

Preparing for Practice

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CV, cover letter and interview preparation

A curriculum vitae (CV) is a type of résumé used by professionals in the fields of academia, medicine, teaching and research. A CV is an overview of your life's accomplishments, most specifically those that are relevant to the academic realm. It is a living document that should be updated frequently to reflect the development of your career. This chapter provides an overview of strategies for writing an effective CV.

Differences between a résumé and a CV

There are several notable differences between a résumé and a CV, including the following:

- Education is always listed first on a CV. Most candidates who use a CV have an educational background directly related to the positions they seek.
- CVs almost never list an objective and seldom have a long narrative profile. If you want to make a more elaborate argument for your application, do it in a cover letter.
- CVs should be understated. Self-congratulation can make you appear overconfident, so keep your CV descriptive yet simple.

- Name-dropping is more common in CVs than in résumés. For example, if you performed research under a certain professor, you would probably include his or her name and title. Science and academia are small worlds, and it is likely that a prospective employer will have heard of a given specialist in his or her own field.
- Unlike résumés, which typically should be limited to one or two pages, CVs often run for three or more pages. However, length is not the determinant of a successful CV. You should try to present all the relevant information that you possibly can, but also try to present it in as concise a manner as possible.
- CVs often contain more categories of information than résumés and should be neatly organized with clear headings and distinct conceptual divisions. Experience may be divided between headings for “Teaching” and “Research”; education may be divided between “Degrees” and “Continuing Education” or “Advanced Training.” How you organize this material determines its impact on the reader.

Is there a standard CV format?

One of the most important things to remember when working on your CV is that there is not one standard format. A good CV is one that emphasizes the points that are considered to be most important in your discipline and conforms to standard conventions within your discipline. So how can you find out what these conventions are?

A good place to start is to find as many examples as possible of CVs by people in your discipline who have recently been in the job market. You can find these by asking a mentor or colleague or by doing an Internet search.

What should I include?

Your CV should include your name and contact information, an overview of your education, your academic and related employment (especially teaching, editorial or administrative experience), your research projects (including conference papers and publications), and your departmental and community service. You should also include a reference list, either as part of your CV or on a separate page.

What comes first on your CV depends both on your background and on the job for which you are applying. Typically, the first item on a CV for a job candidate directly out of residency is education. The remaining items depend on the requirements of the jobs you are interested in and where your strengths lie. When determining what comes after your educational credentials, remember that the earlier in your document a particular block of information appears, the more emphasis you will be placing on that block of information. Thus, the most important information should come first.

How do I construct my work description entries?

Two common strategies that apply to CVs as well as résumés are gapping and parallelism.

Gapping is the use of incomplete sentences in order to present your information as clearly and concisely as possible. For example, instead of writing “I taught composition for four years, during which time I planned classes and activities, graded papers, and constructed exams. I also met with students regularly for conferences,” you might write, “Composition Instructor (2000–2004). Planned course activities. Graded all assignments. Held regular conferences with students.” By using incomplete sentences here, you cut out unnecessary words and allow your reader to see quickly what you have been doing.

Parallelism is also important to a strong CV. Generally, you will want to keep the structure of your phrases and/or sentences consistent throughout your document. For example, if you use verb phrases in one portion of your CV to describe your duties, try to use them throughout your CV. Verb phrases are a strong way to describe job responsibilities. To write them, pretend you are telling someone about your job, beginning each sentence with “I ...” For example, “I supervise 10 residents. I organize the call schedule.” On your CV, simply omit the “I” and use only the remaining verb phrases to describe the work you do. Use the present tense for jobs you currently hold and past tense for former jobs. If you have difficulty finding the right verbs to describe your work, choose from the following list.

Verbs for your CV

accomplished	completed	diversified	improved	oversaw	revised
achieved	composed	drafted	increased	participated	revitalized
acquired	conceptualized	edited	influenced	performed	saved
acted	conceived	educated	informed	planned	scheduled
adapted	concluded	eliminated	initiated	prepared	screened
addressed	conducted	enabled	innovated	presented	set
adjusted	consolidated	encouraged	inspected	presided	shaped
administered	contained	engineered	instructed	prioritized	screened
advanced	contracted	enlisted	interpreted	processed	selected
advised	contributed	established	interviewed	produced	simplified
allocated	controlled	ensured	introduced	programmed	solidified
analyzed	coordinated	estimated	invented	projected	streamlined
applied	corrected	evaluated	investigated	promoted	strengthened
appraised	corresponded	examined	kept	provided	summarized
approved	counseled	executed	launched	published	supervised
arranged	created	expanded	lectured	recommended	surveyed
assembled	critiqued	expedited	led	reconciled	systemized
assigned	decreased	extracted	managed	recorded	tabulated
assisted	delegated	facilitated	manufactured	reduced	taught
attained	decided	familiarized	marketed	referred	tested
authored	defined	finalized	mediated	regulated	trained
automated	delivered	focused	moderated	rehabilitated	translated
balanced	demonstrated	forecast	modified	related	traveled
brought	determined	formulated	monitored	remodeled	updated
budgeted	designed	founded	motivated	repaired	upgraded
cataloged	developed	generated	negotiated	reported	validated
chaired	devised	guided	observed	represented	worked
changed	diagnosed	handled	operated	researched	wrote
clarified	directed	headed up	ordered	restored	
communicated	dispatched	identified	organized	restructured	
compared	distinguished	illustrated	originated	reversed	
compiled	distributed	implemented	overhauled	reviewed	

Particularly within entries, make sure that the structure of your phrases is parallel so your reader can easily understand what you are communicating.

One distinction between the work description sections of résumés and CVs is that bullets are very commonly used in résumés but tend to appear somewhat less frequently in CVs. Whether you use bullets to separate lines in your CV should depend on how the bullets will affect the appearance of your CV. If you have a number of descriptive statements about your work that each run to about a line in length, bullets can be a good way of separating them. If, however, you have a lot of very short phrases, breaking them up into bulleted lists can leave a lot of white space that could be used more efficiently. Remember that the principles guiding any decision you make should be conciseness and ease of readability.

Assembling your CV

When putting together your CV, consider the following:

- **Name**—list your full legal name. This is particularly important if you were single when you received your MD degree and have since married or changed your name for other reasons. This allows prospective employers to verify that the information you provided is accurate.

- **Address**—provide home and office/hospital addresses. If you do not want to receive correspondence at your work address, do not list it. Make sure that the addresses are current.
- **Phone, fax, pager numbers**—make it easy for a potential employer to contact you by providing home and office/hospital telephone, fax and/or pager numbers. Do not provide numbers where you do not want to be reached.
- **Education**—list in descending order, with most recent first. Note the name of the institution, degree received and dates.
- **Certification and licensure**—list applicable board certification(s), national board examination and licensure data (including year and state). Give dates of completion for each. If you are in the so-called board certification pipeline but have not yet taken the final boards, you may want to state just where in the process you are—e.g., written boards, oral boards, awaiting results, board-eligible (only if your specialty board recognizes this designation).
- **Postgraduate training**—cite all training, such as internship, residency and fellowship, with name of institution and dates. List the most recent training experience first.

- **Practice experience**—again, begin with the most recent experience and work backward. This makes the CV much more practicably usable.
- **Professional or teaching appointments**—include academic and professional appointments, fellowships and other unique training experiences. Also mention special expertise in a certain medical procedure, administrative experience and fluency in foreign language.
- **Research and publications**—cite presentations and publications. If this listing is long, you may want to tailor this section to the position you're seeking.
- **Accomplishments**—if you have a track record for getting results, you may want to add this category to your CV. Here you can provide concise results from committees on which you served, projects and task forces you directed or managed, or highlight your clinical and nonclinical administrative or managerial skills. If appropriate, a bullet format may help your accomplishments stand out and make them easier to read. It also will help you prepare brief statements. When listing your accomplishments, do not go into great detail, as this tends to clutter and lengthen the CV unnecessarily.

