# THE FAMILY PHYSICIAN RESIDENT'S Guide TO HOSPITAL EMPLOYMENT

North Carolina Academy of Family Physicians INCORPORATED

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# INTRODUCTION

As a resident in family medicine thinking about career options in a time of rapid change in health care, you may have more questions than answers. Should I join a family practice or a multi-specialty practice? Should I strike out on my own with a solo practice? In either case, how will I get paid? [1] Would my future be more secure as an employee of a hospital? Wherever I decide to work, how do I negotiate the best deal for myself? [2]

Although there are many questions and uncertainties, one trend is clear, and that is what one observer has called "[t]he mad dash by hospitals and health systems to employ physicians." [3] Over the past decade, an increasing number of doctors are bypassing traditional career paths – like starting a solo practice or joining a single- or multi-specialty practice group – in favor of direct employment by a hospital or health system. In fact, the employment of doctors by hospitals grew by 32 percent between 2000 and 2010, according to a recent American Hospital Association survey. [4]

Just because it's a trend does not mean it's the right choice for you, however. To assist you in making well-informed decisions about your future, this white paper presents:

(1) Some options that lie before you as you complete your residency and begin a career in family medicine;

(2) Potential advantages and disadvantages of employment with a hospital or health system; and

(3) Guidance on negotiating the terms of employment with a hospital or health system, should you decide to take your career in that direction.

One important theme of the discussion that follows is this: If you decide to become an employee of a hospital or health system, it is critically important that you fully understand the key terms of any proposed employment contract, and that you negotiate the best possible employment arrangement. If you become actively involved in a thorough and thoughtful negotiation with your future employer, you may be surprised at the latitude you have to negotiate a better deal for yourself. As health care shifts to value-based payment, recognizes the economic importance of prevention, and focuses on wellness strategies and medical homes, family physicians should carefully assess the new options and leverage becoming available to them.

**DISCLAIMER: This White Paper is general in nature and can provide general guidance, but should not be considered legal advice.**

# PART ONE: PRACTICE OPTIONS

A 2012 survey of physicians by the American Medical Association ("AMA 2012 Survey") found that most physicians belong to a single-specialty or multi-specialty practice group, have a solo practice, or are employed by a hospital.[5] The AMA 2012 Survey, the American Hospital Association survey mentioned above, and many other sources have noted a strong trend toward the last of these practice settings—physician employment by a hospital. These and other practice settings are discussed below.

## A. SOLO PRACTICE

Although it is no longer the most popular career path, solo practice is the most straightforward option. Opening a solo practice means hanging out a shingle and practicing family medicine on your own, without other physicians and typically with a relatively small staff and patient base.

The primary advantages of solo practice are autonomy and control. With a solo practice, you decide how to treat your patients. You decide whether to set up your own office or share space with other practices; and you decide where to practice, what hours to practice, what staff to hire, what fees to charge, and what patients to see. You do not have to negotiate these matters with other physicians in a practice group. You are the boss.

The primary disadvantages of solo practice involve sole responsibility and risk. In solo practice, you are responsible for every aspect of your business – not only caring for your patients, but also paying the rent, managing human resources, dealing with billing and compliance issues, developing your information technology infrastructure, and addressing the myriad of other administrative and technical details of running a medical practice. For a physician in a solo practice, these details—often called "the business of medicine"—can be challenging. As one physician stated, "I found myself spending a disproportionate amount of time on billing and coding, arguing with insurance companies over why I prescribed the drug I did rather than a cheaper one, [and] trying to demonstrate 'meaningful use' of electronic patient records in order to receive an incentive." [6]

Some of these challenges can be mitigated. For example, you likely will need to network by contract with other physicians to gain needed access to technology and business expertise. A common approach

is joining an independent practice association ("IPA") model accountable care organization ("ACO").

Even something as simple as scheduling a family vacation can present unique challenges for a physician in solo practice, who must find doctors outside her practice to care of her patients when personal or professional obligations take her away from the office.

As a physician with a solo practice, you also assume 100 percent of the risk that your practice may falter or fail due to your own skills as a doctor and business owner or to other factors that may lie largely beyond your control, such as unexpected personal or family illness, demographic shifts in your patient base, changes in Medicaid or Medicare reimbursement, new state or federal regulations, or coverage decisions by private payers.

Although solo practice used to be commonplace, the number of solo practices has declined in recent years as the complexity of practicing medicine has grown. Among members of the American Academy of Family Physicians, for example, the share of physicians in solo practice dropped from 44 percent in 1986 down to 18 percent in 2008. [7] Confirming the trend, the AMA reports that 18 percent of physicians were in solo practice in 2012, down from 41 percent in 1983. [8]

Despite all of the risks and challenges, there are many physicians – including recent medical school graduates – who place a high value on the autonomy and control they enjoy in solo practice and who continue to strike out on their own in communities across the nation.

