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Disaster-proof your practice

By Howard Larkin

From minor setbacks to worst-case scenarios, planning for bad news is vital.

While vacationing in Hawaii with her son and daughter in April 2007, pain-management specialist Lynne Carr Columbus found herself confronting a pain of her own. Her gall bladder had been removed two weeks earlier, and she was suddenly experiencing severe upper thoracic and back pain. "It was so bad I couldn't sleep," she remembers.

Back home in Palm Harbor, FL, she found out why: A CT scan showed multiple pulmonary nodules and a PET scan revealed lesions on her spine and hip. Biopsy of a tumor at T4 revealed that the 43-year-old had Langerhans cell histiocytosis, a rare, cancer-like immune disorder that primarily affects children.

By the end of May, Columbus started chemotherapy. Between the fatigue of chemo and excruciating pain from the lead apron pressing on her tumors when she delivered radio-guided spinal injections, she wasn't able to work much. So in June she started filing insurance claims to keep open her 3,000-patient practice and multidisciplinary pain center.

Fortunately, Columbus had planned ahead. The solo practitioner had disability coverage to replace her income and overhead coverage to pay her 12 employees and office expenses. She had comprehensive health insurance and even a supplemental cancer policy to pay non-medical costs, such as travel expenses.

Even so, when disaster struck, some holes in her plan appeared. She hadn't counted on the three-month income interruption before her long-term disability policy kicked in. And, in her weakened condition, she found insurance documentation demands burdensome. Columbus' attempt to keep the practice running by hiring locum tenens midlevel providers was a disaster. She ended up taking on a temporary physician partner who may eventually take over the practice.

Despite these glitches, the steps Columbus took to protect her practice are paying off. While her income is down by about half, she's able to support her family. And the practice she worked years to build will be there when she's ready to return.

For most physicians, a hardship like Columbus' would wreak havoc on their professional and personal lives. Below are some steps to take — and some pitfalls to avoid — to protect your practice, and you, should you become unable to work.

Think worst-case scenario

The threat Columbus faces looms over every solo and small group practice. If you're not able to work —

even for a short time — you could lose it all. "In a two- or three-physician group, if one doctor becomes disabled, it can bring the whole practice down," says C.J. Millett, a financial planner with the Commonwealth Planning Group in Boston. "There is a need for income to cover overhead that doesn't go away."

A crisis action plan can help, says Bob Cimasi, president of Health Capital Consultants, a St. Louis firm specializing in practice valuation and value enhancement strategies. The place to begin is with the worst-case scenario. "Painful as it may be, you need to ask yourself what you'd do if Dr. Jones gets hit by a truck. How will you generate income for your family and yourself? How will you pay practice bills? How will you keep the practice running? How will you take control of the practice?"

These questions are related, but have very different answers, Cimasi says. In general, crisis needs fall into two categories: personal and business. Your plan should include not only insurance coverage for income replacement and business expenses, but also detailed operational plans for keeping the practice running until you can rejoin it or sell it. Power of attorney and other legal documents should be prepared to facilitate transfer of practice control in an emergency, he adds.

For the ultimate disaster, life insurance is an option. Separate policies should be in place to provide income for survivors and to fund practice needs. The amount of coverage you need will depend on individual circumstances.

On the personal side, you'll need enough to support your family after you're gone. That amount may decline as you accumulate assets and your children get older. On the business side, your need will depend on whether and how long the practice will continue operating. If you have partners, buy enough insurance to fund a buyout and cover locum tenens and overhead costs required to replace your services.

Cimasi recommends planning for replacement costs even if the intent is to sell. He points out that the practice will be much more valuable as an ongoing concern. "We get calls from grieving families all the time wanting to sell the practice four or six or eight months after the doctor has had a stroke. They tell us their colleagues all helped out and took care of the patients. But now the patients are all gone and the medical records are dispersed, and there's nothing left to sell."

Similar considerations apply for disability. Income replacement is covered by disability insurance, while business needs are addressed by some form of business interruption insurance, such as overhead insurance or "key man" insurance, Cimasi says.

Here again, income replacement needs change over time, says Brian Abeles, a disability claims specialist with Everest Ventures in Tampa. "If you're under 50 and you don't have a lot of assets, you may want a policy that covers your whole life. But I have a client who is 59, with a fully funded retirement plan, who just cut her coverage to age 65 because her retirement income needs are taken care of."

