MONOGRAPH

PREPARED BY THE MONOGRAPHS TASK FORCE OF THE AMERICAN SOCIETY FOR HEALTHCARE RISK MANAGEMENT

Perspectives
on the state of the insurance market

Answers
to health care risk managers' million-dollar questions

Published May 2002

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the PANEL

Providing an insurance carrier's perspective

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the QUESTIONS

Perspectives on the state of the insurance market

& Answers
to health care risk managers' million-dollar questions

With the withdrawal of carriers from malpractice insurance and the general turmoil and volatility of the marketplace, health care organizations must seek new financing solutions to cover their risks.

For an overview of this situation, Daniel Conner, chair of the ASHRM Risk Financing Special Interest Group, posed questions to four risk management professionals. In their varied roles as insurer, broker and risk manager, they deal with this challenge daily.

Their views (edited for this monograph) cover the history of the current situation, reasons for it and advice to risk managers about ways to deal with it. Education of top management and the board of directors is crucial because more dollars will be spent for less coverage – and the entire organizational team needs to know why this is so.

Risk managers play another important part in presenting their organization in the best possible light when applying for or renewing insurance. Brokers and underwriters need to know that an individual risk manager is focused on appropriate actions and is administering a solid risk management program. If quality and risk efforts are integrated, it is more likely that underwriters will see a hospital as a better insurance risk.

What's your view of the current insurance market for hospital/health care risks? How does this compare to past cycles?

✷ CARRIER / Judy Hart:

In 1999, the medical professional liability product line ended a 12-year streak of outperforming the property-casualty industry when its combined loss ratio spiked to 129.5 percent. Loss experience continued to deteriorate in 2000 to an estimated combined ratio of 134 percent in 2001. This has resulted in dramatic changes in the marketplace that will be evident in all renewal placements.

From the early 1990s, premiums began a slow reduction that continued until 2000 due to the prolonged "soft" insurance cycle. High investment income and the desire for market share led carriers to ignore warning signs of loss deterioration. Health care inflation was ignored, as were increases in exposures; in some instances, claims made step factors (built in annual increases were not applied). Actual operating losses were offset by reserve changes by some carriers in this market. Some carriers struggled, and some did not survive.

The medical professional market began a correction in January 2001. Capacity was reduced and risk managers saw rate increases ranging from 25 to 100 percent, changes in terms in conditions and in some instances higher minimum retentions. Then came 9/11. The tragedy provided a wake-up call to writers of this line of coverage and drove the entire insurance industry into a hard market cycle. Risk appetites changed, causing carriers to re-think strategies and reallocate their capacity to more profitable lines of insurance. This has thrown the medical professional marketplace once again into crisis. The medical professional market is more dramatically affected during a hard insurance market because of its limited size.

The crisis of the mid 1970s has been noted as the "market of unavailability." Many health care organizations were unable to purchase this line of coverage at any price. Buyers responded with the development of a new market supported by state hospital associations and provider groups. The crisis of the mid-1980s has been described as the "market of unaffordability." Coverage was available in most jurisdictions; however, premium increases in the magnitude of 1000+ percent were experienced. Many view the current crisis as a mixture of the past. Most carriers have restrictions on the limits of liability they will write in certain jurisdictions, while many health care organizations are experiencing price increases in excess of 200 - 500 percent.

BROKER / William McDonough:

Today we see all lines of insurance for health care organizations (HCOs) in turmoil. HCOs will continue to see rapid inflation in cost of coverage. As well, and as important, all coverages will see increased retentions. In some cases, depending on the type of HCO risk (consider long-term care beds) or loss runs, markets may not be willing to participate on any level of the risk – this is happening fairly regularly with insureds. For medical malpractice, highly protected risk (HPR) property coverage for HCOs and to a lesser extent for directors & officers, employment practices liability (D&O/EPLI), we are in a "hard" market on pricing. There is still much capacity available but at an increased price. This is dramatically different as compared to other hard market cycles where limits were not available and pricing was prohibitive. Thus, key to this cycle is:

- All lines of cover for HCOs are troubling (usually we saw a medical malpractice upswing only)
- Retentions are a given; physician groups will have the most difficulty accepting, funding and controlling large retentions
- Capacity is increasing, but pricing will provide for "sticker shock"
- Underwriters are much more interested in their return on investment, and are looking closely at patient safety initiatives/medical error reduction at the insureds' shop.