## B. FAMILY MEDICINE PRACTICE GROUP

To avoid some of the risks and challenges of solo practice, you may decide instead to establish or join a family medicine practice group. As the name implies, a family practice group is two or more family physicians practicing medicine together as a partnership, professional corporation, or limited liability company (which combines elements of a partnership and corporation). Over 40 percent of family physicians practice in such a setting, according to the AMA 2012 Survey. [9]

Participating in a group practice with other family physicians can help you lessen or avoid some of the risks and challenges of a solo practice. Typically, this setting offers greater financial stability and security than a solo practice. In a family practice group, you and your colleagues have the ability to pool resources to rent, build, buy, or renovate facilities; to purchase equipment; and to hire professional staff with the skills to address the many administrative, technical, business, and compliance challenges of operating a medical practice in time of rapid change in the way health care is delivered and paid for.

Moreover, partnering with other family physicians in a group practice may offer you a more stable and less stressful lifestyle, since you are able to share call coverage, and you have colleagues to handle the medical needs of your patients when personal or professional responsibilities take you away from the office. Practicing in a group setting also means that you will have mentors as you launch your career and colleagues to consult on difficult cases. Many experts think that this model is an ideal structure to succeed in the emerging value-based care era. For example, a family medicine practice can function as an ACO or the essential core of one, with family physicians reaping most or all of the shared savings distributions.

On the other hand, as a family physician in a group practice, you would have less autonomy and less control than you would in solo practice. Group practices may range in size from two or three to dozens of physicians, and – generally speaking – the larger the practice, the less autonomy and control you will enjoy as a physician fresh out of residency. In contrast to a solo practice, a group practice requires consensus on major decisions such as the renovation or relocation of facilities, the purchase or sale of equipment, or the hiring or firing of staff. Such consensus may be easy or hard to reach, depending on the difficulty of the issue at hand, the structure of the practice, and the personalities involved

## C. MULTI-SPECIALTY PRACTICE GROUP

You may also wish to consider joining a multi-specialty practice group, which shares many of the characteristics of a family medicine practice group. As the name implies, a multi-specialty practice group unites physicians from multiple specialties, not just family medicine. More than 20 percent of physicians overall, and nearly 30 percent of family physicians, practice in such a setting, according to the AMA 2012 survey. [10]

Compared to a solo practice (where you have sole responsibility and risk), a multi-specialty practice group offers the same advantages as a family medicine practice group (where responsibility and risk are shared). In addition, by offering multiple patient services in a single practice – and often at a single physical location – a multi-specialty practice group may be better positioned than a single-specialty practice group to negotiate favorable contract terms with payers. Multi-specialty practices may generate extra income from laboratories and other ancillary services that a solo practice or family practice group would not offer. On a very practical level, both doctors and patients may benefit from a more efficient referral process in a multi-specialty practice group, where family physicians can arrange rapid consultations with specialists within, rather than outside, the group. These patient-centric benefits obviously can translate well into new value-based payment models.

On the downside, multi-specialty practices introduce an additional layer of complexity, namely, the need to manage the practice not only with other family physicians but with other specialists as well. When you are negotiating with multiple physicians from multiple specialties, you may find it even more difficult to reach consensus on important management decisions. As payment moves from rewarding high-dollar volume to rewarding value, beware of the multi-specialty practice with the wrong mix of specialists to succeed in a value-based payment world. There must be a strong primary care core.

HOW DO I GET PAID? As a physician in a family medicine or multi-specialty practice group, you may be compensated in a number of ways. If you are forming or joining a relatively small group, you may have the immediate opportunity to become a partner or part-owner. Alternatively, you may begin as a salaried employee of the group and then, after a successful "trial period," have the opportunity to become a partner in or part-owner of the practice. In other cases, particularly with large group practices, you may be a permanent salaried employee, with no expectation that you will ever become a partner or part-owner. When serving as a salaried employee of a group practice, whether that status is temporary or permanent, you may receive a straight salary with no opportunity for additional compensation, or you may receive a base salary with opportunities to earn bonuses based on productivity, quality, or some combination of these and other factors.[11] Experts predict that in the next seven to 10 years, up to 75 percent of total reimbursement will be performance-based. Be aware that production-only formulas based on Relative Value Units ("RVUs") are too shortsighted to value properly the contributions of family physicians.

To complicate matters further, many hospitals and health systems have been buying up – or acquiring an ownership stake in – physician practice groups. When physicians sell their practice to a hospital or health system, the physicians may retain an ownership interest in the practice group, become employees of the hospital, or make any number of other arrangements.

## D. DIRECT EMPLOYMENT BY A HOSPITAL OR HEALTH SYSTEM

As noted above, a growing number of physicians are choosing direct employment by a hospital or health system. Part Two of this White Paper addresses potential advantages and disadvantages of this option, while Part Three offers guidance to you should you choose to go down this career path.

## E. NEW WAYS OF DOING BUSINESS: ACCOUNTABLE CARE ORGANIZATIONS

As a physician launching your career during a time of change and reform in the health care system, you will encounter both risks and opportunities that were not present 10, 20, or 30 years ago. Although the nature and pace of change are uncertain, most observers believe that the focus of the health care system will continue to shift from fee-for-service payment (where you are paid for the quantity and intensity of care you provide) to value-based payment (where you are paid for improving health outcomes and lowering costs over the long term).