- **Professional society memberships**—list the societies to which you belong, as well as those societies in which you hold leadership positions. Indicate the name of the committee, the position held and the time period in which it occurred.
- **Personal and professional references**—include physicians who can comment on the quality of your clinical skills and on your personality within the past several years. You may also consider asking hospital administrators, residency training directors, nurses and referring physicians to be references. Be sure to inform those whom you would like to list as references that you are seeking a new practice opportunity and would like to include their names on your reference list.

State on your CV that references will be furnished on request. This protects your references from being inconvenienced by many unsolicited telephone calls and allows you to evaluate a potential practice opportunity before you release your references.

What not to include

Never include the following types of information on your CV: race, religion, anticipated compensation, reasons for leaving previous positions, personal health problems or disabilities, examination scores, and license and DEA numbers. It is also permissible to omit references to your age, place of birth, citizenship and marital status.

Printing your CV

Remember, the CV you send out gives an impression of you. Make sure it is a professional product so that it reflects favorably on you.

Your CV should be printed with black ink on high-quality 8½" x 11" bond paper. While paper in subdued shades of beige, blue or gray is acceptable, white or off-white paper is preferable.

Resources

The following topics will link you to samples and more information about preparing a CV and cover letter, obtaining references and recommendations, and preparing for the interview.

- [The Physician in Transition: Managing the Job Interview](#)
Available to AMA members for \$20 and can be ordered online (The following links will take you off the AMA Web site. The AMA is not responsible for the content of other Web sites.)
- [How to create a CV, plus samples of CVs and cover letters](#)
- [How to create a CV, plus samples of cover letters and thank you letters](#)
- [Samples of CVs and cover letters, and ways to request references and recommendations](#)
- [Interviewing tips](#)

- [Interviewing tips from the National Institutes of Health](#)

Job opportunities

There are several sources to help you locate potential positions of interest, including your residency program, physician recruiters or an online search. The following links may help you in your search.

- [JAMA CareerNet](#)
- [HealthEcareers](#) (This link will take you off the AMA Web site. The AMA is not responsible for the content of other Web sites.)

Credentialing, privileges and authorization numbers

Hospital and health plan credentialing

A managed care organization (MCO)—such as a health maintenance organization (HMO), preferred provider organization (PPO) or physician/hospital organization (PHO)—must select and retain qualified health care providers who will provide quality services to its subscribers. This process of selection and retention is known as credentialing, through which the information of a health care provider interested in participating with an MCO is reviewed and verified. Information reviewed and verified through credentialing includes:

- Current professional license(s)
- Current Drug Enforcement Administration and Controlled Drug Substance certificates
- Medical education, graduate training, hospital staff privileges and levels of liability insurance

Credentialing also includes review of the physician's office, also known as a site review or an office audit. An insurance company employee, usually a health care professional who is a member of an MCO's quality improvement or provider relations department, carries out such visits, using a long checklist of items to be examined for compliance with the MCO's standards. Each office is rated on individual items such as quality of clinical records, cleanliness, training and the overall condition of the medical office. Information from a practitioner's site visit is considered in determining whether the practitioner is accepted into the MCO's practitioner panel.

The primary purpose of credentialing is to ensure that applicants meet the minimum requirements for a requested status and to determine whether the applicant's credentials are appropriate for the requested privileges within the MCO. Laws, regulations and accreditation standards increasingly require MCOs to carry out the same level of credentialing that hospitals have long been required to carry out. Most MCOs now establish requirements that practitioners must meet to become members of their practitioner panels, and review the qualifications of applicants for panel membership against these requirements. Because MCOs typically handle many more applicants than most hospitals, the credentialing

process must be done quickly and inexpensively. Many MCOs have found themselves changing the way in which they do credentialing to respond to the demands of the constant changes in the health care industry.

Credentialing can be a burden for any medical practice. In fact, many office managers say that completing health plan credentialing application requirements is one of their biggest administrative headaches.

To help ease this burden, the Council for Affordable Quality Healthcare, which represents the nation's leading health plans, networks and industry trade associations, has developed Universal Credentialing DataSource, a single, national process that eliminates the need for multiple credentialing applications. Providers complete one standardized online application to meet the needs of all participating health plans and other health care organizations. Periodic electronic updates raise the standard on quality and timeliness of data. Universal Credentialing DataSource has achieved support among health plans, providers, accrediting bodies and other stakeholders nationwide. [Access Universal Credentialing DataSource](#). (This link will take you off the AMA Web site. The AMA is not responsible for the content of other Web sites.)

Physician authorization numbers

1. **National Provider Number (NPI)**—your standard unique identifier as a health care provider. The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated the adoption of standard unique

identifiers for health care providers and health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of Medicare- and Medicaid-related health information. The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System to assign these unique identifiers. Covered health care providers and all health plans and health care clearinghouses will use the NPIs in the administrative and financial transactions adopted under HIPAA, including Medicare and Medicaid plan participation.

The NPI is a 10-position, intelligence-free numeric identifier (i.e., 10-digit number). This means that the numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty. [Apply for your NPI](#). (This link will take you off the AMA Web site. The AMA is not responsible for the content of other Web sites.)

2. **Drug Enforcement Agency (DEA) number**—a series of numbers assigned to health care providers allowing them to write prescriptions for controlled substances. Legally, the DEA number is to be used solely for tracking controlled substances. However, the DEA number is often used by the industry as a general “prescriber” number that is a unique identifier for anyone who can legally prescribe medication. [Complete a new or renewal registration application](#). (This link will take you off the AMA Web site. The AMA is not responsible for the content of other Web sites.)

Hospital privileges

Once in practice, you will need to obtain hospital privileges to admit patients to the hospital. Your hospital should have a privileging process that is fair and grants privileges based on documented training, experience and current clinical competence. Privileging based on any other factors is contrary to Joint Commission written standards. Each hospital’s medical staff bylaws should describe the privileging process that is used. The Joint Commission recommends that hospitals develop specific privileging criteria for most procedures and apply those criteria hospitalwide. For example, criteria for electrocardiogram interpretation, pneumonia management or colonoscopy must be the same for all physicians in the hospital, regardless of departmental affiliation or specialty. There should not be one set of criteria for family physicians and another for internists. If your hospital does not have hospitalwide criteria for the major procedures, work with your department and credentialing and executive committees to develop them.

Applying for hospital privileges is a process similar to many others that you have already gone through. Most hospitals will have a form for you to fill out. Details of your education and practice to date might be asked, including:

- Residency, fellowships
- Clinical positions
- Teaching positions
- Previous hospital privileges
- Any previous denial, suspension or revocation of privileges

- Any involvement in malpractice suits or medical school investigations

Items requested may include copies of your:

- MD degree
- Curriculum vitae
- Board certification documents
- State medical license
- Evidence of successful completion of advanced training
- Reference letters
- Recent photograph

Hospital privileges usually require approval by the medical staff and possibly others. Check with the hospital about how long you should expect this process to take and plan accordingly. If your request to obtain privileges has been denied, request a written explanation of your denial. Familiarize yourself with the hospital's appeals process and seek the support or assistance of colleagues.

Continuing medical education

After completion of graduate medical education, physicians are required to maintain competence in their field through participation in educational activities to improve their practice of medicine. These continuing medical education (CME) activities may include live events; enduring materials such as written publications, online programs, audio, video or other electronic media; journal-based CME; structured performance improvement

CME; point of care CME; approved test-item writing; and manuscript review. Content for these programs is developed, reviewed and delivered by faculty who are experts in their areas. Similar to the process used in academic journals, any potentially conflicting financial relationships for faculty members must be both disclosed and resolved. Most states require a minimum number of CME credits for medical professionals to maintain their license. [View a list of AMA-sponsored CME opportunities.](#)

Making the right choice— assessing practice options and demographic locations

Perhaps the most significant lesson is that there is no single strategy or set of questions that will help you make every decision you will face after training. However, this document provides resources that will assist you in making two of your most important decisions: choosing a practice setting and then finding the most desirable geographical location in which to practice and live. The perfect practice opportunity would be a combination of one's ideal practice setting, an attractive compensation and the most desirable geographical location for you and your family. The reality is that most choices involve a number of compromises and selecting the overall best mix of advantages and disadvantages.

