucratic complications. Several state exchanges have already shut down and several others are at risk. With the *King* ruling, many states will see no reason to create or continue their own exchange. The battle with regard to the expansion of Medicaid continues in many states, and the budget battles over that expansion will continue for years.

In addition, The Center for Medicare and Medicaid Services (CMS) and related agencies continue to pump out new and revised regulations at an alarming pace that will create an unsettled compliance effort in the industry, likely increase administrative costs, and require changes in business models, benefit plans, provider and pharma contracting, etc. For example: new CMS rules for re-enrollment in the Federal Exchange for 2016 would automatically re-enroll those who do not go back on the system to select a plan into lower cost plans if there had been an increase of a specific amount in the current plan pricing “to protect them from ‘unknown’ price increases.” That is going to cause a great many problems as enrollees may be unwittingly re-enrolled in lower cost/lower benefit or higher deductible plans because they did not affirmatively select the same plan despite the price increase. This, of course, will increase litigation expense and potential liability for exchange participating plans when beneficiaries discover they have a lesser inclusive plan than they thought they had after the fact. Additional changes to Medicaid, Medicare and the exchange products and requirements, and continued pushes to reform value-based contracting and drug costs, will also complicate the landscape.

## **ACCOUNTABLE CARE ORGANIZATIONS AND JOINT VENTURES**

The Supreme Court ruling has calmed investors and ACOs, and other hybrid MCOs can now move forward with their business plans and strategies. However, fewer than 1 in 3 ACOs signed up with the CMS Medicare Shared Savings Program earned a bonus (were allowed to retain the savings created by their participation in the program) in the last year despite the effort and attention the program has received from the administration under the ACA. The total saved was 833 million dollars and only 97 of 353 ACOs met the targets. This is well below the expected numbers. Very few ACOs have even signed up for the Next Gen

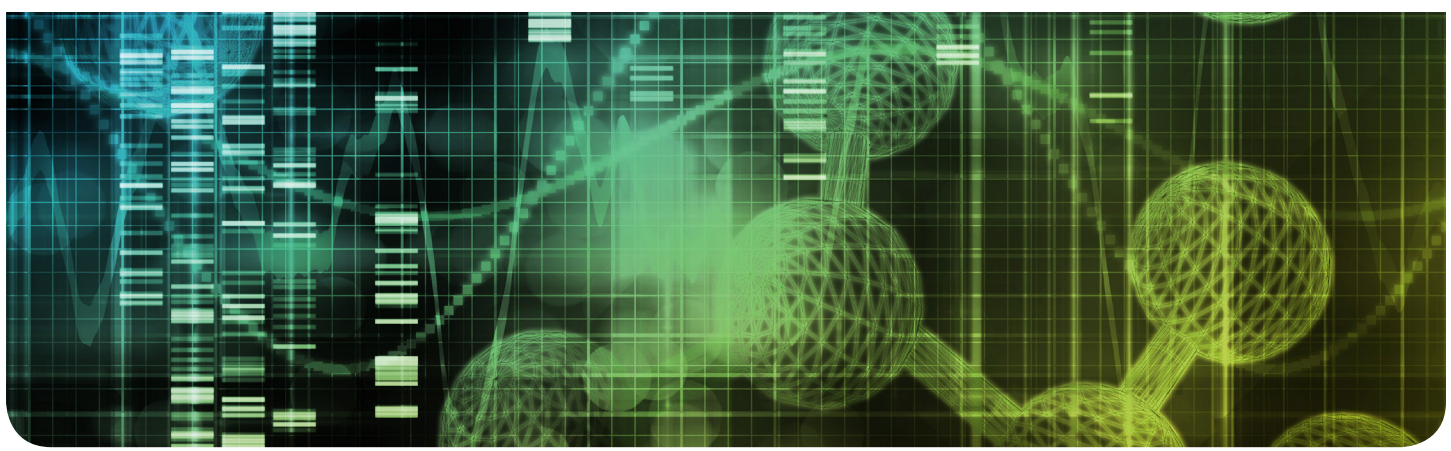
ACO program that includes downside risk. The Next Gen model, unlike stage one/two, has downside risk built in to the contract. This is not the “full risk” contracts we saw in the 1980s/90s but is a move in that direction. This business model is very risky and is not for the faint of heart, those provider entities that do not have substantial competent administrative support or those with no control over a wide range of aligned treatment options.

Medicare released 2014 results for 353 accountable care organizations, which include hospitals and physician groups that agreed to meet targets for quality and slow spending. Those that succeed can keep a share of the money they save. In January, the Obama administration announced plans to aggressively increase the share of Medicare spending under accountable care and other alternative payment models through 2018. Last year, 97 ACOs earned bonuses totaling \$422 million out of \$833 million in savings they produced. Savings are awarded under formulas that account for performance on quality targets after the first year in the program. (For ACOs in their first year, organizations must report quality scores but do not have to meet performance targets.)