As you complete your residency and contemplate your career path, you may wish to consider opportunities to practice medicine on the cutting edge of health care, including opportunities to practice medicine in an ACO. This practice model can involve a network of independent practices, a single multi-specialty practice, or an integrated hospital system with employed physicians. Although the pay-for-value concept has been around for some time, the Patient Protection and Affordable Care Act of 2010 "makes it official" by authorizing ACOs in Medicare and other federal programs through "shared savings" and other incentives. [12]

> What is an ACO? ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. [This] definition emphasizes that these cost and quality improvements must achieve overall, per capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients. ACOs may involve a variety of provider configurations, ranging from integrated delivery systems and primary care medical groups to hospital-based systems and virtual networks of physicians such as independent practice associations. **All accountable care organizations should have a strong base of primary care.** [13]

For more information about ACO's, you may wish to consult "The ACO Guide: How to Identify and Implement the Essential Elements for Accountable Care Organization Success," available on the website of the North Carolina Academy of Family Physicians ("NCAFP") at: http://www.ncafp.com/files/ACOGuide-CME_1.pdf

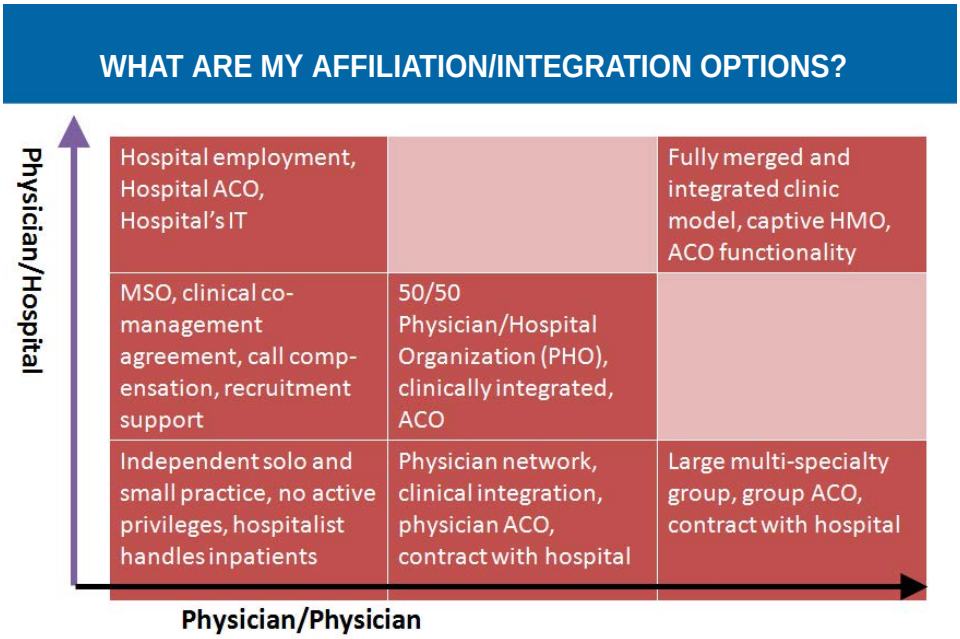
You will find a range of additional resources through the Toward Accountable Care Consortium ("TAC Consortium"), of which NCAFP is a member, at http://www.tac-consortium.org

## F. OTHER OPTIONS: CONCIERGE OR CASH-ONLY PRACTICES

Although the practice settings discussed above include some of the more common career choices by family physicians, the list is not meant to be complete or comprehensive. There are many other career paths out there for family physicians interested in exploring them, including (for example) a "concierge" practice or a "cash-only" practice.

In a concierge practice, each of your patients pays a monthly or yearly retainer in exchange for the opportunity to receive primary care services as needed at no additional charge or for significantly reduced fees. Although many concierge practices cater to wealthy patients, a growing number of such practices are serving middle-class patients as well. [14]

In a related development, cash-only medical practices do what their name suggests: they take cash only from their patients, declining to accept Medicare, Medicaid, or private insurance. By accepting cash only, physicians free themselves not only from the crushing burden of insurance-related paperwork and bureaucracy, but also from the many rules and restrictions imposed by both public and private insurers.[15] With overhead per physician approaching $250,000 per year to handle insurance billing and paperwork, many primary care physicians realize that the non-insurance route can give them a most precious commodity—time. Physicians realize that they can spend more time with fewer patients when relieved of that tremendous level of overhead. Although concierge and cash-only models can fit into any of the practice settings described above, they tend to be found in a small or solo single-specialty "boutique" practice setting.



# PART TWO: PROS AND CONS OF DIRECT EMPLOYMENT WITH A HOSPITAL

Working as an employee of a large hospital or health system offers both advantages and disadvantages over starting a solo practice, joining a group practice, or pursuing other options described above. Some of the most significant pros and cons are outlined below. [16]

## A. ADVANTAGES OF HOSPITAL EMPLOYMENT

Greater financial security and fewer administrative burdens are two of the most commonly-cited upsides of hospital or health system employment.

