

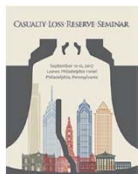
Pennsylvania Medical Professional Liability Alternative Risk Funding

(September 11, 2017)

Moderator: Alice H. Edmondson, ACAS, ASA
Principal, Complete Actuarial Solutions Co.

Panelist: Dianne P. Salter
Executive VP, Corporate Insurance Services

Panelist: Roger C. Fell
Managing Director, Marsh USA



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Key Learning Objectives for Session

We hope to increase your awareness and understanding of . . .

- Professional liability coverage features unique to PA, and their impact on
 - claims management
 - risk retention
 - and loss reserving
- The ever-changing healthcare landscape, and its affect on
 - risk management practices
 - funding programs
 - and loss reserving
- Issues and approaches in the structure of overlying reinsurance



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Ingredients for a Successful Risk Funding Program

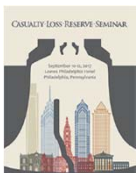
- Strongly supported by top management
- Physician buy-in
- A senior experienced “point person” inside the organization
- Willingness to take the long view
- Lots of communication, both internal and with outside advisors
- Relationship-building with excess/reinsurance markets
- Healthy discussions of actuarial results



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Two Pennsylvania Health Systems Meeting the Challenge

Dianne P. Salter, EVP
Corporate Insurance Services



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Main Line Health

Background:

- Not For Profit Health System
- Community Based System
- Organization Includes:
 - Acute Care Hospitals
 - Rehabilitation Hospital
 - Drug and Alcohol Recovery Center
 - Home Health Services
 - Multi-Physician Network
 - Outpatient Health Centers

Exposure Summary (2016-17):

Revenue: \$1.6 Billion
Total Occupied Beds: 958
Outpatient Visits: 2.30 Million
Physicians/Residents: 673 and growing



Main Line Health

Well ahead.®



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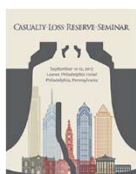
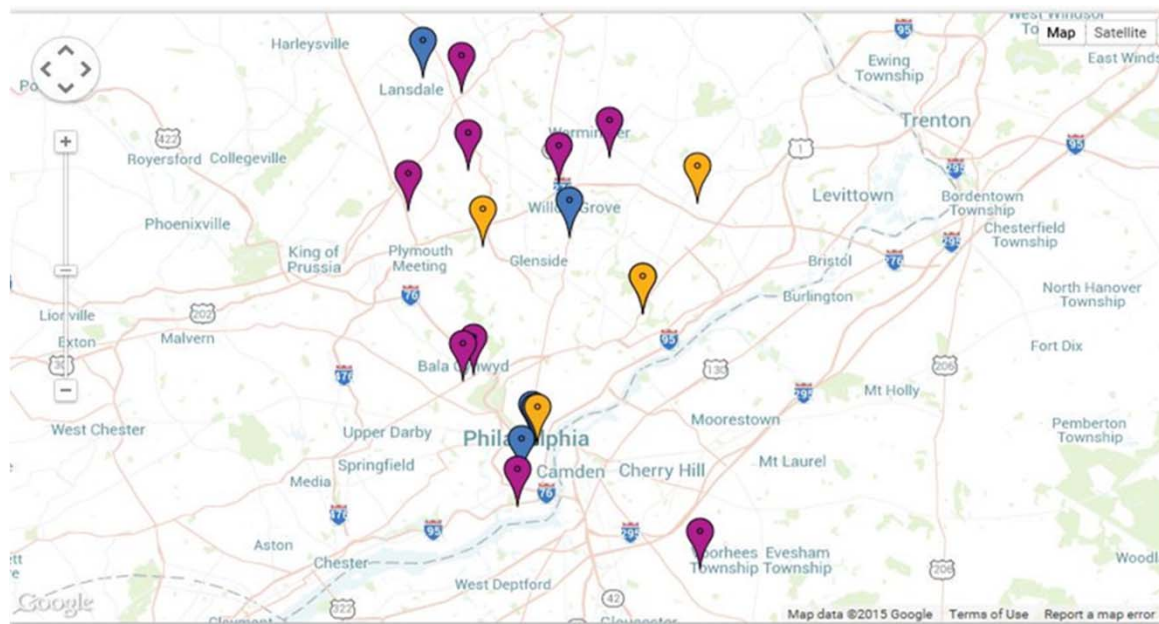
Thomas Jefferson University

Background:

- Not For Profit Health System
- Organization Includes:
 - Academic Medical Center
 - University (Medical School and Undergraduate)
 - Community Based Acute Care Hospitals
 - Urgent Care Centers
 - Multi-Physician Network
 - Multi-State Provider

Exposure Summary:

Revenue: \$5 Billion
Total Occupied Beds: 1,494
Outpatient Visits: 1.8 Million
Physicians and Residents: 1,829



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Focus on the Future:

- Mergers and Acquisitions
- Strategic Alliances/Partnerships
- Delivering Convenient Care Close to Home
- Innovation/Technology
- Capital Improvements
- Building Physician Networks



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Why Alternative Risk Funding (Initially):

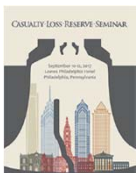
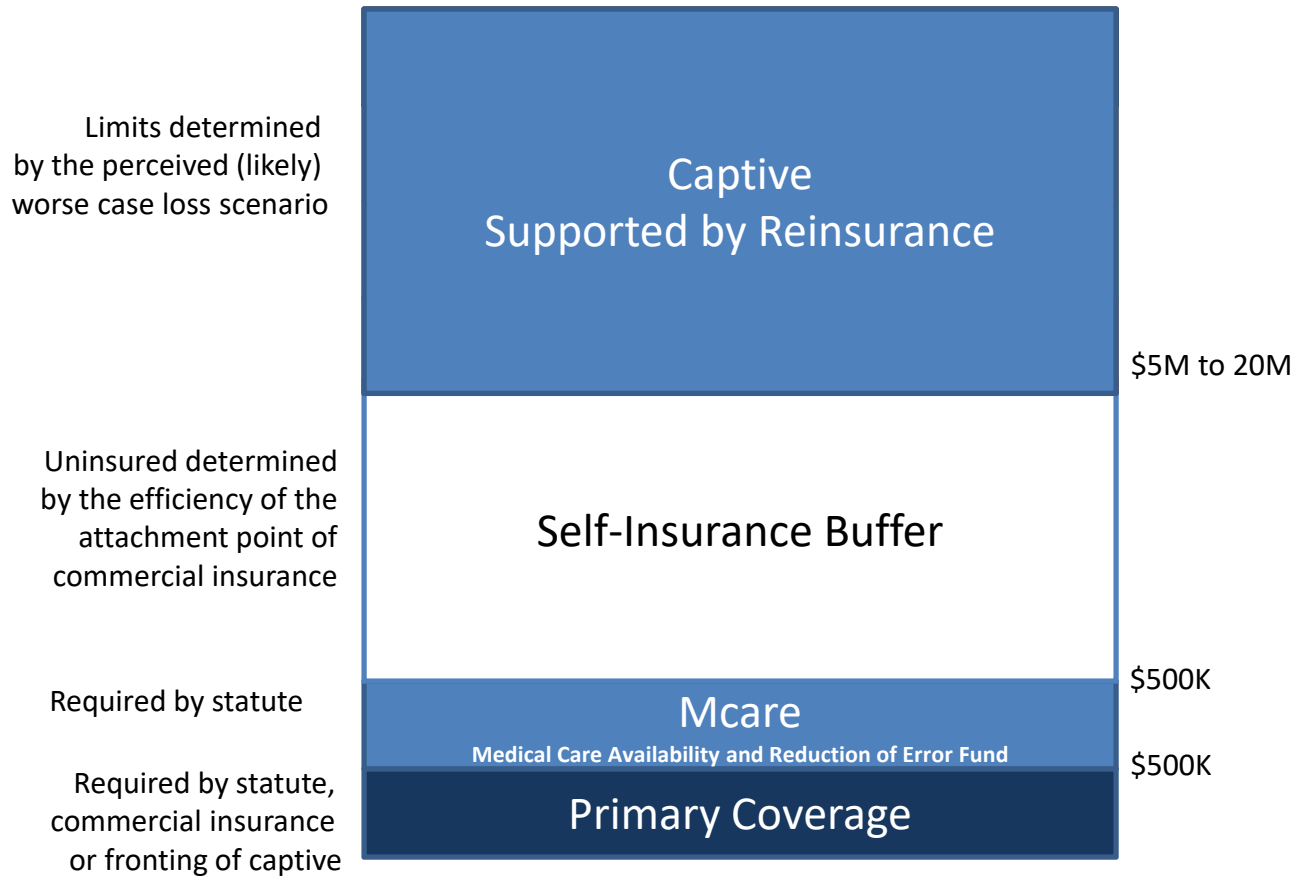
- Unavailability of medical malpractice insurance for hospitals and physicians in Pennsylvania
- Commitment to risk management and claims/litigation management
- Long term commitment of senior leadership to captive risk financing vehicle
- Need to meet PA statutory requirements for “approved” carrier
- Acknowledgement of need for “appropriate” actuarially driven funding/premium



