

By  
Sandy Berkowitz, RN, JD  
and Kathy Kunigiel  
Willis Health Care Practice

After much anticipation and gnashing of teeth, PPACA's individual mandate provision was upheld by the U.S Supreme Court as constitutional in a June 2012 ruling, while doubts were sown about the extent the states could be coerced into further expanding Medicaid eligibility. Implementation milestones range from as early as 2014 for Health Insurance Exchanges (HIX), with "federal intervention" consequences for states who delay. For payors, each step along the PPACA path presents a challenge, be it risk or opportunity.

We group these payor challenges in three buckets:

- Reform Readiness
- Provider Alignment
- Payment Transformation

## 2012 HIGHLIGHTS

### I. REFORM READINESS → SPEED OF CHANGE IN THE HEALTH CARE INDUSTRY

Now that PPACA has been upheld, health care reform's unmet implementation timelines will have statutory consequences in terms of more federal control of exchanges in states that dawdle. And marketplace consequences are also increasingly clear. If payors are not able to bend the health care cost curve, next in line is government intervention that could set hospital rates for all payors as in Maryland; or mandate transition to a global budget within five years as in Massachusetts. The Centers for Medicare and Medicaid Services (CMS) is already leading the way with global budget payments to select Accountable Care Organizations (ACOs) and Consumer Operated and Oriented Plan (CO-OP) Programs.

But even apart from cost control; the public option scare in 2009 opened plan eyes to the fact that the public may trust the government more than the private sector; when it comes to customer service, health insurance companies rank dead last. In a



In this 2012 MCO E&O Market Update, factoring in a year of observation and a recent conversation with each of our E&O market partners we:

- Comment on 2012 health care highlights, with emphasis on post-reform changes in the group health insurance (MCO) sector from the standpoint of the MCO as E&O buyer
- Turn to Willis' view of the MCO E&O market response to these changes over the past and coming 12 months
- Conclude with renewal strategies for a marketplace that is still pliable but firming, including several operational risks and coverage responses associated with each bucket

survey rating 206 companies across 18 industries, U.S. consumers gave the health insurance industry the lowest scores, according to the Temkin Group, a customer service consulting company. Insurers received “poor” or “very poor” marks and were one of only three industries to receive an average rating of “poor” as part of the *2012 Temkin Experience Ratings*.

So what? The speed of change spells challenges. These could come in many forms, for example, the danger of payor disenfranchisement. And yet there is the possibility of the emergence of new opportunities such as care management start-ups of every stripe, ACOs, Health Insurance Exchanges and CO-OPs. Will these entities be operating effectively by the 2014 deadline? Will MCOs moving into non-regulated businesses get big simply to match up with rapidly consolidating providers? Or will they selectively acquire entities that synergize with their cost control strategies? In its 2012 paper *Power to the People?*, Deloitte suggests another strategy contributing to the speed of change: a group insurer segment loathe to turn its back on its profitable business-to-business segment needs to buy the retail sales capability that will thrive on the HIX by meeting the price point needs of the 20 million newly insured individual and small group Americans.

## REFORM READINESS

RISK	E&O SOLUTION/COMMENT
<p><b>RISK MANAGEMENT NOT RISK AVOIDANCE</b></p> <ul style="list-style-type: none"> <li>■ No risk avoidance by underwriting sicker members</li> <li>■ No lifetime maximums (2012)</li> <li>■ No pre-existing conditions (2014)</li> <li>■ Aggressive population management</li> <li>■ Change in who is the customer: retail vs. wholesale sales distribution. The balance of individual vs. employer or government as policyholders is shifting</li> </ul>	<ul style="list-style-type: none"> <li>■ Solutions include reinsurance, and clear definition of “managed care services” to include:               <ul style="list-style-type: none"> <li>● Disease management</li> <li>● Marketing, eligibility determination and enrollment</li> </ul> </li> <li>■ Challenges:               <ul style="list-style-type: none"> <li>● When does care management become an excluded medical service?</li> <li>● Different exposure with business-to-consumer vs. business-to-employer</li> </ul> </li> </ul>

## II. PROVIDER ALIGNMENT → START-UP, JOINT VENTURE AND M&A ACTIVITY RAMPES UP

Publicly traded health insurers facing rebates to policyholders if minimum Medical Loss Ratios (MLR) expenditure is not satisfied must find new ways to be profitable and attract investors. The larger commercial plans are buying their way into three areas.

