



NATIONAL HEALTHCARE PRACTICE

2014 WILLIS MANAGED CARE MARKET REVIEW / 2015 WILLIS MANAGED CARE MARKET FORECAST

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The implementation of the Affordable Care Act is ongoing. In addition to the regulatory changes, legal challenges, political realities and basic health care economics play a part in the unsettled environment. Network and plan design issues, Medicaid expansion, government reimbursements and exchange competition, the actual cost of care, cyber attacks, judicial opinions and the difficulty of achieving quality improvements under value-based contracts – all of these affect risk, exposure and the markets for the shifting of that risk. What changes did the health insurance industry witness in 2014?

- Health insurance exchanges became available for individuals and small businesses. The difficulty encountered by the federal exchange and many state exchanges created a number of ongoing concerns. The “if you like your doctor/plan, you can keep your doctor/plan” misinformation caused lasting problems. The alteration of many plans to high deductible plans has created issues for providers, payors and insureds. Guarantee issue plans and the removal of condition and lifetime caps have affected rates/costs of coverage. Competition on the exchanges did not result in the promised reduction in coverage costs for most. Insurance premiums may vary only by age, place of residence, family size and tobacco use. High deductible plans are the norm and tax credits/subsidies are available for those who qualify. Alternate forms of discrimination are emerging, and states and the federal government are wrestling with changes to the system – as well as with the lack of any real controls on the cost of care.
- The publication of the plans and their networks created confusion with narrow vs. adequate networks. The push for value-based contracting and the implementation of the ACO and other hybrid business models gained steam – and lost it. Regulatory uncertainty has had significant impacts on this environment. Antitrust enforcement and regulatory investigations have increased as well as public and private litigation over competition, whistleblower claims and plan/network design.
- All group health plans must be certified as “qualified” by the removal of annual maximum limits, by providing coverage for all pre-existing conditions and by insuring children up to age 26.
- The expansion of Medicaid – in one way or another – in a slim majority of states has resulted in almost 70 million persons being enrolled in Medicaid. Many states have not realized savings from this expansion and are already struggling with the costs and future costs of the program. Promised changes to Medicare in terms of reimbursement reductions have been delayed. The ICD-10 rollout was delayed. The bonuses available under federal programs for saving money have been essentially wiped out by the penalties for failure to meet quality metrics, and the penalties under the MSSP were delayed for three years.



- The imposition of penalties assessed to individuals for failing to carry health insurance. Unfortunately, there are few enforcement mechanisms, a number of exceptions and very little way to properly identify those who have failed to comply or to collect on any penalty assessed.
- Although the individual mandate was “enforced,” the employer mandate affecting employers with more than 50 employees (substantial penalties if any full-time employees purchase coverage through the exchange as opposed to employer-sponsored plans) was delayed. Regardless, many small employers dropped coverage or shifted employees to Medicaid or the exchanges.
- Tort reform stalled in most jurisdictions and several jurisdictions which had caps and immunities lost those to legislative changes or judicial opinions.
- The M&A environment in health care and in the payor industry is alive and well.
- The ACA and other legislative enactments, regulatory changes and the economics of health care in 2014 and forward have required all health care entities to alter business models and practices to keep up with the changing environment.

Despite all these changes, the sector remains very strong.

2015 will bring its own realities to the health care sector and the insurance marketplace to which it turns for risk protection. The latest challenge to health care reform is whether or not tax subsidies for those who enrolled in the federal vs. a state exchange are allowed under an IRS regulation based on the language of the ACA itself. Given the vast majority of the approximately 11 million people who have enrolled in an exchange plan enrolled through the federal exchange – and the overwhelming majority of those are eligible for subsidies – any ruling by the Supreme Court that determines that the subsidies are improper will have a major impact on all aspects of the industry.

2015 will also see significant efforts by payors to shift substantial portions of compensation by providers to “value-based” or risk sharing contracts. This to date has proven slow and problematic. Most providers are unfamiliar with risk sharing, bundled payments

or quality metrics impacting the bottom line. Payors who are counting on significant savings from a move to this style of provider compensation may be in for a rude awakening and face significant efforts to put limits on how much risk providers are willing to accept. In addition to the difficulty in defining the metrics in public programs and private contracts, not all providers or specialties are amenable to such contracts, and meeting the goals is in large part dependent on the patients who are slow to alter behaviors.

In 2015, we expect further regulatory efforts at the state and federal levels to impact benefits, networks, discrimination and parity in benefits, wellness programs, deductibles, competition and M&A activity. Much of this is consumer protection driven – and runs counter to the efforts of other legislation designed to increase access, increase coverage, lower costs and improve quality. Many will likely discover that having your cake and eating it too is either an unattainable goal or one only attainable at a high cost.

