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Attracting, compensating, and retaining health care providers

The value of physicians[1]—and specifically primary care—has never been higher than it is today. An aging population, labor shortages, and growing evidence that supports risk-based models of care have placed greater emphasis on the importance of engaging and retaining physicians.

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Executive summary

Physician compensation sounds simple—pay physicians a fair-market competitive salary, allow them to practice medicine with clinical autonomy, and treat them well. While that equation has typically resulted in success, the entry of new physician employers, increased non-clinical demands on physicians, and changes to how physician performance is measured and reimbursed turn this into a more complicated matter with regulatory, legal entity, equity-based pay, benefits structure, and workload issues, among other factors.

This paper will introduce many of the evolving conditions that impact physician compensation and argue that to attract and retain physicians in today's workforce, employers must revisit compensation models. We will also offer considerations that go beyond compensation, as it is a component but not the only component of attracting and retaining providers.

Before diving into our point of view on physician compensation, let us center on the market forces heightening the pressure to attract and retain physicians.

Understanding the underlying drivers

America is getting older

It is well documented that America's population is getting older, primarily due to declines in birth rate and advances in modern medicine, resulting in a reduced mortality rate and improved life expectancy.[2] This trend is expected to continue, with forecasts suggesting senior citizens will represent one out of every five (20%) Americans by 2030, and outnumber children by 2035.[3] With increased longevity comes greater prevalence of chronic disease. Treating the complexities and managing the costs that come with age requires health care organizations to shift emphasis from chronic illness treatment to chronic illness prevention. Organizations that implement strategies focused on prevention can derive tremendous value, both in patient and financial outcomes.

Risk-based trends are proliferating

More than 18% of US GDP is spent on health care.[4] With the increased age of the average American, this percentage is expected to go up, accelerating the transition into longitudinal care. Because of this, managed care organizations are entering care delivery as a mechanism to optimize medical cost, as well as to be directly in front of the customer. As we describe in our *Breaking the cost curve* paper, we believe that a strong, value-focused foundation will decelerate spend and improve outcomes over the next 20 years.

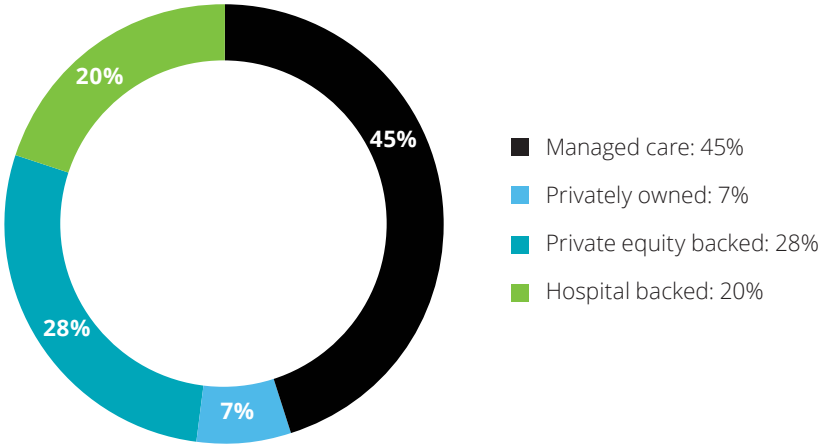
These trends have led to the proliferation of senior-focused, full-risk medical care, which has grown significantly the past five years. Based on publicly available data—there are more than 1,600 clinics in 33 states in the United States today. As figure 1 illustrates, the growth of full-risk care clinics has also diversified ownership, with managed care and private equity companies owning nearly 75% of Medicare Advantage (MA), full-risk clinics.

Physician demand outstrips supply

The last major force affecting physician compensation dynamics in the United States is the continued demands facing physicians. As discussed in our *Addressing health care's talent emergency* paper, physicians are being asked to perform more non-clinical tasks, which is one driver of higher physician burnout, especially in primary care.[5] Today, physician burnout is reported to be as high as 63% of practicing physicians.[6]

The aging population, physician shortages, new entrants, and increasing health care costs in the United States have resulted in primary care physicians having more varied employment opportunities than ever before. While there are a number of strategies that organizations can use to attract and retain physicians, compensation is the cornerstone of any talent model.

