Partial Retirement In A Group Practice

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I. Introduction

The concept of "partial retirement" (i.e., the gradual phase-down or wind-down of one's practice), is often overlooked by groups when structuring their co-ownership agreements. When a group's owners are all relatively young, the neglect is rarely detrimental. However, many groups are comprised of one or more physicians in, or on the verge of, the twilight years of their careers. In such cases, partial retirement is as important a concept as income division, buy-outs and governance and other key concepts under a group's co-ownership arrangements for several reasons: Sooner or later the idea of phasing down will become attractive to the group's physicians who are approaching the final years of their practice; also, because partial retirement directly impacts the aforementioned key co-ownership concepts; and, finally, because the reduction in an owner's workload can have a significant, even substantial, impact on the group's coverage and other operations.

The concept of "phasing down" a physician's participation in the practice includes all forms, from increasing vacation or other leaves of absence, to working full-time only three days per week, to dropping or reducing night and weekend coverage responsibilities, to working half-days, to stopping surgery or some other aspect of practice. As this partial list of reasons for phasing down illustrates, the development and implementation of a policy which tries to identify the form that a particular physician's partial retirement will take is likely to be incomplete at best, and totally ineffective in some situations.

II. Partial Retirement: What Does It Mean?

A. Right or Privilege?

Some groups take an "all for one; one for all" approach regarding partial retirement by not permitting it to anyone. Physicians in these groups usually have adopted the philosophy that each physician should share in all aspects of the practice, from the greater income enjoyed by full-time participation, to the responsibility of continuing to take full on-call coverage, perform all surgical procedures and share all the other activities borne by the group.

Another practical consideration in adopting such a policy is how the group will function if a doctor reduces his or her level of participation. Not only may the group's productivity be affected, but someone must be prepared to assume the management functions which the more experienced doctors normally fill. The number of physicians in the group may also help to shape its partial retirement philosophy. If a group has eight physicians, each will be on-call one weeknight every other week. However, if one or two physicians were to drop their on-call duties, the burden for the ongoing members of the group would increase. Some groups solve this problem by prohibiting a physician from reducing his or her share of call until the group hires another physician. However, in

many cases, the partial retirement of one physician will not justify employing another physician because the practice's overall workload could not support it. In the right situation, though, a new physician's income production from other sources could produce a favorable financial result for the practice. Another approach to resolving this issue is to adopt a policy that allows a senior doctor to partially retire only if a minimum number of physicians are employed by the practice on a full-time basis.

B. Consequences

Because a change in a physician's work patterns may result in fundamental changes within the practice, modifications to that physician's income, participation in governance and ownership interests may be appropriate.

i. Impact on Ownership. The issue here is whether a physician who is partially retired should be forced to sell his or her ownership interest back to the practice as of the date the physician's activities phase down. If the group decides that the physician should no longer be involved in governance matters, then buying back his or her ownership interest is appropriate. Moreover, the group may take the position that a physician who is not involved on a full-time basis should not participate in decisions that can increase the potential financial liabilities and risks that impact the full-time members in a more significant fashion. For example, a partially retiring physician could vote in favor of the purchase of expensive equipment which would ultimately be paid for mostly by the full-time physicians in the group.

If a decision is made to repurchase the physician's ownership interest at the time partial retirement begins, payment can either be made in a lump sum or in installments over a period of time at a reasonable rate of interest, evidenced by a promissory note from the practice. If a decision is made to repurchase the physician's ownership interest at some later date, perhaps at the time of complete retirement, then the group must decide when to value the physician's interest. Many group buy-outs are in some fashion tied to productivity at the time of termination. In this case, the partially retired physician could suffer a substantial loss in the value of his or her interest, were the same determined at the time of complete retirement versus at the outset of partial retirement. If, on the other hand, the value of the physician's interest is tied to the overall group value, then there may be some merit to allowing the determination to be made at the time of the physician's complete retirement since, in this regard, the partially retired physician will share the burden of ensuring the proper transition of his practice from the date of his partial retirement through the complete cessation of his practice.

ii. Impact on Governance. Some groups have adopted a philosophy that a partially retired physician should not participate in governance activities, which could affect others who work full time more than it affects him or her. In theory, such a position or policy serves as a deterrent to over-using and abusing the partial retirement policy. In reality, the idea is probably more symbolic than real. By contrast, many groups value the more mature physician's experience in the fields of management and administration, and value his or her continued participation in decision-making activities.

iii. Impact on Compensation. Because partial retirement can take so many forms, it is not advisable, or even possible, to predetermine what compensation adjustments may be appropriate. For this reason, the physician should include an adjusted compensation arrangement in his or her proposed plan for the group's

consideration and approval. While an argument can be made that a partially retiring physician's reduced work schedule will likely result in increased shares of income to the other physicians in the group, many established group members do not want to trade a heavier workload and increased call duties for increased compensation.

One solution to this issue is to find a physician in the group who wants to increase his or her compensation and is willing to take on the partially retiring physician's patients, call responsibilities and other duties. In this case, the compensation reductions to one physician are matched by increases in the other doctor's compensation as a predetermined amount. Determining the compensation adjustment can be facilitated by pricing similar services that are provided on a locum tenens basis in the community. This approach is advantageous to all involved because the compensation packages of the other physicians remain unaffected by the change.

A similar approach involves the group's agreement on the value of the entire practice's call obligations. Each physician then receives a proportionate share of that value based on the amount of call that he or she assumes.