Tort reform – as envisioned by many states – is still on the table. There have been reversals in other states and federal “tort reform,” as that applies to health care, has never been approved. Some efforts are hampered by the very industry segments proposing the reform. Efforts to protect against civil remedies juxtaposed to efforts by the same people to limit competition, restrict lesser degreed professionals and the practice of medicine across state lines run counter to one another. Significant premium increases and record profits do not offer the payor industry a legislative safe harbor, either.

2015 will see ongoing risk associated with new business models, including ACOs, LLCs, joint ventures and M&A activity. Hybrid delivery models, integrated health systems and the blurring of lines between payor and provider activities complicate the risk. Federal and state regulatory investigations related to competition, billing/payment, plan design, privacy and compliance are on the rise. Ongoing benefit claim and benefit litigation and standard professional negligence and vicarious liability claims still present issues in many jurisdictions. What we will see increase – and increase substantially – is litigation related to cyber breaches under state and federal law.

2014 INDUSTRY HIGHLIGHTS

EXCHANGES UP AND RUNNING

Federal and state exchanges survived their rollout obstacles (despite the loss of a state exchange or two) and have been operating for over a year. The end of open enrollment is upon us for the 2015 plan year. It is believed that for all exchanges, between 10 and 11 million people will have enrolled or re-enrolled in an exchange plan by mid-February. There have been issues but nothing like 2014. There are additional players on the plan side in many jurisdictions, but there have been losses too on that side with a number of new plans – like co-ops – having significant financial troubles. In 2014, the number of participant drops (those who never paid or who stopped paying premiums) was estimated at between 10-20%.

“ THERE IS STILL CONFUSION REGARDING THE TIMING OF ENROLLMENT BECAUSE ENROLLEES ARE UNAWARE THAT OPEN ENROLLMENT HAS STARTED... ”

Reliable data is hard to come by. There has been an equal or larger number of new enrollees in Medicaid based on the expansion of the eligibility requirements for inclusion. These programs have been seen as a significant boost to those entities in the payor industry which can efficiently operate a health plan.

Many individual buyers are new to the process of purchasing insurance. This learning curve has brought about some ambiguity regarding plan networks and whether or not members may keep their physician. The *Wall Street Journal* reported on November 13 that there is still confusion regarding the timing of enrollment because enrollees are unaware that open enrollment has started and what changes will affect their coverage. If consumers wanted to keep their plan on January 1, they must have enrolled by December 15 according to the WSJ. This issue – along with many others encountered during the ACA

rollout – was addressed by regulation making compliance that much more complex.

What does that mean to the managed care E&O insurers? Will claims be brought against insurance carriers when consumers determine they have no coverage? Will the regulatory and legal uncertainty impact the coverage offered and rates? Will the financial uncertainty coupled with the significant changes in the ways these plans conduct business and what is or is not a “managed care activity” result in increased or decreased capacity? We believe the markets are stable and that there is sufficient capacity domestically and off shore to accommodate the needs of most plans. Because of the availability and competition, we have been able to win meaningful enhancements in coverage and to tailor policy language to meet the needs of many of our clients. The markets are skittish over cyber issues, and recent events have made that more pronounced. The markets are more unmoving with regard to regulatory coverage. A few markets are also unwilling to extend the full panoply of antitrust protections. We have been successful in keeping rates down to near flat for most clients.

ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

Health care reform continues to change the environment in which health care is delivered. New ventures and collaborations continue to emerge throughout the industry. These new organizations focus on wellness, the continuity of care and care management to maintain the health of the healthy and to manage chronic illness with the dual goal of improving outcomes and reducing cost. Leading these pursuits are accountable care organizations (ACOs) and other similar “ACO-like” entities. The number of ACOs continues to grow but their future remains unclear. In 2011, CMS approved 32 Pioneer ACOs to pave the way for Medicare Shared Savings Plans. In September, *Modern Health Care* reported that only 19 Pioneer ACOs remain, which suggests these sophisticated partnerships may not be willing to take financial losses as new payment and delivery models are tested. Over 400 ACOs are enrolled in the CMS Shared Savings Program, but many have been unable to earn the bonuses available, and the penalty phase of the program had to be delayed by CMS. While many ACOs and similar entities are on the books, many are not operational or have been closed due to the failure of the business model – at least as run by those participants.

On December 1, CMS released their new proposal to improve ACO success. According to a December 1

CMS website posting, these rules are intended to strengthen Medicare Shared Savings ACOs by placing greater emphasis on primary care services and the transition from performance based to risk based contracts. These improvements include 1) more flexibility in the renewal application process; 2) a “track 3” risk model generating greater performance risk and reward; 3) primary care services to be delivered by nurse practitioners, physician assistants and clinical nurse specialists not associated with a primary care to participate in multiple ACOs; 4) changing the methodology benchmarks to cost efficiency rather than past performance; and 5) streamlined data sharing. This proposed rule has been widely panned by the provider industry.

