SALARY INFLATION—

NEW ASSOCIATES NOW COST MORE

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Base salaries for employed ophthalmologists have increased noticeably in recent years. This has important implications for practices seeking new associates as part of their growth strategy and succession planning.

The primary reason for this increase is basic supply and demand. The government's National Center for Health Workforce Analysis issued a report in December 2016 indicating a projected shortage of 6,180 ophthalmologists by 2025.[1] That gap could grow as institutional and corporate investors create additional market pressure when implementing market expansion strategies.

COMPENSATION COMPONENTS

In most cases, total compensation for employed associates combines two components:

1. a base salary or salary guarantee
2. incentive-based compensation (i.e., "bonus")

Depending on recruitment ease/difficulty, a base salary for a newly trained comprehensive ophthalmologist is currently $190,000–$225,000. Subspecialists are paid at higher levels.[2]

Incentive compensation is frequently calculated as a percentage (typically 25–30%) of gross profit[3] after meeting a minimum threshold (typically three times base salary) (see **Table 1**). In our recent work with ophthalmic practices, we have found increases limited to salary guarantees rather than incentive-based compensation; the latter is likely limited by trends toward increased practice overhead.

IMPACT OF INCREASING BASE SALARIES

This trend in doctor salary increases creates implications for practices anticipating recruitment:

- **Increased financial risk.** As salary guarantees increase, the practice's financial risk of recruitment increases. If the associate requires more time to establish a viable personal practice revenue level (and therefore profits) to offset guaranteed compensation and overhead, the practice incurs greater costs. This is especially of concern if the associate leaves the practice before establishing a viable revenue level.
- **Greater need for timely financial viability.** When salary guarantees were lower, practices were often casual about financial projections for a new associate. Recruitment must now be evaluated rationally, establishing realistic levels for anticipated productivity and rational expectations for reaching desired financial goals. Clear budgets and productivity expectations for new associates are the new normal.
- **Potential associate dissatisfaction.** Although higher salary guarantees would seem to improve happiness, those higher levels require higher revenue thresholds before a bonus is earned. Given the limited financial sophistication of many newly trained residents, that lack of bonus could cause dissatisfaction as their increasing personal productivity does not yield immediate financial reward.
- **Inequitable compensation rates compared to senior physicians.** Some uncomfortable comparisons can arise between the compensation rates of new associates and those of physician owners. Practice owners should expect to subsidize a new physician initially, when salary guarantees are paid and new associate revenue is minimal. That becomes a problem if the associate's compensation as a percentage of personal revenue continues to be higher than that of the owners.
- **Extended timeframes before co-ownership.** Owner-track associates should expect an increase in personal cash flow once becoming a co-owner, allowing the buy-in to be affordable and creating motivation to pursue the co-ownership investment. As salary guarantees increase, though, the gap between employed and owner compensation narrows.

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This makes it difficult for the associate to achieve a level where buy-in is affordable without sacrificing personal take-home pay. The implication is that to be financially viable, the employment period before co-ownership might be extended. This could frustrate the associate who desires ownership and disrupt succession planning within the practice.

- **Limited financial margins.** For practices with above-average overhead or situations where an institutional or corporate investor is involved, available net income might be limited, making recruitment difficult and co-ownership impossible. Since the incremental cost of a new associate is limited to the variable costs involved (e.g., salary, benefits, support staff, supplies, etc.), the associate can be paid at a generous rate while still allowing the practice to profit from resultant contributions to fixed overhead.

HOW PRACTICES ARE RESPONDING

In the face of such challenges, prudent practices implement these key responses:

1. **Empirically evaluate the anticipated financial feasibility of a new associate. Table 2** shows a sample new provider break-even analysis. Note the volume level at which the provider begins to cover expenses associated with employment. Practices must know:
   - Where will patients come from?
   - How quickly can that volume level be achieved?
   - How much revenue can the associate produce?
   - How long is the practice willing to provide financial support while the new doctor's revenue is being built?

