Healthcare Insurance Market Update

What the Market Is Telling Us, What It Demands from Your Program, and Where We See It Going

By Symphony Health

The Q1 2026 renewal cycle confirmed something healthcare leadership needs to hear plainly: this market is not just hard. It is structurally different. And the gap between organizations that came through it well and those that did not had less to do with their loss history than with how prepared they were, and who was in their corner.

Capacity has contracted sharply. Excess layer pricing is up significantly across most programs. Sexual abuse and molestation coverage has become the most contested issue in hospital professional liability. And in case after case, the difference between a complete insurance tower and one with coverage gaps came down to preparation and insurer relationships, not program design.

What follows is what we saw this cycle, what the data suggests, and what it means for your program in the year ahead.

Q1 2026 Market Conditions by Coverage Line

Hospital Professional Liability and Excess

This is the most pressured part of most healthcare programs right now. Rate increases in the 10% to 20% range are continuing, driven primarily by severity and social inflation. These are not temporary distortions. They are increasingly embedded in actuarial projections. This cycle: 31 jury verdicts exceeded $15 million. The top five exceeded $60 million. Per-insurer line sizes have contracted materially, meaning more participants are required to build the same tower. Primary attachment points are averaging $18 million to $19 million among lead insurers. Excess layer pricing is up 40% or more on standard layers, and higher on layers with sexual abuse and molestation (SAM) exposure.

SAM coverage is the most contested issue in the market today. Many underwriters are pushing to restrict, narrow, or exclude it entirely. Preserving that coverage requires early negotiation and a submission that demonstrates proactive risk management. Organizations that arrive late with generic submissions are finding it excluded.

The Domestic Versus London Dynamic

Several major domestic insurers exited this market after years of inadequate pricing relative to severity and verdict trends. Some are returning selectively. In the near term, many programs still depend heavily on London participation. Knowing how to work both markets simultaneously, and sequence a tower across them, is no longer a specialty skill. It is a baseline requirement.

Property

A relative bright spot. Pricing came down 10% to 15% overall for many clients, and competition was stronger than in recent cycles. Accounts with concentrated catastrophe exposure still face tighter underwriting, but for most health systems this was one of the better renewal stories of the year.

Workers Compensation

Still competitive. One nuance worth noting for self-funded accounts: the healthcare cost component of workers compensation trend is growing at 6% to 8% annually. That pressure on the medical benefits side should factor into long-term program economics, not just year-over-year renewal discussions.

Directors and Officers and Cyber

Both lines remain more favorable than the liability environment. Capacity is available and pricing has been competitive, particularly for organizations that can demonstrate strong governance and documented cyber controls. If your organization has invested in those structures, make sure that story is part of your submission.

Captives and Alternative Risk Transfer

Captive participation is growing across domiciles as healthcare organizations find more applications for alternative structures. The current professional liability environment makes the economics of a captive approach more compelling than they have been in years for organizations with the scale and appetite to consider it.

CASE STUDY

Building a Complete Tower When the Market Said No

The January renewal cycle produced one case that illustrates what this market looks like in practice, and what it takes to navigate it.

The client: a large, multi-regional health system. Their program had a complex self-insured retention structure that varied by state, meaningful exposure in one of the country's most difficult liability jurisdictions, and a recent footprint change that introduced adverse prior-period development. By the time the renewal window opened, most domestic insurers had declined to participate.

In plain terms: the market had decided this account was too complicated. Our job was to change that conclusion.

We started the engagement well before the renewal window opened. Throughout the year, we coordinated underwriter meetings, provided mid-term updates, and brought the right people from the client's side into underwriter conversations, including defense counsel, General Counsel, and the CFO. When London underwriters are evaluating a difficult account, they want to hear from the people who own the risk, not just the broker summarizing it.

We also built a submission that told a coherent underwriting story. Not a data dump. A narrative that explained what had changed, what was being managed, and why the program structure reflected deliberate decisions.

The result: a complete tower, without gaps, in a market that had largely passed on this account.