Some doctors even choose to go bare. "Disability insurance is really expensive. I think it's better to put the money in other investments," says anesthesiologist Harold Berner of South Barrington, IL. As a member of a mid-sized group, he had coverage and used it when a burst appendix led to peritonitis and about two months off work. But when he went out on his own at age 55, he decided against coverage. "I have enough assets to get by if I can't work, and social security will give me some income," Berner says.

The need for overhead or business interruption coverage also varies. Generally, policies with a 90-day exclusion make the most sense because they are the industry standard, which makes predicting risk easier, Abeles says. He suggests looking at other options to bridge the gap. Many practices can get by for about a month on accounts receivable. A line of credit to cover the rest is another option that may

make more sense than paying the large premium that typically accompanies a shorter exclusion period, he says.

Forge a succession plan

Business interruption policies can fund overhead to keep a practice going. But skilled practitioners are needed to continue providing services. The amount of insurance you need depends to a large extent on how much it will cost for overhead and locum tenens replacements. Without the ability to serve patients, the practice depreciates quickly, Cimasi emphasizes.

Columbus discovered this economic fact of life the hard way. When she learned she needed chemo, her first thought was to cash out and focus on getting well. With an established patient base and onsite interventional pain management, physical therapy, and mental health counseling, she figured her practice would bring a good price. She figured wrong.

"I talked to several people about buying, but I found I had nothing to sell," Columbus says. "You can sell your equipment, but no one will buy your practice. If you pass away or relocate, they know they will end up with your patients because your patients will have no place else to go. That was a shocker to me." After unsuccessful attempts to keep the practice going using locum tenens midlevel providers to help her see patients, she took on a temporary physician partner who may eventually take over the practice. "Once I had a doctor to help out, things got better," Columbus says.

Millett suggests making advance arrangements with physicians who can take over in an emergency. It may even make sense to strike a deal with a competitor, he says.

Having legal documents in place that allow successors to take control of the practice is also essential, as orthopedic surgeon Jordan Schubert found out. During his first year in private practice in Bangor, ME, the physician who had hired him died suddenly. "We had agreed to my buying into the practice, but we never did any paperwork. Consequently, when he died, I had no ability to sign corporate paperwork or sign checks. We had accounts receivable and bank accounts I couldn't access."

With cooperation from his deceased partner's widow, Schubert was able to buy the practice from the estate and get it back on track. But it took about three months. "I realized my career was in jeopardy. It made the point that anything that threatens your ability to work is a severe threat to family and future."

Since then, Schubert has added six partners. In each case, agreements have been signed before employment commences. The contracts include provisions to cover each other's practice expenses for up to 90 days in the event of a disability and lay out steps to take over each other's practices in emergencies. Schubert also buys the most disability and overhead coverage he can get. Even though he has been unable to operate on several occasions due to treatment for his elbow, he's always been able to do office work and has never been off work for the 90 days it would take to activate the policies.

Beware of the fine print

Schubert is fortunate that he has not had to file a disability claim. As Columbus discovered, doing so can be extremely trying. In addition to extensive documentation of her physical condition, her carriers required details of her practice, including to the number of procedures by CPT code and the amount she spent on office supplies.

"I spent 12 hours on three Sundays in a row getting the information together," she says. "It was killing me." After the initial claim was accepted, Columbus had to refile to get additional payments, and the benefits approved fluctuated from month to month. She finally hired Abeles to handle it.

"It cost me a bundle, and I often wonder if all of this hassle was really worth it. A large percentage of what I've collected from disability has gone toward paying someone to get the paperwork completed," says Columbus.

Cimasi notes that many small practices are not set up to generate the kind of information needed to file a disability or business interruption claim. Most gather financial information on a cash accounting basis. But an overhead claim generally will require assignment of overhead costs on an accrual basis. It may be worthwhile to have an accountant structure your books to support this, even if you continue using a cash system for tax purposes. He also suggests finding out exactly what information will be needed to file a claim before you buy a policy and setting up your office to provide it. That way, you won't have to dig for it when it's time to file a claim.

