Insurance Considerations for Private Equity Healthcare Investors

SYMPHONY RISK

Since 2015, private equity firms have made considerable investments in healthcare services and physician practice management. The macro thesis is compelling – a fragmented industry landscape (aging boomers looking for a liquidity event; freshly minted doctors opting out of private practice), increasing margins and throughput in certain specialties, e.g., ophthalmology and dermatology, and a sea change in regulatory support and societal demand for private behavioral health treatments. Despite increased competition among financial sponsors for these deals, we suspect that this care delivery model is likely to remain relevant for the foreseeable future.

As most PE investors and their advisors working in the space have learned, state laws that prohibit the corporate practice of medicine have resulted in the creation of strawman organizational structures necessary to ensure regulatory compliance. Additionally, these structures can allow physicians to maintain some degree of ownership and autonomy, while facilitating incentive structures that align the clinician's goals with that of the sponsor.

To the uninitiated, the Professional Corporation / Management Services Organization[1], structure can be daunting, and the implications for insurance are unclear, at best. Symphony Risk has been working with physician practice management organizations for over thirty years and has developed best practices to administer insurance and employee benefits programs for even the most complex organizational structures. There are numerous landmines to be avoided and nuances that must be addressed in order to craft programs that will perform in the event of a claim, are adapted to the PC/MSO/DSO paradigm, and are structured to provide maximum economic benefit for portfolio company and sponsor alike.

Symphony Risk will evaluate the challenges that must be addressed in every PC/MSO structure. In these transactions it is critical that the insurance advisor understand both the transaction agreements and management services agreements.

Jurisdiction, ownership, and contractual relationship are three key components for consideration in insurance, risk management, and employee benefits for healthcare organizations. We will outline how each of these impact various coverage lines for both the MSO and the financial sponsor.

1. In dentistry, MSO is often replaced by Dental Services Organization ("DSO").

Workers' Compensation

In all states but Texas, purchase of Workers' Compensation is dictated by statute. Four states operate monopolistic state funds, and in all other states, Workers' Compensation insurance is a requirement for virtually all employees and partners in an organization. The *combinability* of insurance across legal entities is determined by either the National Council of Compensation Insurers, in 15 states, the state's Workers' Compensation board. Regardless of the jurisdiction, virtually all regulators utilize the same test for combinability, which is that two entities/employers must share 51% or greater ownership to be combined under the same insurance policy. This means the Workers' Compensation program must mirror the legal ownership structure of the organization.

Frequently, it is noted that the non-clinical employees are paid through the MSO, while clinical employees will be employed by the friendly PC or the ASC (which may be corporately owned). When friendly PCs exist in multiple states, absent a common, 51% or greater majority owner, each PC must have a separate policy. As new practices are acquired (typically via an asset purchase and utilizing a Management Services Agreement between the MSO and PC), the PC entity, which *may* have a new EIN, must maintain separate Workers' Compensation insurance.

We recommend that each friendly PC is insured with the same insurer as the MSO and other PCs and a common renewal date is obtained. Providing a copy of the MSA to the consolidated insurer is also a best practice. This ensures full understanding of the relationship and simplified administration of the program. Finally, this strategy will maximize the opportunity to leverage the scale of the total organization with insurers. This premium aggregation can also be beneficial in encouraging the insurer to pay claims and as leverage to negotiate reduced rates across other lines of coverage.

The Workers' Compensation program must mirror the legal ownership structure of the organization.

To insure property, the insured must either own the property or have a contractual obligation to insure the property.

Property, General Liability and Real Estate

Provider groups often own, via a separate legal entity ("real estate HoldCo"), the real estate assets in which they operate. In these cases, it is common to see the real estate HoldCo insured under the same policies (both property and premises liability) that covers the clinical practice. The real estate assets are often *excluded* from the transaction, while the practice's assets are *included*. When reviewing this combined insurance structure during due diligence, it is paramount to understand how the insurable interest is achieved, (e.g., through ownership or contractual obligation), as either scenario will lead down predictable paths.

There are two primary considerations in unwinding the pre-close insurance and restructuring the post-close program appropriately.