Practice setting options

You can [view an educational streaming video](#) in which physicians discuss their experiences as practitioners in a solo, group or hospitalist practice. (This link will take you off the AMA Web site. The AMA is not responsible for the content of other Web sites.)

Moreover, the following charts highlight the advantages and disadvantages of the following practice setting options: solo, group, hospitalist, academic and employment. While you may categorize the listed advantages and disadvantages differently, the goal is to consider all of these issues.

Solo practice Start or purchase your own practice	
<i>Appeal</i>	<i>Downside</i>
<ul style="list-style-type: none"> • Significant control and autonomy • Ability to create/manage a practice the way it suits you • Individualized benefit packages • Set one's own schedule • Entrepreneurial freedom • No worry about being dragged down by less successful partners • Sometimes have lower total overhead, but higher per capita than a small group practice • May be able to hire one person to be responsible for all office functions: billing, collections, appointing, records management and HIPAA compliance, and general office management • Can be a less complicated, and therefore less costly, practice to run • Buying an established practice may mean an established patient base, and an equipped and staffed office • Significant potential for continuity of care ("Marcus Welby") 	<ul style="list-style-type: none"> • Need to be a good business person • Sole financial responsibility • Greater personal risk • Need to have a diverse and loyal regional network • Coverage difficulties • Unpredictable work hours/schedule • High startup and overhead costs • Difficulty establishing patient base • Administrative burden • Significant disadvantages in a market dominated by managed care • Cannot reap certain benefits available to practitioners in single-specialty group settings, such as the capital and the patient volume necessary to provide ancillary services • Because of patient volume, may not attract pharmaceutical trials • Increasingly difficult to find one or two people who can do everything required to meet local, state and federal requirements • Existing staff may be used to doing things the way the departing physician wanted them done

Group practice Single-specialty or multi-specialty group	
Appeal	Downside
<ul style="list-style-type: none"> • Often has an established patient base • Shared patient responsibilities • May offer more predictable income and schedule • Camaraderie among fellow physicians • Greater potential for internal patient referrals • Decreased per capita office overhead • Increased coverage flexibility • Increased scheduling flexibility • Better internal quality assurance • More leverage in dealing with managed care • More ancillary assistance • More vacation • Potential to become a partner at some point 	<ul style="list-style-type: none"> • Personality differences • Income division conflicts • Income distribution/overhead allocation may be unfair • Less autonomy • Senior physicians may control scheduling; junior physicians often perform disproportionate share of the work • Decreased ability to individualize benefits package • Little influence on governance issues, office management • Must comply with group utilization review and quality assurance standards • Increased risk of interpersonal conflicts • Lack of control over cross-coverage of patients

Academic medical career	
Appeal	Downside
<ul style="list-style-type: none"> • Youthful and renewing environment • Opportunity for research • At cutting edge of knowledge and skills • Challenging days, never boring • Toughest patients to diagnose and treat • Many opportunities to take on new roles and responsibilities • Multiple specialties in close proximity • Can transition to private practice; the opposite is not as easy • Former trainees may be your future colleagues or employers • Academic medical centers have a rich intrinsic culture that values wisdom and experience • Opportunity to teach/mentor • Appreciative students and residents • Trainees provide a real service—additional hands and eyes 	<ul style="list-style-type: none"> • Complex leadership structure often creates bureaucratic inefficiencies • “Publish or perish” dictum at many institutions • Salaries usually lower, but no overhead costs • Numerous committees • Many institutions financially struggle • Resident duty-hour limits are forcing many attending faculty to work longer hours to fill in gaps in patient care • Advancement may require geographical moves • Locations limited (125 allopathic schools, 400-plus teaching hospitals) • Some academic institutions are very hierarchal • You’re accountable for the mistakes of your trainees • Town-gown tensions

Hospitalist practice	
Appeal	Downside
<ul style="list-style-type: none"> • Opportunity to focus on inpatient care and what residents and fellows are familiar with • A hospitalist can be busy on the first day of work and does not need to spend months or years building a practice, as can be the case for office-based practice • Usually a shift-based schedule—busy while at work but usually free when away from the hospital • More predictable and greater flexibility in scheduling, e.g., many hospitalists don’t follow a typical Monday-to-Friday schedule • More weekdays off (depending on scheduling) • Predictable income, possibly with or without bonus incentives 	<ul style="list-style-type: none"> • Long shift work (12-hour shifts) to include evenings, nights, weekends and holidays • Creates some challenges in scheduling • Can result in a schedule that requires working more nights and weekends than in outpatient-based practice • Limited continuity of care for patients • Have to work well with the patient’s primary physicians • May be under pressure to adhere to organizational/hospital’s resource utilization guidelines

Employment setting <i>Managed care organization, hospital-based specialty, primary care network, locum tenens, VA hospital, corporate health department, public service (military, Indian Health Service, etc.)</i>	
<i>Appeal</i>	<i>Downside</i>
<ul style="list-style-type: none"> • Specialization and sub-specialization possibilities • Possible income guarantees and set hours • Fewer billing hassles • Fewer coverage difficulties; sometimes have greater opportunities for flexible scheduling • No startup costs • Potential prestige of being associated with a well-known institution • More ancillary assistance • Established patient base • May have enhanced opportunities for expanding into other aspects of health care delivery (serving on governance committees, working in nonclinical positions, etc.) 	<ul style="list-style-type: none"> • May have little, if any, ownership interest • Little actual control over practice finances • Decreased opportunity for entrepreneurship • Referral restrictions • Limited control over workload • Must comply with organization's quality assurance, privileging and utilization issues

Selecting a geographical location

There are several important geographical market factors to consider when choosing where to work and live. Consideration of the following questions may influence your choice:

- Is the community the right size?
- Are there seasonable population increases, or is the population stable year-round?
- What are the selling points of the community?
- How close is the nearest large city?

- Is the climate acceptable?
- Is it close enough to extended family?
- Is the quality of schools acceptable in terms of adequate teacher-pupil ratio, special programs, curricula and extracurricular activities?
- Are appropriate recreation/hobby opportunities available?
- What types of social organizations (e.g., fraternal, professional, religious, business) are available?
- How is the economy?
- What type of physician would fit best in the community?
- Is it close enough to scheduled airline service or other transportation services?
- Is the crime rate acceptable?
- Is adequate housing available?
- Is affordable housing available?
- Are shopping opportunities adequate?
- Are there environmental concerns of importance to you (air, water, etc.)?
- Are there employment opportunities for a family member or domestic partner, if applicable?

When evaluating an offer, consider your potential quality of life in that community. It may be beneficial to talk to school officials, religious leaders, civic associations and other physicians who have recently moved into the area.

You may also want to discuss opportunities with a physician mentor. A seasoned physician may be able to offer objective advice or pose additional questions that will steer your thinking. His or her input can be extremely

valuable when considering non-compensatory factors such as reputation of the practice and key partners, malpractice liability issues, opportunity for professional development and relating the job to long-range goals.

Lifestyle, financial and community resources

If you have a position in mind in a given geographical area, the following resources may help you in your decision process. (The following links will take you off the AMA Web site. The AMA is not responsible for the content of other Web sites.)

- [The Best States to Practice: America's Physician-Friendliest States](#)
View this 2007 article in *Physicians Practice Journal*.
- [Read about home buying vs. renting](#)
- [Homefair.com](#) and [Move.com](#)
 - o Salaries—see salaries in different locations (also see [cost of living comparisons between locations](#)).
 - o City reports—obtain information on cost of living, climate, demographics and more by location.
 - o School reports—get in-depth reports on local schools and child care centers.
 - o Crime statistics—get crime indexes for thousands of U.S. cities and Canada.
 - o Check home prices—find out home prices in particular areas.

- o Rentals—obtain contact information for rental placement services.
- o Moving calculator—check out this tool and other resources, including information on neighborhood merchants.

