HEALTH CARE PRACTICE

MCO E&O: 2010 MARKET UPDATE

Fall 2010

www.willis.com

MCO E&O CARRIERS HIT THE PAUSE BUTTON

Health reform turbulence has caused E&O underwriters to step back and think about their approach to, and offerings for, Managed Care Organizations (MCO) in 2010.

From E&O underwriters we observe:

- Less risk-taking
- Increased resistance to broadening coverage (and in some cases efforts to *restrict* coverage)
- Moderating (5-10%) premium reductions
- Greater recognition that no competitor has a game-changing silver bullet

In last year's market update we concluded:

> **"*Ingenix* paid losses, together with poor investment results, will likely spell diminished appetite for MCO E&O as a line of business. It may turn out that these game-changing losses will not materialize – and indeed for *Ingenix* data users, the losses may amount to no more than defense costs – but underwriters aren't buying this view. We believe at least two markets will actively or passively withdraw."**

Twelve months later, we see coverage litigation produce little in the way of indemnity recovery paid to insureds and larger buyers are questioning the E&O product's value. The failure, as large plan Health Net's deputy general counsel describes it, is carriers selling "20th century coverage to 21st century risks." Yes, there will be a price paid for *Ingenix* by the underwriting and brokerage community, but it will be withdrawal of large plan premium from the market (i.e., reduced demand), not market hardening (which is reduced supply).

CHALLENGES FACING HEALTH INSURERS

There is surprising consensus on how MCO risk profiles are being changed by health care reform:

- Medical loss ratio minimums limit plan's control of provider costs, diminishing plan value proposition
- Administrative expense maximums limit plan margins and squeeze costs
- Increased cost of doing business results from new rules of engagement
- Small plans are vulnerable to acquisition; large plans to consolidation mistakes

- Government enforcement actions deliver subpoenas daily, driven by dueling agendas and budget deficits at every level
- Insurance exchange distribution channels commoditize product and brand
- Rate scrutiny is verging on rate setting
- Distribution channel disruption extends beyond providers to sales force agents

What is less clear is how plan strategies will convert these risks into rewards – and what kinds of litigation to expect in the wake.

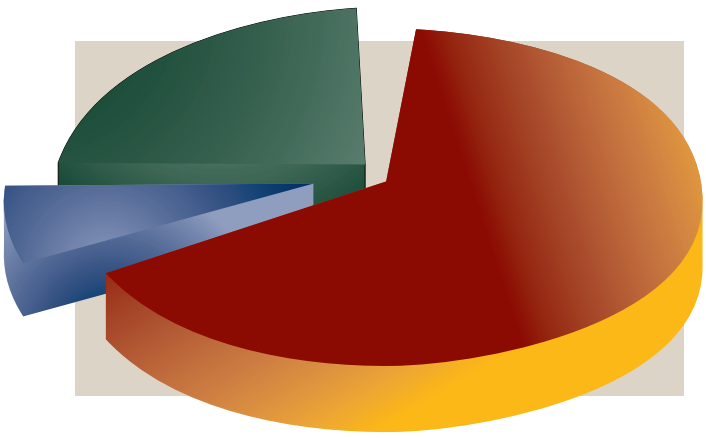
TRADE-OFFS

The Patient Protection and Affordable Care Act (PPACA), enacted March 2010, increases the cost of doing business, even while the slowdown in the economy means lost jobs and fewer insured members on health insurer rolls. Procedurally, health insurers face a future in which they do not underwrite applicants, spend 80-85% of premium on medical loss costs (or rebate unspent premium to policyholders), suffer rate scrutiny and the risk of insurance exchange commoditization – in return for the opportunity to claim their share of more than 31 million newly eligible insureds.

We expect to see small to mid-size plans, which are struggling to amass the capital to survive these new burdens, becoming consolidation targets over the next 18-24 months. ACE sees commercial plans buying small provider-owned plans as a "two-fer": short term, the provider owners get a much needed capital infusion from the sale, while the commercial plan buys itself heavily discounted contracted bed rates. For the ones struggling to survive, against a backdrop of reductions in personnel at small plans, the Travelers Managing General Underwriter (MGU) wonders if these smaller plans and TPAs' survival strategies may be taking them into areas beyond their core competencies; he sees an up-tick in smaller plan business practice litigation frequency.

85% + 15%

Larger plans – regional and national – will survive but will struggle with their value proposition. If they no longer underwrite pre-existing conditions, then plan design is dictated by what a value-driven purchaser can afford, and plans must spend 85% of a shrinking but more affordable premium on medical loss costs. That leaves 15% of a smaller pie for administrative expenses – including insurance and risk mitigation initiatives. One Beacon describes health insurers as in a catch-22 position: if the MCO's value proposition is controlling health care costs (and that means that the medical loss ratio (MLR) shrinks below the 80-85% marker), profits from lower medical costs are rebated to policyholders, not investors. Why would an investor put capital in a low-yield segment? Is the government driving for-profit MCOs into a "utility" mode, and ultimately a single-payer system?