### 1. GREATER FINANCIAL SECURITY

Under most hospital and health system employment agreements, your salary is at least partially guaranteed and potentially less dependent on the revenues and expenses of private practice alternatives. The potential for greater financial security through hospital or health system employment is particularly significant given the well-documented failure of physician payment rates to keep pace with the rising costs of providing health care in recent years. As a hospital or health system employee, you benefit from the fact that hospitals are generally able to negotiate payment rates with health insurers that are more competitive than the rates family physicians are able to negotiate on their own.

From a broader perspective, hospitals and health systems may offer a greater degree of stability than smaller private practices because they can rely on economies of scale. The depth of a hospital's financial resources may allow it to function more competitively in the tightening health care market. Such economic strength on the part of a hospital or health system often gives physician employees access to state-of-the-art medical equipment and information technology systems that not all group practices are able to afford.

However, some experts opine that compensation guarantees for hospital-employed physicians are unsustainable, particularly as hospital compensation becomes more value-based. Some physicians have been disappointed when their guarantees run out and the hoped-for synergies do not materialize

to sustain the economics of the relationship. Under fee-for-service, the physician's referrals create financial gain. Under pay-for-value, the avoidable ones will not.

### 2. FEWER ADMINISTRATIVE BURDENS

In addition to financial security, hospital or health system employment may relieve you of a number of the administrative burdens that you would face in solo or group practice. For example, a large hospital is generally better equipped to provide administrative and technical support, such as compliance solutions, human resources departments, and billing functions. By relieving you of many administrative burdens, hospital employment may allow you to have more time and energy to focus on practicing medicine, as opposed to practicing the "business of medicine." However, there may be more hospital-related meetings and non-clinical assignments than you would face in other settings.

## B. DISADVANTAGES OF HOSPITAL OR HEALTH SYSTEM EMPLOYMENT

While hospital employment provides many advantages, there also are potential disadvantages, including less job security and less autonomy.

### 1. LESS JOB SECURITY

If you decide to work for a hospital or health system, your employment may not be as secure as it would be in other settings. A standard hospital employment agreement allows the hospital to terminate your employment at any time and for any reason – or for no reason at all – by providing you with advance notice of a certain number of days (typically 90 days). Therefore, when you work for a hospital or health system, there really is no guarantee that you will remain employed beyond that standard 90-day notice period.

Keep in mind that there are significant potential disadvantages should your employment relationship with the hospital or health system end sooner than you expected. For example, most contracts include a non-solicitation period during which you may not employ or solicit for employment any employee of the hospital or health system. Similarly, most employment contracts contain non-compete provisions that can limit your ability to provide care in the community for a specified period of time after your employment with the hospital or health system comes to an end.

## 2. LESS AUTONOMY

Another fundamental disadvantage of hospital or health system employment is the loss of control you might otherwise have in solo or group practice. For example, your work schedule, call coverage, administrative tasks, record keeping requirements, and general business operations will more than likely be dictated by the hospital or health system. In addition to business management, the hospital or health system may have the authority to oversee and provide guidance regarding your clinical practices. Furthermore, the hospital or health system will establish the fees that you will be allowed to charge for the medical services you provide. By relinquishing such control to the hospital or health system, you will be surrendering a great deal of the autonomy and independence that you may enjoy in other settings.

WHAT'S IN IT FOR HOSPITALS AND HEALTH SYSTEMS? As you consider the advantages and disadvantages of hospital employment, you may find it instructive to think about the reasons hospitals and health systems are increasingly interested in employing physicians. Having this understanding is all the more important if you begin negotiating an employment agreement with a hospital or health system, because appreciating the perspective of the party on the other side of the negotiating table allows you to seek out "win-win" scenarios that are more likely to be fair to you and sustainable for the long run. Here are some of the reasons hospitals and health systems are seeking to employ physicians directly – or to buy up or buy into existing physician practices:

Hospitals and health systems want to ensure that supply meets demand. Experts predict that by 2015 the nationwide physician shortage will reach 63,000, worsening further through 2025.[17] Hospitals and health systems fear that the traditional medical practice model may be unsustainable. Particularly in rural communities, they fear that failure to employ physicians directly or buy into existing physician practices may leave them without a sufficient pool of primary care doctors or key specialist physicians to meet community health care needs.

Hospitals and Health Systems Want to Gain Market Share: Hospitals and health systems seek to employ or otherwise affiliate with physicians to gain market share through primary care and specialist alignment. Employment of family physicians and other primary care doctors secures the hospital or health system referral base.

Hospitals and Health Systems Want to Prepare for Value-Based Payment: Hospitals and health systems see employment of physicians as a way to influence physician behavior and align incentives. Quality indicators, public report cards, and state quality scores show the need to work with physicians to achieve the best health outcomes possible. Recent health care reforms have accelerated this trend with the creation of bundled payments and ACOs (discussed above). Employment of physicians may allow hospitals and health systems to better respond to these new models.

# PART THREE: TERMS OF EMPLOYMENT WITH A HOSPITAL OR HEALTH SYSTEM

If you decide to become an employee of a hospital or health system, it is critically important that you understand the key terms of the proposed employment contract and that you negotiate the best possible employment arrangement. If you become actively involved in a thorough and thoughtful negotiation with your future employer, you may be surprised at the latitude you have to negotiate a better deal for yourself. Below are some of the major issues you should understand and work through when negotiating an employment agreement with a hospital or health system.