- [U.S. Census Bureau](#) and [ZipSkinny.com](#)
View demographics of the patient population in the areas where you are considering practicing medicine.
- [Bankrate.com](#)
View state information about income and sales taxes levied in each state.
- [Weather.com](#)
Enter a location (by name or ZIP code) to get detailed information about average local weather conditions, including average temperatures, record temperatures, rainfall, and sunrise and sunset times.
- [Kaiser Family Foundation](#)
Visit this site for resources on the latest state-level data on demographics, health and health policy, including health coverage, access, financing and state legislation.

State-specific information

- [Business resources](#)
View a collection of links to state government Web sites with useful information about starting a business or obtaining information about local businesses.

Disability insurance planning for professionals

Physicians often pay attention to life insurance needs, but fail to consider the possibility of a debilitating incident. Statistically, however, a professional is far more likely to suffer a severe disability that damages the ability to work, rather than die prematurely. While some people have the financial resources to fund a disability on their own, most need disability income insurance to cover the risk.

Disability insurance planning has changed dramatically over the past decade, and the insurance industry is offering many options to help professionals protect their most valuable asset: the ability to earn an income.

How policies are offered

Disability insurance can be purchased on an individual or group basis. Group insurance is usually provided by an employer or purchased individually through a sponsoring professional association. Individual insurance plans, on the other hand, are typically purchased through a local insurance agent and in some cases can now be purchased over the phone or through a company's Web site.

Most insurance companies will issue disability insurance coverage equal to approximately 60 percent of earned income. The most common maximum monthly benefit currently available (2007) to professionals is \$15,000. However, some companies, depending on occupation,

may allow a professional to purchase up to \$20,000 in coverage combined with group long-term disability insurance provided by the professional's employer.

Cost of disability insurance

Premium rates are based on factors such as the insured's age, gender, monthly benefit, optional riders and the insured's occupational classification. As a general rule, the younger the policy owner, the lower the cost. The occupational classification assigned to a medical specialty by the insurance company will also affect premium rates, as will the policy provisions made available to the insured.

What to look for in a disability policy

The following provisions should be carefully considered when comparing disability insurance policies.

- **Definition of disability**—probably the most important aspect of a disability policy. Professionals must pay careful attention to the definition of disability found in their policies because it ultimately determines how any claim for benefits will be judged. There are three definitions of disability commonly found in the insurance industry, with significant differences between them.
 - **Own-occupation**—also known as **true** or **pure** own-occupation, this is the most liberal definition of total disability available. It pays benefits if one is “not able to perform the

material and substantial duties of [one’s] occupation.” An insured would collect full disability benefits if he or she could no longer work in his or her occupation, even if he or she decided to transition into another occupation, earning the same or more income prior to disability.

- o **Modified own-occupation**—the most prevalent type of disability policy in the insurance industry and typically pays benefits if an insured is (emphasis added) “unable to perform the substantial and material duties of your occupation *and not working*.” Although benefits are still contingent upon the insured’s ability to work in an occupation, this definition will not allow an insured to continue receiving full disability benefits if working in another occupation.
- o **Any occupation**—the most restrictive of the three total disability definitions and is often found in group or association policies. Under this definition, an insured is eligible to receive benefits only if found to be “unable to work in any occupation which you are reasonably suited to by your education, training or experience.” This determination is usually made by the insurance company, and professionals—being generally well-educated and well-trained—may find it very difficult to collect benefits under this type of policy.
- **Renewability provision**—a key feature of an individual disability income insurance policy. The provision defines an insured’s rights when it comes to keeping the disability policy in force. In general, a disability policy can be guaranteed renewable only, or both noncancelable and guaranteed renewable.
 - o **Guaranteed renewable**—if a policy is guaranteed renewable only, the insurance company cannot cancel or change any provisions of the policy as long as the insured continues to pay premiums. In the event of poor claims experience, however, the insurance company does reserve the right to increase premiums, with state approval, for an entire class of policies.
 - o **Noncancelable and guaranteed renewable**—if a policy is both noncancelable and guaranteed renewable, the insurance company cannot cancel, change provisions or increase the premiums for the life of the policy. Such a policy is preferable because it provides insureds with an added level of security.
- **Residual disability rider**—unless a policy contains a residual disability rider, insureds may have to be totally disabled to collect any benefits. While an own-occupation policy protects an insured’s ability to work in his or her occupation, it may not sufficiently protect the insured’s income level. Many disabilities might allow someone to continue working in his or her

occupation, albeit on a limited basis while suffering a loss of income. Adding a residual disability rider to the policy would allow a disabled person to continue receiving benefits proportionate to the loss of income if he or she returned to his or her occupation on a part-time basis.

Furthermore, with policies such as modified own-occupation or any occupation, a residual disability rider might allow an insured to continue receiving benefits if working in another occupation, or if the insurance company determined that the insured could work in another “reasonable” occupation with reduced earnings. Generally, to qualify for residual disability benefits, one must experience an income loss of 20 percent or more (as compared to pre-disability earnings). Additionally, if the loss of earnings is greater than 75 or 80 percent, then, depending upon the rider’s provisions, 100 percent of the monthly disability benefit might be paid.

Recovery benefits

Self-employed professionals whose incomes are based solely on the number of clients or patients they see must understand how recovery benefits work. While some policies have an unlimited recovery benefit built into the residual disability rider, others make the recovery benefit available as a separate rider.

Consider the example of a physician in a small group practice whose income is based solely on the business generated and number of patients seen. She had been

totally disabled for one year, and after a full recovery she has returned to the small group practice. She can now perform all of her job duties and work the same number of hours as before.

However, the patients who had depended on her have gone elsewhere. Additionally, referral sources with whom she had built relationships had no choice but to refer clients elsewhere. Obviously, it would be difficult to take the business away from the practitioner who had been providing these services during her disability.

As a result, rebuilding a practice and income level might take years. Without a recovery benefit, she would no longer qualify to collect any benefits at all. With an unlimited recovery benefit, however, the physician would continue to receive benefits until her income reached 81 percent or more of her pre-disability income. For a self-employed individual, this can mean the difference between surviving financially or not.

- **Cost of living adjustment (COLA) rider**—designed to help an insured’s benefits keep pace with inflation after a disability has lasted for 12 months. The adjustment can be a flat percentage, or tied to the consumer price index (CPI). Ideally an insured wants a COLA that is adjusted annually on a compound-interest basis with a catch-up feature and no cap on the monthly benefit. This rider is important, but if reducing the cost of coverage is an issue, professionals should consider excluding it from a policy because it is expensive and would be a

significant benefit only when a disability lasts several years. Because one cannot predict or choose the length of a disability, excluding this provision can be risky.

- **Future increase option rider**—offers the ability to increase an insured’s disability coverage, regardless of future health, as income rises. It is important to know when coverage can be increased, as well as by what increments, on any given option date. Some companies may allow an insured to use the entire option in one year, as long as the insured’s current income warrants the increase; others, however, may limit the amount that can be purchased based upon the original monthly benefit in place when the policy was purchased.
- **Tax implications**—according to IRC section 104(a)(3), personal disability insurance benefits are received free of income tax, provided that premiums are paid with post-tax dollars. If an employer provides coverage and takes a tax deduction for the premiums paid on the insured employee’s behalf, however, the benefits are taxable when received. This means that an employee could lose as much as half of the benefits when they are most needed. A better alternative would be for the employee to forgo the tax deduction, or for the employer to give the employee an annual bonus equal to the policy’s premium. The employee will owe taxes on the bonus, but the employer will retain its tax deduction, and the insured employee’s benefits remain untaxed.

- **Catastrophic disability rider (referred to as a CAT rider)**—this rider was introduced by many insurance companies to pay additional benefits if an insured is unable to perform two or more activities of daily living (ADL) without human standby assistance, or if the insured suffers a cognitive impairment or an irrevocable disability. The ADLs are bathing, dressing, eating, transferring, toileting and continence. This same definition of disability is often found in a long-term-care insurance policy. The CAT rider works well when the insured has already reached the maximum benefit level in traditional insurance policies and is still looking for relatively inexpensive ways to supplement coverage.

