
Private Practice or Not: Economic Considerations for the Physician Assistant

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Abstract

The decision of the Physician Assistant whether to enter private practice or an alternate career path can be greatly aided by economic considerations. The potential income both now and in the future for each alternative needs to be assessed. Trends in operating costs and gross revenues for relevant private practices must be researched. Characteristics of the practices, such as, age, size, specialty and location have impact, as well. Issues of fee collection and reimbursements require investigation.

The purpose of this article is to review the role that economics plays in the decision-making process for the Physician Assistant (PA) in terms of the type of practice to pursue. Critical to the decision of a new Mid-Level Professional whether or not to enter into employment in a private practice or hospital / clinical based assignment, is research into the long term economic consequences. A third practice model to add to the mix is the physician / physician assistant owned practice partnership. This entails consideration of the following:

1. Potential salary presently available and its likely growth in the future
2. Any investment costs accounting for loss of future interest
3. Potential revenue, now and in the future from private practice
4. Operating costs attributable to private practice both now and in the future
5. Problems related to reimbursement and collection of fees
6. Type of practice e.g. size, age, specialty, or multi-specialty
7. Location of practice
8. Participation in managed care, HMO's, etc
9. Income disbursement from the practice or

organization

In general, assessing potential salary and prospects for the future can be guided by Bureau of Labor Statistics publications that provide current salary ranges and employment prospects for the future. Among such publications are the Occupational Outlook Handbook and Occupational Outlook Online (<http://www.occupationaloutlook-handbook.net>). For physician assistants, median annual earnings in 2002 were \$64,670 with the middle 50% earning between \$49,640 and \$77,280. These earnings are affected by factors such as specialty, practice setting, geographical location and years of experience. Physician assistants are expected to be in very high demand over the period extending to 2012, even more so than other professions. To the above data, one would need to make some estimates of the fringe benefits which would be in addition to salary. Perhaps a percentage estimate typical for these professions could be used.

If a PA is entering a private practice as a partner, as many are beginning to do, one then would need to determine whether a capital investment would be required, and if so, what the amount would be. To this, one would need to add an estimate of the lost interest earnings over time using a low risk long term interest rate. Next, an estimate of the revenues and costs associated with private practice must be made.

While it may not be possible to obtain precise information related specifically to the PA, one can utilize private practice

data to elicit trends in both revenues and costs that most likely would have effect on their practices and salaries. For the following analysis, we will primarily utilize data from office based private practices of primary care physicians. This is viewed as being the most akin to the PA profession. For ease of comparison, it has been determined that only data from various surveys conducted by Medical Economics over the past ten years related to office-based MD's and DO's in office-based private practice will be utilized in the following analysis. A limitation is that this may not be the most exact or best data available. In fact, professional organizations may possess more specific data necessary for the final decision making process. While there is no reason to believe the exact same population was sampled and responded to each of the surveys, the nature of the list gives some confidence that it is representative. It should be noted that the subsequent revenue and cost data is presented on a per physician basis.

Tables 1 and 2 present data related to the revenue side of the picture. Median net earnings for 1995 and 1999 are presented in Table 1 and total compensation for 2002 and 2003 in Table 2. While these are not strictly comparable, for eliciting a trend they serve the purpose. The data for 1995 and 1999 show either almost no growth or even a loss in year earnings when inflation is accounted for (consumer price index is utilized as a measure of inflation over the period). The total compensation picture for 2002 to 2003 is mixed across the various specialties but pretty much flat.