This demonstrates the pressure on the model from many fronts, including the need to change the behavior of the providers in the network for the ACOs – something that is slow to happen, the need to alter the reimbursement methodologies and compensation plans for the providers, and the need for the public to engage the system and take responsibility for their own care and consequences. While this process is ongoing, the very real need for a broad range of coverage for these entities is important. This includes D&O and E&O cover, regulatory coverage, and cyber/NSP as well as stop loss/reinsurance. Without these coverages and the proper terms, these entities are losses waiting to adversely impact the companies that invested in them.

## **REGULATORY SCRUTINY**

Here is another reason to ensure that you have proper regulatory coverage. The Department of Justice (DOJ) now has a new “compliance counsel” to help it determine if those entities under investigation have the proper compliance program. The failure to have the proper compliance program, or having a proper one, will impact the DOJ’s decision whether to prosecute per its guidelines. Thus, compliance programs and coverage that help any entity prove its compliance program is robust and meets all best practices would be a significant value add. The Federal



Trade Commission (FTC) and the DOJ, as well as the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS), are ramping up investigations of white-collar crime related to health care (Medicare/Medicaid fraud), antitrust scrutiny, compliance with regulations and other regulatory requirements. The DOJ has just announced a concerted effort to investigate and prosecute individuals for corporate wrongdoing in addition to the increased emphasis on health care entity wrongdoing. These efforts demand that any entity in the space, including the new business model hybrid MCOs, have sufficient regulatory coverage that covers defense costs, fines, penalties, punitive damages, etc., and have favorable choice of laws provisions.