London feedback confirmed the outcome held up well relative to peers. The client maintained retention levels significantly below the $25 million to $60 million primary attachment points that comparable systems are carrying. SAM coverage was preserved at a time when exclusions and restrictions are appearing across peer towers, and relative pricing held up better than peers after step-factor impacts were factored in.

Programs that look difficult on paper can still achieve viable terms. Programs that arrive late with incomplete submissions have limited ability to recover, regardless of loss history.

What the Market Now Requires from Your Program

The organizations that came through this renewal cycle well shared a few characteristics, and the gap between them and everyone else is wider than it has been in years.

The first is timing. The renewal window is not a decision window. Programs that engage the market six to nine months ahead of expiration get meaningfully different attention than those that arrive in the final 30 days with open questions. By the time quotes are moving, the important variables are already set.

The second is the submission itself. Underwriters are flooded. An incomplete or generic submission becomes a default decline. What moves the needle is a submission that explains what has changed in the organization, what is controlled and improving, how claims are being managed, and why the program structure reflects deliberate choices rather than inertia.

The third is who shows up. Defense counsel, General Counsel, and the CFO matter. When those stakeholders participate in underwriter conversations throughout the year, not just at renewal, insurers underwrite with more confidence. That confidence shows up in capacity, pricing, and coverage continuity.

Retention tradeoffs need to happen mid-term with finance at the table. The first $15 million to $20 million of many programs functions like a working layer, and that shapes how the rest of the tower views probability of a limits loss. Those conversations should not be happening under renewal pressure.

Finally, tower mechanics. Insurers declining adjacency with certain markets, or refusing to participate in layers that create conflicts between domestic and London placements, are not negotiating positions. They are structural constraints. Navigating them requires knowing insurer preferences in advance and sequencing intentionally. This is where experience in both markets directly affects outcomes.

Looking Ahead: Clinical Risk Management as an Underwriting Differentiator

The market is increasingly distinguishing between health systems that can demonstrate active, data-informed clinical risk management and those that cannot. It is a real underwriting factor.

Claims reflect human behavior and system design. When a health system can demonstrate it understands where claims originate and is actively changing the inputs that drive them, the underwriting conversation changes. Sophisticated underwriters can tell the difference between generic compliance activity and targeted, measurable risk improvement.

Symphony Health is rolling out Grail Blueprint in 2026, clinical training programs built around the specific claim patterns we see across our book of business. The distinction matters: instead of generic annual compliance modules, these programs target the documentation and communication failures that actually generate claims in a given clinical setting. A clinician trained on the failure patterns relevant to their environment is measurably less likely to produce one. Underwriters are beginning to ask whether your organization can demonstrate that level of specificity. We can help you get there.

How Symphony Health Approaches This Market

Most brokers manage the renewal. We manage the year.

The case study in this piece is not an outlier. It is what year-round engagement looks like when the market gets difficult. The account was complicated, most domestic insurers had stepped back, and London was scrutinizing everything. We built a complete tower anyway, because the relationship work and submission discipline had been done continuously, not compressed into 30 days.

In practice that means disciplined submissions, year-round relationship management across domestic and London markets, mid-term strategy conversations with finance at the table, and the ability to sequence a tower when capacity shows up in smaller pieces than you need. It means your underwriters know your account before the renewal window opens, because we have been keeping them current.

That is the difference. Not a capability list. A way of working that shows up in outcomes when the market stops being cooperative. If you want to understand what that looks like for your program, contact us at health@symphonyrisk.com.

Let Us Play For You!

About Symphony Risk and Symphony Health

Symphony Risk is built around industry-focused specialty businesses. We deploy specialists by sector, not by office, so clients work with senior experts from day one. With 14 specialty businesses and a single firm-wide standard, we bring depth without bureaucracy and pull in the right partners when a situation demands it.

Symphony Health is the healthcare specialty business of Symphony Risk, focused exclusively on the risk and insurance needs of healthcare organizations, from providers to payors. Led by Frank McKenna, Symphony Health helps clients navigate professional liability, stop loss, regulatory pressure, and shifting reimbursement environments. The goal is straightforward: reduce uncertainty so leadership can stay focused on patients and performance.