PROPERTY: To insure property – whether that is FF&E, property improvements, or the buildings themselves – the insured must either *own* the property or have a *contractual obligation* to insure the property.

With respect to acquired assets, this is usually straight forward – the clinical assets can be insured under the MSO's property insurance policy.

With respect to real property (i.e., the actual buildings), it is important to consider (a) which entity will own the property post-close, and/or (b) the terms of the lease agreement (e.g., the physician-controlled real estate HoldCo might maintain ownership of the building but, under the new lease terms, the MSO might be required to insure damage to the building from accidental perils, such as fire or windstorm). While the building can be insured under the MSO policy if required by the lease, we recommend consideration is given to modifying the lease (which is often re-written in concert with the transaction) to mandate that the *lessor* insures the building under its policies. This ensures that, in the event of a loss, the MSO is not in the middle of a claim between the lessor and the insurer.

LIABILITY: If the real estate is owned by *any* other entity other than the MSO (e.g., physician-controlled real estate HoldCo), that entity should be required to maintain a separate General Liability insurance policy, which provides protection known as *Lessor's Risk*. This policy covers the landlord's liability exposure for slips, trips and falls of patients, visitors, or vendors visiting the insured premises. In some instances, it can also insure the landlord for the negligence of a 3rd party vendor that causes injury to a patient, (e.g., a snow removal service that creates an ice hazard in a parking lot).

Another example: A clerical employee of the MSO sustains a workplace injury on the premises of the clinic. While the employee injury might be initially covered by the MSO's Workers' Compensation policy, the MSO may want to assert its right to subrogate against the landlord, if the landlord was negligent. Or, the family of the injured worker may want to bring a claim against the landlord.

Some MSOs have provided *Additional Insured* coverage for the lessor as a substitute for the lessor maintaining its own insurance. This is a mistake for several reasons: (1) The comingling of insurance diminishes the clear separation of fiduciary interest and liability, which is a critical to maintaining the established autonomy and independence of the MSO and PC; and (2) "Additional Insured" status does not provide the full breadth of protection the lessor would have under a discrete General Liability policy, leaving the lessor unprotected in the event of a claim.

Medical Liability

The challenges related to Medical Liability (a/k/a Professional Liability or Medical Malpractice) usually stem from (a) matching coverage periods to contractual dictates – this is a result of the "claims-made" coverage trigger that is often used in Medical Liability policies, (b) covering the MSO for claims arising from professional services performed by clinicians (vicarious liability), and (c) direct liability of the MSO for errors or omissions in the professional services it provides the PC that result in injury to patients.

A refresher on "claims-made" vs: "occurrence" coverage trigger:

An **OCCURRENCE** trigger provides coverage for incidents that occurred during the policy year, regardless of when a claim is reported to the insurer. Occurrence triggers are usually considered to be favorable to the insured because (1) once the policy has been paid in full, the coverage remains in-force in perpetuity until the limit is exhausted, negating the need for "tail" coverage, (2) the limit of insurance is refreshed at each renewal, which reduces the possibility that the limit could be exhausted by multiple claims in a single year. These advantages come with increased financial exposure to the insurer and, as a result, insurers will charge an increased premium for an occurrence trigger policy relative to a claims-made policy.

CLAIMS-MADE insurance provides coverage if *two* conditions are met:

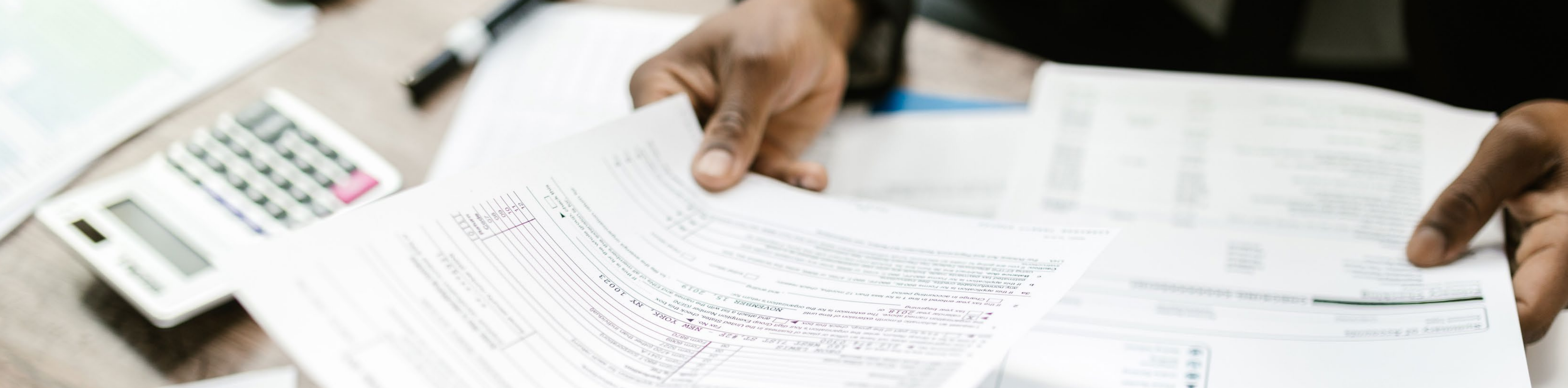
(a) The incident giving rise to the claim must have occurred after the policy's retroactive date. The retro date is often the date coverage is first purchased and is a unique facet of claims-made policies; and

(b) The claim must first be made against the insured during the policy's effective period.

Claims-made policies offer an advantage to the insurer by providing (a) a finite period in which claims can be made, (b) limits their potential exposure, and (c) allowing them to reprice historical risk to account for inflationary trends and/or an unfavorable legal climate.

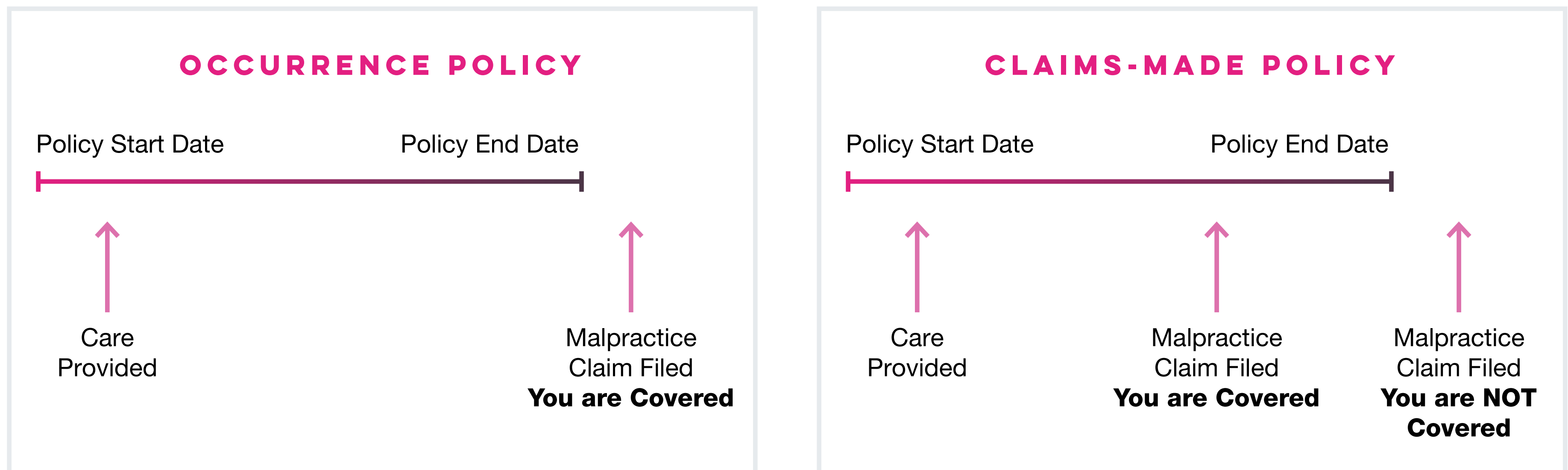
Claims-made coverage is often less expensive and the ability to precisely define the period for which coverage applies can be helpful when structuring policies to mirror the treatment of liabilities under purchase agreements, management service agreements, and employment contracts.

If a claim is made after the policy expiration date, the claim is not covered.



