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First Opinion

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Managed Care Organizations Errors & Omissions Liability Limits Survey 2005

Editor's Note

Beginning with this issue, our managed care E&O benchmarking study will be reflective of the calendar year's renewals (beginning with January 1 renewals) and will be released the first quarter of the subsequent year. To ensure accuracy in our year-to-year comparison, all data have been restated on a calendar-year basis for this publication.

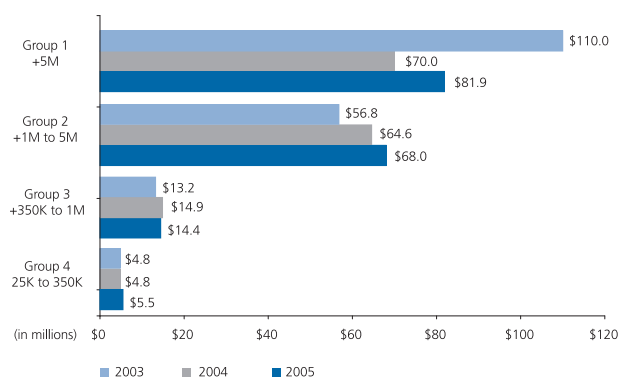
Key Findings

The 2005 renewal year started with further moderation in pricing of managed care errors and omissions (E&O) insurance. That confidence, however, was shaken mid-year with the announcement by Chubb Executive Risk that the renewal rights to its managed care E&O book of business had been sold to One Beacon. While that created some temporary jitters, confidence was gradually restored as competition escalated among the remaining markets. Market competition increased for Group 3 and 4 clients. As a result, throughout 2005, pure premium pricing decreased between 7 percent and 10 percent, limits purchased remained relatively steady, and retentions increased slightly for certain groups where the economic incentive for assumption of greater risk was present. Unfortunately, in the fourth quarter, excess insurers started expressing some discomfort with declining rates in the primary layers.

Limits in Most Peer Groups Unchanged

In 2005, there was \$245 million of excess capacity available worldwide for managed care E&O protection, with more than half of the capacity coming from Bermuda markets. In general, however, limits remained the same on renewal for most groups. (See Figure 1.) The greatest shift in limits over the three-year period occurred in Group 1 (more than 5 million enrollees)—first in 2004 with some of our largest clients decreasing limits dramatically to a level more consistent with their peer group, followed in 2005 by clients making decisions to purchase additional limits due to more favorable market conditions.

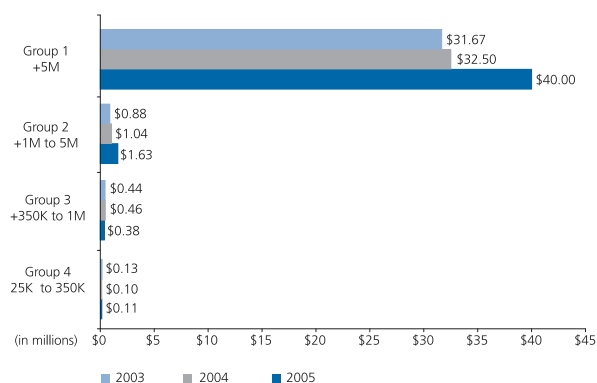
Figure 1: Average Limits by Number of Enrollees



Self-Insured Retentions Increasing

The most dramatic change in self-insured retentions occurred between 2002 and 2003 with the hard market. Since that time, however, retentions have remained relatively static. For clients in Groups 3 and 4, retentions remained the same. (See Figure 2.) Insurers, however, are beginning to drive up retentions for clients with enrollment in excess of one million by offering rate concessions in exchange for the assumption of greater levels of risk. While class action coinsurance has been virtually eliminated, it should be noted that substantially higher subretentions have been imposed on a number of larger managed care organizations.

Figure 2: Average Retentions by Number of Enrollees



Cost per Enrollee

As demonstrated in Figure 3, average cost per enrollee in Groups 1 and 2 remained relatively stable between 2004 and 2005. The fluctuations in cost per enrollee observed in Group 3 participants is a function of organizations shifting in and out of the group during the three-year period studied. The largest decreases were experienced by Group 4—a very attractive market segment for most of the carriers.

