Today, few new physicians entering the practice of medicine are starting their careers by way of an independent medical practice, opting rather for employment. Physicians with established practices are experiencing greater difficulties in managing them. Both are turning to hospitals, healthcare systems, insurance companies, private equity groups and others to find relationships that will allow the physician to practice medicine without many of the distractions from patient care that are tied with the management of a practice. Hospitals have been responding with eagerness, believing that an alignment with physicians will improve the quality of care, and patient safety as well as the bottom line.

This relationship has been tried before in the 1990s through early 2000s and failed due to frustrations on both sides. Physicians became frustrated with how hospitals managed the practices and hospitals became frustrated with the physicians’ lack of motivation and declining productivity. Hospitals and Physician Practice Management Companies lost money and, eventually, physicians returned to independent practices. Yet, here we are in 2012 with hospitals and physicians seeking relationships again. Why? Will it work? And moreover, what are the risks?

According to the latest survey statistics from the American Hospital Association (AHA), hospitals employed 211,500 physicians in 2010, a 34% increase since 2000, which now encompasses almost 25% of all active physicians.
Employing physicians has the potential to improve quality and efficiency through better clinical integration in all care settings, but hospitals also utilize physician employment strategies to gain market share by increasing services across their business lines.

**Hospital Perspective**

When we look at the recent rise of commercial payor P4P programs and CMS’s movement toward bundled payments under the ACO service model, we see that an integration strategy is needed to both improve quality as well as enter into broad-based financial risk sharing arrangements. According to the latest survey statistics from the American Hospital Association (AHA), hospitals employed 211,500 physicians in 2010, a 34% increase since 2000, which now encompasses almost 25% of all active physicians. With 60% of hospitals currently using hospitalists, 37.9% of hospitalists on the medical staff are employees.¹

Employing physicians has the potential to improve quality and efficiency through better clinical integration in all care settings, but hospitals also utilize physician employment strategies to gain market share by increasing services across their business lines. Hospitals can also negotiate better health plan contracts on behalf of employed physicians gaining higher rates that likely lead to higher compensation. For hospitals in markets where physicians are less inclined toward employment (or not allowed such as in California and Texas), contractual arrangements are still pursued to strengthen relationships in the move toward Medicare payment reforms.²

**Physician Perspective**

Physicians have experienced stagnant reimbursement rates and rising costs of private practice. Navigation through the complex changes in the insurance and delivery systems under healthcare reform may be done with less effort while employed by a hospital, bringing relief from the administrative burdens associated with participating in the private and government-sponsored insurance programs. Further, in private practice there is often not enough capital available to invest in new technologies, including electronic medical records. Accountable Care Organizations (ACOs) may be too costly for individual practices to


implement as nearly 75% of office-based physicians work in groups of five or fewer clinicians. This is nearly 95% of all medical practices in the United States. Many practices do not offer nor can they afford to provide services required by the Affordable Care Act. Outside of hospital employment, financial risk for the physician will depend on the type of contractual arrangements made for shared risk, but it is fairly evident that unless a physician decides to no longer accept Medicare or Medicaid patients, some financial arrangement will be necessary with community healthcare providers.

Quality of life and financial security improve with employment, although the traditional salary compensation has changed since previous physician employment contracts. While volume related to physician productivity will likely continue, quality metrics are gaining ground. In MGMA’s 2010 Physician Compensation and Production Survey, 62% of physicians had incentive-based compensation tied to quality metrics in 2009, a 300% increase in just one year. Some quality metrics include detailed physician focus on chronic conditions such as asthma, congestive heart failure and diabetes. If quality benchmarks are achieved, compensation may be anywhere from 1 to 10 percent.

What are the Risks?
A complete assessment of all risks associated with integrating a physician or a physician practice with a hospital is beyond the scope of this limited discussion. So, let’s suppose that those involved with valuation of a physician practice and physician compensation will negotiate an agreement that will not be in violation of federal or state laws applicable to such an agreement. Depending upon the dominance of the healthcare system

Physicians with established practices are experiencing greater difficulties in managing them.
The physicians’ continuing liability for prior activity can be a significant risk for the acquiring hospital and may well affect the insurance risks or risk financing programs from acquisition date forward. After physician practice acquisition, let’s also assume that any non-compete language will not invite the Federal Trade Commission’s interest as was seen with Renown Health of Reno, Nevada upon its acquisition of two cardiology practices in Reno.5

It just may be that the health system has managed to avoid a D&O claim, but the risks clearly do not stop here.

