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Introduction

Aon is pleased to present the findings of our 2014 Health Care Industry Report. The health care sector continues to face many risks and challenges, which affect how organizations view and prioritize their resources in response to risk. We would like to highlight a few key findings and observations to guide you through the multitude of interesting risk management facts and figures within the report. Aon conducts a risk management survey every other year. Listed below are just some of the findings from health care providers responding to our 2013 report,

- When you look at the top 10 risks as a whole, there is an undeniable interdependence among many of these risks. It continues to be important for organizations to embrace an enterprise-wide approach to managing risk, and to optimize their strategies on a holistic basis.
- Regulatory/legislative changes remain the top risk for the health care sector as respondents are concerned over the broader implications and impacts of health care reform laws and legislation.
- Failure to attract or retain top talent is ranked as the second top risk. As baby boomers start to retire in the next three to five years, the federal government is predicting that by 2020, there will be a shortage of nearly 100,000 doctors (HealthLeaders Media, 11/14/2013) and close to one million nurses in the U.S. In addition to potential staff shortages, the health care industry must also contend with training and deployment inefficiencies, which could lead to declining health care quality and accessibility.
- The nation’s slow economic recovery continues to weigh heavily on the minds of survey respondents who have ranked economic slowdown as the third top risk, the same as it has been for the last few years.

History provides only a partial understanding of risk for the future. Without a doubt, health care organizations face ever-evolving challenges and risks. To effectively manage risks, organizations must assess the likelihood and potential impact of all viable risk events in order to be prepared for the next challenges while maximizing future growth opportunities.

If you have any comments or questions about the survey, or wish to discuss the findings further, please contact your Aon account executive.

Best regards,

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Executive Summary

Organizational sustainability in the health care industry demands proactive understanding and management of risk. In the current and still evolving economic, legal and regulatory landscape, health care organizations’ risk profiles can change quickly. Challenges such as health care reform laws and legislation, as well as continued concern about the recovering economy, weather disasters such as tornadoes, hurricanes and flooding, all remind us that potential threats to organizations come from all directions and in many different forms. The ability to manage these risks is key.

For 2013, most of the major lines of coverage for the health care sector experienced no major market changes. For 2014, we expect to continue to see flat to increasing rates except in property where we expect to see rate decreases, and hospital professional liability, where we anticipate a continuation of the stable market, with increases for adverse loss experience. Retentions (deductibles), limits and coverage terms and conditions should remain fairly stable.

The report is comprised of four main components:

- **Risk insights** include top 10 risks faced; reported readiness; losses related to risks; how organizations are identifying and assessing risks; external drivers affecting risk management; claim frequency and severity and emerging risks
- **Client insights** include priorities in choice of insurer and desired market changes.
- **Market insights** include discussions of coverage terms and conditions; retentions; limits and premium rates for the major property and casualty lines of coverage purchased by health care providers.
- **Use of Captives** include captive insurance company strategies, captive demographics, reasons for creating a captive, coverages insured by a captive, reasons for a domicile choice, and healthcare captive committees.

**Key Findings**

**Risk Insights**

- **Greatest risks** – At a time when health care reforms are being implemented and continue to dominate political debates, it is no surprise that respondents to Aon’s 2013 Global Risk Management Survey indicate regulatory/legislative changes as the top risk for the health care sector.
- **Risk preparedness for the top ten risks** – Health care respondents report a low level of preparedness for several of the most complex and difficult to control risks – economic slowdown (65 percent state they are not prepared); increasing competition (62%); cash flow/liquidity risk (68%) and regulatory/legislative changes (71%). In addition, 76% of respondents indicated that they were insufficiently prepared for their technology infrastructure to support business needs.
- **Loss of income associated with top risks** – For the health care industry, regulatory/legislative changes top the list of risks with the most losses in the past 12 months, at 83 percent.
- **Identification and assessment of major risks** – Respondents have cited senior management’s intuition and experience as the primary method used by survey respondents to identify and assess major risks facing their organization. In practice, respondents typically utilize a combination of risk registers, a structured enterprise-wide approach and senior management’s intuition.
- **External drivers strengthening risk management** - Increased focus from regulators and economic volatility remain the most important external drivers strengthening risk management for the health care sector.
Claim Frequency and Severity – Aon’s 2013 Hospital Professional Liability and Physician Liability Benchmark Analysis shows that the frequency of medical professional liability has stabilized, while severity continues to grow at a constant inflationary trend.

Emerging Risks – The health care sector faces many unknowns, most of which stem from the global economic uncertainties as well as regulatory changes related, in one way or the other, to the current health care reforms. We find that health care organizations are coping with these challenges in a range of ways. Two prominent trends are ongoing mergers as well as the continuation of the trends of hospitals and systems employing more physicians.

Client Insights

Priorities in choice of insurer – Health care respondents rank value for claims service and settlement as the most important issue in selecting an insurer, followed by financial stability/rating.

Desired market changes – Surveyed health care organizations are looking for recognition of investments in internal risk management efforts through lower premiums, broader coverage/better terms and conditions and more flexibility (i.e., underwriting, coverages, pricing).

Market Insights

Market Conditions – For 2013 most of the major lines of coverage for the health care sector experienced no market changes, except for property premiums which began to see an upward trend in the second half of the year, but we expect to see rate decreases for property in 2014. For hospital professional liability, we anticipate a continuation of the stable market, with increases for adverse loss experience. Retentions (deductibles), limits and coverage terms and conditions should remain fairly stable.

Use of Captives

Coverages Insured by Captive – While medical malpractice continues to be the major line of coverage for a health care captive, Aon’s 2013 Health Care Captive Benchmark Study shows that captives are assuming a range of new exposures, such as employed physicians, auto liability, workers’ compensation, medical stop loss and D&O liability.
Risk Insights

In today’s global environment, health care organizations are facing increasingly complex challenges – extensive regulatory oversight and the increasing cost of compliance, rising litigation, and technology failures that could potentially disrupt businesses. The stakes for organizations are high. It has never been more critical for businesses to access accurate and the most up-to-date information and proactively address business risks at every level of the organization. Within this section of the report we provide industry-specific insight into:

- Top 10 Risks
- Risk Preparedness for the Top 10 Risks
- Losses Associated with Top 10 Risks
- Identification and Assessment of Major Risks
- External Drivers Strengthening Risk Management (past two years)
- Hospital Professional and Physician Liability Claim Frequency and Severity
- Long-Term Care Industry Liability Claim Frequency and Severity
- Health Care Workers Compensation Trends
- Aon Hewitt Health Care Survey
- Emerging Risks

Top 10 Risks

Respondents are provided a list of 50 risks and asked to select 10 that they believe to be the top risks facing their organizations. Given the controversy surrounding the changes underway with health care reforms, it is not surprising that surveyed companies have chosen regulatory/legislative changes as the top risk category for the health care sector.

Ranked second on the list is the failure to attract or retain top talent. The huge population of baby boomers is starting to retire, removing a core base of the workforce while adding to the demands upon the health care industry. The federal government is predicting that by 2020, nurse and physician retirements will contribute to a shortage of at least 100,000 doctors and close to one million nurses. Moreover, the aging population and the addition of over 20 million newly insured individuals under health care reform will further exacerbate the situation.