How can ACOs protect their balance sheets? ACOs face many exposures that may be beyond their control, but some of these exposures are insurable. Network Security and Privacy coverage will respond to patient information breaches created by data sharing and losses arising from hackers, lost or stolen equipment and disgruntled employees, to name a few. Many of these entities are either not carrying cyber coverage or are carrying inadequate limits. ACOs are also prime targets for provider excess coverage to protect them from risk based contracting. D&O and E&O coverage is available in the market to insure those risks created by ACO and business operations, including antitrust investigations/lawsuits, whistleblower litigation and regulatory investigations. The standard professional liability policy will not protect ACOs and an MCO E&O policy is almost a necessity. Risk management, provider excess, analytics, tailored coverage based on business model, proper cyber coverage and full E&O and D&O coverage can help these entities remain solvent and protect their assets.

LITIGATION TRENDS

FALSE CLAIMS

Anxiety persists over the potential for high false claim penalties. FCA (False Claim Act) 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 subject 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 approach insurance markets to provide a more comprehensive solution.

PRIVACY

- Network Security & Privacy remains worrisome 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 damages award 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.

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 elaborate corrective action 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 allegedly also 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.
- There have been a number of breaches in the last six months, including the large Anthem attack which



may have exposed some records of up to 80 million members of the multiple Anthem plans and other plan members through the BCBSA affiliations. Theft of hardware and data theft are major issues that multiple private security and federal law enforcement entities are working overtime to address. Personal identities, financial records and health records are the targets.

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.

At the same time, additional providers sought to join in as plaintiffs. Their request was rejected by Judge Moreno in Miami (who was the judge on what is often referred to as the Mussleman, Love and/or Shane litigation – MDL 1334), because Moreno held that they are barred from joining by the settlement release in the MDL 1334 litigation. That decision is on appeal to the 11th Circuit, but we expect the 11th District to uphold the trial judge’s decision and that 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. This is 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.

MARKET CONDITIONS AT A GLANCE

The managed care E&O insurance environment remains interesting due to all the facets of health care reform, such as provider alignment, accountable care and accountable care-like joint ventures, and participation in exchanges. In order to keep a finger on the market pulse, we keep close contact with key underwriting, claim and senior business personnel, review significant business and insurance publications, legal opinions and papers, and conduct individual interviews on matters of interest. Jeff Stetson of Chatham reminded us that the one constant is still – change. This environment creates additional and unknown risk for both managed care organizations and carriers.

Despite this uncertainty, we have seen MCO E&O rates remain stable, and new capacity has entered the market. Berkshire Hathaway entered the market in 2014 writing only excess E&O and has quickly moved to a primary offering as of 2015. Other markets continuing to write managed care E&O coverage are ACE, AIG, Allied World, Berkley, IronShore, OneBeacon and Travelers. As the industry becomes more dynamic due to health care reform, the managed care E&O markets remain stable. Jennifer Bray of IronShore told us that underwriting has changed and that examining each entity by drilling down to business structure and activities is a must. All markets interviewed continue to support flat rates, with the exception of AIG, which has taken rate increases on average to 5%. Premium increases are being seen throughout the industry based on exposure growth, including membership, revenue, operations and M&A.

Because of a heightened concern about the impact of



cyber claims on their books, managed care E&O carriers are moving away from providing full network security and privacy coverage in their E&O and other non-cyber policies. Over the past year, OneBeacon has been evaluating the developing network and privacy liability exposures and managed care E&O risks. It strongly prefers that any network security exposures be addressed through stand-alone Network Security and Privacy Liability policies, which are designed appropriately and comprehensively to address these expanding risks. We anticipate that this opinion will spread across the rest of the E&O (and the D&O and PL) markets based on recent mass breaches in the health care industry. The carriers we interviewed believe that cyber, network security and privacy will be an area of increased risk and exposure that will require further evaluation and present future underwriting challenges.

Anti-trust continues to prey on everyone's mind. Carriers watch current litigation, especially the claims that Blue plans are currently battling. Kim Delaney of Allied World noted that the managed care environment remains in a state of flux, that new, non-core services are being provided and the M&A activity has been steady. AWAC sees this leading to a shrinking market and increased exposure. In 2013 Allied World began pulling anti-trust coverage out by decreasing limits, increasing retentions and applying co-insurance. Other carriers are also watching current litigation, especially the *Conway Class Action* and other claims being battled by Blue Cross plans, but only Allied World has pulled back coverage to date.