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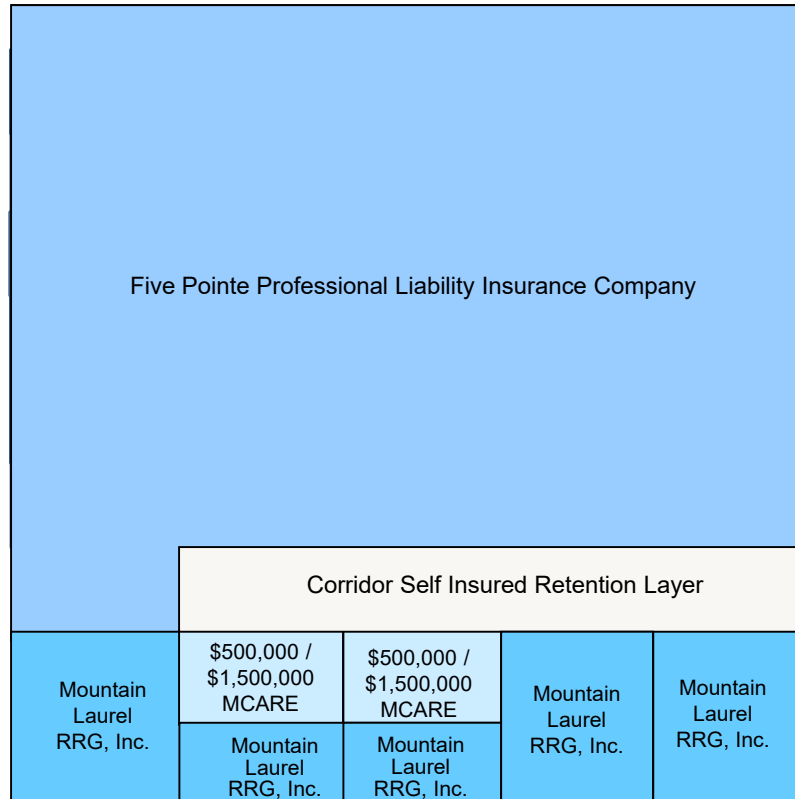
Typical Structure:

Large Pennsylvania Academic Medical Center



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Our Professional Liability Insurance Structure



\$1M / \$3M Miscellaneous Prof. Liability	\$500K / \$2.5M per Hospital Professional Liability	\$500K / \$1.5M per PA Employed Physician / Resident Professional Liability	\$1M / \$3M per Employed Physician/ Resident / Dentist Professional Liability Non-PA	\$1M / \$3M Non-Health Care Provider Prof. Liability
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Program Structure

- \$95M total limits for Professional Liability (PL) (A separate \$95M applies for other liability lines.)
- Primary PL coverage written by VT-based MLRRG, the 5th largest malpractice insurer in PA and 3rd largest RRG, based on premium.
- Five Pointe, a DE-based segregated cell captive, reinsures primary PL and directly writes Excess PL and Umbrella (excess and umbrella fully reinsured commercially).
- MCare layer is statutorily required coverage for health care providers in PA.
- PL coverage is claims made and features NO risk sharing between members.
- PL Corridor layer above Primary and MCare and below Excess PL attachment is self-insured.