Tied to this concern is “increasing competition,” which is rated as the fourth highest concern. The health care industry is going through a significant number of mergers and acquisitions. Hospitals and systems are merging and expanding their physician workforce by either hiring on an individual basis or by acquiring physician practices. Beyond hiring physicians and merger and acquisition (M & A) activity, there are increased efforts among health care organizations to align more closely with physicians and physician practices. Systems are looking to align through insurance programs, electronic health record systems, sharing of best practices, management service organizations as well as other ways.

The economic slowdown remains a key issue for health care organizations, most likely fueled by concerns over continued uncertainties in the global economy and the potential for further deterioration.

At the same time, organizations have to grapple with the rising cost associated with capital, reduced levels of reimbursements, accessing and hiring adequate professional staff and a range of technology upgrades, as well as meeting the increasing regulatory and legislative demands. Moreover, an aging population and millions of newly insured patients added to the health care system will further compound the problems.
When you look at the top 10 risks as a whole, there is an undeniable interdependence among many of these risks. It continues to be important for health care organizations to embrace an enterprise-wide approach to managing risk, and optimize their strategy on a global basis.

**Health Care Industry Top 10 Risks**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Health Care Industry 2013 Top 10 Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regulatory/legislative changes</td>
</tr>
<tr>
<td>2</td>
<td>Failure to attract or retain top talent</td>
</tr>
<tr>
<td>3</td>
<td>Economic slowdown/slow recovery</td>
</tr>
<tr>
<td>4</td>
<td>Increasing competition</td>
</tr>
<tr>
<td>5</td>
<td>Damage to reputation / brand</td>
</tr>
<tr>
<td>6</td>
<td>Failure to innovate / meet customer needs</td>
</tr>
<tr>
<td>7</td>
<td>Lack of technology infrastructure to support business needs</td>
</tr>
<tr>
<td>7</td>
<td>Political risk/uncertainties</td>
</tr>
<tr>
<td>9</td>
<td>Workforce shortage</td>
</tr>
<tr>
<td>10</td>
<td>Cash flow / liquidity risk</td>
</tr>
</tbody>
</table>

Data Source: 2013 Global Risk Management Survey
Where ranking numbers are duplicated that indicates a tie
Risk Preparedness for the Top 10 Risks

Preparedness for risk means having a plan in place to address the risk or having undertaken a formal review of that risk. Health care respondents report the following levels of preparedness for the below identified risks:

Top Ten Risk - Reported Readiness - Health Care

- **Regulatory/legislative changes**: 71%
- **Failure to attract or retain top talent**: 68%
- **Economic slowdown/slow recovery**: 65%
- **Increasing competition**: 62%
- **Damage to reputation/brand**: 60%
- **Failure to innovate/meet customer needs**: 76%
- **Lack of technology infrastructure**: 76%
- **Political risk/uncertainties**: 46%
- **Workforce shortage**: 65%
- **Cash flow/liquidity risk**: 68%

Data Source: 2013 Global Risk Management Survey
The lowest level of preparedness is in the area of political risk uncertainties, which would reflect the uncertainty health care providers feel about the PPACA and all the changes underway in the transformation of the health care delivery system. Health care providers now are evaluated for their overall risk based upon traditional underwriting issues such as claims history and increased exposures. Underwriters will increasingly look at health care providers quality indicators. As hospitals consider options for risk financing, they need to integrate quality factors into their programs.

Besides political risk uncertainties, respondents also gave themselves a score of 65% for not being prepared for the economic slowdown. These two risks, typically more complex and difficult to control, carry a higher degree of unpredictability.

As risk management is becoming more embedded in an organization’s culture and with additional demands for improved quality outcomes, we expect to see an upward trend in risk preparedness over the next few years.
Losses Associated With Top 10 Risks

Among the top 10 risks, regulatory/legislative changes are cited by the health care sector as causing the most loss of income in the past 12 months, at 83 percent.

Top 10 Risk – Loss of Income – Health Care

- Regulatory/legislative changes: 83%
- Failure to attract or retain top talent: 59%
- Economic slowdown/slow recovery: 54%
- Increasing competition: 46%
- Damage to reputation/brand: 40%
- Failure to innovate/meet customer needs: 40%
- Lack of technology infrastructure: 40%
- Political risk/uncertainties: 38%
- Workforce shortage: 37%
- Cash flow/liquidity risk: 35%

Data Source: 2013 Global Risk Management Survey
Top Five Risks Projected 3 Years From Now

When asked to project the top 5 risk concerns in the next three years, Health Care survey respondents pointed to economic slowdown/slow recovery as a number one risk. When comparing it to the overall top ten list the overall key risks change very little.

Projected 2016 Top 5 Risks

<table>
<thead>
<tr>
<th>Rank</th>
<th>Health Care Industry 2016 Top 10 Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Economic slowdown/slow recovery</td>
</tr>
<tr>
<td>2</td>
<td>Regulatory/legislative changes</td>
</tr>
<tr>
<td>3</td>
<td>Increasing competition</td>
</tr>
<tr>
<td>4</td>
<td>Failure to attract or retain top talent</td>
</tr>
<tr>
<td>4</td>
<td>Failure to innovate / meet customer needs</td>
</tr>
</tbody>
</table>

Data Source: 2013 Global Risk Management Survey

Where ranking numbers are duplicated that indicates a tie
Identification and Assessment of Major Risks

Survey participants cite senior management’s intuition and experience as the primary method used to identify and assess major risks facing their organizations. In today’s fast-evolving business environment, where the past may not always be the best predictor of the future, exclusive reliance on senior management’s intuition and experience to identify and assess risks could result in a significant loss to an organization. Some of the reasons include the following:

- risk identification based on experience tends to miss emerging or new risks;
- risk identification based on intuition may not be consistent and may not be given credence by others;
- there may be a tendency toward risk aversion by managers with the view “better safe than sorry.”

On the contrary, the use of risk registers, quantitative analysis and an enterprise-wide approach to identifying and assessing risk is desirable, adding consistency to the process and enabling the organization to more effectively assess the potential impact of an identified risk on the organization so it can deploy appropriate resources for treatment.

As risks increase in complexity, health care organizations must integrate intuition and experience with sophisticated analytics to make the most informed objective and predictive decisions.