- 1) Government-sponsored Medicare and Medicaid business (which have the added plus of their retail marketing orientation to individual beneficiaries – a skillset essential for success on insurance exchanges)
- 2) New provider alignments (think backroom administrative services to ACOs and CO-OPs)

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- 3) Direct medical services delivery through the purchase of IPAs such as Monarch of Southern California and CareMore Health Plan, a Medicare Advantage plan delivering direct medical services using both employed and friendly PC physician models. Smaller plans, facing the costs of complying with reform mandates, have become targets mulling their exit strategies.

So what? Plans are re-entering the government sector, two examples being Aetna pulled out of Medicare but is re-entering with the Coventry acquisition, and WellPoint, historically reticent about the Medicaid space, acquired AmeriGroup in order to be a player in Medicaid expansion but also independently for its retail sales orientation to Medicaid beneficiaries.

The resurrection of once-rejected government sponsored plan strategies suggests there are risks created by government business such as partisanship and volatile reimbursement that these payors will need to master. With these major acquisitions, the MCO client base is shrinking into fewer but larger health insurers that present not only MCO E&O exposures to be underwritten, but now, medical malpractice and technology E&O for backroom services plans supply to ACOs and to insurance exchanges.

The HIX technology platform levels the playing field by standardizing and digitalizing the uninsured’s application process and subsidy calculation, enabling new competitors to emerge that were not even on the group insurer’s radar (such as banks and big box retailers, in addition to monoline Medicare and Medicaid plans, says Deloitte). At Willis’ 2012 MCO Roundtable, the refrain of day one became “Who will buy Walmart?” But the reverse is equally plausible: “Who will Walmart buy?”

In addition to smaller, cash-strapped plans being in play, physicians are also for sale. If health systems can successfully integrate physicians, they will have more control over delivery of care but will also inherit more regulatory exposure: anti-kickback, self-referral, false claims and HIPAA. For better or worse, physician alignment (aka system transformation) is the secret sauce in the payment transformation journey.

## PROVIDER ALIGNMENT

RISK	E&O SOLUTION/COMMENT
<p><b>PHYSICIAN INTEGRATION</b></p> <ul style="list-style-type: none"> <li>■ Ban on Corporate Practice of Medicine (CPOM) creates challenges - hired physicians or “friendly PC” relationships?</li> <li>■ Managing risk of physicians typically outside core competencies of MCO risk management</li> <li>■ Insurance issues with PCs as subsidiaries - tail coverage at acquisition and/or departure</li> </ul>	<ul style="list-style-type: none"> <li>■ Coverage response: Separate or integrated medical malpractice program?</li> <li>■ Will require clinical risk management controls and capabilities to track and manage physician membership</li> </ul>
<p><b>CONSOLIDATION</b></p> <ul style="list-style-type: none"> <li>■ M&amp;A due diligence may be outside core competency due to unfamiliar risk exposures of new entities</li> <li>■ Antitrust risk and potential for trebled damages</li> </ul>	<ul style="list-style-type: none"> <li>■ Coverage response           <ul style="list-style-type: none"> <li>● Trebled damages and fines and penalties should be subject to Most Favorable Jurisdiction wording</li> <li>● Representations and warranties coverage for M&amp;A deals</li> </ul> </li> </ul>