When an insured moves from a claims-made to an occurrence trigger, changes the policy retro date, or retires from practice, “tail” insurance must be purchased to insure claims that are made after the expiration of the claims-made policy.

Tail insurance may be purchased from the incumbent insurer, which is referred to as an Extended Reporting Period Endorsement. Alternatively, a standalone tail policy from a different insurer may be a better fit, for example, utilizing the PC/MSO’s insurer to provide tail policies to acquired practices.



PC/MSO MASTER PROFESSIONAL LIABILITY: CLAIMS-MADE

Target: Claims-made

A common structure contemplates medical liability coverage consolidated with the MSO and PCs in a single policy maintained by the lead PC. Assuming both the MSO/PC and target practice purchase claims-made coverage when joining the MSO, the provider maintains the retroactive date of its pre-acquisition policy. This approach ensures continuity of coverage for the clinician through the acquisition and negates the need for tail insurance. **Of critical importance, this does 'stretch' the existing limit over pre-close and post-close services rendered.**

Alternatively, there can be an economic benefit to the MSO to require each acquired physician group obtain tail coverage when joining the MSO/PC master professional program. In this scenario, the acquired practice purchases tail insurance at close and is simultaneously added to the PC/MSO "go-forward" coverage under the master program, utilizing a retroactive date matching the date of acquisition and inception of the MSA. In addition to the potential run-rate savings, this clear bifurcation of insurance ensures that past acts of acquired physician groups cannot diminish the available limits of insurance for the operating business.

PC/MSO MASTER PROFESSIONAL LIABILITY: OCCURRENCE

Target: Claims-made or Occurrence

When both the PC/MSO and target acquisition purchase medical liability insurance on an occurrence trigger, the acquired practice can simply join the PC/MSO policy at close. Unfortunately, in most specialties, this is a rarity.

If the PC/MSO purchases coverage on an occurrence trigger and the target practice purchases coverage with a claims-made trigger, the target will need to purchase tail insurance before it can be added to the PC/MSO policy.

The "best practice" is for the MSO to have clearly defined parameters that steer how professional risk is treated in transaction documents, service agreements, and insurance policies.

Dedicated vicarious liability policies tend to be more expensive, and there are relatively fewer insurers willing to provide coverage.

MSO - VICARIOUS AND DIRECT LIABILITY

Vicarious liability is often one of the least understood nuances of Medical Professional Liability. While the existence of the MSO does not inherently create any additional liability exposure, Symphony makes the argument to insurers that the MSO does not perform any medical services and the very existence of the CPOM laws shield the MSO.

It is possible that the MSO could be named in a lawsuit by an injured patient. The medical professional policy covers medical professional acts for the named insured, which must be the clinician performing the medical services. As a matter of public policy, the MSO should not be able to buy a medical professional liability insurance policy. Some insurers understand that the MSO has a very curious exposure to medical professional claims by virtue of its existence and contractual relationship with the physician group. These insurers will agree to include the MSO as an insured under the medical professional policy.

Other insurers take the stance that the MSO should never be covered under a medical professional liability policy sold to a professional corporation. In these cases, a standalone liability policy should be considered. This policy provides coverage to the MSO for claims made against it arising from the professional services performed by clinicians and the services the MSO may perform, such as scheduling patients, notification of patients, etc. This dedicated liability policy should offer the best protection for the MSO, as its limits of insurance are not shared with the clinicians. Dedicated vicarious liability policies tend to be more expensive and there are relatively fewer insurers willing to provide coverage. These are referred to as “Practice Management E&O” policies.

Addressing how the extended reporting period (tail liability) will be managed, covered, and funded early on in the transaction is strongly recommended. Note that these same precepts apply to hired physicians.

MSO – MEDICAL BILLING ERRORS & OMISSIONS

An often-overlooked exposure arises from medical billing E&O. Insurance can provide legal and audit expense reimbursement, as well as coverage for fines and penalties associates with medical billing errors or violations of HIPAA, EMTALA or STARK proceedings. This exposure is not covered under Medical Professional policies and must be purchased separately.