Figure 1

Table 1: Median Net Earnings (\$)

| Practice Type | 1995 | 1999 | % Change |
|---------------|---------|---------|----------|
| OB/GYN | 197,260 | 191,270 | -2.3 |
| FP | 123,620 | 128,490 | 6.1 |
| Internist | 122,440 | 127,090 | 2.9 |
| Pediatrician | 126,980 | 133,750 | 13.0 |
| GP | 97,440 | 106,990 | 6.7 |
| | | | CPI 12.4 |

Note: Data obtained from Goldberg¹

Figure 2

Table 2: Total Compensation (\$)

| Practice Type | 2002 | 2003 |
|---------------|---------|---------|
| OB/GYN | 220,000 | 208,000 |
| FP | 150,000 | 149,300 |
| Internist | 150,000 | 150,000 |
| Pediatrician | 130,000 | 140,000 |
| GP | 116,000 | 120,000 |

Note: Data obtained from Guglielmo,² and Lowes³

One then could look at how much of practice revenue is kept after expenses by seeing the proportion that total compensation is of total practice revenue. Table 3 represents the comparisons for 2002 and 2003.

Again there are mixed results across the specialties with OB/GYN's and Family Practitioner appearing to keeping less and the others appearing to be keeping a slightly more. Care must be given to the analysis, since samples from year to year differ.

Figure 3

Table 3: Total Practice Revenue (\$)

| Practice Type | 2002 | 2003 |
|---------------|---------|---------|
| OB/GYN | 500,000 | 500,000 |
| FP's | 350,000 | 379,100 |
| Internists | 318,600 | 310,000 |
| Pediatricians | 350,000 | 365,000 |
| GPs | 249,000 | 250,000 |

Note: Data obtained from Guglielmo² and Lowes³

Figure 4

Table 4: Ratio of Total Compensation to Total Practice Revenue

| Practice Type | 2002 | 2003 |
|---------------|-------|-------|
| OB/GYN | 44.00 | 41.60 |
| FP's | 42.86 | 39.38 |
| Internists | 47.08 | 48.39 |
| Pediatricians | 37.14 | 38.36 |
| GPs | 46.59 | 48.00 |

Note: Data calculated based on data in Tables 2 and 3.

We can look at data by size and type of practice to assess whether or not this is a significant factor. Data problems hinder the analysis. The 2003 data for all practices appears to indicate a larger proportion kept as practice size grows (excluding solo) up to 10-24 and then a large drop. This is possibly indicative of entering the range of diseconomies of scale and deserves additional study. The limited size breakdown for 2002 doesn't allow for confirmation. From the more limited data for primary care in 2003 we still can't confirm this, but there appears to be a similar pattern. Care must be taken since the sample could be causing this. Looking at data from 1999 for the ratio of net to gross revenue we see a pattern of increased proportion through the 50+ category with some bleeps along the way.

Figure 5

Table 5: Compensation to Practice Revenue

| Practice Size | Net/Gross | Total Comp / Total Practice Revenue | | |
|---------------|-----------|-------------------------------------|-------|---------------------|
| | 1999 | 2002 | 2003 | 2003 (Primary Care) |
| Solo | 54.41 | 47.51 | 45.34 | 43.25 |
| 2 | 62.19 | 38.85 | 38.57 | 35.47 |
| 3 | 56.83 | 46.68 | 41.13 | 41.67 |
| 4 | 65.74 | 34.20 | 44.20 | 43.90 |
| 5-9 | 67.67 | 43.58 | 49.00 | 40.18 |
| 10-24 | 72.56 | 42.86 | 50.00 | 43.32 |
| 25-49 | 69.22 | ----- | 34.28 | |
| 50+ | 73.58 | ----- | 32.76 | |

Note: Calculated with data from Goldberg,¹ Guglielmo,² and Lowes.³

What appears to be occurring over time is a smaller portion of practice revenues is being kept by the practice physician.

Looking at regional data for 2002 and 2003, the absolute total compensation is highest in the South, but when looking at the portion of practice revenue kept, the picture is not as clear. The 2003 data indicate that the region with the highest HMO penetration shows the lowest total compensation, however it has the highest portion of practice revenue kept.