Take the example of a young professional who loses both legs in a car accident. He would meet the definition of disability if he were unable to perform the material and substantial duties of his occupation or is considered presumptively disabled. However, he does not require a physician or other skilled health care provider to take care of him—he simply needs help performing ADLs. As a result, this would not be covered by health insurance. The additional benefits of a CAT rider would pay for the cost of the caregiver and preserve the value of the insured’s disability benefits to meet monthly expenses. Generally, this rider can provide up to \$8,000 a month in benefits, not to exceed 100 percent of the insured’s prior monthly income, in addition to the monthly disability benefits under the policy.

- **Maximum monthly benefit**—someone who has an old policy with a future purchase option rider might be subject to the rules that applied at the time the policy was purchased. In such a case, the insured might be able to purchase coverage in excess of the maximum monthly benefit (typically \$15,000 per month). Other possibilities might be to supplement an existing individual policy with a group disability policy or to purchase additional disability policies that protect the insured's retirement plan contributions, overhead expenses or ownership interest in a practice.

Group long-term disability insurance

An individual whose employer makes group long-term disability (LTD) insurance available, or who is changing employers, may have the opportunity to supplement individual disability insurance coverage. Once purchased, an individual policy would not be affected by subsequently enrolling in a group LTD plan. If, however, an individual policy is not already at its maximum benefit level, this strategy might prohibit the insured from further increasing an individual policy.

Disability insurance protection for retirement plan contributions

Group and individually owned disability insurance plans traditionally are designed only to replace a portion of the insured's current income, not to replace monthly contributions into company or individual defined-contribution retirement plans. Nevertheless, a few

disability insurers have developed programs designed specifically to replace lost retirement savings.

One approach is to use an individual disability insurance policy that pays benefits into a trust set up specifically for the insured's benefit. If a disability occurs, monthly benefits are paid directly into the trust. The trustee, with input from the disabled individual, then invests the money in mutual funds or individual securities until the insured (the trust beneficiary) reaches age 65. At that point, the trust's assets are distributed to the individual to provide supplemental income for retirement.

Policy benefits and trust earnings are subject to the normal rules that govern the taxation of trusts and individual disability income insurance. Trust earnings are generally taxable to the insured as the beneficiary of the trust. As noted above, disability insurance policy benefits may be taxable or tax-free, depending on who paid the premiums.

Protecting professional practices and professionals

To protect your practice and partners, the following policies should be considered.

- **Disability overhead expense insurance**—a professional responsible for some or all of the monthly expenses required to keep an office open should consider purchasing a business overhead expense (BOE) policy in addition to a disability policy. A BOE policy provides reimbursement for the expenses of

operating a practice if one of the practice owners is sick or hurt and cannot work. These expenses may include staff salaries, rent or mortgage payments, utility bills, professional liability insurance premiums, and other fixed costs normal to the operation of a professional practice. In addition, some policies may even provide benefits for disabled professionals to hire a temporary replacement to fill in during a disability. This way, the practice's expenses are covered until the disabled partner returns to the practice or until the disabled partner's share in the practice can be sold. Premium payments for BOE insurance are tax-deductible as a reasonable and necessary business expense (Revenue Ruling 55-264, 1955-1 C.B. 11). Benefits received during disability, while taxable upon receipt, are used to pay practice-related expenses, which are tax-deductible. As such, the net tax result is a wash, meaning no taxes are owed by the practice on the money received from the policy.

- **Disability buyout insurance**—partners in a group practice will also want to consider a policy known as disability buyout (DBO) insurance, which is designed to help provide funds toward the purchase of a disabled partner's ownership interest if, due to a lengthy disability, the individual is no longer capable of being a productive member of the practice.

Due to the specific skills each individual brings to a practice, attorneys often recommend a buy-sell agreement that details what is to occur upon the death, disability or retirement of each partner/

owner. Having a proper buy-sell agreement in place before disability occurs can avoid the hard feelings and the conflicts of interest that often result from a partner's disability. The agreement should set forth the purchase price to be paid or should provide a formula for determining the price. Perhaps most important, the agreement must have a mechanism for providing the funds needed to make the purchase.

Furthermore, in conjunction with a disabled partner's individual disability income insurance and BOE insurance, a DBO policy will allow the business to continue to generate an income for the healthy partners, while a disabled partner is supported by the benefits from an individual disability policy. Any continuing share of business expenses is reimbursed by the disabled partner's BOE policy until the buyout is in effect. Premiums paid for DBO policies are generally not tax-deductible, whether paid by corporations, partnerships or individuals. The benefits, therefore, would not generally be subject to tax.

Planning options

Purchasing high-quality disability insurance has never been easy. Although the additional options available today create more flexibility, they also mean that the individual disability insurance marketplace has become even more complicated for professionals. Policies vary greatly in terms of the quality of the insurer, definitions offered, maximum benefit limits and premium rates. It is more important than ever for professionals to take the

time to compare the contractual provisions of the policies under consideration and to understand how and why they differ. A professional insurance adviser or financial planner who specializes in working with physicians or other professionals will be familiar with which policies are best suited to the needs of an individual physician or the **physician's practice**. (The following links will take you off the AMA Web site. The AMA is not responsible for the content of other Web sites.)

[Lawrence B. Keller](#), CLU, ChFC, CFP, is the founder of Physician Financial Services, a firm specializing in income protection and wealth accumulation strategies for physicians. Mr. Keller is also an approved member of AMA Insurance Agency's Trusted Source NetworkSM.

[Harry R. Wigler](#), CPA/PFS, specializes in tax and financial planning for professionals and small business owners.

Medical professional liability insurance

Purchasing professional liability insurance is one of the most important—and expensive—decisions you may make in your medical practice. The current environment of increased litigation makes this decision more important than ever. Before purchasing a policy, you should try to learn as much as possible about the types of coverage, carriers and other options that are available.

Insurance—what is it?

Insurance takes many forms but generally serves to provide security to those who purchase it in an attempt to provide predictability in uncertain situations. Insurance makes dollars available to compensate for losses incurred from unpredictable or undesirable events. Insurance is one

mechanism used to protect individuals and organizations against the risk of loss by distributing the burden of losses over a large number of individuals. Based on the law of averages, actuarial projected losses drive formulas for premium dollars that are then paid to contribute to the coverage reserves. These reserves are used to provide compensation for any member of the group who suffers from a defined loss.

Medical professional liability insurance (MPLI) is purchased to protect a physician or health care institution from the financial liabilities of practicing medicine. More specifically, it protects the physician from the consequences of a patient's claim that he or she was injured as a result of the physician's negligence. This insurance is purchased through a contractual agreement with an insurance company—called the policy—in exchange for a premium paid to the insurance company. Through this agreement, the insurance company agrees to financial responsibility for the defense and payment of claims against the policyholder (i.e., physician) up to a fixed ceiling of coverage (i.e., liability limit) for a specified length of time (i.e., the policy period). When physicians purchase insurance they **transfer risk** to the insurance company. That is, with the payment of premium dollars, they transfer responsibility for any claim against them and place the insurance company instead of themselves at risk for any dollars paid on claim defense or resolution.

In spreading the risk of loss, insurance companies seek to insure a broad group and collect appropriate premiums. In the case of MPLI, premiums are based on

numerous issues including physician specialty, practice patterns, past claims history and geographical location. It is common for insurers to consider **experience ratings** of a physician based on claims experience, with higher premiums charged for physicians with greater claims experience. Premiums are calculated using complex formulations that consider how much the insurer believes it will have to pay in losses, when payments may be required, costs of business, desired financial margins and returns on invested premium dollars. A predictor of future claims is a history of past claims. Once collected, premium dollars are invested by the insurance company in order to generate additional reserve dollars and maximize investment income.