Identification of Major Risks

<table>
<thead>
<tr>
<th>Category</th>
<th>Health Care Industry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board and/or management discussion of risk during annual planning, risk assessment or other processes</td>
<td>63%</td>
</tr>
<tr>
<td>Senior management judgment and experience</td>
<td>72%</td>
</tr>
<tr>
<td>Risk information from other function-led processes (e.g. internal audit, disclosure, compliance, etc.)</td>
<td>62%</td>
</tr>
<tr>
<td>Industry analysis, external reports</td>
<td>43%</td>
</tr>
<tr>
<td>Structured enterprise-wide risk identification process</td>
<td>40%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
</tr>
</tbody>
</table>

Assessment of Major Risks

<table>
<thead>
<tr>
<th>Category</th>
<th>Health Care Industry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board and/or management discussion of risk during annual planning, risk assessment or other processes</td>
<td>45%</td>
</tr>
<tr>
<td>Senior management judgment and experience</td>
<td>68%</td>
</tr>
<tr>
<td>Risk modeling/risk quantification analysis</td>
<td>37%</td>
</tr>
<tr>
<td>Consult with external service provider/advisor</td>
<td>33%</td>
</tr>
<tr>
<td>Structured enterprise-wide risk assessment process supported by a standard toolkit and methodology</td>
<td>32%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
</tr>
</tbody>
</table>

Data Source: 2013 Global Risk Management Survey
External Drivers Strengthening Risk Management (past two years)

Increased scrutiny from regulators and economic volatility remain the most important external drivers strengthening risk management for the health care sector, which is one of the most highly regulated industries in the world. Organizations in this sector are exposed to a myriad of regulations, and face a great deal of uncertainties relating to the health care reform laws. Health care providers have to continue providing services while trying to accommodate the many changes and challenges of the transformation of the health care delivery system.

*External Drivers Strengthening Risk Management*

<table>
<thead>
<tr>
<th>External Driver</th>
<th>Health Care Industry</th>
<th>All Industry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure from suppliers / vendors</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Natural weather events</td>
<td>3%</td>
<td>18%</td>
</tr>
<tr>
<td>Demand from investors for greater disclosure and accountability</td>
<td>12%</td>
<td>22%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>9%</td>
<td>12%</td>
</tr>
<tr>
<td>Pressure from competitors</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Pressure from customers</td>
<td>11%</td>
<td>22%</td>
</tr>
<tr>
<td>Risk events/black swan events</td>
<td>20%</td>
<td>23%</td>
</tr>
<tr>
<td>Political uncertainty</td>
<td>15%</td>
<td>27%</td>
</tr>
<tr>
<td>Workforce issues</td>
<td>12%</td>
<td>27%</td>
</tr>
<tr>
<td>Large third party liability losses / litigation</td>
<td>14%</td>
<td>28%</td>
</tr>
<tr>
<td>Economic volatility</td>
<td>37%</td>
<td>47%</td>
</tr>
<tr>
<td>Increased focus from regulators</td>
<td>34%</td>
<td>45%</td>
</tr>
</tbody>
</table>

Data Source: 2013 Global Risk Management Survey
Hospital Professional and Physician Liability Claim Frequency and Severity

Based on Aon’s 2013 Hospital Professional Liability and Physician Liability Benchmark Analysis released in October 2013, the frequency of medical professional liability continues to be stable. Claim severity, including both indemnity and defense costs, continues to increase at a consistent rate and is projected to rise 2.5 percent annually (subject to a USD 2,000,000 per occurrence limit). This matches the lowest rate of claim severity growth in the 14-year history of Aon’s projections.

**Frequency per OBE**

The frequency per OBE can be interpreted as the annual cost of risk for the hospital’s self-insured layer of coverage (at an assumed $2 million retention level). The health care industry experienced a relative low point in costs for professional liability in the mid 2000’s. Since then, the cost of risk has been increasing at an estimated 2.5% annual rate.

Loss Rate per OBE Limited to $2M per Occurrence

The following table presents a summary of our findings for long-term care GL/PL:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Projected 2014 Estimate</th>
<th>Annual Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Claim Frequency*</td>
<td>0.91</td>
<td>2.00%</td>
</tr>
<tr>
<td>Indemnity Claim Frequency*</td>
<td>0.68</td>
<td>2.00%</td>
</tr>
<tr>
<td>Severity</td>
<td>$213,000</td>
<td>3.00%</td>
</tr>
<tr>
<td>Loss Rate**</td>
<td>$1,940</td>
<td>5.00%</td>
</tr>
</tbody>
</table>

Overall claim frequency is the number of claims per 100 occupied beds. Indemnity claim frequency is the number of claims that resolve with a payment to the claimant per 100 occupied beds. Claim severity is the average size of claims, with claims limited to $1 million per occurrence. The loss rate is the annual amount per occupied bed required to defend, settle or litigate claims in a given year.

Long-Term Care Industry Liability Claim Frequency and Severity

Aon conducts a benchmarking study of the long-term care industry, based on the actuarial analysis of general liability (GL)/professional liability (PL) claims data from long-term care providers on a national level.

- Liability costs for long-term care providers continue to increase. This year’s study suggests that claim frequency is on the rise. Combined with claim severity, overall loss rates can be expected to grow 5% year over year.
- Through the latter part of the last decade, claim frequency was relatively flat, and severity growth was stable. Claim frequency has increased since 2010, driving loss rate inflation.
- The causes of this frequency growth are difficult to isolate, and will vary by state. One possible influence is changes in plaintiff attorney’s behavior.
- Tort reforms in the early 2000’s changed the way plaintiff attorneys operate. Conservative jurisdictions with long-standing tort limits are less economically attractive to attorneys. The firms have focused their attention on venues with no tort limits, less mature tort laws or more liberal judiciaries.

Data Source: Aon’s 2013 Hospital and Physician
Health Care Workers Compensation Trends

- For the 2013 accident year, the Aon Workers Compensation Barometer Study projected health care systems will experience an annual loss rate of $0.79 per $100 of payroll.
- Study projects that loss rates are increasing at a 1% annual rate.
- The frequency of workers compensation claims has been slowly and consistently decreasing over the ten-year experience period study.
- Study projects that claim frequency will decrease at an annual trend rate of 1%.
- Claim severity, including medical, indemnity and expense costs, has been slowly increasing at a trend rate of 2% per year.

Managing Workers Compensation Costs:

- Patient handling has been identified as the number one concern by health care risk managers participating in the study.
- Patient handling claims have the highest average indemnity payouts and account for 25% of all health care workers compensation claim payments.
- 75% of all respondents self-insure their workers compensation risks.
- Retentions between $500,000 and $750,000 are the most popular. Only 20% of respondents have retentions greater than $750,000.
- Two-thirds of the survey respondents:
  - Do not have a return to work program
  - Do not have any way to test the effectiveness of their return-to-work program.
- Of respondents with metrics in place to test the effectiveness of their return-to-work program, 100% of them deem it to be effective.

Workers Compensation Loss Rate:

The darker bar, labeled 2012, represents a forecast based on the 2011 bar and the study’s selected trend factors.

The health care industry experienced improvements in the workers compensation loss rates through 2008. The loss rates have been very stable since.

Workers Compensation Claim Frequency

The improvement in workers compensation loss rates has been driven by frequency. There are several factors likely responsible for the consistent decrease in frequency.

The health care industry’s intense focus on patient safety has direct implications for workers’ safety. Patient and worker safety programs share many of the same characteristics. In other words, an environment safe for patients is also safe for employees.

