2021 AAPA Salary Report

NATIONAL SUMMARY

AAPA CAREER CENTRAL

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A Word **From the CEO**

Dear PAs and Future PAs,

2020 was one of the most challenging years for healthcare providers, as the COVID-19 pandemic swept the world. PAs were on the front lines and responded to the healthcare crisis with amazing perseverance, dignity, and grace. You stepped up as you always do — when patients needed you most.

The 2021 AAPA Salary Report reflects the ways PAs were challenged by COVID-19, whether you responded to increased patient visits via telehealth, changed specialties on a temporary or permanent basis, worked long days or faced a reduction in hours, or lost your job. Some of the trends reported by the more than 13,000 PAs who responded to the 2021 AAPA Salary Report include the following:

- Not surprisingly, 15% of those who responded to the survey indicated that they became infected with COVID-19 in 2020.
- Almost 63% reported using telemedicine in their practice in 2020 compared to 10% in 2019.
- After years of steady growth, PA median compensation decreased — from $111,000 to $110,000 in 2020 — due in part to reduced hourly wages.
- Other COVID-19 impacts on PAs' compensation and benefits included in a change to their hours worked, bonuses, annual merit pay, professional development funds, paid time off, and retirement benefits.
- Only slightly above one in three full-time PAs experienced no impact to hours worked, salary, merit increases, or select benefits as a result of COVID-19.

There are more insights reflecting 2020 changes due to COVID-19 in the 2021 AAPA Salary Report. AAPA is the only PA compensation resource that provides information about base salary and base hourly wage across a variety of groups that includes specialty area, work setting, employer type, and years of experience. This is particularly important information for PAs to have when negotiating a contract. In addition, AAPA's report provides data on bonuses, separate from base salary and wages, as well as fringe benefits.

We hope the 2021 AAPA Salary Report will be of assistance as you continue to navigate the changes and challenges 2020 brought and as you venture out looking for new opportunities.

Feel free to contact the AAPA Research Department with feedback or questions.

Sincerely,

Lisa M. Gables

Lisa M. Gables, CPA
CEO, AAPA

Methodology

Data for 2021 AAPA Salary Report were collected via the 2021 AAPA Salary Survey between February 1 and March 1, 2021. The survey was open to all non-retired PAs (physician assistants) in the United States (U.S.) via internet and social media. In addition, PAs were sent a link via email if AAPA had their information on file, and they had not opted out of communication from AAPA Research, were based in the U.S., and were not retired. A total of 13,865 PAs responded to the 2021 AAPA Salary Survey. The overall margin of error for the survey is +/- 0.79% at the 95% confidence level. Response rates and margins of error vary by section and breakout.

To be included in the compensation section of the 2021 AAPA Salary Report, respondents must have worked 32 hours or more per week in 2020 and have been based in the U.S. The primary reason for exclusion of respondents from this report was their omission of hours worked or full-time status, or if they worked fewer than 32 hours per week. Table 2 of the report includes limited data on PAs who worked fewer than 32 hours per week.

Given the COVID-19 pandemic throughout 2020, the survey included a series of questions on various elements of work that were impacted as a direct result of COVID-19. When respondents indicated their base pay was impacted as a direct result of COVID-19, for example, they were asked to provide their base pay from the prior calendar year (2020) as usual, as well as in 2019, prior to the onset of the COVID-19 pandemic. This enables additional analyses to quantify the impact of the pandemic on base compensation and select benefits. In this report, compensation and benefits are reported regardless of COVID-19's impact on them, but future analyses and reports from AAPA will examine the pandemic's impact in more depth.

AAPA has identified two sources to help benchmark PA salary data: the National Commission on Certification of Physician Assistants (NCCPA) and the U.S. Bureau of Labor Statistics (BLS). Chart 1 compares the methodology used by the three organizations.

The main differences are:

- NCCPA reports total PA income, averaged over time. Compensation data from NCCPA include self-reported PA income from all sources, across employers, including bonuses, call, profit sharing, and shift differentials. NCCPA collects compensation data in $10,000 ranges rather than exact figures. The midpoint of this range is used for calculations and given that it reflects "all income" some PAs may report their bonus as part of this number.