## LITIGATION TRENDS

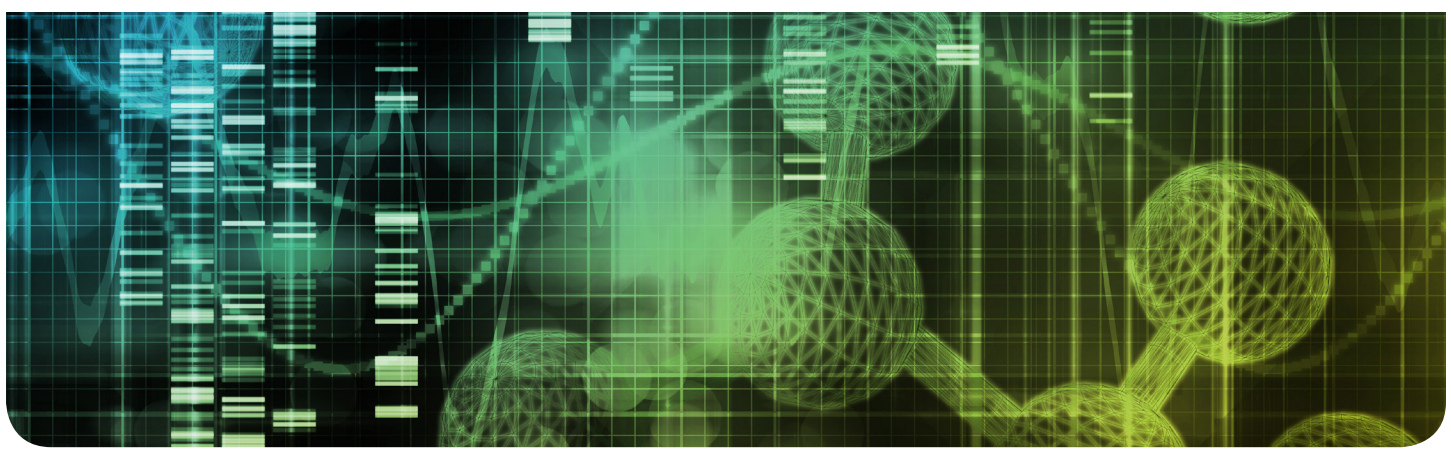
### PRIVACY

Network Security & Privacy continues to be a large concern for the health care industry. In fact, given recent cyber-attacks on health care companies, cyber crime and losses top the list for new risks and exposure. There are federal laws related to these breaches, including HIPAA, HITECH and GBLA, and state statutes which mirror them. Although the federal laws provide for fines and penalties, the HHS Office of Civil Rights prefers to identify and correct the technical problems related to the breaches. The OCR, DOJ and OIG continue to step up enforcement activity and the size of fines for HIPAA/HITECH/GBLA violators. However, state laws often provide private rights to causes of action and compensatory damages. For example, California's Confidentiality of Medical Information Act (Cal. Civ. Code § 56, et seq.) (CMIA) is the most notable exception and could become a model for other states. The CMIA creates liability if a person or entity "negligently released" confidential information or records. (§ 56.36) and provides for (1) nominal damages of \$1,000 and/or (2) actual damages, if any sustained by the patient (§ 56.36). (See also § 56.35.) Constitutionality of mass nominal damage awards remains an open question, but CMIA exclusions are beginning to appear on E&O and cyber policies. Due to the nature of medical data breaches (e.g., one theft may affect thousands or even millions of individuals), class actions have been used as a tool to seek redress. Most jurisdictions still require actual damages to proceed with a claim related to a breach. While most courts still require proof of actual damage for any given claim to continue, given the mass data breaches in

health care, the millions involved, the types of records and data lost, discarded or stolen and the fact that most of these claims are filed as one or many class actions (the number of individual lawsuits filed against Anthem – many of which have been consolidated in a MDL claim in federal court – approaches 100), and the attacks are coming from crime syndicates or foreign governments, this may change. The failure to timely discover the attack also permits more mischief before the breach is made public. The Excellus breach first occurred in late 2013 was not discovered until the spring of 2015 and not disclosed until September 2015. Some notable claims are:

- Managed care company is assessed a \$1.2M penalty following the breach of electronic PHI of 344,557 individuals. The PHI was discovered on the hard drives of copy machines that had been returned to a leasing company. An OCR investigation revealed that the organization failed to incorporate ePHI stored on photocopier hard drives in its risk analysis of vulnerabilities as required by the HIPAA Security Rule.
- In April of 2014, a hospital was attacked by a "hacker collective" known as Anonymous. While the attack was classified as "hacktivism" (motivations revolved around a high-profile pediatric case), the "group" issued direct threats prior to launching a sizable distributed denial-of-service (DDoS) attack on the hospital. The attack was short lived (about a week) but escalated quickly and did have an impact on critical communications including email services for the entire hospital
- Two large hospitals settled for a combined \$4.8M, with both entities agreeing to an elaborate corrective action plan following a breach of electronic PHI of 6,800 individuals. The breach included information regarding patient status, vital signs, medications and laboratory results.
- Provider is fined \$4.3M civil monetary penalty after 41 patients are denied access to medical records. Following an investigation by the OCR, the provider was also alleged to have refused to respond to the agency's demands to produce records, to cooperate with investigations of complaints from patients and to produce records in response to subpoena requests.





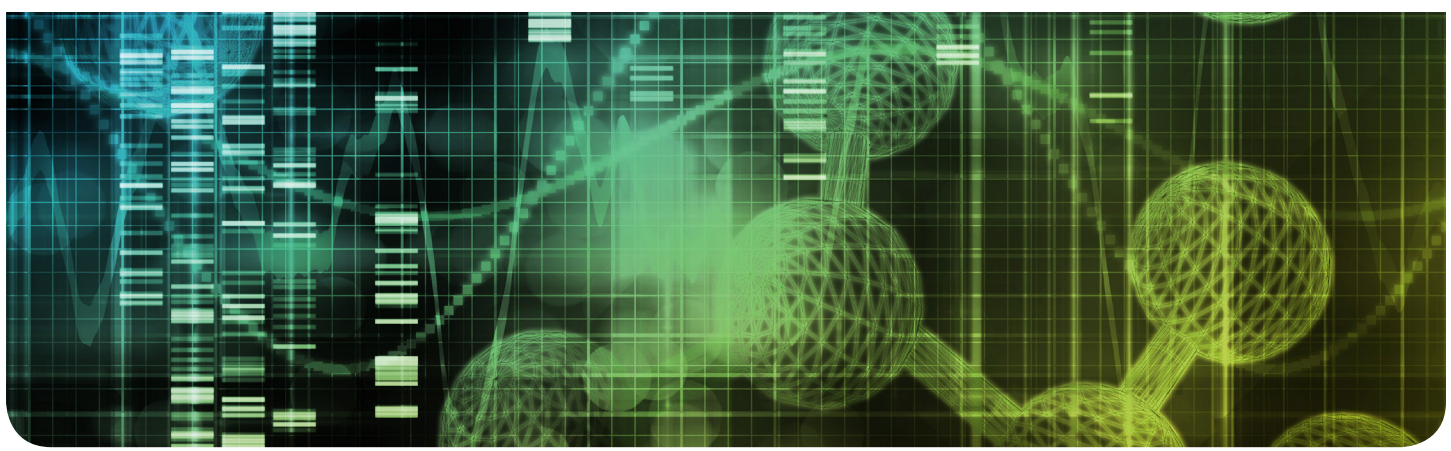
- The Office of Civil Rights of HHS is the federal agency that investigates HIPAA/HITECH breaches. That agency has investigated well over 100,000 alleged breaches, but has fined very few of those entities involved and the total fines are – with fewer than 10 exceptions – nominal. The majority of fines and penalties are handed down by state and territorial agencies. However, the costs of the investigations, forensic investigations, disclosure and notification, and remediation efforts, defense costs, etc., are very significant; and the costs of defending against the civil liability claims dwarf the fines and penalties handed down.
- There have been a number of breaches in the last six months, including the large Anthem attack that may have exposed records of up to 80 million members of the multiple Anthem plans and other plan members through the Blue Cross Blue Shield Association affiliations. This breach appears to have been limited to “personal information” and not financial or health information. The Premera breach affected more than 10 million persons but included personal, health and financial data. The Care First data breach was not as extensive, though the very recent disclosure of a data breach by Excellus indicates that this breach may be as extensive in terms of numbers and types of data as the Premera breach. The fact that all of these breaches involved Blues plans has not escaped anyone, including the insurance industry. Theft of hardware and data theft are still major issues that multiple private security and federal law enforcement entities are working overtime to address. By volume, the majority of alleged breaches are still the “old fashioned” kind, not cyber-attacks. However, in terms of the quantity of those impacted, the cyber breaches dwarf all others. The number of persons affected by all breaches prior to 2014 was approximately 30 million. Since 2014, that number is approximately 175 million. Personal identities, financial records and health records are the targets, and MCOs have a vast library of those records.