Also, the landscape for nursing employment has changed rapidly in the last five years. With nursing staff turnover at the lowest levels in years, the average experience and competency has risen dramatically with favorable implications for workers compensation. Lastly, the use of new technology, including beds and patient lifting devices, has helped make the workplace safer.

Countrywide Frequency per $100,000 of Payroll

The darker bar, labeled 2012, represents a forecast based on the 2011 bar and the study’s selected trend factors.
Health Care Workers Compensation Trends (cont)

Accident Year Results: Claim Severity

Claim severity has been subject to a constant inflationary trend throughout the historical period. The severity amounts shown in the graph have been limited to $500,000 per occurrence. Limiting large claims reduces the effect of “outlier” events. The $500,000 limit is chosen because it is a common retention for workers compensation, and the most prevalent seen in the data in this barometer study.

The darker bar, labeled 2012, represents a forecast based on the 2011 bar and the study’s selected trend factors.

Countrywide Loss Rate per $100 of Payroll – Limited to $500,000 per Occurrence

Ultimately, risk managers are trying to decide if a single source disability management program, which would include workers compensation into their overall disability management program, would produce system-wide savings.

Survey Results: What Is Your Number 1, 2 and 3 Concern/Risk?

When combining all the scores for first, second and third concerns, managing cost moves to the top. Patient handling is still a primary concern while aging workforce moves into the third position followed by return-to-work program.

It is interesting to note that employee turnover is at the bottom of this list. The recent economic downswing has dramatically changed the employment landscape for nurses. Older nurses are working when they would rather retire, part-time nurses are working full-time and nurses that left the profession for other industries are coming back to nursing.

Absence management was ranked high as a number one risk but falls when all results are combined. There is an increased focus on the coordination of benefits (i.e., short-term disability, FMLA, work comp, long-term disability) and the ability to manage employees’ time away from work.
The Aon Hewitt Health Care Survey benchmarking report was issued in 2013. Looking at study results for the health care providers that responded provides some interesting insight into their attitudes and expectations for their employee benefit plans.

- According to health care respondents to the survey, 12% currently offer high-deductible, consumer-driven health plans as the default plan option, but 47% are considering using this option in the next 3-5 years.
- 24% currently contribute to employees’ HSAs, but 46% are considering doing so in the next 3-5 years.
- Only 2% currently match contributions to the HSAs, but 49% are considering doing so in the next 3-5 years.

Besides managing cost, the top health care outcomes they wanted to achieve in 2013 were the following:

- 78% identified “Increase participation in wellness, health improvement/disease management programs” and “Lower health risk of population” as top risks.
- 72% identified “Increasing participants’ awareness of, and decision making related to health issues,” as a top risk.
- 58% identified “Improve disease management/health improvement program compliance” as a top risk.

When asked to identify the most significant challenges facing them (internal or external) in terms of accomplishing these desired outcomes, the following were identified as the top five:

1. Motivating participants to promote behavior change (72%)
2. Understanding employee attitudes toward health and wellness (46%)
3. Government regulations/compliance (e.g., health care reform) (43%)
4. Maintaining participants engagement/satisfaction with health plan (42%)
5. Chronic disease prevalence (40%)
Emerging Risks

1. Health Care Reform

A Shift in the Health Care Delivery Marketplace: One of the primary objectives of the health care delivery and reimbursement reforms within the Patient Protection and Affordable Care Act (PPACA) is to promote better outcomes and drive greater efficiencies within the Medicare and Medicaid marketplace. However, the PPACA has triggered a shift within the provider and payer communities in the manner in which care is being managed and delivered to the commercial (non-Medicare/Medicaid) marketplace. A fundamental shift from “volume-based” reimbursements to “outcomes-based” reimbursements is currently underway. This shift is driving the evolution of “commercial ACOs.”

Emerging Risk Management needs related to Health Care Reform: ACOs have the potential for driving better outcomes while reducing costs, but achieving these goals will require changes in organizational structure and operational workflow. In some cases this transition will require a major cultural transformation, depending on the current state of the organization. Additionally, providers must digest and manage unfunded regulatory requirements not seen in the past. These dynamics have related financial and operational risks that will require unique risk mitigation strategies.

Move to Employing Physicians: We continue to see an increase in employed physicians. A new business model—emphasizing hospital employment of physicians—has emerged within the health care industry. The shift has many business implications for health care systems, including a significant impact on the organization’s self-insurance programs. This development also introduces additional challenges to health care providers in establishing sufficient employee benefits for this elite group of employees. For example, most long-term disability programs do not adequately address the overall needs for physicians, which is why Aon is studying these exposures and has developed a range of products specifically addressing these needs.

Accountable Care Organizations. The health care reform legislation enacted in March 2010 authorizes the Medicare program to contract with Accountable Care Organizations or ACOs - networks of physicians and other providers that could work together to improve the quality of health care services and reduce costs for a defined patient population. In theory, ACOs provide financial incentives to health care organizations to reduce costs and improve quality. In reality, given the complexity of the existing system, health care providers are facing more challenges than ever before. The evolving health care landscape is characterized by the following:

- Center for Medicare and Medicaid Services or CMS is moving to tiered risk payments and performance-based quality care.
- New alignments will be developed across all providers and care settings, and among multi-hospital and multi-physician groups.
- Payer-provider links will promote risk sharing, data integration and patient management.
- Accountable care will be driven by quality metrics and efficiency rather than volume and unit pricing.
- Financial and data transparency; IT infrastructure and process improvement will be keys to success.
- Health care providers will be required to become both clinically and financially accountable.
2. Cyber/Privacy Challenges:

According to a Premier online survey for Economic Outlook, Fall 2013, “the largest area of capital investment continues to be IT and communications, which was identified by 38% of survey respondents as the place where their organizations will spend the most next year.”

In a study released in February 2014, Norse, a Silicon Valley cybersecurity firm, and SANS, a security research institute, found that health care organizations “are being routinely attacked and compromised by increasingly sophisticated cyberattacks.” [Los Angeles Times, 2/19/2014] This study showed that health care organizations were often unaware of these compromising attacks.

“What’s concerning to us is the sheer lack of basic blocking and tackling within these organizations,” said Sam Glines, chief executive of Norse. “Firewalls were on default settings. They used very simple passwords for devices. In some cases, an organization used the same password for everything.” [Los Angeles Times, 2/19/2014]

Besides privacy issues, health care providers need to purchase and maintain appropriate IT infrastructure. They are being offered a plethora of options for electronic information technology. While they are required to network with other providers and publish outcomes, they also have to keep the information entirely private. The ramifications of a breach in privacy & security may include:

- The duty to notify potentially affected individuals;
- HIPAA (Health Insurance Portability and Accountability Act) fine;
- Regulatory action;
- Class action potential; and
- Reputational damage.

3. Shortage of Health Care Professionals:

According to HealthLeadersMedia, November 14, 2013, “Current utilization patterns suggest that by 2020 there will be a shortage of 91,500 physicians—45,400 primary care physicians and 46,100 subspecialists.”

While states and schools are increasing the number of medical students, “that alone will not increase the supply. The unwillingness of Congress to fund additional Medicare GME positions may lead to U.S. medical school graduates who lack opportunities to complete their residencies.....”

