



THE INS AND OUTS OF GROUP PHYSICIAN DISABILITY PURCHASING

There was a time when life was less complicated. Or so it seems. I just can't remember when! This has led me to think about the challenges of approaching a physician's practice regarding purchasing or upgrading their Group Disability and Life coverages. More specifically in regards to who makes the decision to purchase the benefits for the group and, as importantly, who drives or provides the critical information necessary for the decision making process. In days gone by it was easy: for a small group- go right to the doc; the larger the group, the more likely it moved the analysis of benefit plans, carriers and selection of the vehicle to either the board or a paid administrator, but in the end it was the physician "partners" who voted nay or yea. Simple and straight forward, comparatively speaking, but no more.

Today, with the amalgamation of smaller groups into larger practices and the re-emergence of physician practices being absorbed by hospitals and health systems, the issue of who actually makes the decision may not be obvious. Determining benefit design is also complicated by the fact that MD income is not nearly as discretionary as it once was and every practice is experiencing pressures to keep costs down.

Let's examine the approach to a physician's practice by dissecting this discussion into three parts based on size and affiliation of the physician group (number of physicians are approximate to facilitate and provide foundation for the discussion):

1. **The small independent practice.** This usually consists of one or two MDs up to 10 MDS; and varies in size upwards of 10 to 40 total employees
2. **The large independent practice** made up of more than 15 physicians.
3. **The system/hospital owned practice.** This last division can be any number of MDs and can be multiple "groups" of physicians within the same organization.

For the purposes of the first discussion, we focus on the more traditional practice approach: the smaller physician practice. This can be a partnership, a LLP, or any other legal entities that can be described under the heading of "physician owned." We will explore in the future articles the additional complexities exhibited by larger practices- growth translating into enhanced or more sophisticated administrative staff, more "physician owners", and a centralized vertical management structure. Lastly, we will review the complex structure found in those practices that are part of a very structured and organizationally traditional environment of a hospital or system setting.

The Small, Independent Practice

If the past is any indication of the future, then small physician practices will vest the ultimate decision for benefits with the owner or owners, otherwise known as the physicians. In some

“smaller getting to be larger practices” the role of the decision maker may be delegated to the board. But, make no mistake about it, the end result of those decisions affecting each “partner’s” benefit package and pocket book will be voted on and approved by the group as a whole. The smaller the practice the more driven it is by the physicians. And, quite obviously, if they are to succeed they have to be closer to the operations and finances of the practice. A primary concern in the arena of insurance benefits is maximizing those benefits to the physicians. As in many organizations there is an informal pecking order – driven by seniority and by productivity. This usually translates into a few docs having the “influence” to drive decisions such as changes in the LTD contracts.

The key here is... who holds the key to the purse? Who are the folks you need to talk to? How can you contact the right person? These are all difficult to answer because there is no formula or rule and it may be (and quite often is) a moving target! It will take a feel for practices in general and that practice specifically. It is more than whose name appears first on the sign. The informal leaders are known in the medical community. Contact your other physician clients. Or, ask folks you know at the hospital.. The best way to get in the door is by a referral from a physician colleague. The best contact is one where you are recommended by one of their peers.

What are these doctors really looking for? Value. And value is defined here as maximizing their benefits at what they consider to be a reasonable cost. You will need to work with the physicians to determine exactly what those are. Be sensitive to the fact that each physician in the group may be at a different stage in their career and family situation. Translated, this means varying degrees of income to allocate to insurance benefits. Offering varied and flexibly individual approaches will significantly improve your chances of making a sale.

An additional complicating factor in the small practice is the financial advisor. Lest you think that what we have described above is “easy”, each physician often has his or her own advisor. This of course could be anyone from a spouse or a cousin to a well-educated counselor. A decision passed by the governing board or group may be nixed by the practice allowing the intervention of such individuals.

Summary:

In the smaller practice, decisions are made by physicians, for physicians, in order to maximize their own benefits. Most obviously, the art is getting to the buyer and then determining these variables.

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