Willis Towers Watson

Health Trek

January 2019

An acquisition property and casualty risk and insurance case study

A large urban teaching hospital system (UTS) was given the opportunity to participate in an RFP to acquire a community hospital system (CH) in their geographic territory. The combination would expand UTS's footprint in the market and greatly expand its primary care capacity. It would be a marriage of un-equals. UTS is well endowed and doing well financially. CH was struggling. Both were non-profit so the acquisition would take the form of a member substitution, with UTS accepting all assets and liabilities. Thorough due diligence would be crucial for determining the risks and opportunities the acquisition presented. Did CH's financial troubles mean that corners had been cut on risk management, patient safety and quality programs? Were there liabilities that hadn't been fully identified and quantified? The success of the combination would be determined by dozens of factors – patient, staff and physician perceptions, compensation and benefit structures, the coming together of cultures, town versus gown issues, the financial underpinnings, etc. This case study will focus on property and casualty risk and insurance issues, but also touch on a few other items along the way.

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Thorough due diligence is crucial for determining the risks and opportunities acquisitions present

The community system would represent an increase in occupied bed equivalent exposures of about 20%. This increase in exposure was perceived as considerable enough that UTS's insurers wanted/needed comprehensive underwriting information for CH to consider program options and combinations. A first step in the due diligence process was to collect a complete insurance summary for CH and to fully understand their various insurance program structures and service providers. CH carried a comprehensive portfolio of insurance with all the typical policies we'd expect to see, and none of the more esoteric covers that few health care systems purchase – wage and hour insurance, regulatory penalties insurance for fraud and abuse, reputational risks coverage, etc. Carriers were high quality, long-term players in their respective lines of coverage, and terms were broad. UTS evaluated the protection CH purchased and the risks presented by uncovered exposures, and felt comfortable moving forward with the acquisition.

Interestingly, many of the insurers were the same for UTS and CH. For example, the carrier for independent medical staff was the same for both parties, as was the network privacy and security carrier.

Deductibles and limits of coverage varied by line of insurance, but for the most part, programs were similar. UTS did carry coverage for some international exposures that CH didn't have. CH placed coverage for some joint ventures and ancillary operations that were not mirrored in UTS programs. No problematic uncovered risks were immediately identified.

Most of the insurance purchased by CH was provided on an occurrence basis. This means that covered claims arising from acts during the time the policy is in force are covered, regardless of when claims might be made. Since these occurrence policies' historical deductibles and limits were judged to be appropriate, additional limits and/or deductible buy-downs were considered, but no retroactive protection was pursued. Retroactive coverage is rare and often costly, but can help address a historical program that is found to have insufficient limits for today's claim environment. UTS would live with the small possibility that claims that occurred before the date of closing wouldn't be adequately covered by these existing occurrence policies.

UTS might have wanted to more fully evaluate CH's risk management, loss control and patient safety programs prior to combining programs and assuming potential risk. Maintaining separate programs could have afforded the opportunity to both evaluate and integrate best practices prior to assuming any historicall CH claims. It might have also provided additional time to prepare for administrative issues, such as premium allocation issues, new claim reporting requirements, certificate issuance, etc.

CH historically maintained some lower deductibles/retentions. For example, their property program featured an all perils deductible of $50,000, while UTS maintains a $500,000 deductible. A case could have been made for maintaining the lower deductible, at least temporarily.

However, it was decided to combine all occurrence policies into UTS's programs at closing. Savings as compared to stand-alone programs were meaningful.

So long as deductibles, limits and terms are appropriate, occurrence policies can often be combined at closing

The CH general liability (GL) program was written on an occurrence form while its medical professional (MP) program was on a claims-made basis. UTS has both their MP and GL coverage on a claims-made basis. The situation would have been more challenging if CH had claims-made GL cover and UTS had occurrence protection and the programs needed to combine. Directors and officers (D&O), fiduciary, network privacy and security and environmental coverages were also provided by claims-made policies. CH's medical professional and other claims-made coverages deserved special attention.

Claims-made policies provide protection for claims that occurred after a specific date (either the inception date of the policy or a so-called retroactive date) and are reported during the time the policy is in force. Since some incidents that occur may take time to be discovered and reported, claims-made coverage creates a risk that claims that occurred aren't reported until after the policy expires – the tail risk. There are three options for dealing with this risk:

- Keep on-going coverage in force with a retroactive date of the earliest time a policy was purchased – possible in this case if UTS was willing to keep CH's pre-acquisition programs in place, but usually not practical. This stand alone solution simply wouldn't be as economical as combined programs long term.