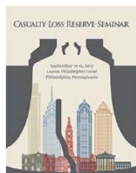
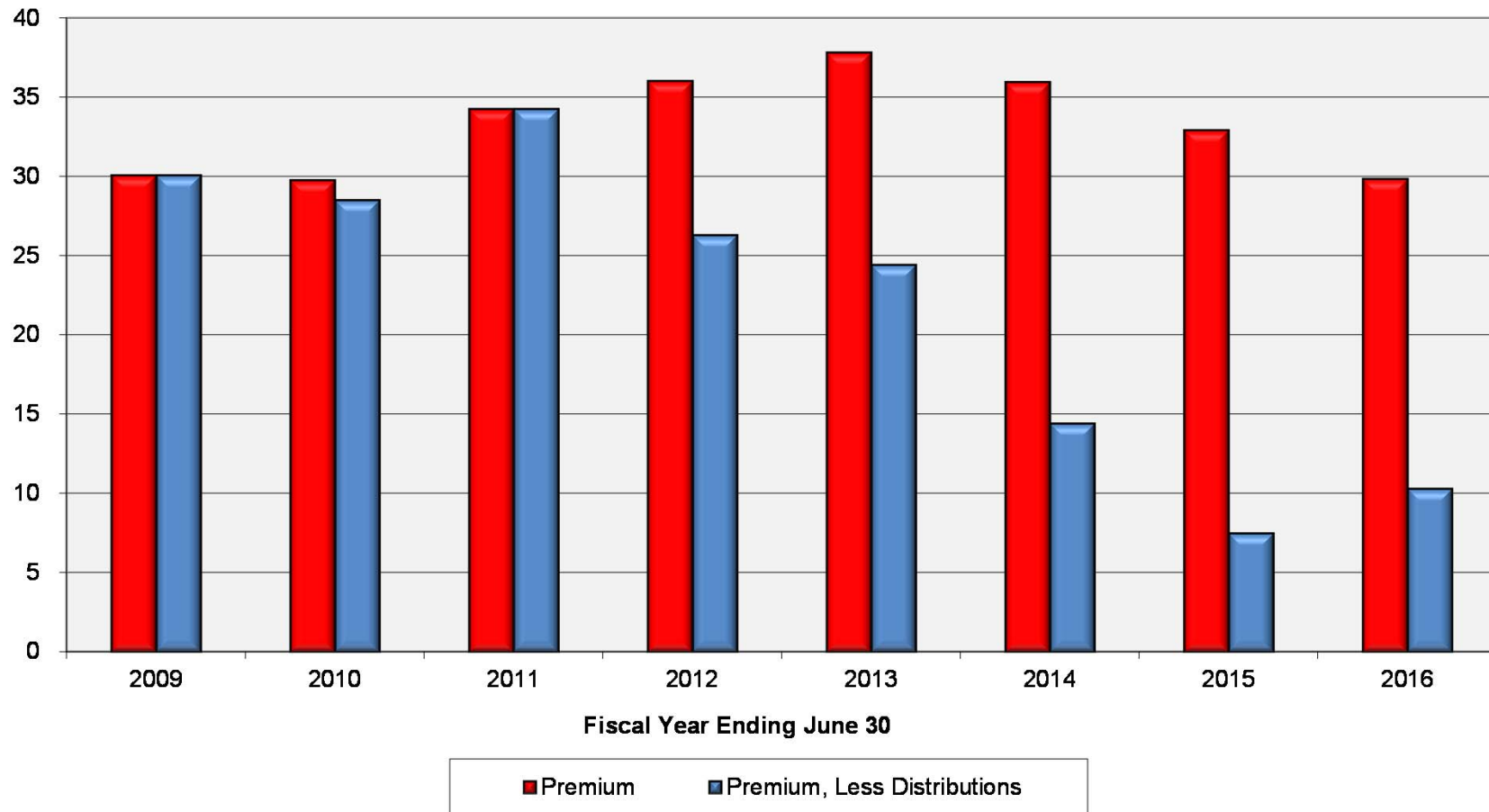


