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Performance-based compensation in member-owned firms: An examination of medical group practices☆

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Abstract

We examine the importance of agency considerations for the mix of salary and performance-based compensation in member-owned medical practices. Performance-based pay increases with the informativeness of clinical productivity measures, and declines with greater reimbursement from capitation contracts. Inexperienced physicians receive more compensation from salary, but compensation mix does not change as physicians near retirement. Larger practices and practices using outside management companies place more weight on performance-based compensation. However, when more physicians in the group practice the same specialty, less emphasis is placed on performance-based compensation. Finally, the presence of an executive partner has no influence on compensation mix.

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1. Introduction

The underlying model for most empirical studies on managerial incentives is agency theory (e.g., Lambert and Larcker, 1987; Bizjak et al., 1993; Garen, 1994; Bushman et al., 1996; Aggarwal and Samwick, 1999; and others). However, considerable debate still exists regarding the extent to which observed compensation contracts reflect agency concerns. Prendergast (1999), for example, argues that empirical research supports the notion that agents respond to incentives, but has been considerably less successful in finding compelling results regarding the expected tradeoff between risk and incentives.

Our objective in this paper is to provide stronger tests of agency theory using a more powerful research setting than most prior compensation studies. We provide empirical tests of agency models on compensation practices in *member-owned* firms. These firms are unique in that a firm member can be both a principal (i.e., a partner) and an agent (i.e., an employee of the firm). Although compensation and governance issues in member-owned firms have been the subject of a number of analytical agency models (e.g., Lee, 1990; Kandel and Lazear, 1992; Narayanan, 1995; Ferral, 1996; Gompers and Lerner, 1999), empirical evidence on these issues is limited.

Our study focuses on compensation practices for physicians in member-owned medical group practices. This setting has several distinctive features that enhance our ability to study a wide variety of agency issues. First, unlike compensation contracts in most large corporations, physician compensation contracts tend to be relatively simple combinations of fixed salary and annual cash bonuses.[1] This simplicity enables us to obtain reliable measures of the compensation risk imposed on employees. Second, medical group practices operate in the same service sector, implicitly controlling for confounding industry effects that hinder cross-sectional studies spanning multiple sectors. Third, compensation contracts in these groups exhibit considerable variation, ranging from strictly performance-based to entirely salary-based. Finally, medical group practices employ a wide variety of management structures. Members can jointly manage the practice themselves, can appoint one member to serve as "executive partner" or "physician executive," or can hire a professional management company to manage the firm. Variations in these dimensions, together with the lack of confounding industry effects, allow us to conduct powerful tests of hypotheses derived from general agency models, as well as from agency-based models investigating compensation practices in member-owned firms.

We conduct our analyses using survey data collected by the Medical Group Management Association (MGMA) in 1999. Our sample covers 9,851 individual physicians in 596 practices. We find that practices place less weight on performance-based compensation when a larger percentage of group revenues is derived from capitation (where the practice receives a fixed payment to provide care for a patient over the course of the year) versus fee-for-service arrangements, consistent with efforts to reduce goal conflicts between the physician and practice. We also find that the weight on productivity-based bonuses relative to fixed salary is lower when the physician spends a greater amount of time on non-clinical activities or when the group staffs a hospital or considers quality

[1]Our use of the term "performance-based compensation" refers to performance-based cash bonuses. Only 11.9% of medical group practices in our study provide stock or stock option benefits to any of their physicians. Generally, these benefits are only provided when one of the physicians in the group is appointed to manage the practice, and then only to the managing physician.