#### **FALSE CLAIMS**

Concern continues over the potential for high false claim penalties. False Claim Act (FCA) claims have increased in recent years based on RAC audits and whistleblower claims as the RAC entity and the whistleblowers are compensated. RADV audits, which focus on Medicare reimbursement calculations, may also result in increased investigations/claims. There is

also apprehension that subsidy overpayments received by an insurer through the public exchange and held for more than 60 days subjects the insurer to liability under a reverse false claim theory. Given the issues surrounding the subsidies, the problem getting proper information from voluntary “on your honor” applications and the inability of the IRS to conduct real time – or any – detailed checks on eligibility for the subsidies, FCA claims based on retaining the subsidy payments is a developing risk. The extension of FCA liability to those that bill Medicare Advantage and Medicaid plans and changes in reimbursement for those plans increases exposure. Currently there is no False Claim Act regulatory pure insurance risk transfer product available for managed care organizations except for defense and some limited coverage in the MCO E&O forms. Penalties and Fines are still excluded, though Willis has won coverage enhancements for its clients in the area of statutory damages, civil compensatory damages arising out of similar claims and defense costs. Willis continues to urge insurance markets to provide a more comprehensive solution.

FCA lawsuits, whether “whistle blower” claims or those initiated by the government, extend well beyond the traditional direct claim or invoice matter. FCA violations now include violations when the invoice was made to a government intermediary – not just directly to the government. They also include claims and invoices for any good or service covered by the act (and those state versions of the FCA which most states have). This certainly extends to ACOs and other hybrid MCOs and PBMs, case management companies, etc. As *qui tam* relators (whistleblowers) are compensated for their “snitching,” there is a significant incentive for an entity’s employees or vendors to bring claims. Not all relators are compensated. For example, recently a PBM executive failed in his attempt to be an original source relator under the False Claims Act because the allegations of conduct were known to the public. Unless the relator has first-hand or original source information of the alleged fraud, prior disclosure or public knowledge of the wrongful act will defeat a claim for compensation. Another fact that may defeat or reduce compensation is if the relator was “involved” in the fraud. This PBM case is of importance because it limits the opportunities of former executives to claim relator status for *qui tam* actions. Insured vs. insured exclusions must be carefully tailored so as not to void coverage when the named plaintiff in one of these lawsuits is also a named or covered insured.



## ANTI-TRUST

Antitrust litigation has been undeniably active and costly for a subset of health insurers in the class action *Conway v Blue Cross Blue Shield of Alabama et al* under liability theories ranging from Most Favored Nation to market collusion. Plodding along, all of the provider and subscriber claims against all of the Blues Plans and the Association have been consolidated for class certification, discovery and pre-trial motion practice as Multi District litigation (MDL 2406) assigned to Judge David Proctor as of December 2012. The initial Motions to Dismiss based on jurisdictional and other defenses were denied by the court. Motions to Dismiss remain pending, but are unlikely to be granted unless treated as Motions for Summary Judgment. The time line, as set by the court, for discovery – primarily related to class certification and the underlying facts/claims – goes into 2018. There is unlikely to be a determination on class certification for years. There is unlikely to be a settlement – at least not in the near future. The majority of the pending motions to dismiss have been heard and denied. Discovery is under way and the courts are dealing with the additional of new claims and lawsuits to the mix and the efforts by others to join the fray.

