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Employed Physicians

What to Do When It Doesn't Work Out

This article is the fourth in a series exploring alternatives to the traditional private practice.

Many physicians have made the jump. They've gotten out of the business of running a private practice and into the business of being an employee. Others joined a hospital or health system as an employee right out of medical school — typically, younger physicians and female docs.

The Pursuit of Happiness

To be sure, many physicians are satisfied with their move. Whether it's a hospital, clinic, academic or government setting, they've found new lives as employed physicians.

But others are not so happy. A recent *Medscape Medical News* survey asked more than 4,600 U.S. physicians about their work environment and job satisfaction. Among physicians who moved from self-employment to employment, about 49 percent said they are happier now, while 25 percent said they were less happy. By comparison, 70 percent of doctors who moved from employment to self-employment reported they were happier, and just 9 percent said they were less happy.

Steady Paycheck vs. Autonomy

There are certainly pitfalls to becoming an employed physician. Although most practitioners probably expected some loss of autonomy and control, many have found the reality of answering to a boss tougher than anticipated. Less than half of employed doctors said they are satisfied with their degree of autonomy at work, while about a quarter are neutral and another quarter are unsatisfied, according to *Medscape's 2014 Employed Doctors Report*. Employed doctors complained about the profusion of rules and the lack of input into how they practice.

Other "negatives" with regard to employment reported in the *Medscape* survey included:

- Limited influence in decision-making (45 percent)
- More limited income potential (44 percent)
- Too many rules in general (34 percent)
- Less control over work/schedule (32 percent)
- Being "bossed around" by management (30 percent)

Greener Grass

Thanks to technological advances, changes in care delivery and a shift in consumer expectations, employed physicians considering going private have plenty of practice options:

- **Direct Pay** – Primary care providers charge patients a monthly fee that covers unlimited sick and well visits as well as basic in-house lab services. This model also includes direct contracting with employers.
- **Concierge** – In this niche practice model, providers accept insurance but

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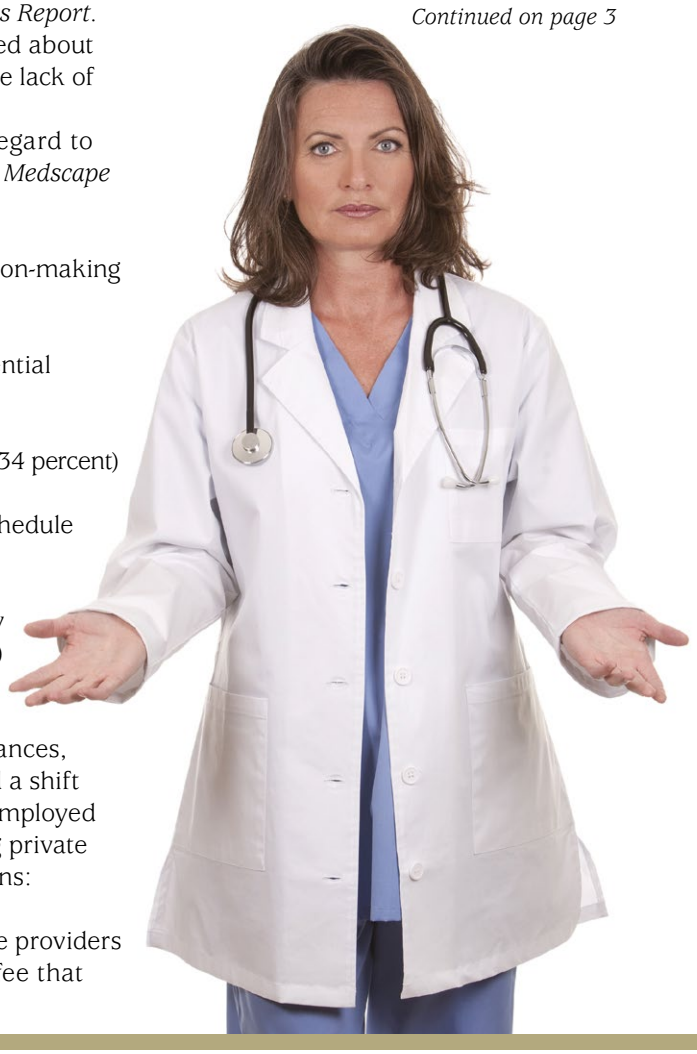

Physicians and Prenuptials

Romance Killer — or Wise Move?