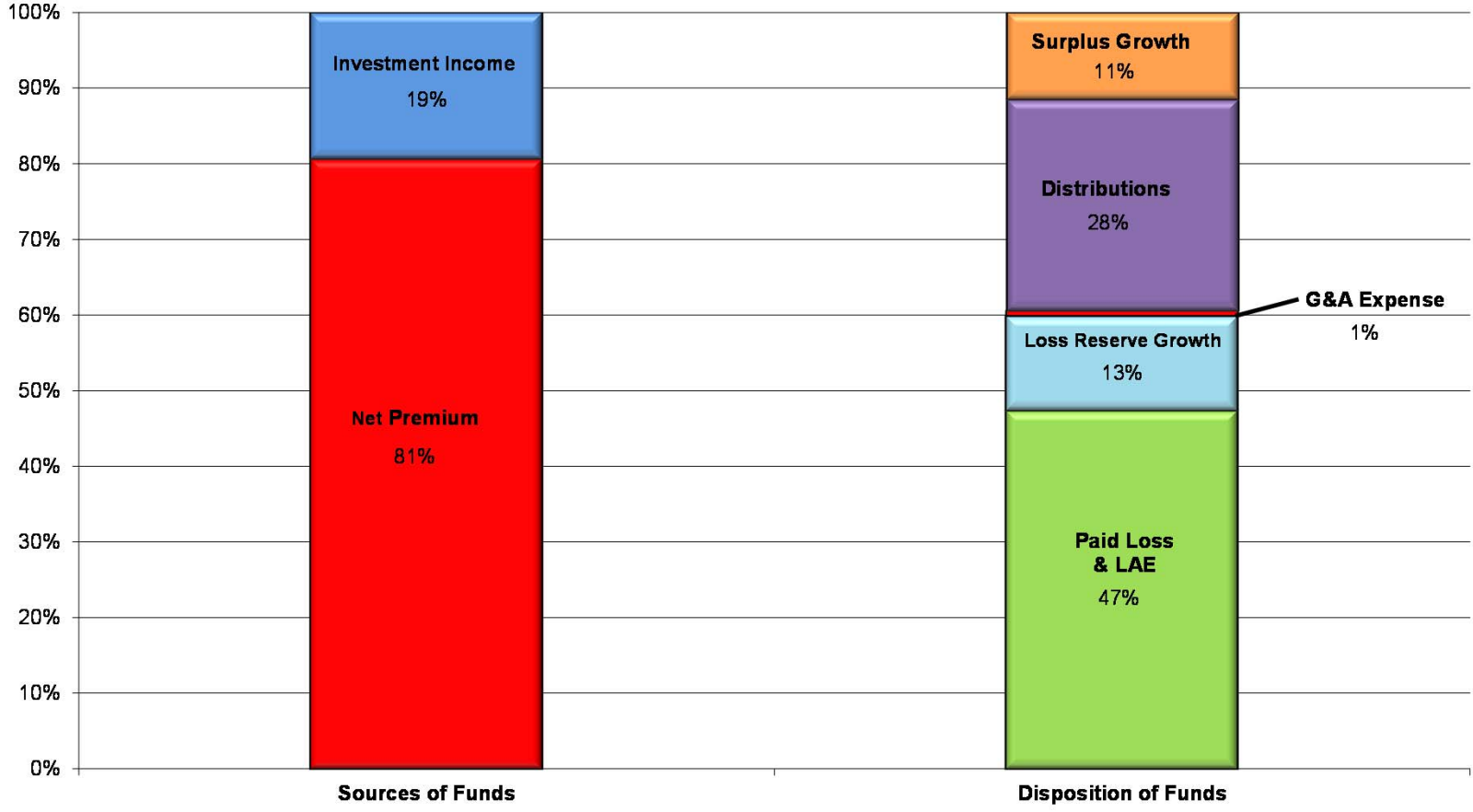
Exhibit 1. Premium History (\$ millions)



Notes:

1. All captive and general overhead expenses are included in these premium figures. Excludes corridor layer accruals.
2. Rise in premiums from FY 2010 to 2013 primarily reflects growth in physician group.
3. Reduction in premiums in recent years reflects positive impact of full claims integration between hospital and physician group.