- Include coverage for incurred but not reported (IBNR) claims within another program – in this case UTS's continuing programs. This is accomplished by adding the CH exposure to the UTS program with the original CH retroactive date. This is referred to as prior acts or nose coverage. This combined program solution is usually the most economical, but would require UTS to take the risk of claims arising from acts of CH prior to the closing date. This could create costs within UTS's substantial deductibles/retentions and would definitely impact UTS's costs for insurance above deductibles.
- Purchase extended reporting protection from CH's carriers. This coverage is also known as run off or tail coverage and comes with sizeable insurance premiums (in the case of MP coverage, 200% of expiring annual premium is not uncommon). If no IBNR claims develop, the cost of extended reporting will appear to have been high. If IBNR claims do develop, the tail could more than pay for itself. So the questions are: Will we have claims arise from prior acts? How certain are we? Should we buy protection or take the risk? Also consider that deductibles still apply and total limits of extended reporting coverage can be exhausted by claim payments, so the protection afforded by run off coverage is not complete.

Run off or tail coverage needs to be considered for claims-made policies

On a policy-by-policy basis, each claims-made coverage needed to be evaluated to determine the cost/benefit of purchasing extended reporting protection, versus the best estimate of future payments for IBNR claims if policies are rolled into UTS programs.

So, the next due diligence step was to collect loss information for all exposures – insured and uninsured. This meant requesting loss runs from all of CH's insurers. CH was substantially self-insured for MP and GL programs as well as for workers compensation. Loss runs created by third-party administrators were collected for these risks. Since there is the potential for IBNR claims, losses needed to be subjected to analytical evaluation. The amounts shown as reserves for reported open claims needed to be tested and potentially challenged as claims often develop over time. That is, they can grow as more information is discovered, as inflation continues and so forth, so claim information is trended and developed to forecast future ultimate value.

Audit individual claim files and the claim administration process

An audit of medical professional claim files was conducted. An aggressive incident reporting process can identify potential claims early on, can set appropriate settlement value and move an event toward resolution earlier than a less robust approach. The audit would confirm whether such a program was in place at CH. While CH was pro-active in identifying potential claims, they did not place reserves on these incidents, potentially understating their liability. Their claim reserving practice was also less sophisticated than UTS's. Some of CH's MP claims were evaluated to need several million dollars in reserve strengthening. This analysis led to revaluing the financial commitment UTS made toward the acquisition. A similar file review could have been conducted for workers compensation claims if the portfolio was significant.

We provided updated loss information to CH's claims-made program carriers, asking them to price extended reporting coverage for each line. We asked for multiple options – unlimited tail, as well as tails with specific durations, e.g. three, five or seven years. We received underwriters' proposals for the MP, directors and officers (D&O), fiduciary, network privacy and security, and environmental programs.

We provided complete underwriting information to UTS's carriers and asked for pricing, including the CH exposures. We know that closing dates on transactions can move, so we asked for pricing for each month until UTS's programs renewed, as well as projected costs at the annual renewal date.

Compare underwriters' extended reporting options with claim projections

Having claim information and analysis in hand, we evaluated the cost of underwriters' extended reporting options with those anticipated for combined programs.

UTS's D&O insurer would not provide nose coverage for CH's prior acts. Our options for those risks were:

- Combine programs, accepting the potential for future claims with no insurance to mitigate their impact
- Buy run-off coverage from CH's carrier

Since UTS itself could conceivably have a D&O claim against CH for wrongful actions prior to closing (as well as the potential for claims from third parties), the run-off proposal was accepted.

Individual physicians may require special handling

UTS also purchased the tail solution for certain independent medical staff. Those with an exceptionally long tail risk, like obstetricians and pediatricians were singled out. And a few physicians near retirement were allowed to continue their independent policies, because they featured provisions for cash accumulation and pre-paid tail coverage. After considering the premiums involved, and the evaluation of potential losses within self-insured retentions, UTS decided on combined program solutions for all other coverages.

There was a difference of opinion among UTS stakeholders surrounding these decisions. While actuarial analysis guesstimated that the combined solution was most cost effective (due in large part to hefty tail premiums), the risk presented by the potential quantity and severity of CH's prior acts was daunting for some. This concern was mitigated by working with CH's risk and claim management personnel to aggressively identify and report incidents under all claims-made coverages. CH's community physicians were reminded several times prior to closing of the need to report adverse outcomes and other potentially compensable events. This pro-active approach minimized the potential for IBNR claims falling into the combined programs post-closing.

There are IT system and other issues to consider

Bringing programs together consists of more than evaluating the costs of stand-alone and combined programs. Integrating programs also means blending loss information and loss information systems and re-evaluating defense counsel and other service providers. Helping carriers become comfortable with new exposures and personnel can be time-consuming but will pay dividends long-term.

A few months post-closing the combination seems to be going well. There are discussions with state authorities about combining self-insured workers compensation programs that had previously used separate TPAs and discreet collateral. There has been some turnover in staff as departments and services come together. But the careful due diligence that was conducted paved the way for (almost) painless integration. In fact, the approach taken by UTS insurance and risk staff in many ways led the way to shared best practices and improved processes, integrating several key groups from both legacy systems into the combined organization.

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A solid approach to managing risk and fully evaluating insurance approaches early in the acquisition due diligence process can allow stakeholders to sleep at night and may even serve as a model for overall organizational integration.

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WTW-NA-2018-WTW13832

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