Types of coverage

MPLI may be purchased in two forms: **occurrence** or **claims-made**. Where an occurrence policy covers acts of negligence that occurred while the policy was in effect (regardless of when the claim may be filed), claims-made policies cover claims reported against physicians while the policy was in effect (regardless of when the negligent act occurred). Occurrence policies are much less common and more expensive because events that occurred while the policy was in effect will be covered, even after the policy period has ended. Rates for occurrence may vary significantly because they are based on actuarial projections of the cost of future claims and do not take into account current experience.

A claims-made policy is the most common type of MPLI coverage currently carried by physicians. The premium for a claims-made policy may initially be small, because patients usually do not sue for malpractice for at least a year after an alleged act of negligence has occurred. After the first year of a claims-made policy, premiums may increase incrementally, accounting for the risk of lawsuits spanning each year the policy is in effect, until a mature premium is reached. If a physician terminates a claims-made policy, he or she may purchase **extended reporting endorsement coverage**, or **tail coverage**, allowing the physician to continue reporting claims related to negligent acts that occurred during the years he or she was insured under the original policy. Although expensive, tail coverage may be well worth the investment if you change insurers, move to a different state or stop practicing. Some policies include provisions for free or prepaid tail coverage in the event of death, disability or retirement. Alternatively, physicians may be able to obtain **nose coverage** from their new carrier, which covers the physicians for incidents that occurred before the inception of the new policy.

A variation on claims-made coverage is a **claims-paid** policy. Under claims-paid coverage, all the events associated with a claim—the triggering incident, the filing of a lawsuit, the reporting of the suit to the insurer, and the final resolution or settlement of the claim—must occur while the policy is in effect (usually a 12-month period). Although it is inexpensive, claims-paid coverage can be risky. If a claim is not settled during the term of the claims-paid policy, the insurer may look for a legitimate reason to refuse coverage or to refuse to renew the policy.

Coverage and liability limits

Limits are provided in accordance with the stipulated terms and conditions of the policy. You will need to ascertain whether the state, hospital or managed care plan with which you may be associated requires a specific coverage limit.

Exclusions

Every medical liability insurance policy has an exclusions section, which sets out specific circumstances under which coverage will not apply. Such circumstances may include liability assumed by contractual agreements with managed care organizations (MCOs), actions by employees of the medical practice other than the physician, practicing outside of certain standards of care and others. It is important to understand what is covered and what is excluded. The following are some exclusions you may encounter.

- **Hold-harmless clause**—some MCOs require physicians to agree to hold the company harmless if it is sued by a patient because of the physician's alleged actions or failure to act. Many policies, however, exclude coverage for liability a physician assumes by contract. A physician who agrees to a hold-harmless clause may be forced, in the event of a lawsuit against an MCO, to assume liability not only for his or her own defense costs (and, possibly, monetary settlements and judgments) but also for those of the MCO. Because the MPLI policy may or may not specifically mention the term **hold harmless**, it is important to carefully review

the exclusions section in the policy to ensure that there is no gap in coverage. Ask your carrier whether you will be protected if you sign a hold-harmless clause or whether this restriction can be waived.

- **Defense costs**—these include the fees of the attorney hired by the medical liability insurer to defend a claim, the fees of expert witnesses, as well as court reporters' fees and clerical expenses. Not all policies fully cover defense costs, and those that do sometimes place a limit on such costs. In this case, the physician is responsible for costs that exceed the policy's limit. Other policies require a deductible amount to be paid by the insured physician, in which case the MPLI insurer pays only the amount exceeding the deductible. Be sure your policy adequately covers defense costs. Defense costs that are subject to a deductible or are capped can be costly for a physician. In the event of a lawsuit, be sure to review defense costs carefully.
- **Vicarious liability**—a policy may also exclude vicarious liability, which arises from the actions of a third party (such as a physician's employees). For example, an employed laboratory technician's labeling error may result in treatment that harms a patient, resulting in a lawsuit against the physician for the employee's error. If the physician's policy excludes vicarious liability, the physician may be liable for defense costs or any damages awarded. Some policies provide coverage for the actions of employees other than allied health practitioners. If requested, some

insurers may add coverage for vicarious liability for an additional premium. Examine your policy carefully to ascertain who in your practice is not covered, and purchase vicarious liability coverage as necessary.

- **Mandated standards of care**—in some MPLI policies, physicians are required to adhere to certain standards of practice. Such mandated standards may include, for example, requiring the use of only board-certified anesthesiologists rather than certified registered nurse anesthetists or use of certain equipment. Although it is important to abide by your MPLI policy, it also is vital to be aware of any mandated standards of care before you agree to it. Be sure that any mandated standards of care in your policy do not restrict your practice style or significantly increase overhead expenses.

Other exclusions

Most policies exclude coverage for claims arising from the following factors:

- Sexual misconduct
- Practicing under the influence of alcohol or illegal drugs
- Antitrust violations
- Criminal or grossly negligent acts
- Libel or slander
- Practices for which you have not received credentials
- Newly developed or experimental procedures
- New drugs still under investigation
- Accidental injury of an assistant during a medical procedure

- Violations of patient confidentiality
- Failure of medical devices
- Inadequate quality control of medications

Physicians should be aware that not all MPLI insurance is the same. It is important to understand what is covered under the policy and what is excluded. Some policies only cover direct patient care and exclude care outside of geographical boundaries (i.e., state or nation). Some policies allow for coverage in work-related activities such as emergency medical service (EMS) supervision, committee work or peer review. Some insurance may assist with legal expenses related to adverse actions against the physician's credentials or license. Many physicians desire coverage for activities outside of direct patient care, such as supervising residents, providing community services for events, or while serving as an event physician or a good Samaritan. In the current litigious environment, with insurers sensitive to high-risk exposures to litigation, it is best to ensure associated activities are covered through a policy by having a letter stipulating the activity is covered under the policy. Often it is necessary, and safest, for the physicians to have the event's sponsor provide the physician coverage.

Settlement clauses

Any settlement of a case can adversely affect a physician's insurance status and ability to participate in an MCO. Yet the decision to settle, rather than contest, a lawsuit often is not up to the insured physician. The MPLI can provide various degrees of control over whether,

how and when to settle a dispute. These issues may be addressed by options written into the policy, such as the following:

- **Right to consent to settlement**—some MPLI insurance policies contain a clause guaranteeing the physician’s right to consent to settlement. If this clause is absent from the policy, the insurer can settle a case against the physician’s wishes, even if the physician is blameless. Disagreements between the physician and the insurer concerning settlement are sometimes referred to a committee for resolution, in which case the insurer usually evaluates the case and determines an appropriate settlement figure.
- **Hammer clause**—instead of a right-to-consent-to-settlement clause, a policy may contain a hammer clause. This clause takes effect in the event that a physician refuses an insurer’s settlement recommendation and an ensuing trial results in a higher award. Under a hammer clause, the insured physician is required to pay the amount exceeding the insurer’s original settlement recommendation.

Types of insurance carriers

There is considerable variability among medical liability insurance companies. Different companies are legally structured to provide an array of services by offering products with varying benefits and costs. These are marketed and sold to physicians directly by company representatives (i.e., agents). Insurance agents are often

the first contact in purchasing insurance. The agent acts on behalf of the MPLI insurer and solicits purchasers of insurance. However, an agent for an insurance company is different from a broker. A broker acts as the agent for the insured and assists the purchaser in determining the policy best suited to the purchaser’s needs. An agent of the insurance company typically has the authority to bind the company to policies, to accept payments on behalf of the company and to represent the interests of the company in other authorized ways when dealing with the insured.

All insurance carriers operate on the principle of distributing, or **pooling**, risk. They may be owned or sponsored by commercial enterprises, physician groups, state medical societies or self-insuring organizations. Insurers also vary in terms of how they are organized, who owns or controls them, their financial stability, and whether and how they are regulated by state laws. The following describe the structures and potential advantages and disadvantages of medical liability insurance carriers.