Providers who were class members in the Shane, Musselman, Love, etc. litigation (UCR litigation) sought to join the Conway litigation as plaintiffs but their request was rejected in Miami by Judge Moreno (the judge on what is often referred to as the UCR litigation – MDL 1334), because Moreno held that they are barred from joining by the settlement release in MDL 1334. That decision is on appeal to the 11th Circuit, but it is our guess that the 11th District will uphold the trial judge's decision and the U.S. Supreme Court will decline to take the result on appeal.

## TELEPHONE CONSUMER PROTECTION ACT (TCPA) LITIGATION

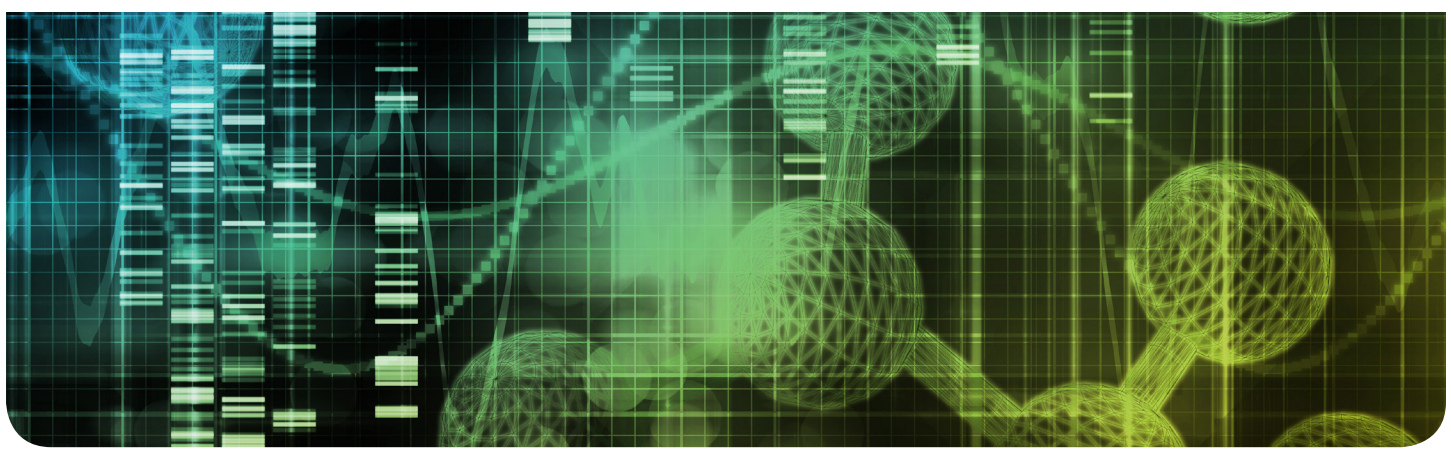
The Telephone Consumer Protection Act of 1991 restricts the use of telephone solicitations and limits the use of fax machines and text messaging for telemarketing purposes. There has been an uptick of regulatory action brought in many industries including health care. Managed Care E&O carriers have seen an increase in claim activity, which is a concern due to a flurry of class action litigation that is expensive to litigate. Willis has been successful in negotiating coverage for these claims as statutory damages.

## NARROW NETWORK CLAIMS

In response to health care reform, health care is becoming more consumer-centric, which creates a problem for carriers offering narrow networks to their members. In California, Anthem Blue Cross was hit with a class action lawsuit that included allegations for misleading members about the providers participating in their networks. They are not the only entity investigated or sued. California statutes and regulations have been enacted to address this perceived problem, much of which is related to misinformation and inaccurate online documents related to exchange networks. There is a difference between “narrow networks” – those where there are limited numbers of providers in any given geographic area in the network – and “inadequate networks” – where there are insufficient providers in a network to serve the needs of the plan membership. Narrow networks have historically kept individual health insurance premiums down by reducing costs; inadequate networks are generally a violation of statutes, regulations or member contracts. This litigation has not gained a foothold in other jurisdictions and appears to be limited to issues related to notice/disclosure vs the actual makeup of the networks. Narrow networks are a hallmark of cost cutting plans and provider entities such as aligned health networks and ACOs. It is not the “narrowness” that is a concern (despite spawning some litigation), it is the “adequacy” of the network that is important.