RISK MANAGER / Linda Walker:

The major difference I see between the 1986 hard market and the current market is the availability of capacity. In 1986, insurers determined that they would not provide coverage to certain types of risks at any price. This capacity withdrew from the market, leaving physicians and health care organizations with no access to insurance. As a result, we saw the development of physician-owned insurance companies to pick up the physician risks.

However, there is still capacity in the market and the market seems to have recognized in the wake of 9/11 that there is an opportunity for new insurers to provide capacity even if the "old standbys" are leaving or restricting. The market response to the potential capacity crunch has been much faster than it was in 1986. For example, Endurance Insurance, the AON/Zurich collaboration, has targeted medical malpractice as a line they wish to write.

Overall, I think there are problems in the medical malpractice market that result from the reactive method in which insurers operate. When banks and capital market operations entered the insurance arena, the traditional insurers immediately reacted by reducing prices to retain and attract market share. As the returns on insurers investment rose, the insurers were willing to write business at well below expected losses to attract premium dollars that could be invested. Prudent underwriting business was set aside in order to maintain or expand their share of the market.

Insurers reacted predictably to the downturn in investment income coupled with increasing severity of losses – they raised their prices. The events of 9/11, the loss of malpractice markets and the impact of the Enron and Kmart bankruptcies have created a pricing spiral.

✷ RISK MANAGER / Dorothy Bazan:

The insurance market for hospital and health care risks is undergoing another metamorphosis. Many insurance carriers find themselves in a situation of under-reserving for claims over the past 10 years. Forecasting the frequency and severity and type of claims was inaccurate. The market failed to see the development of losses far beyond established reserves.

What are ways you see health care facilities addressing the problems created by market conditions?

✷ CARRIER / Judy Hart:

The key to success in the current marketplace is to become aware of market conditions and allow time to consider alternatives. During the 1980s, many health care organizations developed self-insured programs or captive insurance companies to retain a portion of their risk. It is estimated that 70 percent of all health care organizations in the country have adopted a self-insurance strategy to their risk financing. Many of the long-term strategies of these vehicles centered on using them when the market hardened.

✷ BROKER / William McDonough:

One way is to improve their risk in the view of the underwriter. Another is to be creative in accepting higher retentions – this may necessitate the creation of a captive, trust or risk pooling arrangement (usually for PL/GL only). Major steps include:

- Revisit budgets with broker consultants and increase estimates of cost
- Educate senior administration and clinical leadership on market conditions, costs restrictions and major retention increases
- Educate board committees on market and outcomes this year
- Benchmark renewals for neighboring HCOs
- Plan for funding mechanisms of the retentions
- Explore alternative risk financing techniques (understand captives, trusts, risk pooling mechanisms)
- Be prepared to work harder on submissions
- Be prepared to "prove" risk/loss prevention efforts (safety).

✷ RISK MANAGER / Linda Walker:

- Increase self-insured retentions in our self insurance programs and deductibles in insured programs to avoid "trading dollars" with our insurers
- Schedule early renewal meetings with strategic underwriters
- Create detailed submissions
- Educate insurers on loss prevention activities – inviting them to attend loss prevention conferences, providing updates on benchmarks
- Compare our costs and performance to those of similar-sized institutions
- Consider reviews of actuarial funding determinations
- Require greater accountability from the hospitals for performance and managing risk.

✶ RISK MANAGER / Dorothy Bazan:

- Review contracts, identifying time frames, compliance with conditions, insurance requirements, each party's contracted expectations as well as penalties for failure to comply
- Review internal loss control activities
- Focus on increased areas of risk, implementing frequent loss control and quality review activities
- Consider closing departments/facilities
- Don't open planned departments
- Review quality and risk data in conjunction with attached cost analyses
- Change contracted services to those that provide increased service at the same or less cost, increased contract monitoring
- Monitor AM Best ratings
- Increase reporting to the board of directors on requested data elements
- More frequently report to senior management of specific information; from semi-annual to quarterly
- Intensely monitor potential JCAHO issues.

How do you see alternatives such as captives, self-insurance trusts or other alternative financing mechanisms impacting day-to-day risk management activities?

✶ CARRIER / Judy Hart:

A self-insured program, whether via a self-insured trust or a captive insurance company, places the burden of risk at least in the primary layer on the part of the health care organization. Effective risk management and claims management are mandatory and require a commitment from the top down in an organization. This commitment is executed by the risk manager and does impact day-to-day risk management activities. Those activities should be a critical part of a risk manager's role whether they self-insure or transfer risk to an insurance company.