Figure 1: National full-risk MA capitation clinic ownership breakdown



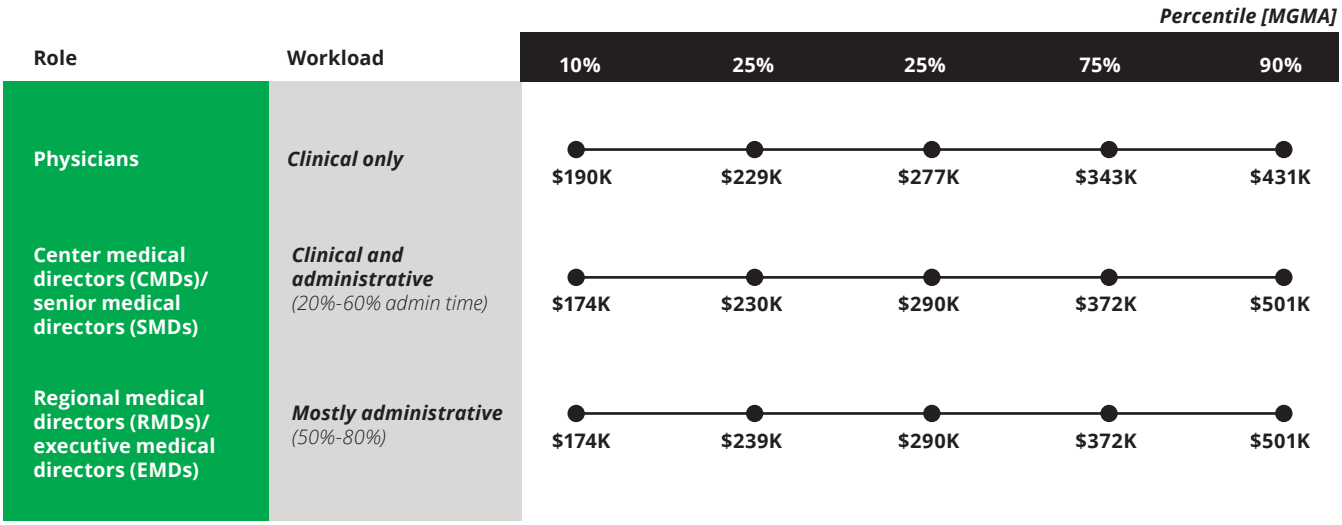
Source: Deloitte internal research

Physician compensation today

We conducted a study that surveyed primary care physicians who currently work for managed care organizations to understand physician compensation, as well as evaluated industry benchmarks utilizing 2023 data. Based on this analysis, several important findings emerged informing our strategies for physician retention and attraction.

We learned that physicians' annual compensation in value-based care (VBC) models of care varies from $190,000 to $500,000 or more (figure 2).

Figure 2: Medical Group Management Association (MGMA) benchmarks for primary care provider total compensation



Source: MGMA 2022 report based on 2021 data

Findings from our study suggest that the traditional talent model for primary care physicians is a cash-based salary of about $250,000 (median), which increases as work evolves to become more administrative in nature. As the health care landscape changes so, too, do the employers. As of 2022, roughly 22% are employed by non-provider corporate entities such as health plans, managed care organizations, private equity, or traditional technology companies.[7] This opens the door to non-cash-based compensation, which may serve as a strong mechanism for retention, as well as alignment to VBC models of care (e.g., continued vesting options can keep providers connected to their patients for longer).