GET GOOD LEGAL ADVICE. Like the North Carolina Academy of Family Physicians and the American Academy of Family Physicians, the American Medical Association recommends that you "obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts." [18] At a bare minimum, you should have qualified counsel review any proposed employment agreement and identify key issues and potential problems before you sign the agreement. Bear in mind that your hospital employment contract may have a dramatic impact on your professional life for months or years to come – not only your compensation, but also the rules by which you will practice medicine, your job satisfaction, and your options for practicing upon termination of the agreement. With so much at stake, you should ensure that you understand the agreement you are signing and that you are getting the best deal possible. Failing to do so puts you squarely in the category of "penny wise and pound foolish."

## A. COMPENSATION

Compensation will almost certainly be a major concern – if not the major concern – as you enter into an employment relationship with a hospital or health system. While compensation arrangements can vary dramatically from one employer to the next, compensation will typically consist of either a fixed salary, a percentage-based salary, or a combination of both. Regardless of the compensation method used, you should understand exactly how you will be compensated and ensure that your expectations are clearly set forth in the employment agreement.

## SAMPLE PHYSICIAN COMPENSATION PROVISIONS: BASE SALARY, PERCENTAGE-BASED, AND COMBINATION [19]

To make the discussion of compensation from a hospital more concrete, the sample contract provisions below describe fee-for-service compensation based on salary only, percentage-based compensation, and a combination of the two, and concludes with an important tip on how to protect your compensation in an era of accountable care.

Salary Only: "Physician shall be paid a base salary of $240,000 in equal installments of $10,000 on the fifteenth and the last day of each month throughout the term of this agreement. Hospital shall pay Physician's compensation subject to all appropriate payroll deductions, including but not limited to federal and state income taxes, Social Security, and state disability amounts."

Percentage-Based Compensation Only: "In exchange for Physician's services, Physician shall receive 30 percent of his Net Collections, defined as all amounts collected by Hospital (minus patient refunds or payer overpayments) for professional medical services rendered by Physician to patients on behalf of Hospital. Hospital shall pay Physician the compensation due hereunder every two weeks, on the date specified by Hospital, with respect to Net Collections received in the immediately preceding two-week period. Hospital's payment to Physician shall be accompanied by a statement setting forth the calculation of Physician's Net Collections for the time period for which payment is being made."

Base Salary Plus Percentage Bonus:

"(1) In exchange for Physician's services, Hospital shall guarantee Physician minimum compensation of $180,000 per year ('the Minimum Compensation'), paid in equal installments of $7,500 on the fifteenth and the last day of each month throughout the term of this agreement. Hospital shall pay Physician's compensation subject to all appropriate payroll deductions, including but not limited to federal and state income taxes, Social Security, and state disability amounts.

"(2) In addition to the Minimum Compensation, Physician shall be entitled to receive 'Additional Compensation' equal to 50 percent of the amount by which 'Physician's Net Collections' exceed $300,000. 'Physician's Net Collections' shall mean the amount of Hospital's gross collections (less patient refunds, overpayments and returned checks) received by Employer during the one-year term of this Agreement, attributable to Physician's provision of professional services to Hospital's patients. Hospital shall pay Physician's Additional Compensation on a quarterly basis" [by means of a formula and process too lengthy to spell out here].

Tip: In addition to base salary, and salary or bonus tied to production or productivity, you should negotiate for a contract term that the hospital may offer you performance incentives tied to a variety of quality and efficiency measures. Although this is a complex and rapidly-evolving area, value-based bonuses may take into account measures as diverse as patient satisfaction surveys, peer review, supervision of nurses and residents, appropriate use of health information technology, and timely completion of patient charts and other required tasks. At a minimum, you should request that the agreement provide that if and when the hospital or its employed physicians are offered value-based compensation, you be afforded the fair distribution amount based on merit.

During negotiations over compensation for employment with a hospital or heath system, one area of discussion – and often confusion – stems from federal laws known as the federal anti-kickback statute and the Stark law. [20] Without getting into the weeds of these notoriously complex laws, it is sufficient for present purposes to state the following: The federal anti-kickback statute and Stark law generally prohibit a hospital or health system from paying a physician more than the "fair market value" of her services or from basing her salary on the volume or value of referrals she makes. This is important to you as a prospective employee of a hospital or health system for three reasons:

First, you need to know that there are legal limits on the amount of compensation that a hospital or health system can offer you.

Second, you should expect that a hospital or health system will cite these legal limits as justification for offering you less compensation than you would like.

Third, while such assertions by a hospital or health system may or may not be accurate, they should *never* be taken at face value and should *always* be examined and – where appropriate – challenged. For example, a hospital may tell you, "We can only offer you an annual salary of $150,000 because we believe that is the fair market value of the patient services you will be providing, and it would violate federal law for us to offer you more." What the hospital may fail to mention is that it would be permissible under federal law to pay you an additional $35,000 per year as reasonable compensation for the *leadership and administrative* duties contemplated in your employment agreement.