- BLS data are reported by employers for a given point in time and are averaged over several years and adjusted, based on changes in wage over time. BLS is a good resource for PAs who are interested in what PAs in major metropolitan areas earn from a single employer, or for those who are interested in wage estimates based on employer-reported wages. It is important to note that the Bureau of Labor Statistics compensation estimate was produced by BLS using data collected in the May 2020, November 2019, May 2019, November 2018, May 2018, and November 2017 semiannual panels. Five of these six panels occurred before the COVID-19 pandemic, so only the most recent (May 2020) survey panel would reflect changes related to the COVID-19 pandemic, and thus any increase or decrease as a result of COVID-19 may be masked.

- AAPA is the only PA compensation resource that provides information about base salary and base hourly wage across a variety of groups that includes specialty area, work setting, employer type, and years of experience. This is particularly important information for a PA to have when negotiating a contract. Additionally, AAPA's report provides data on bonuses, separated out from base salary and wages, as well as fringe benefits. This level of specificity is crucial to fair salary and contract negotiations with a current or future potential employer.

Chart 1. **Summary of Data Collection Methods**

	AAPA	NCCPA	BLS
Data year	Calendar year 2020	Rolling collection From January 1, 2018 to December 31, 2020	Rolling collection over three years, with adjustments based on over-the-year wage change
Who is included	PAs, including clinicians, educators, administrators, and researchers	Certified PAs	Clinically practicing PAs, full-time and part-time, not self-employed; not employed by the U.S. government (civilian or military)
Sampling	PAs in the U.S. whom AAPA Research could contact via email	PAs who updated their NCCPA profile between January 1, 2018 and December 31, 2020	Employed PAs sampled in a wide range of employment settings
Reporting	Self-reported	Self-reported	Employer-reported
What is included in "compensation"	Base salary or productivity compensation, as well as hourly wage (annualized for certain analyses).	Previous calendar year's total gross income from all PA positions, including bonus. Data are collected in ranges of $10,000, beginning at "under $40,000." Midpoints of ranges are used to calculate median and mean.	Base hourly/annual rates from employer. Hourly wage is multiplied by 2,080 to produce an annual wage.
Level of detail	Salary, hourly wage, bonus, fringe benefits	Annual compenation	Hourly and annualized wages
Area detail	National, state	National, state	National, state, metropolitan statistical area
Breakouts available	Overall, specialty, experience, setting, employer type, and more	Overall, specialty	Overall, industry
Median compensation	$110,000	$115,000	$115,390

Note: More information is available on the organizations' websites: aapa.org, nccpa.net, and bls.gov/oes/oes_ques.htm. The listed Bureau of Labor Statistics compensation estimate was produced by BLS using data collected in the May 2020, November 2019, May 2019, November 2018, May 2018, and November 2017 semiannual panels. Five of these six panels occurred before the COVID-19 pandemic, so only the most recent (May 2020) survey panel would reflect changes in occupational proportions related to the COVID-19 pandemic.

Notes on the Presentation of the Data

In the tables that follow:

- Only data points based on five or more respondents are displayed. Even when data are masked, all applicable data are used in calculations.

- "Compensation" is often used in the National Summary (front material) of the Salary Report, and this refers to annual compensation, regardless of compensation type. These numbers include PAs who are paid a base salary, paid based on productivity, or paid an hourly wage. For hourly PAs, wages were annualized based on hourly wage, hours worked weekly, and weeks worked per year. "Compensation" does not include bonus. This information can be found separately in the data tables.

- "Base salary" refers to the fixed annual income from a PA's primary employer. It was collected using the survey question, "In calendar year 2020, what was your base salary from your primary employer?"

- "Bonus" refers to variable annual income based on production incentives, milestone achievements, or other performance-based criteria. It was collected using the question, "How much did you receive in bonus or incentive pay from your primary employer in 2020?"

- "Hourly wage" refers to the hourly rate of pay from a PA's primary employer. It was collected with the question, "In calendar year 2020, what was your hourly wage from your primary employer?"

- "Median" earnings are those at the 50th percentile, i.e., half of responses are equal to or above the median and half are equal to or below the median.

- "N" refers to the number of respondents for a given question, table, or breakout.

- Portions of the survey methodology and notes, as well as descriptions of the PA profession, charts, figures, and tables, will resemble prior editions of the AAPA Salary Report series. All numbers and statistics are reflective of the 2021 AAPA Salary Survey, the PA profession, compensation, and benefits in calendar year 2020.