In 2005, the Managed Care Practice began tracking the average cost per enrollee in the primary layer of coverage in order to eliminate aberrations in cost caused by differences in limits and retentions chosen by our clients. (See Figure 4.) Restating this benchmark back to 2003 revealed the cost per enrollee to be declining in all groups. The reduction in cost in the primary layer for Groups 1 and 2 is in part a function of enrollment increases realized by industry consolidation and favorable pricing based on those economies of scale.

Coverage Terms

Policy terms and conditions have also remained relatively static throughout the year. Endorsements that underwriters are generally amenable to include are those adding punitive damage coverage, most favorable venue language, “carve-

backs” to existing governmental exclusion to cover claims brought on behalf of enrollees, and amendments to the definition of managed care activity to include unique aspects of a client’s operations.

Judicial Climate

Class Action Update

In 2005, Humana, WellPoint, Prudential HealthCare, and HealthNet reached settlements with physicians in the MDL’s *Shane* litigation, leaving just three of the original ten defendants. The settlement payments to date can be classified into three categories: payments to the physician settlement fund, payments to foundations, and estimated value of business practice changes. Agreed-upon payments to the physician settlement fund have ranged from \$40 to \$135 million, with WellPoint’s being the highest cash payment to physicians of any of the insurers that have settled thus far. Payments to foundations have ranged from \$5 million to \$20 million. The largest portion of the settlement, however, relates to the estimated value of business practice changes that must be instituted to comply with terms of the settlement. These have been valued as high as \$300 million in some organizations. Legal fees are also a large expense ranging between \$20 and \$58 million to date. Similar actions like the Thomas and Solomon litigation that have been brought against the Blues remained unresolved in 2005.

While the major focus has been on the MDL litigation, underwriters continue to express concern over the increased frequency and severity of disputes over business practices. It could be argued that the passage of the Class Action Fairness Act in February 2005 should calm underwriters’ apprehension. The main focus of this Act is to eliminate “venue shopping” where plaintiffs’ counsel seek to file cases in state jurisdictions perceived as most sympathetic to plaintiffs. Its effectiveness has yet to be tested. Therefore, we are still seeing some pressure by the markets to increase class action retentions on some of our larger accounts.

Other Litigation

The \$4.2 million verdict in July 2005 against Humana may have implications for the industry as well. In the *Smelik v. Humana* case, a San Antonio jury found Humana partially (35 percent) liable for negligently mismanaging a member’s care. This is an example of how claimants have circumvented the ERISA preemption by creating a state law action against Humana based on medical negligence (failure to exercise ordinary care) and not denial of benefits. The plaintiff’s argument was based on alleged misrepresentations about what Humana would do for members in terms of utilization management, concurrent review and medical case management in the Humana HMO *Member Handbook*.

Figure 3: Average Cost per Enrollees

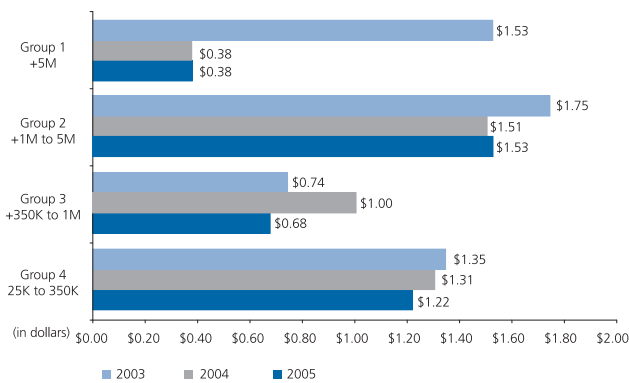
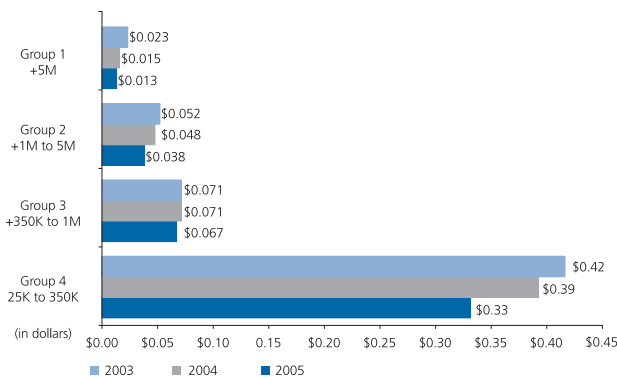


Figure 4: Cost per Enrollee per \$1M Primary



Absent the *Smelik* litigation, the trend in litigation has shifted away from traditional bodily injury claims related to utilization review disputes and/or vicarious liability. This is, in part, due to the presence of external review mechanisms available to subscribers in most states, as well as the Supreme Court ruling in the *Davila v. Aetna* claim.