This discussion of the federal anti-kickback statute and the Stark law illustrates a larger and more important point: Compensation packages offered to physicians by hospitals and health systems are often complex, confusing, and sometimes even misleading. **Physicians often leave "money on the table" – sometimes tens of thousands or even hundreds of thousands of dollars – because they fail to fully understand the formula being proposed, fail to challenge questionable assumptions or explanations offered by hospitals and health systems, and fail to make even**

**the most minimal effort to determine whether their prospective employer has offered a fair and reasonable compensation package – or a "lowball" number that does not reflect the fair market value of the services the physician will provide.** While we "find" fair market value according to accepted industry valuation methods, and we do not "horse trade" for it, it is always worth your while to check outside sources to confirm the range usual for a family physician in your circumstances.

## B. MALPRACTICE INSURANCE AND OTHER BUSINESS EXPENSES

Before entering into an employment agreement with a hospital or health system, you should carefully consider which party will be responsible for your business expenses, including (for example) malpractice insurance, professional association dues, continuing medical education, license fees, periodicals, and other professional and educational resources. Whether the hospital covers such items, and the amount the hospital or health system agrees to pay for them, should be considered in connection with your compensation package.

Because medical malpractice insurance is so important and so expensive, you should pay close attention to the malpractice-insurance-related terms of your proposed employment agreement with a hospital or health system. While there are no guarantees, there is a reasonable likelihood that the hospital or health system will propose to cover the cost of malpractice insurance for you during the term of your employment. Less certain is whether the hospital or health system will agree to cover the cost of so-called "tail coverage." You need tail coverage to address malpractice claims that (1) stem from patient care you provided while you were an employee of the hospital but (2) do not come to light until after your employment with the hospital has ended.

### SAMPLE MALPRACTICE INSURANCE TAIL PROVISIONS: PRO-HOSPITAL, PRO-PHYSICIAN, AND COMPROMISE [21]

To illustrate the complexities of malpractice insurance in general and tail coverage in particular, sample contract language favoring the interests of the hospital or health system ("Pro-Hospital"), favoring the interests of the physician ("Pro-Physician"), and compromising between the two ("Compromise") are provided below.

Pro-Hospital: "Hospital shall obtain and maintain, throughout the term of this Agreement, professional liability insurance on a "claims made" basis, covering Physician with minimum coverage limits of $1 million per claim and $3 million in the aggregate for the policy year. If

Physician's employment with Hospital expires or terminates for any reason, ***Physician*** shall purchase extended reporting endorsement coverage ("tail coverage"), with an unlimited reporting period, with the same coverage limits, within 10 days of the date Physician's employment with Hospital expires or terminates."

Pro-Physician: "Hospital shall obtain and maintain, throughout the term of this Agreement, professional liability insurance on a "claims made" basis, covering Physician with minimum coverage limits of $1 million per claim and $3 million in the aggregate for the policy year. If Physician's employment with Hospital expires or terminates for any reason, ***Hospital*** shall purchase extended reporting endorsement coverage ("tail coverage"), with an unlimited reporting period, with the same coverage limits, within 10 days of the date Physician's employment with Hospital expires or terminates."

Compromise:

(1) "Hospital shall obtain and maintain, throughout the term of this Agreement, professional liability insurance on a "claims made" basis, covering Physician with minimum coverage limits of $1 million per claim and $3 million in the aggregate for the policy year.

(2) If Physician terminates his employment without cause, or if Hospital terminates Physician's employment with cause, then, upon termination of Physician's employment with Hospital, ***Physician*** shall purchase extended reporting endorsement coverage ("tail coverage"), with an unlimited reporting period, with the same coverage limits, within 10 days of the date Physician's employment with Hospital expires or terminates."

(3) If Physician's employment with Hospital expires or terminates for any reason not stated in (2) above, then, upon expiration or termination of Physician's employment with Hospital, ***Hospital*** shall purchase extended reporting endorsement coverage ("tail coverage"), with an unlimited reporting period, with the same coverage limits, within 10 days of the date Physician's employment with Hospital expires or terminates."

Comment: Because tail coverage (like all malpractice insurance) is important and expensive, you should try to avoid contract terms (like the "Pro-Hospital" example above) requiring that you obtain and pay for tail coverage. Instead, you should negotiate for contract terms (like the "Pro-Physician" example above) requiring that the hospital or health system obtain and pay for tail coverage. Failing that, as a fallback position, you should negotiate for contract terms (like the "Compromise" example above) requiring that the hospital or health system obtain and pay for tail coverage unless the hospital or health system terminates your employment with

cause or you terminate your employment without cause. The bottom line is that you should pay very close attention to hospital employment contract terms relating to malpractice coverage in general and tail coverage in particular. Because the devil is in the details, and the details are complicated, this is another area where it would be wise for you to "obtain the advice of legal counsel experienced in physician employment matters." [22]

## C. CONTROL

One of the advantages of hospital or health system employment noted above is that you may be relieved of a number of the administrative burdens that you would face in solo or group practice. With this advantage, however, comes a significant disadvantage: loss of control. As noted above, under a typical employment agreement, your work schedule, call coverage, administrative tasks, and record keeping requirements will be dictated by the hospital. Furthermore, the hospital or health system will usually have control over the hiring and firing of staff, as well as the purchase of supplies and equipment. By relinquishing such control to the hospital, you will be surrendering a great deal of the autonomy and independence that you might otherwise experience in private practice. However, you may be able to negotiate with the hospital or health system to ensure that you have some measure of control over (for example) clinical decisions and personnel decisions directly affecting the clinical personnel with whom you work.