We have seen underwriters become more cautious with accountable care organizations, clinically integrated networks and other like entities. The underwriters at OneBeacon believe ACO activity has slowed (which might explain the reluctance of some markets to underwrite this hybrid MCO business model) and we see the larger

managed care space by either creating or acquiring a health plan, value based/risk contracting or assuming traditional managed care activities as services for their customers. The markets have also observed a number of traditional health plan companies expanding into non-traditional activities.

ACE has been a leader in providing primary coverage to large complex MCO risks and is willing to negotiate broad terms. Recently IronShore has developed an appetite for these larger plans and, if not offering primary, will likely write an excess layer lower in the coverage tower. Berkshire Hathaway Specialty Insurance, Travelers and AIG are amenable to primary and/or excess discussions as well. Allied World remains comfortable with primary and excess layers with the caveats noted above. OneBeacon is more comfortable with taking an excess position on large Blue plans and for-profit public entities. Let us not forget Bermuda and London who continue to offer competitive excess capacity.

2015 FORECAST

Markets will likely continue offering flat rates in 2015 unless unforeseen litigation arises. However, pullback on cyber coverage will continue and anti-trust will be carefully watched. Carriers will aggressively seek premium where increased exposure exists.

Other areas to watch in 2015 are Telephone Consumer Protection Act claims. ACE will be underwriting for this risk and is applying an exclusion where it sees a heightened risk. Regulatory risk continues to be on everyone's radar with fines and penalties becoming more frequent in the health care industry. The markets are still trying to adapt to the different business models and the inclusion of traditional and non-traditional MCO activities in non-health plan entities. Willis is working with all markets to adjust policy forms and individual policy language to best accommodate these changes so that our clients have the coverage they need – but not pay for unnecessary coverage. Willis is also active in detailed policy language reviews for all MCOs, as these entities continue to evolve and alter their business practices.

It is anticipated that we will see significant changes in the availability, coverage terms and limits of network privacy and safety coverage in MCO and hybrid E&O policies. The reduction of available limits, shifts away from first party coverage, increased retentions and restrictive coverage terms are likely to be utilized by the markets in 2015 to reduce their exposure to hacker style attacks. We may even see some markets refusing to underwrite these risks in E&O policies without substantial stand alone cyber policies.

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entities moving to captive programs. 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, the environment is ripe for overly conservative pricing.

Large plans, including complex Blue plans and large for-profit plans, continue to challenge carriers. Mary Nolan of Berkshire Hathaway Specialty Insurance sees the MCO industry trending to integrated health systems resulting in the need for direct liability for professional negligence coverage. Christian Andrews of AIG noted that AIG sees many large provider organizations moving into the

How can you position your organization in 2015 for potential market changes? Our advice is:

- **BUDGET** for flat to 5% rate increases in 2015, assuming no relevant change in exposures has occurred.
- **BUDGET** an 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
 - 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
 - Consider adding or increasing subpoena defense coverage and defense costs for regulatory investigations
 - Remove any anti-stacking of limits conditions
 - Seek time limitation on related claim clauses
 - Limit applicability of conduct exclusion
 - Adjust retentions as analytics suggest and look at separate limits or retentions for class action coverage
 - Clarify coverage for statutory damages
 - 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 use of the notice-prejudice rule on claims made policies
 - Seek six-year pre-negotiated Extended Reporting Period
 - Maximize continuity when moving carriers, e.g.: retro and pending & prior litigation dates must match expiring program dates; narrow the known circumstance exclusion; reported claims 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.
- 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-, VIII	\$40M
Berkley	A+, XV	\$10M
Berkshire Hathaway Specialty Insurance	A++, XV	\$25M
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, Allied World Bermuda, AIG Cat, Arch, Argo Re, Endurance, Catlin, IronStarr, Lloyd's, Market; and XL. Travelers and Berkley, through MGU Chatham Insurance Services, Inc. provides lead and/or 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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SOURCES

1. www.topics.wjs.com/article/2014/11/13/ Consumers Still Confused Ahead of Health-Care Sign-ups
2. www.modernhealthcare.com/article/2014/09/25/ Medicare's Pioneer Program Down to 19 ACO After Three More Exit
3. www.cms.gov/posting/2014/12/01
4. Kunigiel and White interview with Jeff Stetson, Chatham Insurance Services, Inc., September 2014
5. Kunigiel interview with Jennifer Bray, IronHealth, September 2014
6. White interview with Kim Delaney, Allied World Insurance Company, February 2015
7. Kunigiel and White interview with Mary Nolan, Berksire Hathaway Speciality Insurance, September 2014.
8. Kunigiel interview with Christian Andrews, AIG, September 2014.
9. Kunigiel interview with Susan Angelo and Laura Williams of OneBeacon Professional Partners, September 2014
10. Kunigiel interview with Annick Charles and Aaron Turner, ACE USA October 2014

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