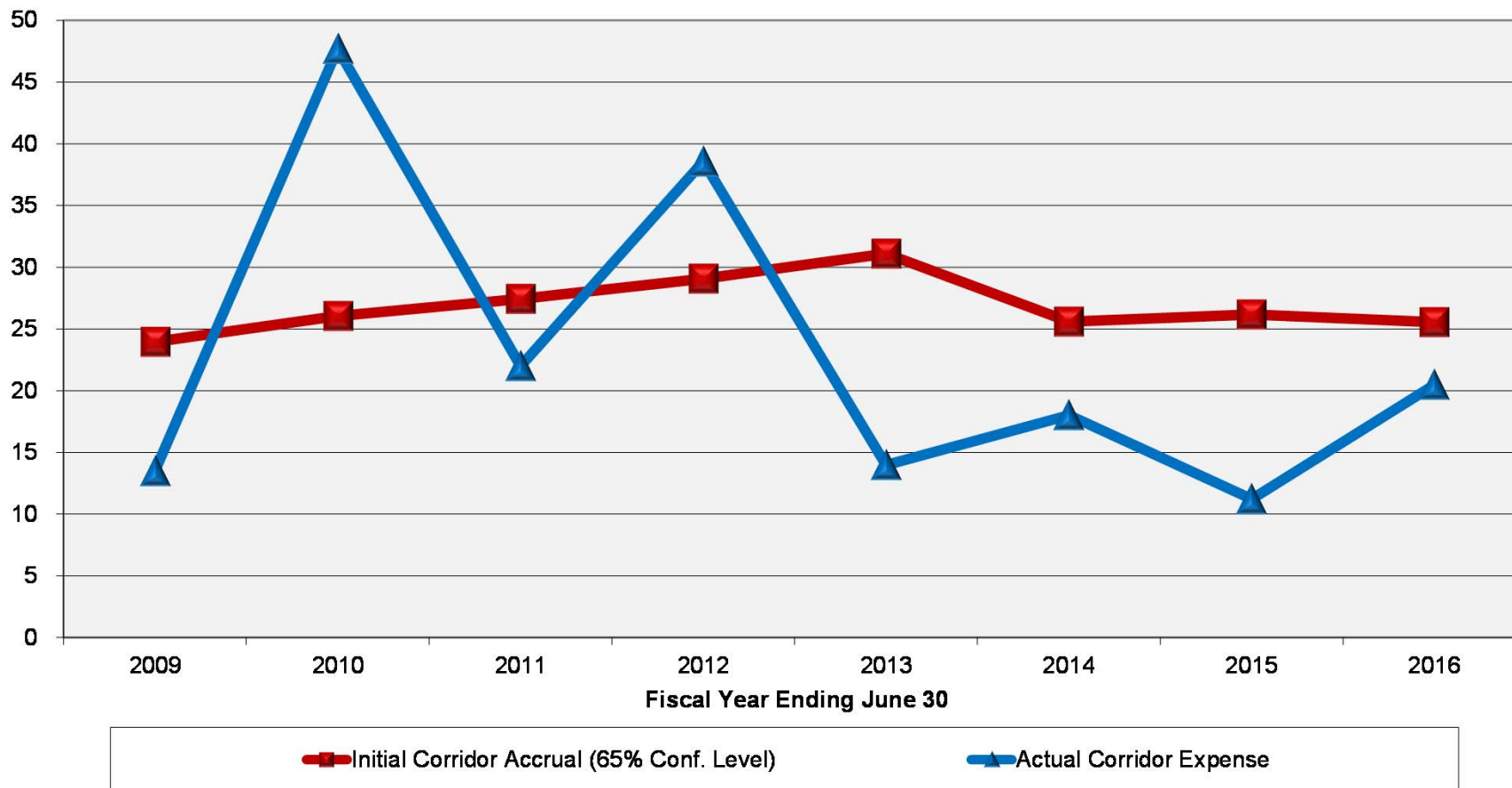
Exhibit 2: 10-Year Cumulative Activity



Notes:

- 1. Investment returns, measured at 6/30/16, averaged 6.3% over 10 years and 5.7% over 5 years.
- 2. Total program expense (incl. overhead) is about 4% of total program costs.
- 3. Distributions plus undistributed surplus represent nearly 50% of initially funded premiums.
 Investment Income gains (earnings greater than the assumed 3.0% rate) contributed about 12%. Release of the 65% confidence level margin as claims were resolved contributed 3% and better-than-expected claims experience contributed 35%.