New CMS rules related to enrollment may result in potential risk for some plans employing significantly narrow networks. This includes private exchanges, self-insured plans, provider side network plans and health system plans. Much of this relates to the makeup and adequacy of the network. Insurers are at odds with providers and consumer advocacy groups over the Obama administration's guidance on network adequacy. In the proposed rule, the CMS indicated that it will hold off on issuing additional regulations dealing with provider networks until after the National Association of Insurance Commissioners completes drafting a model state law. Narrow networks have been a major source of contention since the exchanges launched. Insurers have insisted that limiting networks is a crucial means of holding down premiums, and exchange customers have flocked to low-cost plans. But consumer advocates and providers worry that unsophisticated customers are choosing plans that may not include their doctors or otherwise meet their coverage needs.





## MARKET CONVERSATIONS

The managed care E&O insurance environment is in a state of wait and see – what will this brave new world look like in 2016? It continues, therefore, to be stable, but carriers are carefully watching cyber breaches and merger and acquisition activity. The June Supreme Court ruling has taken some uncertainty out of the market place, but health care reform continues to create unknown risk for both managed care organizations and carriers. Jennifer Bray of IronShore said, “Managed care organizations are still trying to figure out how to operate in this new market. We are already starting to see some clear winning and losing strategies.”<sup>2</sup> Jeff Stetson of Chatham Insurance Services added, “It may be a new world, but some of the old solutions are still working. Steady as you go is the course Travelers is charting in this brave new world.”<sup>3</sup>

Despite the tremors caused by cyber breaches, anti-trust litigation, ACA changes and M&A activity, MCO E&O rates remain stable, but there has been some shake up with the coverage offered. Carriers have not left the space, but some have taken a different approach on how they integrate cyber/network security and privacy risk into their MCO E&O policies. Kim Delaney of Allied World Assurance Company said “Cyber is the stick in the spokes of the wheel this year as to how it will affect the market and where coverage will fall.”<sup>4</sup> Some carriers feel it will not be the E&O market’s response to just assume privacy liability in their programs. Mary Nolan of Berkshire Hathaway Specialty said “They will not fill the gap without a shift in pricing.”<sup>5</sup>

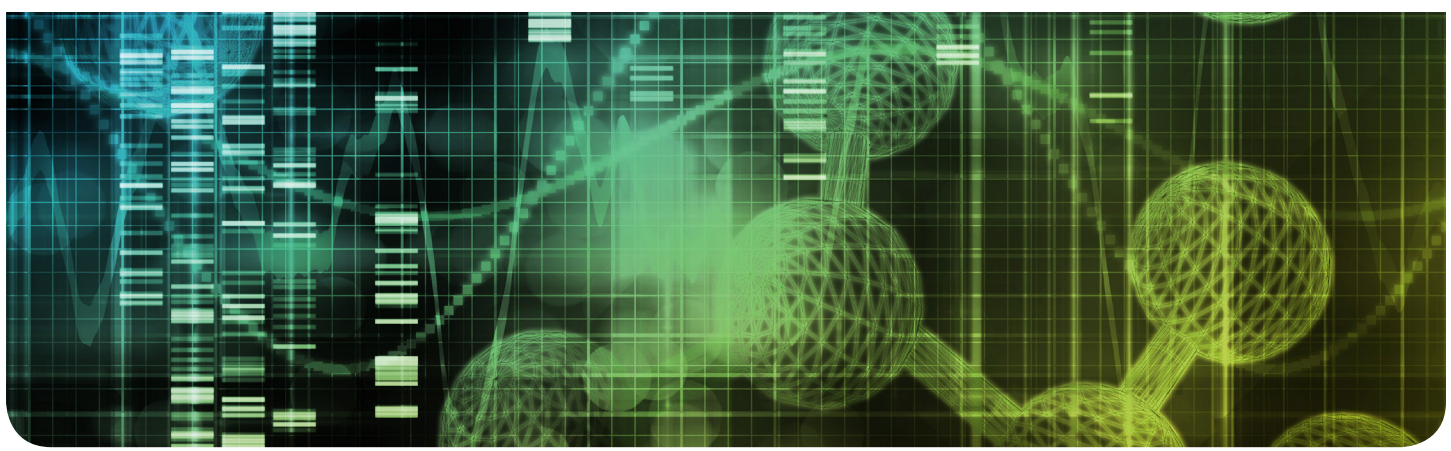
Limit management, driven by cyber and anti-trust claims, is the new buzz and will continue into 2016. Cyber attacks have sent a shock through the system and the market is in agreement that it will not slow down. Regulatory risk continues to be an area of focus for all MCOs and PBMs. And of course, all eyes remain on the Blue Plan anti-trust battle currently being fought. Christian Andrews of AIG agrees, “Uncertainty lies with cyber and anti-trust and capacity management will continue to be a theme in 2016.”<sup>6</sup>