✶ BROKER / William McDonough:

When incorporating a captive or other alternative risk financing (ARF) vehicle, loss prevention and risk control must mature quickly to both drive the quality and patient safety efforts within the parent HCO and utilize claims data (with a captive, "the parent owns the risk") to drill down on opportunities for clinical improvement. As far as impact, the risk management department must be at the table (board meetings) regularly as a key component of the strategic plan and process for the captive. Risk management:

- Is a key component of day-to-day staffing of the captive company
- Is key to the strategic plan and process of the captive company
- Must have authority and accountability in addressing loss prevention, patient safety and medical error reductions (the captive owns the loss now, and must invest in these processes)
- Must be key to the captive board
- Must use claims data to drill down and learn from this rich data – and bring back data to clinicians to effect change.

✶ RISK MANAGER / Linda Walker:

It is imperative that the self insurance program be supported by effective loss prevention programs that hold personnel accountable for the success of these programs and be advocated by senior management. Self insurance places the burden of loss control squarely on the organization. It is more difficult to ask for increased funding from the participants for a poorly managed self insurance program than it is to blame the increased premium cost on the "insurance company."

An increase in the use of self insurance/self funding should increase the number of effective loss control programs and make each employee aware of the need to control and manage risk and losses.

How can risk managers monitor and protect their organization from insurance carriers' financial impairment?

✶ CARRIER / Judy Hart:

It is necessary to receive continuous information on the financial stability of carriers. Most brokers monitor the financial integrity of the carriers they deal with and share this information with customers. Recent years have seen the rehabilitation or liquidation of several medical professional liability carriers such as PHICO, Physicians Insurance Co., Frontier, Reliance and Physicians Insurance Exchange. In addition to monitoring the financial condition of the facility's carrier, it is important to monitor the stability of physician carriers providing staff physician professional liability coverage. Their insolvency can leave a hospital standing alone in a difficult claim situation.

✶ BROKER / William McDonough:

Risk managers should rely on their brokers and consultants for information on market integrity and carrier financial performance. As part of the client service agreement, the risk manager should require that the broker provide minimally quarterly updates on financial performance (AM Best reports) for all lines of coverage. This should be provided in some form of "dashboard" reporting, which the risk management could use for internal reporting to the risk management committee, board level committees and administration. As well, if a captive is in place, this topic should be a regular agenda item at board meetings.

✶ RISK MANAGER / Linda Walker:

We establish minimum financial standards for insurers and obtain information on our carriers from the security committee of our insurance broker. The problem with these reports and the standard measures of insurer solvency like S&P ratings or Best ratings is the timing. Before a rating changes or the broker issues a warning, the insurer could be in very poor financial shape. The risk finance director needs to read trade journals and Web-based daily financial news to keep abreast of the changes in insurers' fortunes.

✶ RISK MANAGER / Dorothy Bazan:

Establish baseline rating requirements for internal insurance purchase as well as contracted insurance coverage.

Do you see any changes in coverages being offered (e.g. restrictions, additional exclusions)?

✷ CARRIER / Judy Hart:

Most carriers are re-evaluating terms and conditions. Underwriters are attempting to negotiate more restrictive coverage terms for coverages such as punitive damages and terrorism. Other carriers are re-writing policy forms to clarify intent that may not be to the advantage of the health care organization.

✷ BROKER / William McDonough:

For all lines, there are major changes being offered (or restricted). Generally, carriers are offering less and if an insured want higher limits, they must pay dearly for them. In the medical malpractice arena, the following trends are applicable to renewals:

- **Restrictions on capacity**
  Primary carriers still committed to the health care industry remain wary and have generally reduced the capacity they are willing to commit to any one risk, in some cases halving previous maximums or worse.
- **Reinsurance**
  Due to the lag time in the reporting of claims (up to three years or more), reinsurers are being hit severely now for past years' losses. In response, most reinsurers are cutting back on limits provided and the price for the capacity that is being offered has increased substantially.
- **Changes in insurance coverage for acute care hospitals and physicial groups**
  Carriers are insisting on the use of their policy forms and narrowing the scope of their coverages. Specifically:

  Claims reporting
  Specific conditions are being imposed on the reporting of excess losses and potential excess losses. Settlement offers that may affect excess carriers need to be reported in a detailed fashion to ensure that no conflicts arise from late notice.