As legislators look to both balance the budget and reform health care, The Centers for Medicare and Medicaid Services receive considerable attention because they account for about one-fifth of the national budget. CMS has been empowered with the resources to research, audit, and recoup the money it has paid wherever it can identify an overpayment, independent of whether the overpayment occurred due to fraud, dishonesty, or a legitimate error.

Contracted auditors typically look at records up to six years back and receive incentives in the range of 9-12% of the errors they find. They can also extrapolate the data found in a single audit to all your billings and charge additional fines and penalties.

Management Liability

PROGRAM STRUCTURE

Management Liability includes Directors and Officers, Employment Practices and Fiduciary Liability coverage. These coverage lines are often packaged in a single policy. They are distinct in that (a) the coverage inures to the benefit of both the legal entity or corporation, as well as the individual insured directors and officers, and (b) the coverage is *always* written with a claims-made coverage trigger.

MSO/PC structure presents several challenges. The MSO is often created concurrently with the first PC platform acquisition. At that time, the platform practices' management liability is "run off" (i.e., tail insurance is purchased), and new, go-forward policies are incepted in the name of MSO.

In practice, the PC is scheduled as an insured under the MSO policy. Underwriters intuitively understand that, despite the distinct and discrete ownership of each entity, the two are mutually dependent and could not exist without the other. Underwriters make an exception to commonly held underwriting principals and insure two discrete entities under a shared D&O liability policy.

There are several scenarios where this comingling of insurance could be an issue and result in a denial of coverage. For example, if a friendly physician wants to bring a claim against the MSO, the friendly physician would most assuredly be denied coverage under the "insured vs. insured" exclusion of the management liability policy.

These issues have yet to be make headline news as significant insurance claims of note.

The best practice would be for the MSO and each discrete PC to maintain separate Management Liability policies. However, given cost considerations and underwriters' willingness to accept the risk, this approach has not yet been broadly adopted across the industry.

Consideration should be given to establishing a playbook for how future practice acquisitions treat preacquisition liability exposure.

ACQUISITIONS

After the MSO platform is established, consideration should be given to establishing a playbook for how future practice acquisitions treat preacquisition liability exposure. Many smaller medical practices do not purchase Management Liability coverage. Is the MSO willing to take the risk that pre-close acts or incidents could lead to post-close claims? While these claims may be relatively immaterial, the "sleep at night" protection that tail management liability coverage offers can be meaningful, especially when the friendly physician plays an important role in the go-forward business.

While the D&O exposure is less significant, employment practices liability coverage is certainly of concern. An employee of the practice could make a claim post acquisition alleging discrimination or harassment prior to the acquisition and continuing post close (often called a straddle claim). If economically feasible, Symphony recommends the acquired practice purchase tail insurance for pre-close management liability risk. If the practice does not purchase management liability coverage, a standalone tail policy can be obtained. Ideally, the tail coverage should be written by the same insurer providing coverage to the MSO. Which party bears the expense of tail coverage is often a negotiation point within the context of the transaction, without a universally accepted dictate.

If an acquired practice will not have a significant role in the MSO going forward, many buyers simply choose to rely on seller indemnification and robust bifurcation of assets and liabilities in the purchase agreement to provide protection from claims made post-close arising from pre-closing acts of the practice.

CYBER INSURANCE

Cyber insurance needs to be addressed as part of the M&A process, particularly if representation & warranties insurance is used.

If an acquired platform has an existing cyber policy, it is possible to amend the named insured to cover the MSO. However, given these policies contain change of control provisions, it can be preferable for the seller to purchase tail cyber insurance and insert a new Cyber policy for the MSO at close. Further complicating the issue, some Medical Liability insurers include some minimal Cyber coverage in their policies. The quality and breadth of coverage offered varies significantly from policy to policy.

Add-ons present an additional dynamic. If the acquired practice will continue to operate on a separate network, depending on its scale relative to the MSO, some Cyber insurers may refuse to include it under the MSO Cyber policy. In these cases, a separate policy must be maintained until the networks are combined.

SUMMARY

The variety of permutations in organizational and transaction structures necessitates the myriad of insurance structures.

The importance of having an experienced insurance advisor work in concert with the legal, regulatory and diligence teams to ensure coordination and alignment of insurance policies with the intent of the purchase agreement and management services agreement cannot be overstated.