“Even if current health care delivery reforms are implemented and successful, the U.S. population will need a larger health care workforce, including more physicians. It is anticipated that up to 20 million more insured people will be created through implementation of the PPACA.”
Client Insights

The right knowledge at the right time can literally change the world. The health care sector has capitalized on timely information being available for some time. Similarly, the value Aon offers through content is empowering our clients with analytical, relevant, and timely risk insights that can help them make not just better decisions but the right ones to achieve their goals. Within this section of the report, we provide industry-specific insight into:

- Priorities in Choice of Insurer
- Desired Market Changes

Priorities in choice of insurer

Claims service and settlement was rated number one by health care respondents. Financial stability/rating of the insurance company was rated number two. In the 2011 report, “value for money/price” was rated number one but in the 2013 report this issue was rated number three.

Of interest, the health care industry continues to lower the priority on long-term relationships, going from number two in priority ranking during the 2009 survey to number five in 2011 and number 7 in 2013. Long-term relationships do matter to health care providers, but the ongoing economic challenges and active, competitive market—with several new players capturing their share of the market—compel health care organizations to pay close attention to the bottom line, making the long-term relationships somewhat less important.

### Priorities in Choice of Insurer

<table>
<thead>
<tr>
<th>Factors</th>
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</thead>
<tbody>
<tr>
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<tr>
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<td>Capacity</td>
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<tr>
<td>Long-term relationship</td>
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<tr>
<td>Speed and quality of documentation</td>
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<td>9</td>
<td>10</td>
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<tr>
<td>Ability to deliver a global program</td>
<td>10</td>
<td>10</td>
<td>9</td>
</tr>
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</table>

Data Source: 2013 Global Risk Management Survey
Desired Property and Casualty Market Changes

When asked what changes health care organizations would most like to see in the insurance market, the majority of respondents desire:

- Recognition of investments in internal risk management efforts through lower premiums
- Broader coverage/better terms and conditions

**Desired Market Changes**

![Diagram showing desired market changes for health care industry and all industry.]

Data Source: 2013 Global Risk Management Survey
Market Insights

Access to timely insights on policies, premiums and carriers allow health care clients to make faster and more accurate decisions while seeking to obtain the best coverage and rates. Aon has invested resources to develop the industry leading research and platforms and ensure our clients have the data they need, when they need it. Within this section we provide insights into the following coverages:

- Hospital Professional Liability/Medical Malpractice
- Managed Care E&O
- Managed Care HMO Reinsurance, Excess-of-Loss and Provider Excess
- Workers Compensation
- Directors and Officers Liability
- Property

Impact of Health Care Reform

At this point it is not known to what degree reform will impact the traditional lines of property and casualty coverage. We are seeing its effect on medical professional liability, as hospital providers employ more physicians, as ACOs assume some of the financial risk of providing care and as reform may have an effect on vicarious liability and antitrust exposures. As more physicians are employed, we anticipate the underwriting of those physicians to be more rigorous to include not only the traditional criteria of specialty and losses but also non-traditional underwriting criteria such as infection rates, readmission rates and other quality indicators. For example, Physicians Compare, the CMS-run website, recently added “group-level quality data for physician group practices and accountable care organizations in its database for the first time.

Some areas Aon has identified that must be considered in dealing with risk under reform are the following:

- Risk management and financing of programs which are aligned to the “patient” or “network” instead of a specific “entity”
- The standard of care across the network
- The management of information among related and unrelated parties
- The changing role and practice of providers, nurse practitioners, and the team members serving the medical home approach to care
- Maintaining control of your risk financing program and control of claims/joint defense of claims/control of claims
- Ownership vs. contractual relationships
- Utilization management, managed care and the financial risk of providing care
- Risk financing of programs on an integrated basis
- Building quality into the risk financing programs
- Addressing patient and employee satisfaction and safety as one
We anticipate reform will affect some of the traditional coverage lines such as D&O and workers compensation. In addition, there is an immediate impact on managed care exposures, including medical stop loss and provider stop loss, as health care providers develop ACOs and assume more risk. ACOs will require that the D&O, privacy, vicarious medical professional and business risk of ACOs, among other risks, are considered in risk management financing treatments. As reform changes evolve, additional exposures will develop.

Hospital Professional Liability/Medical Malpractice

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<thead>
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<th>Category</th>
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<tbody>
<tr>
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<tr>
<td>Deductibles/Retentions</td>
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<td>Limits</td>
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<tr>
<td>Coverage Terms &amp; Conditions</td>
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Pricing

Although rate strengthening is taking place for some coverage lines the global health care and excess liability market place was stable in 2013 and we expect it to remain so for 2014 and 2015. Our 2013 HPL and Physicians benchmark report indicated that claims frequency is stable and severity expected to increase at 2.5% annually. Note that pediatric severity can be as high as 4.5 times the median claim in a non-pediatric hospital. While combined ratios are on an upward trend, medical professional liability is still one of the lowest insurance lines, just over 95%, so even with depressed yields on investment returns medical professional liability is still a good and stable investment for the capital market.

Deductibles/Retentions

Retention levels are at historically high levels, but continue to remain stable. Health care providers have become accustomed to higher retentions as a result of the hard market of several years ago. Markets continue to provide aggregate protection in certain situations.

Limits

For professional liability, limits purchased range from zero (“going bare”) to well in excess of USD 100 million. The question of limits is answered by understanding a range of issues: venue, state liability caps, statutory protection such as municipal immunity for some health care providers, financial resources or board attitudes toward risk.

Insurers are reporting successful reinsurance renewals that mirror results Aon sees in insurance pricing. In addition, several commercial insurers who ceased to purchase reinsurance report that given the favorable pricing, they may be interested in purchasing reinsurance. This will serve to further increase the already abundant medical professional liability capacity.

Coverage Terms and Conditions

As health care organizations are challenged with what health care reform means to their particular organization, so are underwriters challenged with how to effectively respond to each client’s needs for flexible and cost effective risk transfer. For the most part, risks and exposures under health care reform are not expected to be different than those which now exist for providers and payers. What is different is the owner of these risks, the blending of exposures, and the need for a more enterprise approach to risk management and financing. A number of underwriters have developed an integrated approach where they “package” various coverage lines such as E&O, privacy, medical professional liability, managed care liability, D&O, regulatory claims coverage, employment practices, fiduciary liability and crime. Other underwriters prefer a more manuscript approach, taking the forms they currently write separately and blending them together. Since each organization’s approach can be different the most important first step is for consultants or brokers to thoroughly understand the various contractual relationships that currently exist and are anticipated in the near future.
Managed Care Errors & Omissions

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**Pricing**

2014 has begun to show signs of market hardening. As indicated in last year’s report, carriers are citing the industry’s systemic risk and emerging areas of increased risk (i.e. antitrust, discussed further below) as the main drivers for the rate need. Some carriers have cited current rates as unsustainable, indicating a stronger stance against any additional rate decreases. However, with any broad sweeping comment, there are always exceptions. For clients with good risk profiles, clean claims history, limited acquisition activity/expansion, there remains good potential for near flat pricing. These comments on pricing are focused simply on the “rate” component of premium, but do not reflect exposure changes which could separately affect premium. One key metric used by carriers to determine premium is enrollment, therefore significant growth in enrollment year over year often results in a corresponding premium increase.