## D. TERM AND TERMINATION

Your employment agreement with a hospital or health system will cover a fixed period of time, typically one to five years. The agreement may also contain an "auto-renew" provision so that at the end of the initial term, the agreement will automatically renew for successive terms until the agreement is terminated by one party or the other.

Although a relatively long initial term combined with an auto-renew provision may create the appearance of job security, you should remember that most hospital and health system employment agreements also contain a "without cause" termination clause. "Without cause" termination provisions allow *either party* to terminate the agreement for any reason – or for no reason at all – provided that notice is given to the other party. The required notice period usually ranges from 60 to 180 days, with a typical provision being 90 days. The obvious risk for you is that you may believe that you are entering into secure, long-term employment relationship, only to find out that your employer may terminate your employment with only a few months of warning.

In some cases, you may seek to reduce this risk by negotiating for a longer notice period (say, 180 days rather than 90 days) or by requiring only "for cause" termination beginning in the second or third or fourth year of a five-year contract. In other cases, you as the employee may affirmatively want the freedom to leave "without cause" and with only a minimal notice period of 60 or 90 days because (for example) you may have doubts about the long-term viability of a particular position or you believe there is a good chance a better opportunity will come along.

The upshot is this: In contrast to the issue of malpractice insurance (where *every* physician *always* wants her employer to obtain and pay for the best malpractice insurance and tail coverage available), there is no "one size fits all" formula with respect to term and termination. One physician might want as much job security as possible, while another might want the freedom to leave a position at any time, for any reason, with minimal notice. The important thing is that you understand what a hospital or health system is proposing with respect to term and termination, and that you determine whether the proposal meets your needs or merits further discussion and negotiation.

## E. AGREEMENT NOT TO COMPETE WHEN EMPLOYMENT ENDS

You must consider what happens if and when your employment with a hospital or health system comes to an end. Often, physician employment agreements will contain "non-competition" clauses. These contractual provisions may prevent you from practicing within a specific geographic area for a set period of time following employment. As a result, you may find that returning to private practice presents a daunting challenge.

You should be aware that several states have outlawed or severely restricted physician agreements not to compete, including Alabama, California, Colorado, Louisiana, Montana, North Dakota, and South Dakota.[23] In addition, when disputes arise, courts generally undertake a thorough review of non-compete agreements to ensure that they are fair to all parties and to the public at large. Courts tend to be particularly skeptical of non-compete agreements that appear to deny the public at large access to needed medical services. As you know, we have a growing national shortage of primary care providers. Generally speaking, a primary care physician should not accept a non-compete provision restricting her ability to go back into private practice, although a provision preventing her from going to a competing hospital might be enforceable.

## SAMPLE NON-COMPETE PROVISIONS: PRO-HOSPITAL VERSUS PRO-PHYSICIAN [24]

Below is a sample non-compete provision generally favoring the hospital or health system ("Pro-Hospital") and an alternative provision generally favoring the physician ("Pro-Physician").

Pro-Hospital: "Physician agrees that upon the expiration of this agreement, or upon the termination of this employment agreement by either party for any reason, Physician shall not practice medicine within a 20-mile radius of any current or future office of Hospital for a period of three years after such termination."

Pro-Physician: "Physician agrees that upon termination of this employment agreement, where such termination is by Hospital and for cause, Physician shall not practice medicine within a two-mile radius of any current or future office of Employer for a period of six months after such termination."

Comments:

(1) Under the Pro-Hospital version, the non-compete requirement kicks in if the employment agreement expires naturally or if it is terminated, regardless of who and what causes the termination. Under the Pro-Physician version, the non-compete requirement kicks in only if the Hospital or health system terminates the agreement for cause.

(2) The Pro-Hospital version requires that the Physician refrain from practicing medicine within 20 miles of any Hospital facility for a period of three years. The Pro-Physician version requires that the Physician refrain from practicing medicine within two miles of any Hospital facility for a period of six months.

(3) The geographic scope of the non-compete requirement can be deceptive. As a physician subject to a non-compete requirement, you might think that the two-mile geographic scope contained in the Pro-Physician version would always be preferable to the 20-mile geographic scope contained in the Pro-Hospital version. But if the two-mile restriction were in midtown Manhattan and the 20-mile restriction were in rural North Dakota, then the physician may well prefer the 20-mile restriction over the two-mile restriction. The lesson is obvious: When negotiating the geographic scope of a non-compete provision, consider the population density around the hospital.

# CONCLUSION

We hope that this white paper has helped you understand and evaluate your career options in general and the hospital employment option in particular. If we can leave you with a single take-home message, it would be this: It is critically important that you understand the key terms of any proposed employment contract with a hospital or health system, and that you negotiate the best possible employment arrangement for yourself. If you become actively involved in a thorough and thoughtful negotiation with your future employer, you may be surprised at the latitude you have to negotiate a better deal for yourself.