### III. PAYMENT TRANSFORMATION → ONE MORE TIME: VOLUME TO VALUE REIMBURSEMENT

New payment models driven by CMS are accelerating the transition from volume to value reimbursement by focusing on accountability for the cost of a population's care – not the cost of care for any one individual. These new payment models all depend on provider alignment, or said another way, system transformation, before full-risk payments can succeed. Here we see care management entities springing up to focus primary care providers (and more so, medical homes), on the % of every health care dollar that could be saved if focus turned to the 5% of the population with preventable acuties in chronic diseases that consume nearly 50% of health care dollars spent<sup>1</sup>. The challenge crystallizes when one acknowledges that physicians control 87% of personal health care spend<sup>2</sup>, yet are in the dark on what kind of data can change physician behavior. “Value” and “budget” reimbursement are capitation synonyms and do require that the physician modestly understand the actuarial nature of capitation payments. However, the big questions proposed by the Roundtable's Payment Transformation workshop, are these:

- How can we expect a change in cost outcomes unless there's a change in physician behavior?
- How we can expect a change in physician behavior unless they understand the new scheme?
- How can physicians understand the new scheme unless it's been properly communicated to them?
- Who is responsible for this communication: health plans and/or provider organizations themselves?
- Will plans share actionable data? Will physicians ask?

#### PAYMENT TRANSFORMATION

RISK	E&O SOLUTION/COMMENT
<b>NEW FORMS OF FINANCIAL INCENTIVES</b> <ul style="list-style-type: none"><li>■ Quality and capitation metrics – increased challenges for MCOs in measuring performance</li></ul>	<ul style="list-style-type: none"><li>■ Coverage response: Definition of managed care services includes financial incentive design</li><li>■ Requires new financial due diligence skills by MCO in measuring incentives that align value and efficiencies</li></ul>

## 2012 MCO E&O MARKET RESPONSE AND 2013 FORECAST

### BENCHMARKING THE 2011-2012 MARKET

Health care reform distracted putative plaintiffs from massive MCO litigation and last year's market malaise continued. Throughout 2011 and up to the midpoint of 2012 we continued to see premiums and rates stabilize, as evidenced by our 2011 MCO E&O Benchmarking Survey.

Small entities (IPAs, DMs) with fewer than 100,000 members saw relatively flat premiums compared to past reductions since most carriers restructured their minimum premiums in past years. In 2013 we will see how the entrance of Accountable Care Organizations skew this competitive business niche.

Mid-size non-government regional plans (including the Blues) with 1,000,000 to 5,000,000 enrollees received average premium decreases up to 4% (compared to a 10% decrease in 2010), but in many cases premium and rate remained flat. The market continues to view these accounts as their sweet spot due to their local membership and lack of systemic litigation. However, recently even the smaller Blues are seeing increased anti-trust litigation which may cause markets to be more cautious with Blue Plans. More about the market impact of this Blue-bashing can be found in the litigation section of this update.

Government-sponsored plans with up to 1,300,000 enrollees continued to see some premium reductions with an average of 4% compared to last year's 5% which puts them more in line with the non-government mid-size plans. Premium increases here are driven by membership growth, not market hardening. We believe pricing will be affected over the next year by continued growth in Medicaid members and the merger and acquisition activity that reshapes government-sponsored plans into "deep pocket" plans.

Large plans with more than 5,000,000 enrollees continued to see premium reductions up to 8% compared to last year's 7%; both years' reductions driven by improvements in excess layer pricing – not by competition for the lead layer.

## **2012 MARKETS GENERALLY STILL IN PAUSE MODE**

Sharon Dold of BCS said it best, "Health care reform has taken all the air in the room." ACOs began to spring up, but most are still in the development stage and are purchasing Directors' and Officers' Liability coverage only. CO-OPs are beginning to emerge in states creating their own exchanges. The Pioneer ACOs, which are already operational, tend to retain or roll the risk into their current insurance programs – assuming (perhaps wrongly) they are already covered. In addition, managed care organizations are expanding into care coordination activities that blur managed care activities and direct medical malpractice exposures. So what did this mean in 2012? Brokers and carriers took different paths to create products to address the exposures of these new ventures. IronShore and Willis developed an integrated product solely for ACOs. This modular product allows smaller ACOs to grow into coverage as they become more sophisticated, "accountable" buyers. (Ditto for CO-OPs). AWAC and even CNA also rolled out products for ACO buyers. But mostly it's a game of hurry-up and wait on the liability side. On the stop loss side, these same E&O markets (IronShore, AWAC, One Beacon) see opportunity but wonder when providers and plans will come together on the kind of data that supports successful population health management and risk-taking.