  Tail/extended reporting period (ERP) provisions
  Many policies had specific provisions for options that would extend reporting periods. When triggered, these provisions allowed clients to evaluate the financial ramifications of tail options at a fixed cost while locking into place a self-insured retention on all incurred-but-not-reported losses. Now, most carriers either refuse to commit to a pre-determined cost for ERP or establish parameters that protect them with a lesser benefit to insureds.

  Terrorism exclusions
  Many January renewals contained new policy language on terrorism developed by the Insurance Service Office and endorsed by the National Association of Insurance Commissioners. The language is not industry-specific, raising questions about the appropriateness of applying these provisions to health care clients.

  Increased deductible levels and self-insured retentions
  Very few accounts with first-dollar coverage still exist. In many cases, deductibles are increasing so much that they are being converted to self-insured retentions (which carriers prefer as a matter of risk-sharing). Medical

malpractice loss development and increased actuarial analysis have combined to put upward pressure on self-insured retentions, i.e., the marketplace is forcing higher risk retentions on many facilities.

Collateralization for retentions
Carriers are becoming more stringent in requiring collateralization for even small retentions at levels close to the aggregate retention amount. Required levels of collateralization are also rising.

Risk management
Carriers are requiring that risk management measures be taken, which may include the purchase of services above the cost of insurance.

- **Changes in insurance coverage for long-term care institutions**
  Much of the narrowing seen in the scope of medical professional liability coverage for hospitals and physician groups has become standard for the long-term care industry. Some of the narrowing seen recently includes:

  Shorter ERP term
  Extended reporting period (ERP) provisions are generally not given at policy inception anymore. Terms of only one-to-two years have become standard for this class of business.

  Reduced limits and increased/unaggregated deductibles
  Carriers are generally not offering per location limits. Aggregated limits and unaggregated deductibles are more prevalent. Deductibles are doubling and tripling. Many carriers now have minimum deductibles of at least $25,000. Quotes are being offered with deductible options running up to $500,000.

  Limited coverages
  Coverage specifications are not negotiable. Carriers adhere to forms and conditions. The punitive damages exclusion is usually mandatory. Sexual abuse and molestation coverage is difficult to get or, if available, the coverage is often sublimited.

Exclusions are now commonplace. Remember the adage: "What the big print giveth, the small print taketh away." Rely on brokerage consultants to track changes in coverage.

RISK MANAGER / Linda Walker:

Major changes in our program include:

- Increases in directors & officers, crime and fiduciary deductibles
- Increases in the cost of extended reporting coverage in excess hospital professional liability
- Lower thresholds for reporting potential claims
- Addition of war and terrorism exclusions in aviation coverage
- Reduction in sublimits
- More underwriting information required – property underwriters required updated statement of values and business interruption worksheets from every location.
- Extension of aggregate across multiple years in some lines of coverage
- Premium increases in all lines.

Have you identified any difference in how claims are being handled by carriers (e.g., coverage denials, reserving practices, fight vs. settle)?

✷ CARRIER / Judy Hart:

I have not seen a difference and have not heard of any concerns from risk managers.

✷ BROKER / William McDonough:

One major theme that is apparent is a closer look at reserving practices. Carriers are less likely to apply across the board "low reserves" to keep loss ratios artificially depressed. Doing so has led, in theory, to the demise of well-respected carriers.

In the medical malpractice arena, unless an underwriter is sure of "defensibility" in a claim, and expert review of the defense is confirmed, settlement strategies are more commonplace. Juries are tougher on medical malpractice cases, and seem to have no tolerance for error.

✷ RISK MANAGER / Linda Walker:

We have not seen any difference in the claims management for our insured claims.

✷ RISK MANAGER / Dorothy Bazan:

There has been an increase in the review of the allegations/language contained within the lawsuit, creating an increased frequency in the carriers' reservation of rights letters. Also, the reservations of rights letters are not always specific to the explanation of the issues under which the insurance carrier is reserving its rights of coverage.

How do carriers actually come up with premiums?

✷ CARRIER / Judy Hart:

For traditional accounts, a rating methodology is utilized applying an exposure base to a base rate subject to experience credits or debits and schedule credits/debits based on a subjective view of the risk.

For non-traditional placements, premiums are developed based on actuarial development of expected losses based on the accounts historical loss data. An underwriting analysis is performed on each account evaluating the effectiveness of risk management and claims management, the volatility of the jurisdiction(s) applicable to the particular account, and subjective factors such as the longevity of the relationship with the carrier.