**Deductibles/Retentions**

Many carriers have demonstrated a renewed focus on retention levels to provide stability to their book of business. While there remains inconsistency between carriers on the correct attachment for a particular risk, we are beginning to see higher levels of retentions overall, and specifically those addressing antitrust claims. Retention levels are also adjusted with any significant enrollment growth, but should be weighed against claims experience to be properly aligned.

**Limits**

Limits purchased by managed care entities have been relatively flat to slightly higher for the prior three years. Some entities which have expanded operations, either organically or via acquisition, have increased their total program limits. Many of the carriers who participate in the MCE&O space have indicated a concern over systemic risk, and are monitoring overall limit exposure. Where a carrier has significant marketshare in a particular sub-class of MCE&O (i.e. Blues, Medicare/Medicaid plans, etc.) we expect increased focus on capacity management and possible rationing. Furthermore, certain carriers have stated that they will enforce new maximum limit caps, either on the entire policy or via a sublimit on certain key coverages (i.e. Antitrust). These caps / lowered limits should be evaluated in light of the core exposures that are central to managed care and a particular entity’s risk profile.

**Coverage Terms and Conditions**

Coverage is relatively stable, with some broadening features still emerging. As new services are developed and business arrangements are structured, it is all the more critical to closely evaluate and align the scope of coverage provided via the definition of Managed Care Services (or equivalent definition). Additionally, as the trend continues with more managed care organizations expanding into variations of direct care, such as home care and clinics, the E&O policy must either be expanded to address these exposures or dove-tail with the other policies in place for the exposures. As noted in prior years, there remains division in the marketplace over coverage provided in a managed care E&O form for privacy/security/cyber exposures. And while some policies provide limited coverage, the emerging trend by managed care entities is to purchase a separate policy to fully address the exposures.
Aon Risk Solutions

Managed Care HMO Reinsurance, Excess-of-Loss and Provider Excess

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**Pricing**

2013 was a transition year for pricing as the demand for excess-of-loss cover has initiated a hardening of the market that will continue in 2014. Fueling this demand is the reverse flow of risk occurring nationally as both the government and commercial payers delegate financial authority to the many stakeholders involved in the care delivery process. Further, growing speculation exists that the government’s reinsurance program offered to all exchanges will require more than the 10 billion earmarked by the ACA. As such, the commercial market may be required to address high cost claim exposures that are both above and below the $250,000 per-participant per-year threshold set forth in the ACA. Lastly, it is anticipated the probability and severity of adverse claim events will rise as a higher level of reimbursement has been negotiated by many within the provider community for services to be supplied to the marketplace enrollees.

As reimbursement increases, leveraged trend (percent of increase in high-cost claim recoveries year-over-year) grows exponentially. It is anticipated that service demand coupled with higher reimbursement will push leveraged trends beyond the 15 - 25 percent historical trend of the last several years. We also can’t ignore that continued advances in medicine and medical technology in combination with double-digit increases in the charge masters from tertiary and specialty care facilities which will also facilitate the continued growth of high cost claims. These have more than doubled over the past five years and we see no reason for this trend to slow.

To offset the significant trend and corresponding expense of loss, reinsurers have imposed a greater number of limitations within their policies, or have increased premiums to levels that have forced clients to purchase higher retentions and co-insurance alternatives. In response, managed care organizations are seeking variable funding alternatives in order to best improve their chances for a favorable return/net cost of insurance, or have been forced to increase premiums to offset the higher expense of reinsurance.

To further slow the growth of claim severity, reinsurers are offering a series of risk mitigation products designed to reduce the expense of a high cost event. These include care and case management support, transplant network pricing, and claim auditing to name just a few. Each can serve as an outsourced defense to health plans and provider organizations in need of further back-room support to their current risk mitigation programs.

Selected managed care organizations, such as managed state Medicaid programs and developing programs for the uninsured/underinsured, continue to demand excess-of-loss cover. State Medicaid programs that transfer full risk of neonate and hemophilic exposures to managed care organizations are seeking some form of catastrophic protection as the rise in expense within these clinical areas has been highly significant, especially over the past five years.

It is also anticipated that delegated risk from managed care organizations to health care providers will grow rapidly starting in 2014 as ACOs along with Medical Homes convert performance contracts to risk-sharing arrangements. What was once popular in the mid 90’s and remained a contracting strategy in various pockets of the country has again resurfaced as a viable method to facilitate value-based care. Health care reform is forcing the provider community to shift their focus from maximizing revenues, to a changing culture of being both clinically and fiscally accountable for a patient’s health care. We are witnessing significant interest from specialty providers and larger health systems that see this strategy as a means to garner patients and market share.

As the requirements from the new health care reform law evolve, a growing understanding of the population risk that will enter the current insurance pool is becoming clearer. Nearly 30 million uninsured and underinsured have the potential to be enrolled within the health insurance marketplace in 2014 - 2018. Much of this risk class was considered uninsurable by the insurance community in 2013. If this expansion occurs as the federal government anticipates, the demands on the commercial health markets to assume this risk will create the need for alternative markets to cede the poor risk expense. All insurers will find reinsurance imperative as they begin to explore segmenting risk classes within their own enrolled populations. Sufficient worldwide capacity exists today to accept much of this
exposure. However, pricing will rise as demand and leveraged trend continues to gain at a double-digit pace.

**Deductibles/Retentions**

We continue to see higher deductibles for this line of coverage as severity of claims rise and the frequency and predictability of higher cost events grow.

**Coverage Terms and Conditions**

In recent years we have witnessed subtle changes to the health care reinsurance marketplace that have balanced a proper mix of capacity, competition and coverage terms. With the passage of health care reform, we are seeing the onset of further change within the industry as insurers and reinsurers prepare for the evolving exposures anticipated over the next several years. Limitations within excess policies have expanded to account for the changes incorporated to the ACA. We will continue to monitor the terms issued by the markets as they better understand the evolving risks that will arise as enrollment and care management protocols develop over the next several years.

**Workers Compensation**

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<td>Coverage Terms &amp; Conditions</td>
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**Pricing**

Over the past year, workers compensation rates for health care organizations have averaged flat-to-single digit rate increases. While rates are expected to remain in the 3 to 5% (increase) range depending on exposures, losses and risk profile, we expect stable market conditions to continue for insureds with a good loss histories, benign risk profiles, and limited exposure changes. Accounts with adverse loss experience will see more rate depending on the level of loss.

**Deductibles/Retentions**

Deductibles are expected to remain as expiring unless there is something driving them upwards such as losses or the desire to save some fixed-cost premium. Typically the savings realized from moving up deductibles does not make sense on those accounts where the current deductible is doing its job. Having said that, on those accounts where the deductible may have been approached or even pierced, moving it up could potentially save some premium dollars or work to offset any premium increases the insurer may be looking for.