Added to these substantial challenges are strategic dilemmas health insurers must reconcile, like whether to participate in state-based health insurance exchanges which 1) **standardize** benefits designs (reducing risk), but also 2) **commoditize** plan offerings (increasing the risk of impaired brand) and 3) **marginalize** long-standing agency distribution and provider networks (interfering with long-standing revenue streams, and so increasing risk).

SAME OLD RISK-SHIFTING OR SOMETHING NEW?

Another read on the value proposition for larger plans comes from Darwin/AWAC: the swing to Administrative Services Only (ASOs) creates need for unbundled backroom offerings like Prescription Benefit Management (PBMs), Disease Management (DM) and Third-Party Administrator (TPA) services; therefore, the MCO value proposition is more transactional than integrated primary care coordination. In this view, PPACA's challenge to health insurers to control costs could result in larger and regional MCOs capitating providers for the entire medical loss cost (85%), and then selling unbundled clinical and administrative services as well as stop loss protection to the capitated entity, as a way of escaping medical surplus rebating to policyholders.

The unknown is how insurers will do the same things (risk-shifting, e.g.) in ways that will succeed this time – including appropriate due diligence on a provider group's readiness for risk taking. The MCO is still the licensed entity regulated by the state insurance department that assumes the credit risk of medical costs, even if the capitated provider becomes insolvent. The past scenario to avoid is flawed MCO risk-shifting to provider entities – with misaligned incentive and contractual sums-owed claims crouching at the door.

ACCOUNTABLE CARE ORGANIZATION: MORE THAN PHO?

There is a niche for small start-ups that focus on selling care management to TPAs and ASO plan sponsors. In this bucket is also the once-out-of-fashion provider-based entities (PHOs, IPAs) that are the risk-bearing engines of integrated care arrangements like Accountable Care Organizations (ACOs) that PPACA has designated as Medicare Advantage pilots to receive bundled Medicare episode-of-care payments. If not clinically or financially integrated, ACOs taking global capitation other than Medicare's bundled payments still risk antitrust, anti-kickback and state insurance department sanctions – as did their predecessors, Integrated Delivery Systems. Is the ACO a provider? Is the ACO a payer? Dueling federal and state agendas make ACOs dicey, yet alluring risks deserving of their own Willis market report.

CHALLENGES TO MCO E&O CARRIERS

HERE'S THE MATH:

	Soft market pricing
+	Small plan consolidation
=	Further shrinkage in the total MCO E&O premium universe of $225M
+	Health care reform turbulence claim unknowns
=	No ROI

If this equation doesn't cover it, add the disenchantment of the national plans with MCO E&O insurers. Many of these plans, which have been in coverage litigation arising from MDL 1334 for 10 years, have yet to see any insurance recoveries. We estimate these plans represent nearly half of the E&O premium universe noted above. These largest plans believe they paid for, and therefore they want, indemnity allocations for the RICO-styled allegations that produce trebled damages and awarded attorney fees in class actions – even if the contractual sums owed are deemed uncovered loss. What is becoming clearer is the position of E&O carriers that, at best, they have sold class action defense-only coverage. We believe for larger

In sum, the value proposition challenge to capital-constrained health insurers is whether their market-based solutions (rate transparency, value networks, episode of care payments, employment of primary care providers) will control provider costs. If not, regulatory rate-setting solutions leave scant room for health plans at the cost control table, and they compete with the likes of American Express to process claims. Will it be market-based cost control or claim processing in a rate-setting environment? With two very different risk profiles of health insurers on the continuum, their E&O carriers are thinking, but not moving.

and regional plans, the next chapter is shaping up as: 1) "right-sizing" premium, 2) pre-negotiating indemnity coverage with binding ADR that short-circuits years of costly coverage litigation or 3) plans deciding it is more cost effective to self insure class action risk.

MCO E&O CARRIERS HUNKER DOWN

Faced with all these moving parts, E&O carriers are retrenching – and not just with respect to the large plan contractual wrongful act class action coverage. For health plans that have not been marketed, a feeding frenzy still prevails, but mostly carriers concede 5-10% premium reductions to hold onto incumbent business. (The one segment still in play is the Blues plans, enjoying a second round of substantial premium reductions courtesy of BCS' aggressive moves to return these plans to the fold, triggering commercial incumbents' 15%+ further reductions to hold on to these desirable regionals.) Carriers see the energized government activity (e.g., CMS market conduct sanctions, state AG subpoenas of data breach management records, emboldened Qui Tam whistleblowers) and ponder how to trim back the full limits defense expenses baked into most policies. At the same time, clients are looking for expanded False Claims indemnity coverage, e.g., for settlements paid in lieu of civil fines and penalties. Carriers have started pulling the pre-claim notification and monitoring expense sublimit associated with data breaches – another soft market expansion – off MCO E&O policies and are migrating this coverage to free-standing network security policies.