Abeles points out that disability policies vary widely in their requirements and assumptions. He strongly recommends comparing the terms of several policies and "running some scenarios" to make sure they meet your needs. Some elements to look out for include:

Exclusions for pre-existing conditions. A two- or three-year exclusion is typical, but 10 years or more is not unheard of, Cimasi says. Also pay attention to the standard for determining a pre-existing condition. If all that is required to show a pre-existing condition is a note in any medical record, you may not ever be able to collect. A formal diagnosis by a qualified specialist should be required.

Definition of total and residual disability. Policies generally require demonstration of disability based on standard tests. The problem is, the threshold for failing the tests may be lower than the performance level required to practice medicine. A physician who is suffering dementia may still have enough intellectual capacity to pass the test, but not enough to practice. Static disability tests also may not pick up issues like loss of stamina that may sharply limit a person's ability to work every day, Abeles notes.

Benefits determined by percent disability vs. income loss. Some policies base benefits on the percentage of disability determined by standard tests. These, too, can underpay if a "minor" disability, such as impaired hand strength, makes it impossible for you to perform procedures as you have in the past.

Benefits offset by residual income versus percentage of loss. Some policies — particularly overhead policies — will reduce benefits dollar-for-dollar for any income you still receive, while others adjust the benefit based on the percentage of income you are losing. The difference is important. If you have 50 percent coverage for overhead of $50,000, and you are still generating $20,000, an income offset would cut the benefit to $5,000 while a percentage would leave you with $15,000.

Definition of income. If part of your income is characterized as a bonus, it may not be considered income, even if the bonus is based entirely on your productivity.

Cancellation and inflation protection. Look for policies that are not cancelable and increase benefits for inflation. Riders allowing you to buy more coverage increases are also valuable.

How you purchase coverage also matters. Benefits from policies purchased by your practice will come to you as taxable income, while those purchased by you individually will be tax-free, Cimasi points out. Policies bought through your practice may also be considered federally qualified benefits in many jurisdictions, and therefore exempt from state insurance laws, Abeles notes. This makes it nearly impossible to sue if your carrier denies a claim, which could cost you thousands of dollars. "We always recommend individual purchase of disability coverage," he says.

Because disability and overhead policies are so complicated, Abeles recommends consulting a broker.

Ask how policies from different companies differ and what the different contract terms mean. "It's not rocket science if you read the policies side by side." Ask if your agent has consulted with his vendor's underwriters, claims adjudicators, and actuaries on how policy language is interpreted. "If they've only met with the marketing department, they probably don't know how the policies work."

Finally, if you do have a crisis, don't surrender, Columbus says. She goes into her office for a few hours two or three days each week. "I could have easily given up, but I worked too hard for this. It keeps me going mentally. I love my patients, I love my work, and I love my staff."

Crisis planning tips

Start early. Disability, life, and other insurance is cheaper and easier to get, plus you need more protection earlier in life. Get policies that can't be cancelled and can be increased as your income grows.

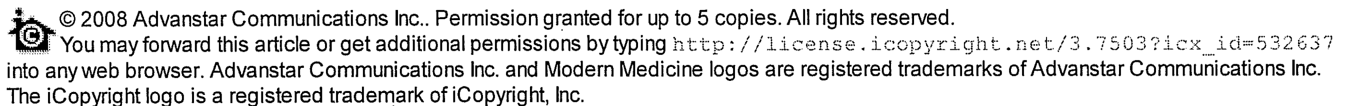
Develop a formal crisis plan. It should include insurance for income replacement and practice needs, as well as operational plans to bring in backup physicians and transfer control of your practice as needed.

Integrate crisis, financial, and practice plans. Your personal insurance needs will depend on your other assets and financial needs. Your practice coverage needs will depend on whether you want your practice to continue, whether you have partners, etc. Your crisis plan should be structured to achieve those goals.

Understand insurance policy terms. Disability and business interruption insurance are extremely complex and specialized. How disability is defined, how overhead is assessed, and how benefits are structured will have a huge impact on how much you'll get when you file a claim. Understand and compare policies to make sure they meet your needs.

Be ready to provide information. Collecting on disability coverage can be difficult. Knowing in advance what information you'll need will help you structure your books to provide it.

Review your plan often. Your needs will change over time. So should your crisis plan. Periodic review and update will help you keep on track.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