Filling in the Gaps: Disability Risk Management for the Medical Community

Executive Summary

Most would agree that changes in the business world move at an increasingly rapid pace, but developments in the healthcare industry are evolving at lightning speed. There is a fundamental change occurring to the underlying infrastructure of hospitals and private practices as larger health systems continue expansion through mergers and acquisitions. These events are leading to significant investment in an employer/employee model between health systems/physicians. The financial commitment of recruiting top physicians requires not only upfront capital but ongoing risk management to ensure long-term success. Disability insurance is often an area of focus that is covered by organizations, but not nearly to the degree that is warranted for a specific group of professionals such as physicians. Often, nearly the existence of a disability insurance program gives a false sense of security for all parties involved. This paper explores the changing forces in the makeup of the healthcare industry and how risk factors such as disability must be addressed for both the physician and organization if this model of employment is going to be successful.

M&A Explosion

The healthcare industry in the year 2011 experienced nearly a 12% increase in mergers and acquisitions activity.[1] A continuation from the last few years of larger consolidation by health systems of hospitals and private physician practices, the trend has been a greater shift towards an employer/employee relationship between health systems/physicians as evidenced by the increase of hospital-employed physicians by 32% from 2002 to 2011.[2] Both sides are seeking specific improvements to the current structure that they cannot accomplish on their own.

The first reason most physicians give for selecting the hospital employment model is work-life balance. Not surprisingly, the second most popular reason that physicians are seeking alignment with hospitals is the desire for competitive benefits and retirement packages[3]. In turn, the health systems are seeking physicians as employees because they are seen as the key driver in improving cost and profitability. This leads one to the conclusion that competition amongst

[1] Irving Levon Associates, Inc. *The Health Care M&A Information Source,* 2012
[2] American Hospital Association, *AHA Hospital Statistics*, 2012
[3] PwC, *From Courtship to Marriage: A two part series on physician-hospital alignment,* 2011

organizations for the strongest talent pool will continue to rise as physician employees become that much more critical to the long-term success.

There is much debate as to quantifying the hard cost of retention, but it may be greater than $1.0 million to the health system when factoring in the actual recruitment process, training, and lost revenue of a departing physician[4]. However, there are other soft costs that are more difficult to quantify, but clearly have an economic impact, such as team morale, organizational intangibles, and interdepartmental referrals to name a few. The ability to recruit physicians will be directly tied to compensation packages, including benefits, but the ability to retain them may be more then just preventing them from leaving for sunnier pastures. Retention can come in many forms, and one obstacle for organizations can be a physician's disability. An effective retention program should include a disability benefit that encourages physicians to return to work quicker, even if only part-time, without penalizing them from a financial standpoint. The sooner the professional returns to work the quicker the employer's loses will be capped.

Physician's Point of View

Income Effect

Physician disability income insurance programs are often a part of an overall benefits program sponsored or paid for by medical employers. Though such plans do get a strategic lookover as a staple of competitive compensation packages, they do not receive nearly the attention that is warranted in light of the changing economic and investment environment that the physician class is now experiencing. The mindset that additional disability insurance above and beyond the group coverage limits is not a concern for administration might be a short sighted strategy.

From 1988 to 1998 the US experienced great prosperity with average annual returns of approximately 18.5% in the stock market.[5] This allowed many highly compensated professionals to grow wealth by investing earned compensation into rapidly growing retirement plans. This accompanied with a rising housing market created the so called "wealth effect" where a physician could feel emotionally secure and confident about the future. This made many

[4] Health Leaders Media, *Strategic Physician Recruiting*, March 2012
[5] http://dqdj.net, S&P 500 Return Calculator

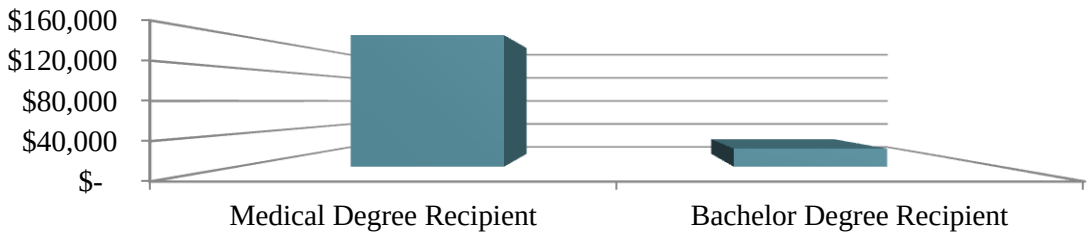
feel insulated from the threat of the loss of income triggered by a disability because a loss of income could be more easily cushioned by a strong investment portfolio.