## **2013 AND 2014: EXPECT E&O MARKETS TO EVOLVE OR WITHER**

Susan Angelo of OneBeacon observed, "We are still in a lull but starting to see the ground move." The dominant view is that merger and acquisition activity that started to spark in 2012 will drive market changes in 2013. M&A activity will produce increased litigation and/or shrink the carrier's customer base, causing rates to rise to cover losses. The large plans have their own work to do to create competition on their lead layers, but they come with leverage. Indeed, malpractice carriers, watching provider consolidations shrink their direct service provider books, are quite interested in the provider acquisitions by large health plans and have made it abundantly clear that their weak appetite for MCO E&O is overshadowed by their appetite for big blocks of premium. So where will the mid-tier organizations land? What will be the market leanings in 2013?

ACE continues to like large plans and PBM business. In addition, Aaron Donovan of ACE also likes regional plans especially those that partner with docs. Cindy Oard and Kim Delaney of Allied World don't see ACOs fitting into their MCO E&O and D&O and have released a separate ACO product. OneBeacon continues to be aggressive on mid-tier plans, focusing on their two new forms that were introduced in 2011 and 2012. IronShore wants to continue providing solutions to ACOs and IDOs and is working on a stop loss product for these organizations. Although hamstrung by Travelers distaste for medical services, Jeff Stetson of Chatham is looking to grow their excess MCO E&O Travelers book with more non-Blue plans as well as writing the E&O and D&O coverage for ACOs. Chartis who was hit with MDL limit losses is maintaining their MCO E&O book, and Jill Salmon "is waiting for rate to catch up to risk on a primary basis in order to be competitive." Sharon Dold and Chad Chaffin of BCS indicate they too are working on an ACO product, but may also be preoccupied with the spate of significant litigation naming Blue plans as defendants.

# 2013 LITIGATION WATCH

## INSURABLE REGULATORY RISK

In a carry-forward from 2011, Network Security and Privacy (NSP) and various other regulatory risks continue to expose plans to severe loss. NSP, fortunately, is insurable and we make some NSP renewal strategy recommendations in the next section. Regulatory risk for today's MCO divides into the (so far) uninsurable fraud and abuse claims (False Claims Act violations) and the historically insurable antitrust claims that typically come with an affirmative grant in MCO E&O policies. The bad news is that the antitrust litigation pile-on facing Blue plans may force markets to post reserves, pay defense costs and justify premium hardening. A quick review of recent Blue plan claim activity invokes defendant permutations including the Association, Anthem, North Carolina, Alabama and Michigan. Michigan is facing "Most Favored Nation" litigation brought by the Department of Justice and by private parties. Other Blue plan litigation, including the recent putative class action brought by chiropractor Conway, alleges Blue plans' collusion to avoid competing with each other in violation of anti-trust laws, alleging vertical and horizontal market actions that beg the question of whether the Blues are one entity, or many.

Carriers suggest that *Conway* coverage will likely fall to D&O due to the allegations associated with *governance* and not the E&O policy's *managed care activity* trigger. This is in contrast to the Most Favored Nation litigation which may involve questions of governance but is arguably also a managed care activity involving design of the provider network and pricing of services. In addition to the BCS captive, Allied World and Travelers write MCO E&O and D&O for Blues plans. We will be watching to see how anti-stacking conditions contained in both MCO E&O and D&O policies affect policy recoveries. Which carriers are concerned about this litigation? Poker-faced, every one.