Merger and acquisition is being watched, but as Kerry Stetz of Allied World said, “M&A is still fresh. How it will play out in the first quarter and what the trickle-down effect will be is yet to be seen.”<sup>7</sup> Pending mega deals still need to work their way through the regulatory web. Susan Angelo of OneBeacon said,

“The recent merger and acquisition deals we are seeing and reading about dwarf the transactions we saw in the 90’s and we thought those were the mega mergers. The result is industry consolidation, leaving us with a smaller pool but overall greater risk to insure.”<sup>8</sup> M&A adds to the challenges carriers face when underwriting large for-profit plans, including complex Blue plans. The need for direct medical malpractice also adds to the complexity of these plans. Large professional services firms that have not traditionally operated as managed care organizations are continuing to offer managed care-related services to their customers, representing a new form of competition for the managed care industry.

ACE has been a leader in providing primary coverage to large complex MCO risks and is willing to negotiate broad terms. But their new position on privacy liability remains a challenge. IronShore has an appetite for larger plans and if not offering primary, they will likely write an excess layer lower in the coverage tower. Berkshire Hathaway Specialty, Travelers, and AIG are carriers amenable to primary and/or discussions as well. Allied World continues to be comfortable with primary and excess layers but anti-trust coverage restriction may apply. OneBeacon is more comfortable with taking an excess position on larger Blues Plans and for-profit public entities. Berkley will consider excess positions and is comfortable with managed care E&O and medical malpractice blended programs. Let us not forget Bermuda and London which continue to offer competitive excess capacity.

Most carriers like to write the regional managed care organizations, and they continue to cautiously underwrite new MCO business models, such as accountable care organizations, clinically integrated networks, and other like entities. Laura Williams of OneBeacon said, “One of the driving forces of reform was to foster competition and create new modes of delivering care, but we are already seeing some of those entities like Co-ops fail.”<sup>9</sup> In order for carriers to underwrite these accounts, business plans and pro-forma financials are required. Due to the nature of the entities and changing CMS rules, these are sometimes difficult to acquire. When membership and revenue projections are unavailable, it creates an environment for overly conservative pricing.



## 2016 FORECAST

Markets will continue offering flat to minimal rate increases in 2016 unless unforeseen litigation arises. However, pullback on cyber coverage will continue and anti-trust will be carefully watched due to the flurry of M&A activity. Carriers will aggressively look for premium where increased exposure in membership, revenue, operation or M&A activity and/or adverse claim activity exists.

Regulatory risk is an area that both MCOs and carriers will keep a watchful eye on especially with an increase in false claims and qui tam actions and the formation of the DOJ's new compliance counsel. New MCO business models continue to populate the landscape and remain an underwriting challenge. Willis remains active in detailed policy language reviews for all MCOs, as these entities continue to evolve and alter their business practices.

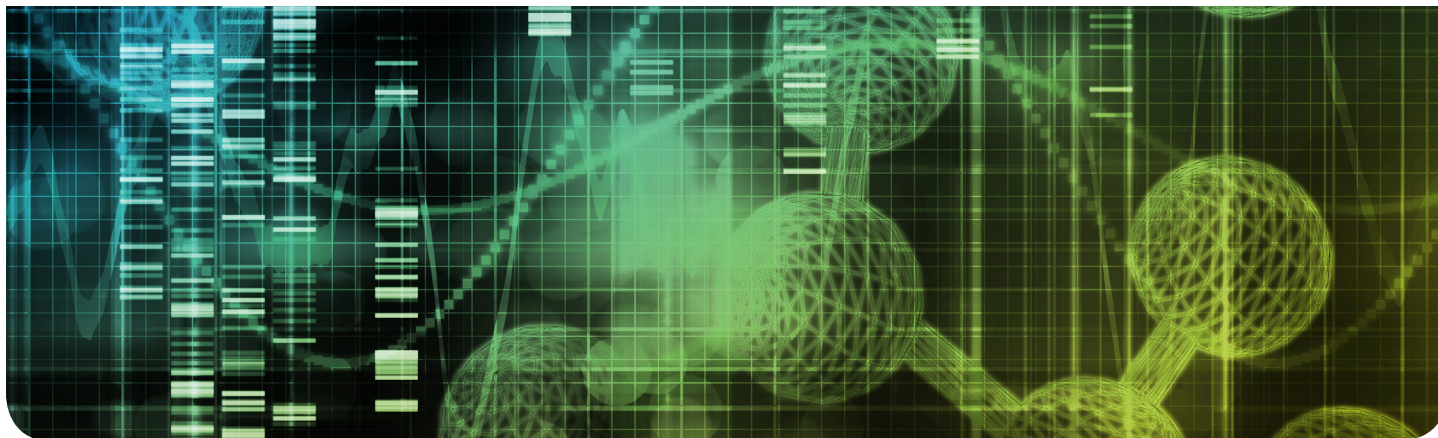
How can you position your organization in 2016 for potential market changes? We suggest that you talk to your insurance consultant/broker about each of the following:

- **BUDGET** for flat to 5% rate increases in 2016, assuming no relevant change in exposures has occurred.
- **BUDGET** increase for exposure changes, including membership growth, revenue growth, acquisitions and new business activities.
- **NEGOTIATE** terms early:
  - Review managed care and care management activities to be sure all exposures are addressed in the E&O policy
  - Look to review policy language for policy enhancements especially for added business activities
  - Confirm how an ACO, joint venture or other business entity would dovetail with your current coverage
  - Look at adding or increasing subpoena defense coverage and defense costs for regulatory investigations
  - Remove any limits anti-stacking conditions
  - Review coverage for anti-competitive behavior claims
  - Clarify the scope of statutory anti-trust coverage, whether government or private party actions

- Obtain disciplinary action defense coverage for medical directors and nurse case managers
- Add late claim reporting forgiveness and related claim cover change
- Six-year pre-negotiated Extended Reporting Period
- Maximize continuity when moving carriers, e.g., retro and pending and prior litigation dates must match expiring program dates; narrow the known circumstance exclusion; reported claim and circumstances exclusion should apply only to those accepted by prior carrier
- **CONSIDER** purchasing a separate network security and privacy (NSP) policy, if not already purchased or additional limits if coverage exists.
  - Dovetail the cyber as primary, with the MCO E&O as excess, so that the “other issuance” condition is not triggered
  - Know whether you have coverage for breach of your data in the custody of a business associate
- **REVIEW** the regulatory coverage provided, especially how coverage would respond (if at all) to false claims.
- **CONTINUE** to scrutinize carrier balance sheets and understand how much each takes net of insurance. Learn who is your lead market's real “decider.”

INSURER	RATING	CAPACITY
ACE	A++, XV	\$15M
Allied World Assurance Company	A, XV	\$25M
BCS (Blues Owned)	A-, IX	\$40M
Berkley	A+, XV	\$20M
Berkshire Hathaway Specialty	A++, XV	\$10M
IronShore	A, XIV	\$25M
Lexington (AIG)	A, XV	\$25M
OneBeacon Professional Partners	A, X	\$25M
Travelers	A++, XV	\$20M





In addition to the domestic markets listed above, other carriers that may participate on a capacity basis include ACE Bermuda, AIG Cat, AIG Europe, Allied World, Arch, Argo Re, Endurance, Hannover Re, IronStarr, Lloyd's, Market, Starr, Swiss Re and XL Catlin. Travelers, through MGU Chatham Insurance Services, Inc. provides lead and excess capacity to both for-profit and nonprofit plans.

**FOR MORE INFORMATION** contact Kenneth White or Kathy Kunigiel of the Willis National Health Care Practice and follow us on the Willis Expertise Portal and Willis Wire.

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*The observations, comments and suggestions made in this report are advisory and are not intended or should they be taken as medical/legal advice. This article is intended to provide general information regarding trends in the insurance industry for managed care organizations. The information is not guaranteed and is not intended as specific advice for any given client or potential client and should not be relied upon to make specific insurance decisions. Please contact your insurance broker for specific advice about your insurance needs.*

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<sup>1</sup> Kunigiel interview with Annick Charles and Aaron Turner, ACE, September 2015  
<sup>2</sup> Kunigiel interview with Jennifer Bray, IronHealth, September 2015  
<sup>3</sup> Kunigiel interview with Jeff Stetson, Chatham Insurance Services, Inc., August 2015  
<sup>4</sup> Kunigiel interview with Kim Delaney and Kerry Stetz, Allied World Insurance Company, August 2015  
<sup>5</sup> Kunigiel interview with Mary Nolan, Berkshire Hathaway Specialty, August 2015  
<sup>6</sup> Kunigiel interview with Christian Andrews, AIG, September 2015  
<sup>7</sup> Kunigiel interview with Kim Delaney and Kerry Stetz, Allied World Insurance Company, August 2015  
<sup>8</sup> Kunigiel interview with Susan Angelo and Laura Williams of OneBeacon Professional Partners, August 2015  
<sup>9</sup> Kunigiel interview with Susan Angelo and Laura Williams of OneBeacon Professional Partners, August 2015