About the American Academy of PAs

The American Academy of PAs (AAPA) is the national membership organization for all PAs. PAs are medical professionals who diagnose illness, develop and manage treatment plans, prescribe medications, and often serve as a patient's principal healthcare provider. Learn more about the profession at aapa.org and engage through Facebook, LinkedIn, Instagram, and Twitter using the handle @aapaorg.

Suggested citation for this report: American Academy of PAs. (2021). 2021 AAPA Salary Report. Alexandria, VA

SUMMARY OF NATIONAL FINDINGS

Who Are PAs?

PAs are medical professionals who are certified nationally and licensed within a state to practice medicine. PAs are in all 50 states and the District of Columbia, as well as in U.S. territories. PAs have been part of the healthcare team in American medicine for more than 50 years. Educated at the graduate level as medical generalists, PAs practice in every medical and surgical specialty and setting. PAs are unique in that they can change medical specialties without a need for additional formal education or training. The boundaries of each PA's scope of practice are determined by several parameters: education and experience, state law, policies of employers and facilities, and the needs of the patients at the practice. PAs practice medicine in teams with physicians and other healthcare professionals.

As clinicians, PAs obtain medical histories, perform physical examinations, diagnose and treat illnesses, order and interpret lab tests, assist in surgery, prescribe medications, coordinate care, provide patient education and counseling, and make rounds in hospitals and other inpatient facilities. As educators, PAs train the nation's future healthcare providers in 275 PA programs across the country, both in didactic and clinical education. As researchers, PAs investigate the issues that will affect the workforce and health policy in ways to move the profession forward. As administrators, PAs are on the front lines of leading a changing healthcare landscape as well as contributing to a more collaborative, team-based system.

PAs are educated in rigorous, nationally accredited graduate medical programs comprised of didactic classes and laboratory instruction, as well as clinical rotations. To enter PA school, students must possess a bachelor's degree and typically have previous healthcare experience. Completion of a PA program typically takes 26 months and covers three academic years. Phase one is the didactic phase with instruction in the basic medical and clinical sciences, including anatomy, physiology, pathology, microbiology, pharmacology, behavioral sciences, medical ethics, and clinical medicine. The second phase includes at least 2,000 hours of clinical rotations in all major specialties of medicine, including internal medicine, surgery, pediatrics, women's health, emergency medicine, psychiatry, and family medicine.

Your PA Can

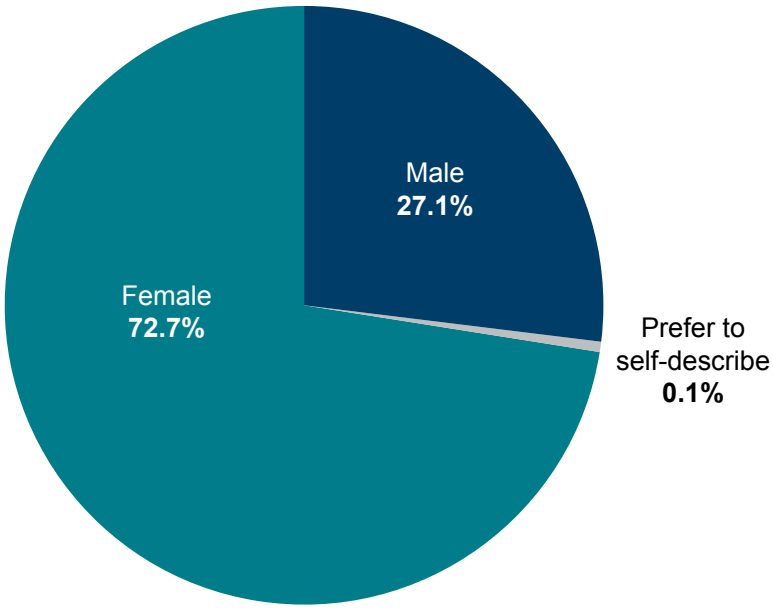
PAs are medical professionals who are educated at the graduate level to diagnose illness, develop and manage treatment plans, prescribe medications, and often serve as a patient's principal healthcare provider. PAs practice team-based care in every state and in every medical setting and specialty, improving healthcare access and quality.

Graduates of PA programs must pass a national PA certifying exam, administered by NCCPA, and then obtain a state license in order to practice medicine. To maintain certification, PAs must pass a recertifying exam every 10 years as well as obtain 100 credits of continuing medical education every two years. Recertification is not required in every state but may be required by employers and insurers.