Life is full of challenges, and marriage brings many. The divorce rate for first marriages in the United States hovers around 50 percent. The odds are even worse for second and third marriages — they end up in a split upwards of 75 percent of the time.

The numbers are especially grim for physicians. The divorce rate for marriages in which at least one spouse is a physician is up to 20 percent higher, according to marriage counselor Mary Sotile, co-author of *The Medical Marriage: A Couple's Survival Guide*.

As the stigma around them slowly fades, prenuptial agreements are becoming a more accepted asset protection tool for physicians of both sexes. In fact, a 2010 survey of American Academy of Matrimonial Lawyers members revealed that women are becoming more likely than men to initiate a request for a prenuptial agreement. The survey also indicated that the overall number of prenups is on the rise.

Who Decides?

In the absence of a prenup, the courts typically consider the role of each spouse in building household wealth — who brought assets into the marriage and who contributed to household wealth during the marriage. The classic scenario in a physician marriage is that one spouse works to support the other through medical school. In the eyes of the court, that spouse may then be entitled to a much more generous settlement because of earnings he or she brought into the marriage early on.

With a prenuptial agreement, the division of assets is agreed upon ahead of time and articulated in a legal contract. The key to deciding if you need one — and what it should cover — is typically driven by where you're at in life.

What Is Your Life Stage?

Young physicians who are not bringing a lot of debt or assets to the union may not need a prenuptial agreement. Yet, the stakes become higher for physicians who wait longer to get married. Typically, more assets and bigger debts — such as credit card balances, mortgages and student loans — are brought to the union. When marrying or remarrying later in life, the need to protect pension and retirement benefits can become an important issue. Plus, there are often children involved, as well as older parents who may need expensive care.

Experts say that doctors who own their own practice would be wise to have a prenuptial agreement, especially if they built up substantial equity in the practice before getting engaged. In most states the appreciation in the value of the practice will be considered a marital asset, unless it's protected by a prenup. Fighting over the value of the practice can be the most expensive and contentious aspect of a divorce, as each side brings in his or her own experts to provide (often divergent) opinions on the value.

Note that even after a marriage, an agreement can be structured to either treat the value of the business as separate property or to agree on a value — and avoid expensive litigation over practice valuation later on.

Will It Hold Up in Court?

Unlike the laws regarding estates, there is a distinct lack of uniformity to the laws on prenuptial agreements. A court may rule that a prenuptial agreement is invalid, for instance, if it is "unconscionable" or extremely one-sided. For example, in many states, a prenup that essentially cuts one party out entirely without some reasonably equivalent consideration is not valid.

You'll increase the chances of a prenuptial agreement being fully enforceable if both parties retain their own separate legal counsel and sign the document well in advance of the nuptials. Likewise, the legalities of prenuptial agreements can vary widely from state to state, making it critical to modify your agreement accordingly if you move to another state.

Of course, having a frank and open discussion with your fiancée is a smart first step for coming to an agreement about your current and future assets. ■

Our professionals have the training and tools to help you protect personal and practice assets. Call us to learn more.

Intermediate Steps

Short of a full-blown prenup, physicians and their soon-to-be spouses can take some common-sense steps to protect assets, including:

Proper titling of property – In marital/community property states (AZ, CA, ID, LA, NV, NM, TX, WA, WI), there is a presumption that most assets acquired during marriage belong equally to husband and wife. In separate property states, the way property is titled typically determines who gets it in case of divorce.

Appropriately named beneficiaries – Name the beneficiaries of your bank, brokerage, mutual fund and retirement accounts so that the assets are protected in the event of a divorce.

Marital Property Agreement (MPA) – MPAs allow you to agree in writing on how property will pass if you divorce or if one of you dies. You can agree that most of your assets will be split equally, or that they will remain separate (or something in between). ■

When Employment Doesn't Work Out

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also require a set annual fee that covers services private insurers generally do not, such as comprehensive annual physicals, home or worksite visits, and even accompanying patients to specialists' offices. For that fee, patients typically are guaranteed same-day appointments and 24/7 access by cell phone and/or the Internet, as well as a host of services including basic blood tests, flu shots and yearly gynecologic exams.

- **Medicare Subscription** – Similar to a concierge practice, providers apply an additional fee for Medicare patients to cover services not covered by their Medicare plan.