- **Commercial carrier**—the most commonly known medical liability insurers, commercial carriers have been known as traditional line companies that offer numerous lines of insurance, including MPLI. These carriers are typically regulated, in various degrees, by state insurance departments. Commercial carriers are typically large companies and have traditionally offered better rates, since their volumes were higher; been safer because they typically have higher reserve accounts to protect the insured against large

judgments and awards; and have been able to transfer policies between states, allowing flexibility for the provider who might choose to change practice locations.

A drawback of commercial carriers is that most are for-profit organizations whose primary directive is to make a profit for stockholders. Multi-line companies tend to view MPLI as a product line with great fluctuations and high risk. Like any profit-making business, commercial carriers may increase rates according to market demands or pull out of a market if it becomes unprofitable. Because of their large financial reserves, big companies can generally do this more easily than smaller organizations. Large commercial carriers also may exert more control over defense strategies and settlement decisions than a smaller company.

- **Captive insurance company**—a wholly owned subsidiary of an association or group (e.g., a university hospital, a physician group or a medical association). Unlike a commercial carrier, a captive company is formed with the express purpose of insuring the association or group that has formed it. Since captives do not have to make a profit, premium rates can be adjusted to claims experiences and actual expenses. Many physicians choose captive companies because they are owned and directed by health care professionals, who are more likely to understand and be supportive of their colleagues' professional problems than are commercial carriers. Captive companies also

may afford the insured greater input into decisions concerning defense strategies and settlements.

Some captive companies, however, may not be as financially stable as their commercial counterparts. Because captive companies generally cover fewer policyholders, their distribution of risk is spread over a smaller population. This increases the risk of failure if the income from premiums is too low to cover expenses or if the company sustains losses that are higher than expected. Also, these companies are not typically protected by state guaranty funds.

Beware of captive companies domiciled in offshore sites. Initially, many captive companies were formed in locations such as the Caribbean Islands to take advantage of tax breaks and relaxed regulations. Be sure you know who formed and operates a captive company before signing on.

- **Mutual insurance company**—set up as a cooperative activity by a group of people who share in the profits and losses of the business. This type of insurance company has no stockholders or capital stock. Size and financial stability can vary.
- **Risk-retention group (RRG)**—a nonprofit, self-insuring corporation or association formed for the sole purpose of providing insurance coverage to members or shareholders. An RRG must be owned by its members, or by a company that in turn is owned by its members, who contribute capital to the group. RRGs

are incorporated and licensed in at least one state and are subject to the insurance regulations of that state. Once licensed in a particular state, an RRG may provide coverage to members in any other state and only has to abide by the regulations of its home state.

The premiums offered by RRGs may be lower than those of other insurers. However, RRGs are not covered by state guaranty funds and, like insurance trusts, they may increase member premiums if losses are higher than expected.

- **Risk-purchasing group (RPG)**—a group of individuals or entities with similar or related liability risks that forms an organization to purchase liability insurance coverage on a group basis. It is not an insurance company. The group does not underwrite its risks, but instead purchases coverage for its members, usually from an established insurance company licensed in at least one state. The RPG can take many forms, and states cannot impose a specific structure on an RPG so it operates more freely than an RRG. Many state protections afforded to other insurance vehicles are not applicable to RPGs, and, therefore, the financial viability of the insurance product must be carefully researched.
- **Insurance trust**—a legal entity that provides another way of spreading risk among policyholders. Medical liability trusts administer insurance programs on behalf of members. These companies may operate without the large cash reserve that is required of other carriers.

For these reasons, trusts may have the advantage of lower premiums and operating costs.

Members of a trust place their personal assets on the line if claims exceed the funds available to pay them. This means that the trust may assess its members for additional payments—more than the cost of their premiums—if losses are higher than expected. Because they are typically regulated through the state’s department of corporations rather than the department of insurance, trusts are not protected by state guaranty funds. Trusts also generally have more stringent requirements for joining than do traditional companies, because of the higher risk involved in operating without a large reserve.

- **Physician-owned company**—such companies have proliferated in recent decades. Like other insurance carriers, these companies also may be formed as trusts, captive companies, mutuals, risk-retention groups or profit-making corporations. Many physician-owned companies are sponsored by state medical societies, and most are regulated under state insurance laws in the states where they were formed.

Physician-owned insurance companies tend to be sympathetic to and supportive of the professional problems of physicians, and they typically will defend them vigorously in the event of a lawsuit. This makes physician-owned carriers an appealing choice for physicians who wish to have a greater say in claims decisions than that afforded by commercial companies.

Disadvantages of physician-owned companies include the fact that they generally provide coverage in only one state. However, with the continuing consolidation of the physician-owned medical liability insurance industry, a number of these companies are now licensed and offer coverage in several states. Physicians who move to another state or who practice in more than one state should determine whether they need to purchase additional coverage.

- **Joint underwriting association (JUA)**—the name for nonprofit risk-pooling associations that were created by many state legislatures in response to the insurance availability crisis of the 1970s. JUAs are operated as a branch of state government and have appropriated funds to ensure that insurance will be available. JUAs operate by charging premiums for operating expenses and indemnity obligations but allow additional premium contingency assessment if a deficit is experienced. Therefore, retroactive adjustments may be charged to individuals. Often the JUA may not reject applicants and must accept even higher claims histories. This can result in a rise in premiums across the board and has led to the insolvency of some JUAs, particularly during times when other insurance products are more affordable and predictable.

The bottom line

Before choosing an insurance carrier and purchasing a policy, you should investigate the company's background, reputation and services. Your state insurance commissioner's office can provide [information about insurers licensed in your state](#). (This link will take you off the AMA Web site. The AMA is not responsible for the content of other Web sites.)

You can also consult the [A.M. Best Company](#), which independently rates thousands of property and casualty insurance carriers across the country. In its evaluation, A.M. Best looks at a carrier's risk spread, assets, loss reserves, capital structure and other business aspects. (This link will take you off the AMA Web site. The AMA is not responsible for the content of other Web sites.)

Independent insurance consultants (who are neither agents nor brokers) may also offer helpful advice, counseling and assistance in negotiations with insurers.

Weighing options: Medical practice startup, purchase or buy-in

Starting a practice—12 basic tips

Starting a practice is complex and can consist of many variables. The following 12 tips provide important points to consider when starting a practice:

1. First, decide where you want to live. You may be there a long time, so you want to enjoy your limited

- free hours. You can make money almost anywhere. Most people find themselves most comfortable in situations similar to what they experienced in childhood (e.g., urban, suburban or rural, semitropical or desert).
2. Find out how long it takes to be seen as a new, non-urgent patient by other physicians in your specialty who are already established in the location you are considering. If many are booked at least one to two weeks in advance, there is room for you, too. Within a year, your wait times will likely be similar.
 3. Ask whether anyone wants to sell their practice to you. You may get lucky. Buying a practice at the right price can be an excellent investment. Don't buy or buy into a practice without a professional valuation. Starting a practice, buying a practice or joining a group usually costs around the same amount of money, either in reduced income or startup costs.
 4. Cruise around the hospital neighborhoods and identify the medical office buildings. Look for "office for rent" signs. Too many or none may indicate a problem. Find out what the problem is by asking the hospital administrator, chief of staff or other local physicians.
 5. Be cautious about hospital income guarantees (forgivable loans) if offered. They differ widely and may or may not be a good deal for your individual situation.
 6. Rent—don't build or buy—an office if at all possible. If you want a nicer office than is currently available, one will probably become available if you are patient. You may be able to get a month-to-month tenancy to start, or a sublet. If you are buying a practice, don't move it for at least one year.
 7. Rent housing the first year, so you get to know the neighborhoods and the market. Alternatively, buy a modest house or condo needing minimal maintenance in a modest neighborhood with easy resale. You will be too busy your first year to enjoy your house, won't have time to do maintenance, and in a year or two you will probably be able to afford a better house anyway.
 8. There are lenders that specialize in medical practice purchase and startup and that offer up to 100 percent financing, including living expenses for up to a year. Seek them out to save yourself hassle.
 9. Hire the best staff you can find, one that knows more about running a practice—and has more experience—than you do. You will spend more waking hours with your staff than with your family.
 10. Become a master at **International Classification of Diseases, Clinical Modification** (most commonly known by the abbreviation **ICD**) and

Current Procedural Terminology (CPT®) coding, and teach the topic to your peers. That knowledge is the best investment you can make, and it will keep your name out of the newspapers and you out of jail.