## FALSE CLAIMS - NOT INSURABLE (YET)

Regulatory risk will continue to be a large concern in 2013 for MCOs. The Department of Justice is taking a more aggressive position on false claims, creating more balance sheet risk for MCOs since there is not yet a true risk transfer product for them. False claims are on the rise and Medicaid plans are especially vulnerable since rate is being slashed and the temptation to cut corners is great. Allied World has acknowledged receipt of some false claim litigation that was initiated as a HIPAA action in the pre-claim subpoena phase. Willis recognizes false claims/regulatory risk financing requires decision-support tools developed from robust data – not anecdotes.. We are soliciting markets, law firms, clients and friends for sanitized FCA closed claim data. To enhance our current database and develop frequency and severity projections for a specific plan, we are asking for your false claims data – especially defense costs in absolute numbers and as a % of damages.

Contact [Sandy.Berkowitz@willis.com](mailto:Sandy.Berkowitz@willis.com) for ways to support this regulatory risk project. The loss distribution curve we develop enables us to negotiate a fair premium if the client and market agree to risk transfer and may also justify pre-funding FCA limits through a captive.

# RENEWAL STRATEGIES

We update last year's advice on how to position your organization for potential market changes.

1. **BUDGET** – for flat premiums to 5% increases in 2012 and 2013, assuming no relevant changes in exposure have occurred.
2. **BUDGET** – increase for exposure changes, including membership growth, acquisitions and new business activities. Any increase in claim activity should also be considered.
3. **NEGOTIATE** – terms now:
  - a. Clarify carriers' care management definition so that chronic disease programs are not caught up in the medical services exclusion
  - b. Confirm how an acquisition of direct care providers would dovetail with your MCO E&O coverage
  - c. Related claim scope narrowing
  - d. Pre-claim cyber coverage for notice and monitoring expenses
  - e. Subpoena defense coverage
  - f. Narrow the conduct exclusion
  - g. Remove any limit anti-stacking conditions
  - h. Clarify the scope of Anti-trust coverage, whether government or private party action
4. **CONSIDER** – purchasing a separate network security and privacy (NSP) policy, if not already purchased.
  - a. Dovetail the cyber as primary, with the MCO E&O as excess so that the “other insurance” exclusion is not triggered
  - b. Know whether you have coverage for breach of your data when in the custody of a business associate
5. **REVIEW** – the regulatory coverage provided, especially how coverage (if at all) would respond to false claims.
6. **INITIATE** – early and before the first subpoena arrives – C Suite conversation regarding your organization's appetite for affirmative False Claims and Regulatory Risk protection.
7. **CONTINUE** – to scrutinize carrier balance sheets and understand how much each takes net or reinsures. Learn who is your lead market's real “decider”!

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<sup>1</sup> Presentation of Catherine Hanson of American Medical Association to Willis MCO Roundtable, 9/11/12

<sup>2</sup> Ibid

# INSURER AM BEST MCO E&O CAPACITY 2012

INSURER	RATING	CAPACITY
ACE	A+, XV	\$15M
Allied World Assurance Company	A, XV	\$25M
BCS (Blues Owned)	A-, VIII	\$40M
IronShore	A-, XIII	\$25M
Lexington (Chartis Healthcare)	A, XV	\$25M
OneBeacon Professional Partners	A, XI	\$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 Europe, Allied World Assurance Company (AWAC) Bermuda, Alterra Bermuda, Arch Bermuda, Argo Re, Chartis Cat Excess (soon to be AIRCO after their restructuring), Endurance Specialty Insurance Ltd (Bermuda), Hannover Re, IronStarr Bermuda, Lloyd's, Starr, Swiss Re and XL Insurance (Bermuda) Ltd.. Hartford provides excess capacity for Blues plans.

## CONTACTS

For further information, please visit our [website](#) on [willis.com](#) or contact any of the following:

### **Frank Castro**

Health Care Practice Leader  
213 607 6304  
[frank.castro@willis.com](mailto:frank.castro@willis.com)

### **Sandy Berkowitz, RN, JD**

Managed Care Practice Leader  
215 498 6594  
[sandy.berkowitz@willis.com](mailto:sandy.berkowitz@willis.com)

### **Kathy Kunigiel**

Managed Care Placement Specialist  
941 554 3119  
[kathy.kunigiel@willis.com](mailto:kathy.kunigiel@willis.com)

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