- **Telemedicine** – Once the domain of rural care, telemedicine is gaining acceptance and popularity — especially in specialties such as psychiatry and oncology, and for specialty consultations. Accordingly, commercial telemedicine companies are developing new tools to help physicians develop a secure "telepresence" with their patients.

- **House Calls** – Some providers are building practices solely on the house call model, targeting baby boomers with the income and inclination to seek in-home care. These providers accept payments via their smartphones or tablets and use a small or home office to complete paperwork and charting.

- **Nursing Home** – Similar to the house call model, physicians see patients onsite at an extended care facility — again, not having to invest in a brick-and-mortar office.

- **On-Call Specialty Practice** – This model appeals to specialty physicians — typically surgeons, who utilize the office of the referring physician to see pre- and post-surgical patients.

- **Micro-practice** – The ultimate "skinny" practice, a micro-practice entails a physician working lean and mean without any assistants. Using just a computer/EHR system and a single exam room, a micro-practice physician might see just eight to 10 patients a day.

Employee or Boss?

The push toward greater integration among hospitals and physicians has certainly led to a rise in physician employment. Yet, as *Medscape's Employed Doctors Report* clearly shows, many physicians have grown weary of working for others.

Fortunately, medical practice innovation — from solo micro-practices to patient-centered medical homes and direct pay practices — is one of the keys to private practice being a viable alternative to salaried employment. ■

Exploring your options? Give us a call to discuss alternatives to traditional physician employment.

The Single-Specialty/Single-Discipline Group Practice

An intriguing option for employed physicians seeking a return to private practice is the single-specialty group practice. Here, three or more physicians who practice the same medical specialty share clinical and administrative facilities, patient records and employees.

The single-discipline group practice model is similar, but is composed of only one discipline, such as primary care, vision care, surgery, etc. In both models, income and expenses are distributed among the physicians according to a prearranged plan.

A variety of factors favor creation of single-specialty rather than multispecialty groups these days — including the move away from primary care gatekeeping and the Stark II regulations. The benefits for physicians to join a narrowly focused practice include:

- **Capital and scale** – A single-specialty group can better cost-justify (and afford) advanced technology, as all members will benefit from it. By contrast, a large multi-specialty group may find it harder to justify a software purchase if it will only benefit three specialists in a 150-physician practice.

- **Reputation** – A single-specialty group is fine-tuned — they know their specialty backwards and forwards. They're going to do it well, so they can quickly develop a reputation as a high-quality provider.

- **Negotiating leverage** – A single-specialty group in a smaller area could become the go-to group for every insurance company that needs that specialty.

- **Focus** – With its focus on a single specialty or single discipline, the group can also better stay abreast of today's complex business and regulatory environment. For example, a good medical biller for a single-specialty group will excel at that specialty — billing patients accurately and efficiently with fewer wrongly entered codes and information.

Ultimately, a single-specialty or single-discipline group practice is like a tailored suit — perfectly fitted for your specialty. ■

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Future Drivers of Quality Care

As healthcare inevitably moves from fee-for-service to a system that rewards quality outcomes, providers will need to focus on a whole new set of drivers to achieve the much-vaunted "triple aim" of a better patient experience, better healthcare quality and lower per-capita costs. These might include:

- **Clinical Coordination** – At the core of delivering quality care is a slate of robust, end-to-end clinical programs — from wellness and prevention all the way to complex care management. On the practice side, that might simply entail appropriate care coordination, medication compliance and appointment follow-up.

- **Robust Information Technology** – Of course, more sophisticated health information technology is required to tie it all together. This includes the ability to analyze epidemiological gaps and disease prevalence, all the way through EHR, e-prescribing and clinical registries.

- **Patient Engagement** – Online patient portals that allow patients to access their personal health records, request prescription refills and securely message their physicians have proven themselves in engaging patients to play a larger role in the delivery of their own healthcare.

- **Integrated Delivery** – Under healthcare reform, bundled payments may increasingly become the norm, divvying up payment among a group of providers who are incentivized to coordinate care. Success in the brave new world of third-party reimbursement may depend on participation in an integrated delivery system — allying yourself with a total-care team of hospitals, specialists, primary care providers, pharmacists and even home care services.

- **Service Quality** – Few patients understand the quality of their clinical care. Instead, they use service quality as their measure — everything from how they were greeted by your receptionist to how lab results and prescription refills were handled. Their overall service experience drives their perception of your practice. ■