Legislative Developments

According to *Medical Professional Liability Market State by State Analysis 2005*, a recent study of the medical professional liability market conducted by Guy Carpenter, a growing number of states are considered “in crisis.” At last count, 85 percent of states are either currently in crisis or showing problem signs.

At the federal level, pressure to pass major tort reform legislation resulted in the passage of the “Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2005” by the U.S. House of Representatives. The bill was received by the Senate in July 2005 and was referred to the Committee on the Judiciary.

Specific provisions of the act include:

- cap on non-economic damages of \$250,000;
- cap on punitive damages of the greater of \$250,000 or two times economic damages;
- limits on plaintiff attorney contingency fees;
- “fair share” allocation of liability in proportion to relative fault;
- payment of judgments via installments, rather than lump; and
- a three-year statute of limitation following the date of injury (or one year after discovery of the injury) to file a health care liability action.

On a state-by-state basis, less than half of U.S. states have any type of meaningful reform, with caps on non-economic (pain and suffering) damages of \$500,000 or less. To the extent that tort reform is stalled, managed care organizations remain the “deep pocket” target for vicarious liability in medical malpractice claims. It should be noted, however, that even if state tort reform is successful, the benefit of the cap is likely to accrue solely to the provider and not the health plan.

According to the AHIP 2006 *State Legislative and Regulatory Forecast*, 45 state legislatures, including the District of Columbia City Council, will hold regular sessions in 2006. The forecast predicts that a number of health care issues will be high on the legislative agendas, including the growing numbers of uninsureds, movement to managed care in Medicaid programs, transparency legislation (to afford consumers access to more information about the cost of health care services) and further mandated benefits (pp.2-4).

Forecast

As the managed care business model continues to evolve, the product mix is changing as well. A large number of managed care organizations jumped onto the Medicare Part D bandwagon with more than a dozen insurers offering some type of Part D plan in each of 34 regions. Many are also cautiously entering back into the Medicare Risk market by offering regional PPO products. Consumerism is driving the development of consumer-driven health products. The ranks of the uninsured continue to swell, with the percentage of employers offering health care coverage down from 69 percent in 2000 to 60 percent in 2004. Emerging in response are variations of “bare essentials” health insurance coverage for individuals.

New disease management programs targeting chronic diseases, including obesity, are emerging. Pay-for-performance programs which reward providers for implementing quality initiatives are growing in number.

Underwriters are speculating that with these changes in the business model, new risks will undoubtedly emerge. They are beginning to ask more questions about those, as well as questions about the existence of silent PPO arrangements and the extent to which a health plan is outsourcing key functions. Fortunately, underwriters are more than willing to meet with organizations face to face to have that dialogue.

Managed care organizations need to be able to differentiate their own loss experience from the overall industry statistics insurers are gathering. They should be prepared to provide accurate, ground-up historic loss information (including incurred defense and indemnity) back a minimum of five years. While the traditional breakout of bodily injury versus pure economic injury claims is still important, it is even more important to track defense and indemnity payments related to class action, antitrust, and other litigation relating to business practices. They also must have sound claims reporting and management processes in place.

The MDL litigation has “forced” business practice changes upon many managed care organizations. This has not gone unnoticed, however. In Guy Carpenter’s report, *U.S. Reinsurance Renewals at January 1, 2006: Divergent Paths After Record Storms*, there is a glimmer of optimism. It reports that business model changes within managed care organizations have heightened reinsurers’ interest in providing support for managed care liability insurance, creating added capacity for managed care organizations (p.17).

Managed care is a very dynamic industry. Marsh’s Managed Care Practice is constantly monitoring the external environment for emerging risk issues and reviewing coverage in order to ensure that coverage addresses those risks. As part of the annual renewal process, our clients can expect to have a dialogue around these issues with their Marsh client service team so that the most effective and efficient risk transfer programs can be designed to meet their organizations’ unique needs.

Works Cited

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