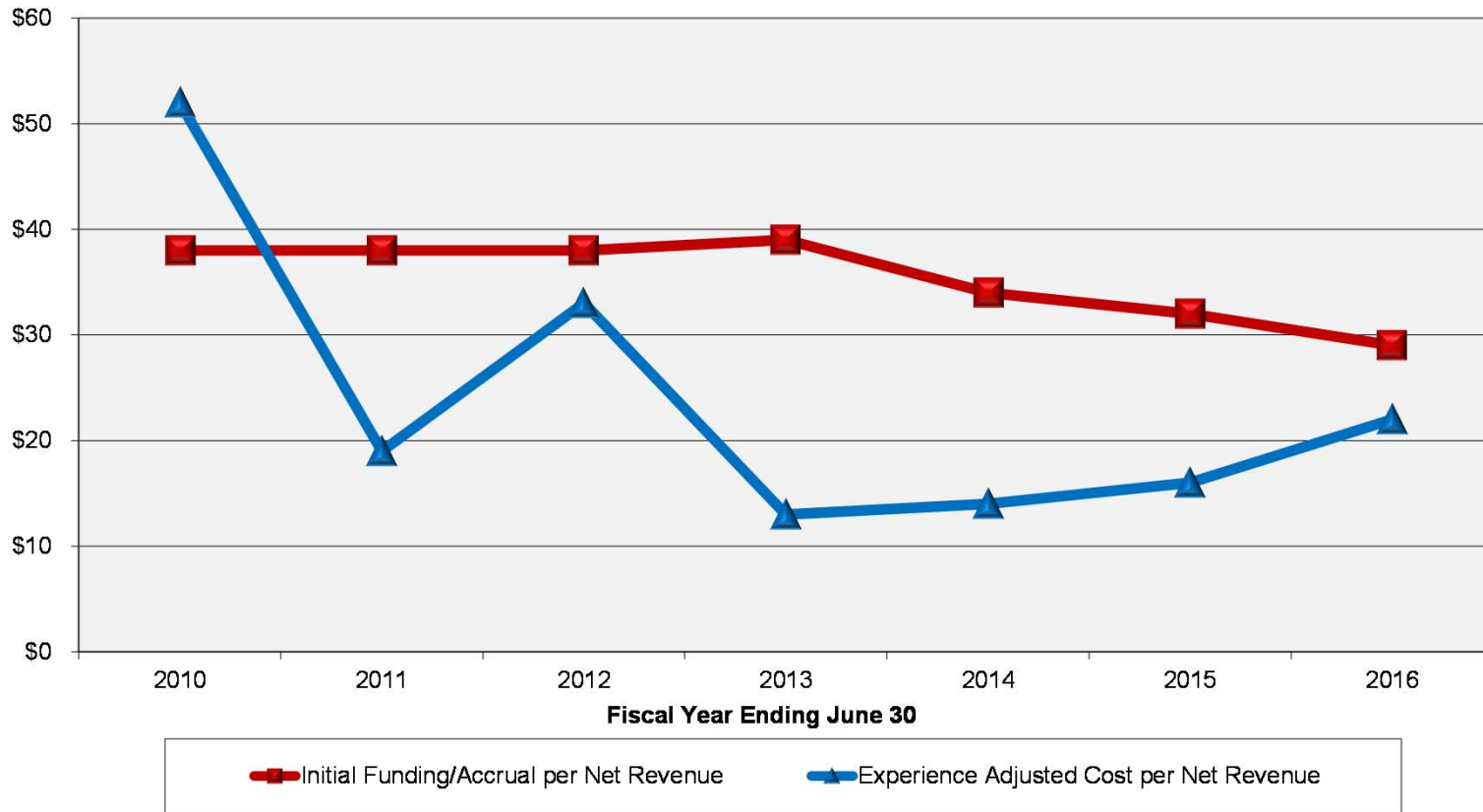
**Exhibit 3: Corridor Layer Cost:
Initial Accruals vs. Actual Expense (\$ millions)**



Notes:

1. Accrual/expense figures reflect only PL loss above primary + Mcare limits and below excess insurance attachment.
2. Rise in accruals from FY 2009 to 2013 reflects both growth in physician group and unfavorable loss development.
3. Recent years' reductions reflect positive impact of full claims integration between hospital and physician group.

Exhibit 4: Total Program Costs, per \$1,000 of Net Revenue



Notes:

1. Accrual/expense values reflect all PL and GL program costs except Mcare Fund assessments and IBNR accruals, divided by Net Inpatient and Outpatient Revenue figures (\$000s).
2. Experience-adjusted costs reflect initial costs adjusted to reflect distributions, growth in undistributed surplus, and year-end adjustments to Corridor liabilities.
3. Cost rise in FY15 and FY16 reflects lower investment earnings and (in FY16) unfavorable Corridor layer loss development.
4. Total program administrative expenses (incl. premium taxes) have averaged about 4% of total program costs.
5. Excess reinsurance costs have averaged 3.6% of total costs and did not increase materially with the addition of physician group.

Strategic Advantages of a Risk Funding Vehicle

- Creating value/evaluating performance
- Adherence to risk management/claims management standards/policies and procedures
- Continued emphasis on quality improvement/ patient safety/risk management
- Strategic direction/insight and coordination with claims management and risk management
- Key leadership providing ongoing input and oversight
- Long term view of the program
- Coverage extensions/flexibility



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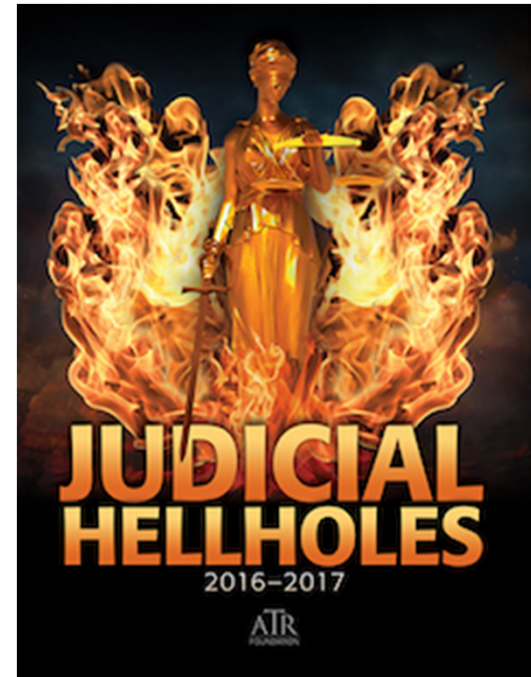
Environmental Challenges:



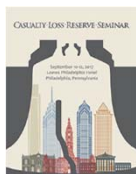
City of
Philadelphia

The City of Unbrotherly Torts

"It's a nice place, but you wouldn't want to be sued there." WALL STREET JOURNAL



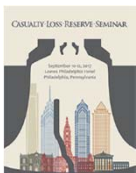
...to be a plaintiff attorney in
Philadelphia County



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Risk Management Challenges:

- Consolidation (Mergers and Acquisitions)
 - Need to address how best to address the increased risks associated with growth
 - Diversity of current programs in terms of reserving, funding, claims management, retentions, limits
 - Reputational risks
- Outpatient Facilities:
 - How to maintain consistent patient safety and quality care in the outpatient or office practice setting
- Technology
 - Learning new processes and applying them consistently
 - Electronic medical records
 - Telehealth consultations
 - Social Media
 - Privacy and data breaches
- Physician/Non-Physician Providers:
 - Growth in employment of physicians
 - Ostensible Agency
 - NPs, PAs, Midwives, OTs delivery of care



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A Broker's Perspective

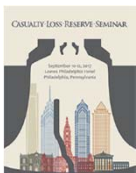
Roger Fell, Managing Director
Marsh USA, Philadelphia



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Broker's Role:

- Traditional Role:
 - Transact insurance placement on behalf of the client
- Today's Evolving Role – Three Fundamentals:
 1. Know the industry...
 - Where is it now
 - Where is it going
 - Leverage information across other healthcare organizations and other industries
 2. Know your client...
 - Strategic plan
 - Risk tolerance
 - Risk Management
 - Claims Management



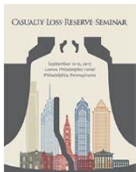
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Broker's Role:

- Today's Evolving Role – Three Fundamentals
(continued):

3. Know the insurance market...

- Where is it now
- Where is it going
- Leverage information across the world



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Broker's Role:

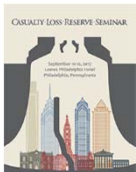
- Today's Evolving Role (*continued*):
 - RIMS Systems
 - Risk ID (ERM) Risk Measurement
 - Data analytics
 - Policy form development
 - Claims analysis
 - Claims advocacy
 - ID Evolving loss trends



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Broker's Role:

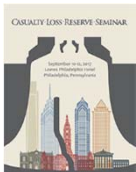
- Today's Evolving Role (*continued*):
 - Captive Management
 - Single Parent
 - Segregated Cell
 - Risk Retention Group (RRG)
 - Monitor global marketplace
 - Monitor carrier strength
 - Insurance placement
 - Traditional
 - Reinsurance placement
 - Alternative Capital



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Broker's Role:

- Today's Evolving Role (*continued*):
 - Program Design
 - Excess Attach
 - Inner Aggregates
 - Batch Clause



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Actuarial Challenges

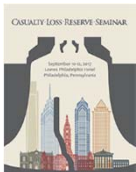
- Consolidation
 - Data recording differences (e.g. what is a claim?)
 - Exposure valuation (physicians, residents, visits, etc)
 - Differences in case reserving philosophy/approach
 - Differences in funding and reserving policies
- Measuring exposure in the ever-changing healthcare world
 - Telehealth, genetics engineering, clinical trials, and other activities with no track record
 - Whether, when and how to move to patient-based exposure measures (e.g. age, gender, other characteristics)
- Communication and presentation
 - Striking right balance between brevity and substance
 - Striking right balance between reinforcement of concepts and keeping material fresh
 - How did we end up here? (reconciliation is essential)
 - Clarity and completeness for auditors and other outside users



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Some Opportunities to Add Value

- Liability and Cash-flow Forecasting, to support
 - Investment policy review
 - Development of distribution strategies or policies
 - ERM analysis
- Retention Limit Evaluation
 - Ongoing, as part of overall ERM analysis, or in mergers/consolidations
 - System-wide attachment limits, plus “internal” limits for individual entities
 - Large loss risk pooling within system to protect smaller entities
- Chargeback of Professional Liability Costs, within a healthcare system
 - Stability vs. responsiveness to claims experience
 - Ensuring competitiveness of physician rates
 - Allows for “quick and dirty” assessment of new venture costs



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Questions?



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