**Coverage Terms & Conditions**

Overall, there has been no significant changes regarding coverage for workers compensation, and we do not anticipate any major changes in the near future.
Directors and Officers Liability

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<tr>
<td>Coverage Terms &amp; Conditions</td>
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Coverage Terms & Conditions

Along with changes occurring in the health care industry at large, so are commensurate changes occurring with the coverage afforded by insurance carriers to address the evolving risks and exposures. The most notable change anticipated for 2014 is the heightened focus, and at times restriction of coverage, around antitrust claims. Most of the dominant carriers writing D&O for health care entities (both providers and payers) have expressed concerns over industry consolidation, the exposures created by the confluence of payers and providers, insufficient guidance from regulatory bodies and/or lack of clarity around safe harbors and the emphasis on qualitative assessments of providers. All of these issues point to a heightened exposure for the health care industry, and have lead carriers to a renewed focus on underwriting antitrust risk. Certain carriers have decided that drastic measures are needed to address what they consider a significant threat to the short- and long-term profitability, and even viability, of their business. Some of these measures are addressed in the limit and retention sections discussed below.

Other coverage terms which are expected to evolve further in 2014 are availability within the D&O (and other coverages) for cyber or privacy breaches, coverage for non-medical professional services, social media coverage within EPL policies and coverage for regulatory actions (outside of antitrust). With some of these coverage areas, carriers are attempting to broaden the scope of the policy thereby creating a competitive edge for new business. In other areas, carriers are restricting coverage in order to address what they consider a significant threat to the short- and long-term profitability, and even viability, of their business. Some of these measures are addressed in the limit and retention sections discussed below.

Pricing

As with any product or service, pricing for insurance is affected by both the cost of the coverage (i.e. claims plus administrative costs) as well as the competitive landscape (i.e. the amount of capacity). Momentum is gaining for additional upward rate pressure given the previously discussed concerns around increasing litigation and claim trends. Many carriers have indicated that rate increases will be necessary in 2014 to fund the industry exposures, and also point to a shrinking pool of premium given consolidation of the health care industry. Although there is abundant capacity in the broader directors and officers liability marketplace across all industry classes, there is a more limited group of carriers which have an appetite for health care, dedicated policy form, underwriting expertise and/or commitment to the industry overall. Due to these factors, our projection for 2014 is for the core carriers to push for overall rate increases in the 5-10% range. Certain carriers have indicated a need for even higher rate increases (15%+) but if the competitive environment becomes more robust and additional capacity enters the mix, this upward rate movement could be mitigated.

Limits

Overall D&O limits purchased by health care entities have been on a slight upward trend year over year. The expectation for 2014 is for total limits purchased to be flat, given the upward premium pressure on renewing programs. One particular carrier has indicated the need to reduce their sublimit for antitrust claims, stipulating a maximum limit of $5 million on any program. Given the importance of antitrust coverage to health care entities,
this reduction of limits creates a significant issue to be considered when making a purchasing decision.

The majority of health care entities purchase their D&O program with full coverage for Side A/B/C through the entire tower of coverage, as well as antitrust coverage through the tower. A growing percentage of entities are adding Side A excess layers onto their programs, and as we see rates increase on the primary A/B/C programs, the premium differential to convert higher layers to Side A might induce more movement in that direction.

**Self-Insured Retentions**

It is common to see various retentions set for health care entities within a D&O and EPL policy form. The different retention levels are often for “standard” D&O claims, antitrust, single plaintiff EPL claims, class/mass action EPL claims, regulatory claims, and so on. Health care entities can expect flat retentions for standard D&O claims in 2014, but should be prepared for upward pressure on the specific retentions for antitrust. On the EPL side of coverage, frequency of claims remains an issue for many health care entities, therefore carriers will match retention levels with both employee count and historical employment claim activity. With employee count growth, either organic or via acquisition/merger, carriers will attempt to adjust retention levels. While some focus on both the single plaintiff and class/mass action retentions, other carriers have shown a propensity to adjust only the class/mass action retention when employee count is bumped up.

### Regulatory / Billing Fraud and E&O Coverage

With records set in 2013 on both the number of health care fraud cases brought (377), as well the amount of health care recoveries (over $2.6 billion), there is no sign of the government easing its efforts. It is estimated that for every dollar spent by the DOJ and HHS in recovery efforts on alleged fraud, their return to the government averaged $8. With that type of ROI, the federal government has a vested interest in placing even more emphasis on the recovery process. As a result of this onslaught, as well as the limited risk transfer available from tradition policies that health care entities purchase (i.e. D&O), there is a significant gap in coverage for a very meaningful risk exposure. Several carriers have recently released policies to address this gap in coverage. Policies vary in their approach to coverage (from traditional to more of a “call option”), but all providing coverage for loss items such as defense costs, outside accountants and fines and penalties. As health care entities evaluate their risk spectrum, the issue of government or regulatory actions must be considered. Assessing which aspects of risk are transferrable versus must be retained, and balancing cost/budgetary constraints with the severity and frequency of these actions, strong consideration should be given to the insurance coverage now available in the marketplace.

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<td>$100k/$150k</td>
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<td>$40,000,000</td>
<td>$500k/$625k</td>
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*Data Source: Aon FSG Proprietary Databases*
While the market was seeking increases in the aftermath of Super Storm Sandy starting late Q4 – 2012, the momentum never really took hold. In the period Q1 – 2013 to Q1– 2014 we have seen rate changes at renewal between just over flat to approximately -5%, in the aggregate across the entire portfolio. For health systems specifically, particularly those with exposures to natural catastrophe, some early Q1 – 2014 renewals saw rates drop between 15% and 20%, but that momentum has slowed somewhat. Subscription programs are seeing larger rate reductions than single carrier programs, with new entrants into the property arena fueling competition. In the absence of any major land-falling named storms for the remainder of 2014, we would expect to see the current competitive market conditions continue into 2015. Low investment returns do create a higher focus on trying to achieve profitability on a pure underwriting basis, which could create a slowing of the current reductions some time in 2015.

New releases of the natural catastrophe modeling software are also expected to affect pricing in next several quarters. The largest reductions in rates derived by the new modeling should be seen for risks in Florida, the southeast and mid-Atlantic regions. A more moderate difference will be seen in Texas and the western Gulf coast. Some counties in the far north will experience slight increases compared to prior versions of the software.

**Deductibles/Retentions**

Over 95 percent of accounts maintained the same or lower deductibles in Q1 – 2014. There continues to be limited pressure from the majority of markets to change deductibles/retentions. The exception is the opportunity to reduce premium for increasing retentions on 100-year flood exposures.

**Limits**

No significant change in limits is expected. We do expect flood exposures to be under the microscope and will be carefully underwritten.

**Coverage Terms & Conditions**

We anticipate very limited change in property coverage except for the some clarification surrounding flood and wind coverages.