Total compensation for physicians employed at non-provider corporate entities is a mix of cash and equity-based compensation (figure 3). The primary methods of equity are Provider Stock Options (PSO), Provider Partnership Program (PPP), and Employee Stock Purchase Plan (ESPP). PSOs and PPPs are usually reserved for senior physicians with more administrative responsibilities, while ESPPs can be available for physicians at any level. As shown in figure 4, the maximum annual equity ranges from $31,000 to $405,000, depending on the role and responsibilities of the physician, with equity becoming more prevalent as administrative responsibilities increase for physicians. This range does not include ESPPs, but physicians at all levels can purchase up to $25,000 (IRS limitation)[8] of employer stock at a discount of about 15%.

When speaking to physicians employed by Fortune 25 managed care organizations, we learned that most prefer a 50/50 split between cash and equity-based compensation. Factors like age, degree of medical school debt, and macroeconomic performance are the primary drivers behind a physician's preference.

Figure 3: Typical physician equity compensation structure

Provider equity compensation details

	Equity compensation types	Description	Type
1	**Provider appreciation grant**	Sign-on cash bonus paid to the newly hired physicians; this may have certain conditions such as minimum serving period	**One-time cash bonus** (Typically, around $10K)
2	**Annual grants**	Annual equity grants typically reserved for medical director roles and above	**Vested over "n" periods, (100/n)% per period** (Generally, n = 3 to 5 in health care industry)
3	**Preferred stock options (PSOs)**	Preferred stock options are offered to the medical director and above roles on an ad hoc basis	**Vested over "n" periods, (100/n)% per period** (Generally, n = 3 to 5 in health care industry)
4	**Provider partnership program (PPP)**	Equity grant under provider partnership programs; eligibility starts after 2-3 years of tenure and can be offered to both physicians and medical directors	**Vested over "n" periods, (100/n)% per period** (Generally, n = 3 to 5 in health care industry)
5	**Employee stock purchase plan (ESPP)**	ESPP program allows all physician and medical director participating employees to purchase company stock at a discounted price (typically 15-20%)	**Annual payroll deductions** (Comes with annual limit of $25K)

Source: Based on interviews with industry experts; Deloitte internal research

Figure 4: Compensation structure of a Fortune 500 diversified health care company

Role	Administrative Time	Compensation					
		Median salary	Equity grant eligibility				Annual total compensation
			Annual grants	PSOs	PPP	Max equity	
NP/PA	**0%**	$127K	*Not eligible*	*Not eligible*	*Not eligible*	$0	$127K
Physician	**0%**	$249K	*Not eligible*	*Not eligible*	*Not eligible*	$0	$249K
Center medical director	**20%**	$235K	$6K	*Not eligible*	$100K	$31K	$266K
Senior medical director	**50-60%**	$264K	$48K	$16K	$100K	$89K	$353K
Regional medical director	**50-60%**	$285K	$85K	$28K	$100K	$138K	$423K
Executive medical director	**80%**	$310K	$300K	$80K	$100K	$405K	$715K

Source: Deloitte internal research

Talent model considerations

While financial compensation is likely the most important component to attraction and retention, it is not a ubiquitous solution to employment satisfaction. Employers should consider three other factors in physician talent models:

1. Emphasize that a VBC talent model can reduce stress by allowing physicians to manage smaller patient panels. Some organizations in the marketplace today utilize panels of 400–500 patients, which is a roughly 75% reduction compared to average US panel size of 2,300, and is possible in a VBC structured organization.[9]
2. Physicians surveyed consistently indicated that the more time spent on tech-based administrative work, the greater their job dissatisfaction (e.g., one physician indicated to our team that "the most enjoyment [at their job] they had had recently was during an electronic health record downtime, where they and their team had moved back to paper-based coding and tracking"). Physicians are drawn to organizations with technology platforms that reduce administrative time and "screen time."
3. Lastly, while there are a number of creative compensation options open to all organizations, STARK[10] and other regulations such as the Friendly PC Practice of Medicine[11] need to be considered prior to implementing.