The good news is that, as you evaluate your options and move forward with your career, you are not alone. Your classmates, teachers, supervisors, and colleagues can be tremendous sources of ideas and advice. In addition, the North Carolina Academy of Family physicians and the American Academy of Family Physicians are dedicated to assisting you in making thoughtful and well-informed decisions about your career in family medicine. For additional information, please visit our websites:

North Carolina Academy of Family Physicians: www.ncafp.com

American Academy of Family Physicians: www.aafp.org

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# ENDNOTES

[1] For ease of reading, we use the terms "hospital," "health system," and "academic medical center" interchangeably because most of the employment considerations are the same. Where they are different, we have so noted.

[2] This white paper draws substantially on a prior white paper by the same law firm – Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P., entitled "The Family Physician's Practice Affiliation Guide" (undated). Given the common authorship of both white papers, the authors of the current white paper have opted not to include what would otherwise be cumbersome and distracting quotation marks and references to the prior white paper.

[3] Alice G. Gosfield, "Is Physician Employment by Health Systems an Answer?," Journal of Oncology Practice, October 22, 2013.

[4]Susan Kirchoff, "Physician Practices: Background, Organization, and Market Consolidation," Congressional Research Service, January 2, 2013, p. 10 (citing American Hospital Association survey data).

[5] Carol K. Kane and David W. Emmons, "New Data On Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment," American Medical Association, 2013, pp. 4-6, 9 (Exhibit 1) & 10 (Exhibit 2).

[6] Carolyn Kimmel, "The Days of Solo Medical Practice are Waning, But Some See Positive Aspects in the Changes," May 31, 2013, accessed November 13, 2013, http://www.pennlive.com/bodyandmind/index.ssf/2013/03/the_days_of_the_solo_medical_p.html (quoting Dr. Scott Setzer, a family physician in Pennsylvania).

[7] Kimmel, "The Days of Solo Medical Practice," (discussing survey data from the American Academy of Family Physicians).

[8] Kane and Emmons, "New Data," at pp. 4-6, 9 (Exhibit 1) & 10 (Exhibit 2).

[9] Kane and Emmons, "New Data," at pp. 4-6, 9 (Exhibit 1) & 10 (Exhibit 2).

[10] Kane and Emmons, "New Data," at pp. 4-6, 9 (Exhibit 1) & 10 (Exhibit 2).

[11] Bonnie Darves, "Physician Compensation Models: Big Changes Ahead," New England Journal of Medicine Career Center, January 2011, accessed November 13, 2013, http://www.nejmcareercenter.org/article/physician-compensation-models-big-changes-ahead/.

[12] Mark McClellan et al., "A National Strategy To Put Accountable Care Into Practice," Health Affairs, vol. 29, no. 5, 2010, p. 982 & n.1.

[13] McClellan et al., "A National Strategy," pp. 982-83 (emphasis added).

[14] Jen Wieczner, "Pros and Cons of Concierge Medicine," Wall Street Journal, November 10, 2013, accessed November 21, 2013, http://online.wsj.com/news/articles/SB10001424052702303471004579165470633112630.

[15] Steve Hargreaves, "Cash-only doctors abandon the insurance system," CNN Money, June 11, 2013, accessed November 21, 2013, http://money.cnn.com/2013/06/11/news/economy/cash-only-doctors/.

[16] Note some states restrict employment by physicians by hospitals or health systems. If you plan to practice medicine in California, Colorado, Iowa, Ohio, Texas, or other so-called "corporate practice" states, hospitals are generally prohibited from directly employing physicians in those states, with certain exceptions and exemptions. In some other states, there is uncertainty whether hospital employment of physicians is allowed. In states where hospital employment of physicians is or may be restricted, many hospitals have developed alternate means – such as the creation of medical foundations in California – to acquire and manage physician practices.

[17] Association of American Medical Colleges, "AAMC Releases New Physician Shortage Estimates Post-Reform, September 30, 2010, accessed November 15, 2013, https://www.aamc.org/newsroom/newsreleases/2010/150570/100930.html.

[18] American Medical Association, "AMA Principles for Physician Employment," adopted 2012, principle (3)(b).

[19] Contract language adapted from American Health Lawyers Association, Representing Physicians Handbook, Third Edition, December 2012, pp. 156-57.

[20] 42 U.S.C. § 1320a-7b(b) and 42 U.S.C. § 1395nn, respectively.

[21] Contract language adapted from American Health Lawyers Association, Representing Physicians Handbook, Third Edition, December 2012, p. 160; and American Medical Association, Annotated Model Physician-Hospital Employment Agreement, March 2012 Supplement to 2011 Edition, pp. 25-26.

[22] "AMA Principles for Physician Employment," principle (3)(b).

[23] Cynthia Y. Reisz and Philip F. Berg, "Use of Non-Competition Covenants in Physician Employment Relationships," American Health Lawyers Association, Representing Physicians Handbook, Third Edition, December 2012, p. 529.

[24] Contract language adapted from American Health Lawyers Association, Representing Physicians Handbook, Third Edition, December 2012, p. 170.