Figure 6

Table 6: Compensation to Practice Revenue

| | Total Compensation (\$) | | Portion of Practice Revenue | |
|---------|-------------------------|---------|-----------------------------|-------|
| | 2002 | 2003 | 2002 | 2003 |
| East | 150,000 | 160,000 | 42.86 | 44.44 |
| Midwest | 161,000 | 180,000 | 41.36 | 42.86 |
| South | 180,000 | 200,000 | 44.44 | 43.47 |
| West | 160,000 | 173,900 | 41.29 | 43.47 |

Note: Calculated with data from Guglielmo,² and Lowes.³

If one intends to join an existing practice, the age of the practice becomes relevant. Data for both 2002 and 2003 show a clear pattern of increasing total compensation as years in practice increase up to 30 years and then a decline. One might also consider the age of the other practitioners since data for 2002 and 2003 show increasing total compensation as age increases, reaching a plateau somewhere in the 40-50 year range.

It appears from the 2003 data that working in an urban area results in the highest total compensation; however the inner city area leads to the least. In both cases higher portions of practice revenue is kept compared to suburban or rural areas. It is necessary to assess whether additional work effort is necessary for the higher practice revenues particularly if a significantly lower proportion is being kept (see table 7).

Figure 7

Table 7: Compensation, 2003

| Location | Practice Revenue (\$) | Total Compensation (\$) | Practice Revenue/Total Compensation |
|------------|-----------------------|-------------------------|-------------------------------------|
| Inner City | 300,000 | 150,000 | 50.00 |
| Urban | 410,000 | 200,000 | 48.78 |
| Suburban | 430,400 | 180,000 | 41.82 |
| Rural | 431,000 | 175,000 | 40.60 |

Note: Calculated with data from Lowes.³

Next is the expense side. The key items continually identified on the cost side are office payroll (non physician), office space (rent or mortgage) and malpractice insurance. For comparability of data from year to year office payroll is defined to include salary, fringe benefits and retirement. Below are the expenditures in 1998 and 2002 in the areas by region. One clearly sees that while they accounted for the bulk of operating expense (over 90% in most cases) in 1998, they account for only about 60% in 2002 except in the East where it was 70%. One must assess what other categories have grown and their particular relevance in the intended

practice setting. What is clear from the data is the sizeable increase over this period in these key expenditures.

Figure 8

Table 8: Key Expenditures

| Location | 1998 | | 2002 | |
|----------|-----------------|---------|-----------------|---------|
| | Median Expenses | % Total | Median Expenses | % Total |
| East | 79,300 | 86.5 | 123,000 | 70.37 |
| South | 88,980 | 90.8 | 133,600 | 63.62 |
| Midwest | 84,920 | 95.6 | 117,500 | 58.75 |
| West | 79,410 | 96.2 | 117,700 | 58.85 |

Note: Calculated with data from Grandinetti,⁴ and Weiss.⁵

Other expenditures that could vary with type of practice and location are clinical supplies, laboratory costs, depreciation of equipment, utilities and payroll taxes. These, as well as others, will enter into the final assessment. Other factors that appear to effect expenditures include total patient visits per week and hours worked per week. According to the 2002 data per head, median expenses rise as hours worked per week rise up to 80 hours and rise as well for patient visits per week up to 200 visits.

Once again, years in practice and the age of the practitioner appear to influence costs. Median expenses account for higher portions of practice revenue in the early years (1-6) and later years (over 30) according to the 2002 data.³ Likewise the practitioners in the youngest age bracket (30-34) show a much higher proportion (60%). Interestingly, looking at 1998, using slightly different variables (overhead as a proportion of gross revenues), a continually increasing proportion is shown as years in practice increases up to the over 30 category.⁴ The proportion increases with regard to the age of the practitioner from the 30-34 bracket, which is the lowest, to the 60-64 bracket.

Looking at the portion of practice revenue expended on operating costs in 1998 and 2002 for the primary care physicians, a sizeable increase is apparent (see Table 9 below).