“Due diligence” should include assessment of liabilities, claims and compliance history of the potential acquisition providers, as well as the corporate organization, not only for purposes of whether to acquire a practice, but for the insurability of the physicians. As many health systems retain a substantial amount of medical malpractice risk, underwriting considerations are a major concern and loss runs should be obtained for review as physicians may not recall their total loss history, especially if they’ve been in practice for a long time. An assessment should include the length of practice, practice specialty (as some specialties have a long lag time from incident to discovery of injury) whether the state location of the practice is subject to malpractice caps or the opposite known as “judicial hellholes.”

Typically, postacquisition malpractice premiums are paid by the hospital for its employed physicians but tail coverage negotiations are paramount. The physician will invariably request that the hospital purchase tail coverage for run-off coverage of a claims-made policy and, likely, this request will come at the end of an otherwise successful negotiation. The physicians’ continuing liability for prior activity can be a significant risk for the acquiring hospital and may well affect the insurance risks or risk financing programs from acquisition date forward. Even in an asset purchase, successor liability

can impose financial responsibility to the acquiring health system for pre-acquisition activities. If the current physician policy is written on an occurrence basis, will the prior limits be sufficient to cover a suit that is brought years later and, as important, will the carrier still be in business? Additional research and insurance alternatives from a well-qualified broker may assist in the evaluation to determine the most cost-effective risk financing solution, information not usually available to law firms.

Additional risk assessment may also be needed for the physician’s corporate entity as to its corporate practices and compliance with federal and state laws. What is the history as to billing coding practices? Recognize that post acquisition, the hospital may well be responsible for payment of any Medicare violations of the prior practice. Unknown to many in the process, such medical billing errors and omissions risks can be insured and provide substantial peace of mind to all parties involved.

“If healthcare systems and physicians use shared ideals and goals when affiliating under an employment alignment, history should not repeat itself.”
Is the organization compliant with the Health Insurance and Patient Affordability Accountability Act (HIPAA) and the Health Information and Technology Act (HITECH)? How are cyber and privacy liabilities going to be addressed? How will the e-risk profile of the organization change after substantial merger and acquisition activity and expanded use of the electronic medical record?

Many physician practices are without a risk manager or human resource personnel—are there exposures with respect to employment liability? Was the physician practice self-insured and therefore accustomed to handling claims and settling same independently?

In additional to the financial risks of new P4P and bundled payment contracts, hospitals have a lot of money at stake with these new hires which often incur high up front costs. The physicians are expected to be significant future sources of revenue for the health system and, as such, should be viewed as “key person” insurable assets of the organization. A new approach toward life, disability and retirement products will be needed for health systems to attract, retain and protect highly valued physician employees in the new model.
Conclusion

Healthcare organizations should not be naïve about the challenges and risks associated with employing physicians. The investment is substantial and hospitals often lose money during the early years of a physician employment contract. Done incorrectly, the acquisition could lose a lot of money. Perhaps more importantly, clinical and business reputations are at stake.

There can be significant culture shock in this process. Physicians give up the autonomy associated with owning a practice under hospital employment, but hospitals need to remember that most physicians have never been taught to think as team members in large organizations. Employment alone will not, in and of itself, bring engagement in the manner that is required to achieve the outcomes needed under this alignment. We need only to look at history to recognize this fact. Physicians are unlike any other employee in healthcare; they are accustomed to being the business leaders, clinical decision-makers, and daily problem-solvers—and they often move at a pace faster than hospital administrators. Physicians new to employment will need mentoring by more experienced, employed physicians.

If healthcare systems and physicians use shared ideals and goals when affiliating under an employment alignment, history should not repeat itself. Success in a shared risk environment will come with a shared ethical foundation and an embraced “we” attitude.

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Our Mission

To be the worldwide value and service leader in insurance brokerage, employee benefits, and risk management

Our Goal

To be the best place to do business and to work