Organizations seeking to capitalize on the prevalent trends in health care must implement compensation and talent structures that are differentiated and aligned to a rapidly changing marketplace. Those that do will be able to attract and retain the most valued asset in health care, primary care physicians, thus improving outcomes for patients, reducing medical costs, and subsequentially driving organizational value (i.e., market capitalization and/or share).

Deloitte's recommendations and next steps

Stock-based compensation will continue to be a critical part of physician compensation. Physicians are becoming increasingly sophisticated financially and will look to the promise of growth in stock-based compensation. We believe organizations looking to attract and retain physician talent need to consider new, equity-based compensation models and talent strategies:

- **Create compensation structures that align with the continued transition to VBC**. The longer a patient is cared for in a longitudinal model of care, the better the outcome. Undeniably, the tenure of the physician's association allows them to diagnose better, build rapport to enable the patients to share sensitive information readily, and increase the physician's ability to influence and direct care. Stock compensation that vests over time is a good retention measure that financially incentivizes the physician to stay in the role longer and organically extends the connection between patient and physician.
- **Incentivize holistic medicine and move beyond Relative Value Units**. Primary care physicians are asked to do more than patient consultation, and the job description is changing beyond traditional volume-based medicine to promote value-based outcomes (e.g., meeting patients in nontraditional check-ins and administrative responsibilities). Physician compensation should reflect these essential activities, rather than conventional fee-for-service structures, and establish career paths that contemplate extending skills with compensated structures calibrated to reflect the new reality.
- **Consider the impacts of M&A on physician compensation**. Many care organizations have an exit strategy involving a transaction or an outright acquisition/buyout. Organizations should carefully consider how a transaction event can affect legacy compensation plans (e.g., transactions can create taxable events, leading to significant physician dissatisfaction), and consider creative temporary employment structures to make a transition more palpable, such as an employee lease agreement.

While our findings suggest that incorporating equity into provider compensation is critical to satisfaction and retention, providing equity is only sometimes an option—due to the corporate practice of medicine or similar regulatory considerations. In those cases,

- **Devise creative compensation structures that can mirror stock-based compensation**. Cash-based compensation plans that mirror or are tied to an organization's stock performance are viable options. If not, it may make sense to compensate providers with cash premiums and/or increased deferred compensation plans.
- **Ensure compensation strategies are compliant with state regulations**. Depending on the location of care, physicians may need to be employed in a separate entity from which they deliver care. Compensation plans should consider these structures (and/or related benefits, such as loans), particularly in states where friendly physician practice of medicine is required.
- **Consider options that can and cannot be provided as a for-profit vs. not-for-profit organization**. The ability to incorporate equity options into an overall compensation package is a valuable lever that for-profit organizations can and should utilize for care providers. That said, not-for-profit organizations have other options, ranging from deferred, tax-exempt programs to creating partnership models with physicians.

While provider equity-based compensation is critical, it should be considered in the broader context of the health care industry:

- **There remains a provider shortage in the United States**. As highlighted in previous research, there are several new entrants in the marketplace. This, coupled with changes in care dynamics, has led to a shortage in physicians and providers, which is expected to continue. Organizations should consider alternative solutions to staffing—such as bringing in foreign-educated physicians and related implications—to manage this shortage.
- **Compensation alone is not enough**. Employers should consider offering access to research and academic affiliations, capping patient panel sizes, optimizing panels based on chronic diseases, and investing in technology-enabled solutions (e.g., telehealth, auto authorization, documentation tools) that minimize out-of-office work that strips away nights and weekends from physicians and their families.
- **Health care is a rapidly changing environment**. The benchmarks and surveys utilized for this study are from 2023. Organizations should continue to assess, evaluate, and optimize compensation strategies to attract and retain clinical talent in a dynamic marketplace.

Endnotes

1. Throughout this paper, "physicians" and "providers" are used interchangeably and are meant to refer to primary care physicians (not including OB/GYNs).
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Acknowledgments

Connor Fedge, manager in the McLean office, and Tyler Hagan, senior consultant in the Denver office, significantly contributed to the research and writing of this paper.

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