The wealth effect is now gone. For the ten year period ending 2011 the average annual return for the S&P was only 2.84%[6] and coupled with the fall in housing values, the importance of maintaining an income has never been more vital. Additionally a disabled physician not only loses the ability to earn an income, he or she loses the ability to defer income into tax deferred retirement plans that is often matched by the employer's contributions. The compounding effect of taxation on income that could have been deferred but was not can be devastating.

The decision to become a physician is one of the largest financial investments an individual will make in their lifetime. As shown in the chart below, the average debt in educational loans for a student graduating from medical school is approximately $160,000 as compared to $22,000 for the bachelor degree recipient, but that does not include the additional costs of room and board, books, insurance, food, and other costs of daily living[7]. These contributing expenses, year over year, make the cost much more substantial. However, the total economic cost of entry is much greater as it includes all the years of foregone earnings that could have been earned had they been working instead of studying and training. Given the intellectual ability of physicians, it is safe to assume they likely would have made significant income in other professions during the years in which they were in medical school and residency training. This double negative, carry cost of student debt and the inability to produce large incomes, prevents physicians from accumulating assets for an extended period. Given these two factors, it becomes clear that once a physician begins to earn an income, protecting the income is vital.

[6] http://dqdj.net, S&P 500 Return Calculator
[7] American Medical Association, *Medical Student Debt*, 2009

Educational Loan Comparison



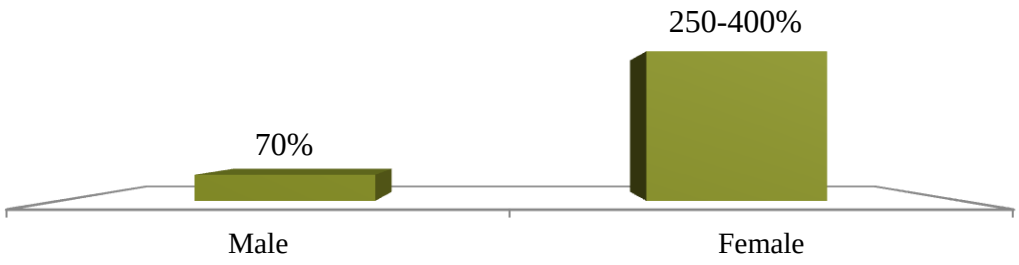
Data sources: American Medical Association and American Student Assistance

Disabling Events

Physicians need plans that address their specific needs. The two most prevalent forms of disability are related to musculoskeletal/connective tissue (30.1%) and mental/nervous system disorders (13.4%)[8] both of which would likely render a physician unable to perform work the way that they need to. A major concern for physicians is the rise of mental/nervous disorders in the medical community with depression and anxiety being present but not treated. There is also a greater risk of suicide among physicians than their non-physician peers. Male physicians are 70% more likely to commit suicide and female physicians are 250% - 400% more likely to commit suicide then non-physicians[9]. Alcohol and drug abuse can also be a problem that disrupts the ability for the physician to perform at the demanded level. It is extremely difficult for physicians to acknowledge a mental/nervous disorder due to state medical regulations, stigmas, or organizational repercussions. Physicians not seeking treatment for any of these reasons may be a driving factor in the higher suicide rates. Often, the group policy or the physician's individual disability insurance policy is inadequate in terms of what it will cover for these types of conditions or for how long it will cover the disability.

[8] Council for Disability Awareness, *2011 Long Term Disability Claims Review,* 2012
[9] American Foundation for Suicide Prevention, *www.afsp.org,* 2012

Greater Suicide Rate of Physicians than Non-Physicians



Male physicians are 70% more likely to commit suicide then their non-physician male peers. Female physicians are 250% - 400% more likely then their non-physician female peers.

Income Protection

Ninety percent of Americans view the ability to earn income more valuable than retirement savings, medical insurance, personal possessions, homes, or any other forms of savings, yet income is often overlooked in terms of insuring it to the fullest.[10] If a physician were to purchase a beautiful new home or vehicle would he or she insure only half of the replacement value or one that excluded damages pertaining to fires? Of course not, but that is exactly what many physicians do when it comes to insuring their income. They obtain disability insurance by way of group coverage and believe they have done enough to protect their income, or their plan design is one that does not cover disabilities that are prevalent in physicians. This is especially true with younger physicians that do not seem to have received as much education on this topic. Participation in weak or poorly designed coverage is perplexing. As discussed herein, the inability to produce income is the greatest risk a physician faces. One must conclude that the physicians and or the employer are assuming the odds of incurring a disability are somewhat low, therefore making the premiums seem high for the risk involved. The statistics show just the opposite.