11. If this is your first practice, and you are coming out of residency or fellowship, you will be experiencing the biggest personal economic change of your life. Plan your budget to live on no more than 75 percent of your after-tax income. It's how much money you keep, not how much you make, that counts! Fund your retirement plan through withholdings from day one so you won't be tempted to use it for other things.
12. Get good advice from a medical-specialist consultant, certified public accountant and an attorney. Ideally, practice startup is something you will only need to do once, so do it right the first time.

Considering your options

Many physicians decide to start their own practice, not just new physicians fresh out of residency or fellowship. Some are early-career physicians who decide they made a mistake in choosing an employer or a location in which to practice, or who found that the position they were planning on evaporated. Some planned from the beginning to work for someone else until they were more comfortable with their clinical and business skills before going out on their own. Some are midcareer doctors whose groups broke up, or those whose groups

are acquired by a bigger group with whom they find they disagree. Some divorce from their marital/practice partners, have a midlife crisis or relocate to follow a new spouse. Others leave their current situations to form new groups. Even senior physicians sometimes find themselves in a situation where going independent is the “lesser of the evils” they face prior to retirement in a few years.

There are quite a few resources available to the physician starting solo practice. The AMA publishes several good books on startups. Some medical societies also sponsor annual practice management symposia around the country with applicable content. Private consultants, most of whom are members of the [National Society of Certified Healthcare Business Consultants](#), offer personalized guidance and support. There are lenders with special financing programs available for startups, including the program offered by [Henry Schein Financial](#). Plenty of books also have been written on various aspects of private practice applicable to startups, including marketing, staffing, coding, computerization and systems. These resources can be combined to satisfy virtually any startup situation; moreover, the [third section](#) of this guide provides the necessary resources to assist you with a startup practice.

Where is the right location?

There is no magic city that will ensure success. The best place to start a practice is where you want to spend the rest of your life outside of practice. In other words, when you leave the office at the end of your day, lock the door

and turn around to face the world, you should be where you want to live irrespective of economics and income. There are very few places in the United States that can't use another physician in your specialty, or where your practice would not be successful. Why not open where you want to live, or live where you would otherwise want to vacation? Even those locations that might be considered grossly over-doctored probably will have a niche community that would work within less than an hour's drive. A valuable source to assist you in your analysis of a geographical location you are considering is the AMA's [Physician Characteristics and Distribution in the US](#), which is divided as follows:

- **Section One:** Physician characteristics for age, sex, major professional activity, specialty and race
- **Section Two:** Geographical distribution by state
- **Section Three:** Specialty data for the nation, states, census regions, MSAs and counties
- **Section Four:** Data for primary care, including the activity, age, sex, board certification, school and year of graduation, international medical graduate state of location, and metro area
- **Section Five:** Trend data for specialty, major professional activity, age and sex; includes physician and population ratios for selected years

This is not to suggest you make a radical, untested change. If you grew up in Florida and have always had an interest in Alaska, then take a job for a year before investing in a startup, just in case you didn't realize what 22 degrees below zero in February really feels like with only two to three hours of semi-daylight day after day. A very high percentage of doctors end up in practice either near or where they grew up, near family, or in an environment (e.g., urban, suburban or rural) they have become accustomed to. If you vary from one of those environments, and if there is a question as to whether you will like your locale, you may want to rent an office and home for the first few years rather than buying or building one, just in case you end up moving.

It is also advisable to do your own research of community need rather than just buying a demographic survey. (See the [Making the right choice](#) section of this guide). Check with medical offices in your specialty to find out the wait for a new appointment. Patients like to be seen within a week of calling for an appointment. For every two weeks of wait, there is room for approximately one more physician. If the only physician in town has a two-week wait, then adding another physician would likely result in two physicians having a one-week wait. If all three physicians in a community each have a four-week wait, then there is likely room for six to nine more physicians.

Start or buy an existing practice?

The answer depends on the price of an available practice for sale. It is less expensive to buy a practice at or below

fair market value (FMV) than to start your own, but it is less expensive to start a practice from scratch than to overpay for a purchase. Both scenarios not only compete with each other but also balance each other out financially, which is what keeps FMV fair.

When buying a practice, the purchase price gives you the advantage of quicker cash flow, fewer marketing expenses and less work to assemble the components of the practice. On the other hand, a purchased practice may have features or pitfalls you may avoid if starting from scratch. Perhaps the lease is too short or the hospital is moving across town.

When starting a practice, you may have to spend a substantial amount of time getting everything assembled, obtaining financing to build and outfit the office, spend money on marketing to let referrers and patients know you are there, then wait the lag time until accounts receivable and patient traffic builds up to give you cash flow. A new doctor should give serious thought to which scenario would be most cost-effective, which is part of what holds down the price of practices for sale. In fact, it might be worthwhile to a physician starting a practice to ask the older doctors in the community whether they might be interested in selling their practices. Buying a practice at the right price could be a very economical way of starting your own practice. There are specialist medical practice appraisers available to calculate the FMV so both parties have confidence in a value that is fair to both parties. Read more on this specific topic in the [Medical practice valuation for purchase or buy-in](#) section of this guide.

Forming or joining a partnership

Another variation in starting a practice is to form or join a partnership. When done correctly, this strategy can give the new doctor a lot of independence in practice, some of the benefits of being in a group, and the ability to share in some ancillary services, such as labs and imaging, that might otherwise be prohibited by Stark or Medicare fee-splitting laws. Other benefits can include separate retirement plans, centralized administration, shared and more-expert billing, shared electronic health care records, less staffing hassles, etc. If you are considering joining an established organization, you must critically examine the established entity. From many perspectives (e.g., operating policies and administration, governance, compensation, benefits, risk and insurance) the assistance of skilled tax and legal advice is strongly encouraged.

Surprisingly, some partnerships are not set up correctly, which can lead to a lot of trouble later if there is a professional-liability incident, a disagreement over operational issues, or in the event of the death or withdraw of another member of the partnership.

One of the most common mistakes physicians make is to worry about the wrong things, or establishing priorities incorrectly. Enormous amounts of time can be saved by either getting a consultant or reading one or more of the startup books in advance. For example, worrying about office design and layout before even deciding where to locate, and whether to have a midlevel provider or partner, makes little sense.

In summary, there are many ways to start a medical career. First decide where you would like to practice, research community need, then look around for available options and support resources. One way or another, with a little bit of thought and planning you will greatly enhance your likelihood of success.

[Keith Borglum](#) is a licensed health care practice broker, appraiser and practice management consultant nationwide.

Resources for starting a practice

- [Physician Characteristics and Distribution in the U.S.](#)
American Medical Association, 2008
- [Buying, Selling, and Owning the Medical Practice, second edition](#)
American Medical Association, 2004
- [Financial Management of the Medical Practice, second edition](#)
American Medical Association, 2002
- [Maximizing Billing and Collections in the Medical Practice \(includes CD\)](#)
American Medical Association, 2007
- [Medical Practice Policies & Procedures \(includes CD\)](#)
American Medical Association, 2005
- [The Physician's Guide to Survival and Success in the Medical Practice \(includes CD\)](#)
American Medical Association, 2008
- [Health Information Technology in your Practice](#)
Great online AMA resource to get you started
- [Handbook of Medical Office Communications: Effective Letters, Memos, and E-mails \(includes CD\)](#)
American Medical Association, 2005

Physician profiling

- [How to challenge your profile or placement in a tiered or narrow network](#) (PDF, 115KB)
This flier from the AMA offers physicians seven steps to follow when challenging their network placement with insurers.
 - [Understanding episodes of care and efficiency ratings](#)
View this streaming video or continuing medical education credit. (This link will take you off the AMA Web site. The AMA is not responsible for the content of other Web sites.)
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