Figure 9

Table 9: Operating Revenues as a Percentage Practice Revenue (Primary Care Physician)

| Practice Type | 1998 | 2002 |
|---------------|------|------|
| OB/GYN | 44.1 | 57.0 |
| FPs | 39.8 | 57.0 |
| Internists | 38.9 | 52.0 |
| Pediatricians | 39.8 | 55.0 |
| GPs | 39.5 | 53.0 |

Note: Calculated with data from Grandinetti,⁴ and Weiss.⁵

The median per head expenditures appears to rise as size of practice increases to 4 then decline in both 1998 and 2002. The 2002 data has what appears to be large increase in

the 10-24 category as opposed to 1998, which could be a function of the sample. Further investigation would be necessary. This aside, indications are that economies of scale prevail.

Figure 10

Table 10: Practice Size

| Practice Type | 1998 | | 2002 | |
|---------------|----------------|-----------------------|----------------|-----------------------|
| | Median Expense | % of Practice Revenue | Median Expense | % of Practice Revenue |
| Solo | 106,530 | 41.5 | 184,000 | 51.0 |
| 2 | 113,780 | 39.7 | 200,000 | 55.0 |
| 3 | 114,810 | 37.0 | 210,000 | 50.0 |
| 4 | 139,950 | 39.3 | 300,000 | 54.0 |
| 5-9 | 101,830 | 35.0 | 259,000 | 55.0 |
| 10-24 | 51,760 | 22.8 | 350,000 | 49.0 |

Note: Calculated with data from Grandinetti,⁴ and Weiss⁵

Another consideration relates to the ability and likelihood of collecting billings. The most recent survey conducted by Medical Economics for 2002 shows that fees for 10 categories of office visits rose by 4.9 %, while reimbursements rose by only 0.5%.⁶ In the primary care group, GPs fared the best with fee increases of 2.1 % and reimbursements increasing 5.7%. With few exceptions the primary care group had fee increases outpace reimbursements. The picture in 2001 was not much different with the group as a whole showing increased fees of 7.5% and reimbursements up 7.3%.⁷

Another area for consideration relates to managed care. Below is data for 1998 and 2000 relating to participation in various plans by the primary care physicians. While there tends to be a reduction in participation in capitation plans, participation in HMOs and PPOs does not appear to have changed much. More recent data would be necessary to confirm this.

Figure 11

Table 11: Participation (%)

| Practice Type | HMO | | PPO | | Capitation | |
|---------------|------|------|------|------|------------|------|
| | 1998 | 2000 | 1998 | 2000 | 1998 | 2000 |
| OB/GYN | 80 | 83 | 87 | 82 | 21 | 25 |
| FPs | 74 | 76 | 84 | 85 | 61 | 53 |
| Internists | 78 | 74 | 83 | 78 | 69 | 58 |
| Pediatricians | 89 | 88 | 90 | 83 | 78 | 62 |
| GPs | 54 | 53 | 58 | 66 | 60 | 46 |

Note: Data from, Terry,⁸ and Terry.⁹

FPs percentage of gross revenue from HMO, rose from 20% in 1998 to 32% in 2000, while internists (office-based practice) rose from 23% to 32%. In the East in 2000 HMOs accounted for 49% of gross revenue while in the Midwest it was only 23%.

SUMMARY

The intent of this article was to demonstrate how economic analysis factors into the decision making process. What has been identified are key areas for consideration. In the final analysis personal and other considerations will need to be entered into the process. Over the period from 1995 to 2003 growth of income flowing to the practice partners has slowed and even stopped in some cases. Much of this is attributable to a faster growth in operating expenses than revenues. Where you locate, the age of the practice and the age of the practitioner are among numerous factors affecting this. If one is considering joining a private practice or partnership, it appears one should find one with a physician or physicians in mid-career and a staff of proper size to run the office efficiently. As well, the number of practitioners should be matched to patient demand as it appears that above 4 providers, the cost per provider is reduced.

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