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### Property

<table>
<thead>
<tr>
<th>Category</th>
<th>2013</th>
<th>2014</th>
</tr>
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<tbody>
<tr>
<td>Pricing</td>
<td>↔↑</td>
<td>↔↓</td>
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<td>Deductibles/Retentions</td>
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<td>↔</td>
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<tr>
<td>Limits</td>
<td>↔</td>
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<tr>
<td>Coverage Terms &amp; Conditions</td>
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**Pricing**

While the market was seeking increases in the aftermath of Super Storm Sandy starting late Q4 – 2012, the momentum never really took hold. In the period Q1 – 2013 to Q1– 2014 we have seen rate changes at renewal between just over flat to approximately -5%, in the aggregate across the entire portfolio. For health systems specifically, particularly those with exposures to natural catastrophe, some early Q1 – 2014 renewals saw rates drop between 15% and 20%, but that momentum has slowed somewhat. Subscription programs are seeing larger rate reductions than single carrier programs, with new entrants into the property arena fueling competition. In the absence of any major land-falling named storms for the remainder of 2014, we would expect to see the current competitive market conditions continue into 2015. Low investment returns do create a higher focus on trying to achieve profitability on a pure underwriting basis, which could create a slowing of the current reductions some time in 2015.

New releases of the natural catastrophe modeling software are also expected to affect pricing in next several quarters. The largest reductions in rates derived by the new modeling should be seen for risks in Florida, the southeast and mid-Atlantic regions. A more moderate difference will be seen in Texas and the western Gulf coast. Some counties in the far north will experience slight increases compared to prior versions of the software.
Use of Captives

**Captive Insurance Company Strategies**

The 2013 Aon Risk Management Study surveyed attitudes toward captives and 27% of health care providers indicated they currently have an active captive or protected cell company (PCC). An additional 7% indicated they plan to create a new or additional captive or PCC. The most common reason for having a captive, at 41% of health care respondents, was its value as a strategic risk management tool.

Provided below is a graphic depiction of some of the wide range of risks that can be covered through a captive insurance company:

Captives exist or are created because they fill a niche that cannot be easily, or as efficiently, filled by the conventional insurance marketplace. While not for everyone, captives can be an important part of a professionally constructed risk financing program that recognizes the value of retaining certain risks in meeting overall corporate financial objectives. Many captive owners benefit from reduced insurance costs, better access to reinsurance, an enhanced ability to insure the “uninsurable” and overall improved coverage. One of the most important things provided by captives is control of all aspects of claims. Many organizations in the health care industry utilize these alternative risk transfer vehicles as part of their risk management/insurance programs.

To gauge the use of captives, Aon conducted a captive benchmark study in 2013. This study included 131 health care captives. Some of the findings from the health care participants are provided below.

**Demographics**

As is the case with Aon’s previous studies, most of the health care captives participating in Aon’s study are hospitals, but, as shown in the exhibit below, a number of other types of organizations have also used captives:
Reasons for Creating a Captive

- More than a quarter of respondents stated that they formed their captive for strategic risk management needs.
- Nearly a quarter indicated they formed their captive for cost savings as well as providing more control over their insurance program.
- See below for additional findings:

2013 Aon Health Care Captive Benchmark Study – Reason for Operation

- Strategic Risk Management Tool: 26%
- Control on Insurance Programs: 23%
- Cost Efficiencies: 24%
- Access to Reinsurance Market: 15%
- Reduction of Insurance Premiums: 15%
- Ability to Establish Reserves: 7%
- Tax Advantages: 7%
- Risk Finance Expense Control: 9%
- Cashflow Operations: 5%
Coverages Insured by Captive

According to Aon’s 2013 Captive Benchmark Study, medical professional liability is the most common coverage line underwritten, at 71 percent. This finding does not come as a surprise because this coverage is typically one of the largest insurance costs for health care providers, and may not be affordable or the coverage not easily available in the commercial marketplace. The study also reveals that captives are assuming a range of exposures, such as employed physicians, auto liability, workers compensation and medical stop-loss and D&O liability.

2013 Aon Health Care Captive Benchmark Study – Lines of Cover Written

Number of times line of coverage written
Health Care Captives – reasons for domicile choice

- Approximately a third of the respondents indicate they chose their domicile based upon the domicile’s experience.
- See below for additional findings from the study:

2013 Aon Health Care Captive Benchmark Study – Reason for Domicile Choice

- Cashflow Operations: 32%
- Legal & Regulatory Infrastructure: 21%
- Geographical Convenience: 17%
- Flexibility & Efficiency of Regulator: 20%
- Capital & Solvency Requirements: 12%
- Favorable Tax Regime: 9%
- Competitive Operating Costs: 9%
- Other – Non US Issues: 11%
Health Care Captive Committees

At Aon, we often say “If you’ve seen one captive, you’ve seen one.” One example of the disparity of health care captive operations is their approach to committees. According to the study, 68% of health care captives have committees. The types of committees are shown below:
Methodology, Notes and Disclaimers

This report is based on data from Aon’s 2013 Global Risk Management Survey, Aon’s 2013 Health Care Captive Benchmark Study, Aon’s Hospital and Physician Professional Liability 2013 Benchmark Analysis, Aon Financial Services Group, Aon GRIP and other proprietary surveys and databases.

2013 Global Risk Management Survey Health Care data shown in this report is based on 63 global company responses. Breakdown of respondent base is as follows:

<table>
<thead>
<tr>
<th>Revenue Range</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; USD 1B</td>
<td>65%</td>
</tr>
<tr>
<td>USD 1B – USD 4.9B</td>
<td>17%</td>
</tr>
<tr>
<td>USD 5B – USD 9.9B</td>
<td>3%</td>
</tr>
<tr>
<td>USD 10B – USD 14.9B</td>
<td>0%</td>
</tr>
<tr>
<td>USD 15B – USD 24.9B</td>
<td>0%</td>
</tr>
<tr>
<td>USD 25B+</td>
<td>0%</td>
</tr>
<tr>
<td>Cannot disclose</td>
<td>14%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Organization</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>8%</td>
</tr>
<tr>
<td>Private</td>
<td>27%</td>
</tr>
<tr>
<td>Government/Government owned corporation</td>
<td>10%</td>
</tr>
<tr>
<td>Not for profit</td>
<td>54%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
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Based in Dublin, Ireland, the Aon Centre for Innovation and Analytics provides Aon colleagues and their clients around the globe fact-based market insights. As the owner of the Aon GRIP, one of the world’s largest repositories of risk and insurance placement information, the Centre analyzes Aon’s global premium flow to identify innovative new products and to provide Aon brokers insights as to which markets and which carriers provide the best value for clients.

Aon Global Risk Insight Platform® (Aon GRIPSM) is the world’s leading global repository of global risk and insurance placement information. By providing fact-based insights into Aon’s global premium flow, Aon GRIP helps identify the best placement option regardless of size, industry, coverage line or geography.

The Web-accessible data produced by Aon GRIP helps Aon brokers evaluate which markets to approach with a placement and which carriers may provide the best value for clients. It also gives Aon brokers a leg up when it comes to negotiations, making sure every conversation is based on the most complete, most current set of facts.
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