[10] Council for Disability Awareness, *CDA 2010 Consumer Disability Awareness Study,* 2010

So what are the probabilities of an individual becoming disabled? A worker has a one in three chance that he or she will be disabled for at least six months during their career with the average disability lasting approximately 31 months[11]. A person that is disabled for a period longer than this drastically increases the chances of not being able to return to work. The probabilities of someone being in a car accident during a lifetime are one in four[12] and the probabilities of a house fire in any given year are less than one in one thousand[13]. In both cases of the car accident and the house fire, the individual may still be able to work, which is not the case for the physician that is disabled. This is certainly an indication that greater awareness of disability gaps needs to be raised.

Enterprise Value for the Health System

Risk Philosophy

A strategic philosophy of risk for the hospital system that is looking to build enterprise value must be one that provides great disability benefits to physicians while at the same time encourages and rewards physicians that return to work. It is not beneficial for the hospital's financial well being, or for society, when a disability results in a better outcome for the physician by not returning to work. As discussed in the M&A Explosion section, with the cost of the physician to the organization estimated at greater then $1.0 million the health system can not afford to lose physicians in any way, shape, or form, including disability. Because of this, hospital administration should have a vested interest in risk management policies that (1) provide the best available benefits in the event the physician is disabled and not working in another occupation, (2) reinforcement that a physician incurring a disability will be highly incentivized financially and emotionally to return to work and (3) alleviate the strain on the organization due to rising costs. For example, the hospital does not want a neurosurgeon in a better situation financially by collecting disability benefits and working as a general physician at the same time. Without a provision offsetting the benefit by income earned in another field of work, the neurosurgeon would be incentivized to not return to surgery. It would also be sound policy to provide the neurosurgeon who is still partially disabled with a return to work incentive that

[11] Council for Disability Awareness, *CDA 2010 Consumer Disability Awareness Study,* 2010
[12] National Safety Council, *Injury Facts*, 2008 edition
[13] National Fire Protection Association, *www.nfpa.org,* 2012

provides complete financial stability otherwise the surgeon won't return at all. There are ways to accomplish both through proper risk management and minimizing expense to the organization.

Providing Benefits

As the health system model continues to evolve, the physicians are being asked to take on more responsibility in the forms of committees and governance. Their involvement is critical to the hospitals success of improved profitability as the physician is more conscious of organizational performance when they have a greater level of high-level involvement. While their schedules are already demanding, the physician will have little time in the future for activity that does not pertain to practice or leadership. Anything the organization can do to assist in alleviating other activity will increase enterprise productivity. Seventy-eight percent of employers say that employees are less productive at work when they are worried about personal financial problems and fifty-eight percent of companies say that personal financial issues lead to employee absences to some degree[14].

Hospitals can help their physicians specifically in the realm of risk management and benefit planning by doing the research on possible programs and providing the physicians with the best options, even if the organization does not bear the cost of the benefit. One way this can be accomplished is by offering benefits such as supplemental individual disability policies that are sponsored by the employer. These plans provide substantial discounts, potential for no underwriting, and other features that are simply not available to physicians that obtain it by themselves.

Employees are altering the way they view benefits in terms of a willingness to contribute more to the cost of sustaining them. This seems to be especially true in the healthcare industry where the receptiveness of voluntary benefits or partially sharing the expense is higher then other industries. New individual disability policies in the medical occupational class increased greater than any other class in 2011.[15] The fact that there is merely the availability of solutions that are more cost efficient, innovative, and unattainable then benefits the employee could receive on

[14] MetLife, *9th Annual Study of Employee Benefits Trends: A Blueprint for the New Benefits Economy*
[15] Gen Re, *2011 Individual DI Market Survey Summary Report,* 2012

their own is greatly appreciated. This can be a tremendous way to increase morale while adding little to no expense to the bottom line.

Conclusion

Risk management initiatives and employee benefits will continue to be a point of focus for health systems as the relationship with physicians moves increasingly toward an employer/employee model. Most organizations will find that in certain situations, having them both closely aligned in the decision process of what is implemented will result in improved efficiencies to the organization. This may require coordinated leadership from the top of the organization, but the outcome will be well worth the effort.

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