WHAT ARE E&O CARRIERS WORRIED ABOUT?

Aside from IronShore's optimism about the PHO/IPA/DM/PBM bright spots, E&O carriers are not planning to grow their managed care book – especially when their direct medical malpractice books offer better return on their investment of capital. In fact, the smaller managed care entities shuttled to MGUs or separate underwriting units (e.g., Darwin's relationship with MGU Swett for managed care accounts that earn <$50M annual revenue) create a situation of diminishing returns, which challenges these units' ongoing viability. Travelers' MGU, Chatham, depends on educating a Travelers field force that doesn't specialize in managed care to boost its policy count, at the same time knowing these managed care entities are disappearing. One Beacon suggests they will compete in their sweet spot, regional plans, with better product and service, citing its new risk management website, but not with more aggressive underwriting. So, what are E&O carriers worried about?

- MCO consolidation into fewer discrete business opportunities with resulting shrinkage in the premium universe and loss of reinsurance support
- Larger MCOs that take higher SIRs or self insure entirely
- Health reform turbulence that produces risk we can't see from here, i.e., "the next big thing"
- Breadth of soft market coverage; as noted, they are proactively narrowing E&O coverage, including:
  - Regulatory defense costs (only IronShore is working on a False Claim liability policy that expands coverage in a free-standing policy form)
  - Pre-claim privacy expenses
  - RICO coverage converted explicitly into defense only
- How to identify when MCOs are operating out of their core competency areas (and how to keep abreast of these liability-laden MCO growth strategies)
- Building on unresolved problem areas, such as provider risk-bearing and cost transparency

MARKET FORECAST: WHAT'S AHEAD?

With the significant increase in government regulatory profile, market hardening could begin with carrier payments for regulatory defense costs, which will unsettle reinsurers who provide support to E&O insurers at soft market rates. Equally likely is that catastrophic loss in other portions of the multi-line carriers' portfolios leads to capital redeployment, leaving the MCO E&O arena for better returns elsewhere. The parallels between capital-constrained large plans and their E&O insurers searching for acceptable return on investment are hard to miss. But for sweet-spot regional plans, the market is not hard yet.

PREPARING NOW

We repeat and update last year's advice on how to position your organization for potential market hardening:

1. Budget for 5-10% premium decreases in 2010 and flat in 2011.
2. Buy down the SIR if premium credit justifies such a move – the ability to increase the retained amount is a negotiating chip for a future rainy day.
3. Use today's savings to add more "next best friends" on excess layers. This will create a foundation for competition among incumbents that are already familiar with your risk and willing to provide continuity (no new warranty statements on applications) and retain existing retroactive dates.
4. Scrutinize carrier balance sheets and understand how much each takes net of reinsurance.
5. Negotiate terms now:
   - Continuity exclusion modification
   - Related claim scope narrowing, if indicated
   - Governmental entity action exclusion deletion
   - Most favorable choice of law for insurability of punitives, civil fines and penalties
   - An affirmative grant for antitrust actions, including multiplied portion awards
   - Conduct exclusions triggered by final adjudication of *willful* conduct
6. Conduct a post-mortem on the managing of UCR as a prototype emerging risk at your plan and develop a strategy for analyzing, communicating and acting on the lessons learned in transforming qualitative to quantitative risk.

INSURER AM BEST MCO E&O CAPACITY 2010

INSURER	RATING	CAPACITY
ACE	A+, XV	$15M
Darwin Professional Underwriters/AWAC	A, XV	$25M
IronShore	A-, XIII	$25M
Lexington (Chartis Healthcare)	A, XV	$25M
Chartis Executive Liability	A, XV	$25M
OneBeacon Professional Partners	A, XIV	$25M
BCS (Blues-owned)	A-, VIII	$40M (Blues Plans only)
Travelers	A+, XV	$20M

In addition to the domestic markets listed above, other carriers that may participate on a capacity basis include Lloyd's, AIG Europe, Arch, Hannover Re, Max Re, Swiss Re, XL, Ace Bermuda, AWAC Bermuda and AIG Cat. Hartford provides excess capacity for Blues plans; Travelers, through MGU Chatham Agency, provides lead and excess capacity to both for-profit and nonprofit plans.

CONTACTS

Sandy Berkowitz
Managed Care Practice Co-Leader
215 498 6594
sandy.berkowitz@willis.com

Kathy Kunigiel
Managed Care Placement Specialist
860 756 7375
kathy.kunigiel@willis.com

Frank Castro
Managed Care Practice Co-Leader
213 607 6304
frank.castro@willis.com

Mary Botkin
Willis Health Care Practice Leader
281 584 1646
mary.botkin@willis.com