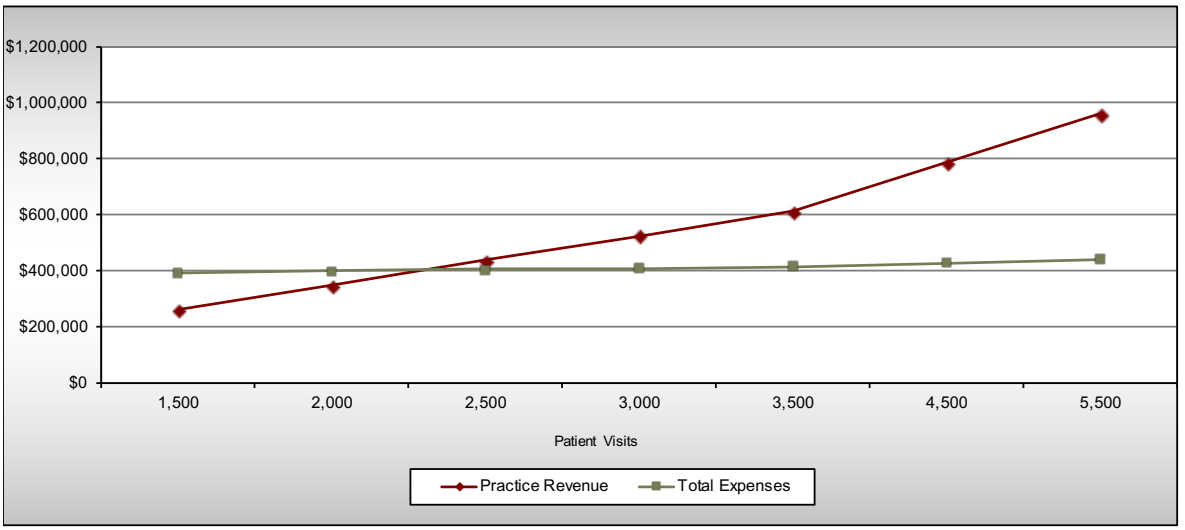
   If concerns arise in response to these questions, consider delaying recruitment or consider expansion of capacity through temporary use of contracted physicians or optometrists.
2. **Avoid overly generous compensation offers.** An overly anxious practice seeking to outcompete others for available talent can create a new problem by offering an unviable compensation rate. This is especially true if the associate is intended for eventual co-ownership. In some cases, the practice may be unable to recruit ownership-track candidates and will instead resort to long-term physician employment agreements.
3. **Communicate effectively with all stakeholders.** This means ensuring the associate clearly understands the compensation structure, how bonuses are determined, and how compensation and productivity affect the timing and affordability of co-ownership. This also means gaining the full support of current physicians, ensuring they understand the benefits to be derived from recruitment despite potential short-term costs.
4. **Exercise appropriate patience as the new associate develops.** Despite best efforts, projections can be overly optimistic and added time could become necessary before the associate reaches a comfortable production level. Projections should include an adequate margin for unforeseen circumstances rather than be built with little or no allowance for variation. The new associate represents an investment that should be protected from impulsive responses when results differ from expectations.

Once the associate's revenue covers the salary/guarantee amount, these concerns are largely abated. Generally, an associate producing revenue at three times the salary guarantee will have reached a viable balance of revenue and compensation. For example, a salary guarantee of $200,000 will normally require a revenue level of $600,000 or so to be viable and would yield a compensation rate of 33%, proximal to industry norms. Lesser revenue leads to a higher compensation rate relative to revenue and greater subsidization by the practice. Greater revenue leads to compensation rates consistent with industry norms when appropriate incentive-based formulas are used.

TABLE 1. INCENTIVE COMPENSATION EXAMPLE.

Base salary = $225,000 with practice gross profit of $800,000
Incentive Compensation = 30% x [Gross profit – (minimum threshold)]
Incentive Compensation = 30% x [800,000 – (3 x $225,000)]
Incentive Compensation = 30% x [800,000 – $675,000]
Incentive Compensation = 30% x $125,000 = $37,500
Total annual compensation = $225,000 + $37,500 = $262,500

Table 2. New physician break-even analysis



DON'T BE DISSUADED

The implications associated with increases in employed physician salary guarantees should not dissuade a practice from recruiting needed associates. Heightening market salary guarantees does mean, however, that practices must thoroughly prepare and approach such decisions more methodically and rationally than in the past. *AE*

NOTES

[1]HRSA Health Workforce. (2016, December). National and Regional Projections of Supply and Demand for Surgical Specialty Practitioners. Retrieved from https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/surgical-specialty-report.pdf

[2]By comparison, similarly trained residents 10 years ago would typically see offers closer to $120,000.

[3]Gross profit equals gross collections for the provider's professional work, less refunds and costs of cosmetic/intravitreal injectables, laser fees, and other major costs of goods.

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