If the income of the group is determined solely on a productivity basis or with some income divided equally and the remainder by productivity, a partially retired doctor's compensation may reflect his or her reduced productivity. However, in many groups, a productivity-based compensation scheme does not take into consideration participation in night or weekend coverage, or hospital rounding and management responsibilities, and thus when the physician's responsibilities decrease or cease, his or her compensation will not be reduced appropriately. For example, a physician's compensation may not decrease at all when he or she drops night and weekend call because these activities do not usually produce any income. Another pitfall which can arise in a productivity-based scheme is that the higher-producing physicians will bear a disproportionate share of overhead costs if compensation is based on net income (*i.e.,* revenues minus expenses). This result arises as a consequence of the fact that as gross income increases, the additional overhead costs, stated as a percentage, usually decline because certain fixed costs (*i.e.,* rent, insurance, and the like) remain constant. Consequently, a lower-producing physician may bear less than a fair share of the fixed expenses. To solve this problem, certain fixed costs (which are agreed upon by the group) might be shared equally among all physicians, and the balance of the overhead charged in proportion to productivity.

Some groups pay a partially retired physician a fixed amount of compensation rather than basing all or any portion of his or her compensation on productivity. For example, some groups have adopted point systems in which the group assigns points for each activity in which a full-time physician is involved, assigning points to office-hour "sessions," night call, weekend coverage, administrative or management duties and other categories. After determining the total points of all physicians' activities, the points earned by the partially retired physician would be totaled and his or her compensation proportionately reduced. The most serious shortcoming of this approach is the difficulty of assigning the appropriate number of points to each activity.

Perhaps the most straightforward approach to compensating a partially retired physician is to pay him or her on an hourly basis. This, of course, raises concerns that the physician will merely show up for work without being very productive.

Another possibility implements a "work-sharing" concept. In a group in which at least two physicians are interested in partial retirement, they could divide the duties that one full-time equivalent physician would typically provide. For example, if one physician wanted to work a full-day schedule but discontinue night and weekend coverage, the call duties could be performed by another physician in exchange for a three-day work week.

iv. Impact on Deferred Compensation Entitlement. Those groups which provide deferred compensation, or some other form of ongoing compensation after the termination of a physician's employment, may also want to consider determining the amount of such deferred compensation as of the date partial retirement begins. (This discussion is related to the previous discussion regarding time of valuation in connection with the purchase of a physician's ownership interest.)

One of the principles underlying deferred compensation is that a departing physician should be compensated for his or her share of accounts receivable and goodwill. However, if that physician's deferred compensation is measured, at least in part, by his or her share of receivables immediately prior to full retirement, a doctor who has been partially retired for a period of years could receive an inequitable share of those receivables, depending on how much that person had reduced his or her activities during the period of partial retirement, and whether the group's receivables have increased or decreased during the period of partial retirement. To prevent this inequity, the amount of deferred compensation should be determined as of the date partial retirement begins, based on the formula used to determine its value in the event of a full retirement by that same physician. The same approach can be applied to goodwill, which is often determined as some multiple of the group's gross revenues at a given time. Payment of deferred compensation should be delayed until the physician fully retires from the group.

C. Other Elements of Structured Plan To Consider

i. Age and Service. For those groups who do allow partial retirement, some basic eligibility guidelines should be developed. The most obvious of these guidelines is determining the minimum age and number of years of service that must be attained to be eligible to partially retire. A minimum age of 55 or 60 and either 15 or 20 years of service are typical eligibility standards. Another baseline criterion for partial retirement may be tied to disability or health problems. In the case of disability, an exception to the minimum age and years of service eligibility standards could be permitted. Fine-tuning of this standard would also involve a determination as to whether the disability must be permanent, and, if so, a definition of "permanent disability" is necessary.

ii. Length of Allowable Phase-down. To prevent partial retirement from becoming a permanent, part-time position, the plan may also specify that a physician's partial retirement be accepted on a limited year-to-year basis. A one-year period also gives the group an opportunity to assess its work levels and financial situation frequently enough to achieve a result with which other members of the group are comfortable.

III. Address in Group Agreements or Not? A Proactive or Passive Approach.

Some groups prefer to establish a written policy regarding partial retirement. The advantage there, of course, is having such a policy reduces the potential for disputes on what each physician may be entitled to with regard to their "phasing" down options. If a practice chooses this option, the partial retirement policy should be adopted in writing. If the practice is incorporated, the policy may be adopted by the Board of Directors in a corporate resolution. For partnerships, the policy can be included in the Partnership Agreement; and in limited liability companies, the operating agreement is an appropriate forum for formalizing the arrangements. The partial retirement policy may also be incorporated into each physician's Employment Agreement.

Other groups prefer not to have a formal partial retirement policy in place. The philosophy there is that it is better to address these issues at the relevant time. This approach can also work because, although, there may be a written plan in place, a practice never really knows what the impact of that plan will be on the practice until such retirement occurs. Not having a plan in place, allows the practice to negotiate the terms of such retirement based on the circumstances at the time and what the practice can bear financially.

One flexible approach involves allowing the physician to design his or her own partial retirement scheme -- within certain predetermined, written parameters. For example, a physician who has satisfied the age and service criteria would submit a written plan to the group. Policy parameters would require that the plan be submitted at least 12 to 18 months in advance and that it identify the reduced work schedule and the accompanying compensation modifications. The policy would also provide that in response, the group, by a super-majority vote, could accept or modify the proposed plan. Some groups also impose an obligation for a partially retired doctor to resume night and weekend call if another physician has become disabled, has resigned or has died. Still others require that the partially retired physician participate in the call rotation in any week in which two or more other physicians are on vacation, ill or otherwise unavailable.

IV. Conclusion

The implementation of a partial retirement policy is as important in the development of any group's physicians' benefits package as defining a vacation, disability insurance or entertainment policy. Although a partial retirement policy cannot be stated with as much specificity as other benefits, the formation of basic guidelines and parameters suggested above will serve most groups well.