✷ BROKER / William McDonough:

In this day and age, premium development is based primarily on (1) loss development, (2) units of exposure and (3) actuarial trending. The most important change is that underwriters must rely on their actuarial teams to price renewal and new business. Gone are the days of "buying" a book of business – again pressure from reinsurers has dictated appropriate pricing, with a profit.

✷ RISK MANAGER / Linda Walker:

As a risk with more than 95 percent of exposures in California, we're concerned that underwriters discount the effect

that tort reform has had on our losses and also the fact that our losses have been significantly lower than those of the health care industry in our location. While we acknowledge that the cost of insurance and reinsurance is based on losses occurring countrywide, companies do not seem to acknowledge regional differences such as effective tort reform in our state and the effectiveness with which we have managed our risks.

Actuaries are more prominent in underwriting. Reviews and projections of losses are important components in pricing decision.

✷ RISK MANAGER / Dorothy Bazan:

Premium can be developed by a formula as well as an underwriter's forecasting methodology based on their and/or industry data. It is wise to ask for the carrier "definitions" requisite to the completion of insurance applications, e.g., extensive professional liability issues. It is best to know what the company considers under the category of "outpatient" therapies. What is an ED visit? Who are employees? What types of programs are in place? Entering wrong data can impact the premium – over- or under-payment of premium due to inaccurate reporting.

What do companies look at when evaluating a risk?

✷ BROKER / William McDonough:

A typical submission would include:

1) Loss runs – 10 years (used to be five years)
2) JCAHO reports, with Type 1s and action plans provided
3) Risk management efforts, infrastructure and patient safety initiatives
4) An application (in years past, an application could be avoided)
5) Insurance Q&A
6) Claims management, litigation management and reserving practices (particularly as more insureds have major retentions)
7) Educational programming, offerings
8) Credentialing processes
9) Clear and exact specifications
10) Financials.

What can risk managers do?

✷ CARRIER / Judy Hart:

The best thing a risk manager can do is to showcase their organization to their underwriter. This includes developing a personal relationship with the underwriter and visiting them along with their broker to discuss renewal objectives. *The quality of the submission is key in this market.* The quantity of information can be a negative. Clear, concise displays of exposure data, historical loss runs for a minimum of 10 years if possible, descriptions of large losses, copies of financial statements, an overview of the organization and its strategies for the coming year all are critical parts of the submission. Loss runs should be provided on disk. The risk management department's capabilities should be highlighted.

Key initiatives in the areas of quality will differentiate an organization in the marketplace. Also, if the organization is self-insured, reserving philosophies are key discussion points as well as philosophies on claims management.

BROKER / William McDonough:

Risk managers can do many things. Most important, promote yourself as the "go-to person":

- Get on agendas to talk about market conditions, risk management program improvements, etc.
- Design an internal one-page "hot topics" monthly to update administration and clinical leadership (and others) on risk management issues
- Prepare and implement a risk management educational plan – be in their face.
- Hold roundtables for physicians or office staff on market forces and tools to reduce exposures
- Work with brokers early to prepare a 5-star submission
- Prepare a risk management directory of services for the HCO and the captive, if applicable
- 24/7 pager contact – be available.

RISK MANAGER / Linda Walker:

Risk managers and organizations must implement and benchmark effective loss control measures. They can work with their CFOs and treasurers to develop levels of retention that will enable the organization to contain the cost of insurance for risks that are transferred. The risk manager can work closely with insurers to educate them on what sets this organization apart from others. While this may not result in cost savings, it does enable the underwriter to learn more about the organization and become an advocate with the actuaries and others involved in the pricing decisions.

RISK MANAGER / Dorothy Bazan:

- Know the issues and why they might be difficult
- Know your entity and its risks
- Know senior management's financial philosophy
- Keep management apprised of external changes that may impact the various markets
- Inform the organization of the risks and implications to the entity in real time, using entity history, philosophy and management styles
- Understand the cost to the entity
- Be not only out front with the broker but also up front with management as to the changes and the identified impact to the entity/team
- Support change
- Choose the issue of most importance to take a stand on … not every issue weighs the same.

This monograph is part of a series of timely summaries on critical risk management issues presented by the Monographs Task Force of the American Society of Healthcare Risk Management. The task force's goal is to provide these reports in formats appropriate to the subject matter. They may be accessed at www.ashrm.org (Hot Topics section). For reprints of this monograph, please call ASHRM at (312) 422-3980.