In the 2021 AAPA Salary Survey, more than seven in 10 respondents (72.7%) were female (Figure 1), a proportion that has been increasing for the past 20 years. More than eight in 10 (86.1%) were white (Figure 2) and 6.2% reported they are of Hispanic, Latinx, or Spanish origin. Two in three (66.6%) PAs were under 40 years of age (Figure 3). Reflecting the recent rapid growth in the number of PA programs and status as the 2021 top job in the U.S. by U.S. News and World Report, more than three in five PAs (64.0%) had fewer than 10 years of clinical experience as a PA (Figure 4).

Three specialties accounted for almost one-third of the PAs in this survey, just as in the last several years: family medicine (14.1%), orthopaedic surgery (10.2%), and emergency medicine (8.4%; Figure 5). AAPA collects "urgent care" as a separate specialty from family medicine and emergency medicine, and it is the fourth-most reported specialty in which PAs practice (6.6%).

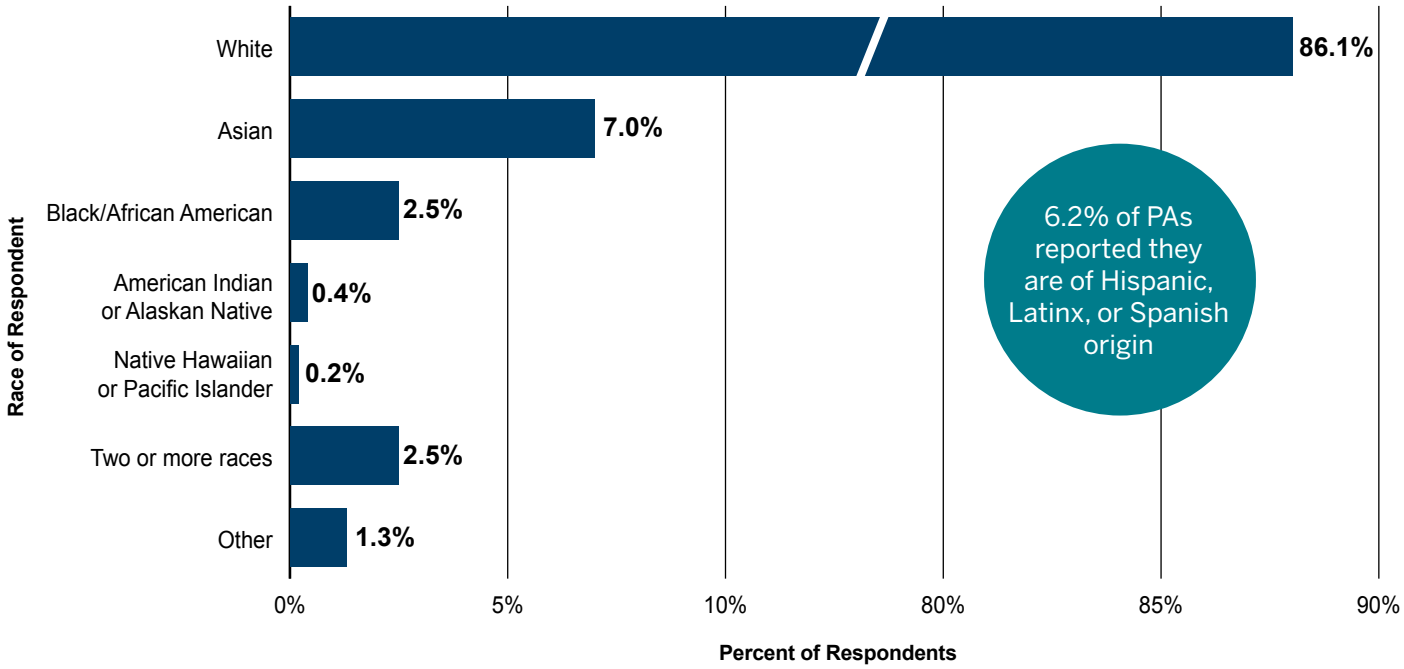
Figure 1. **Distribution of PAs by Gender**



Note: The data reflect all PAs who responded to the 2021 AAPA Salary Survey. Responses do not sum to 100% due to rounding error.

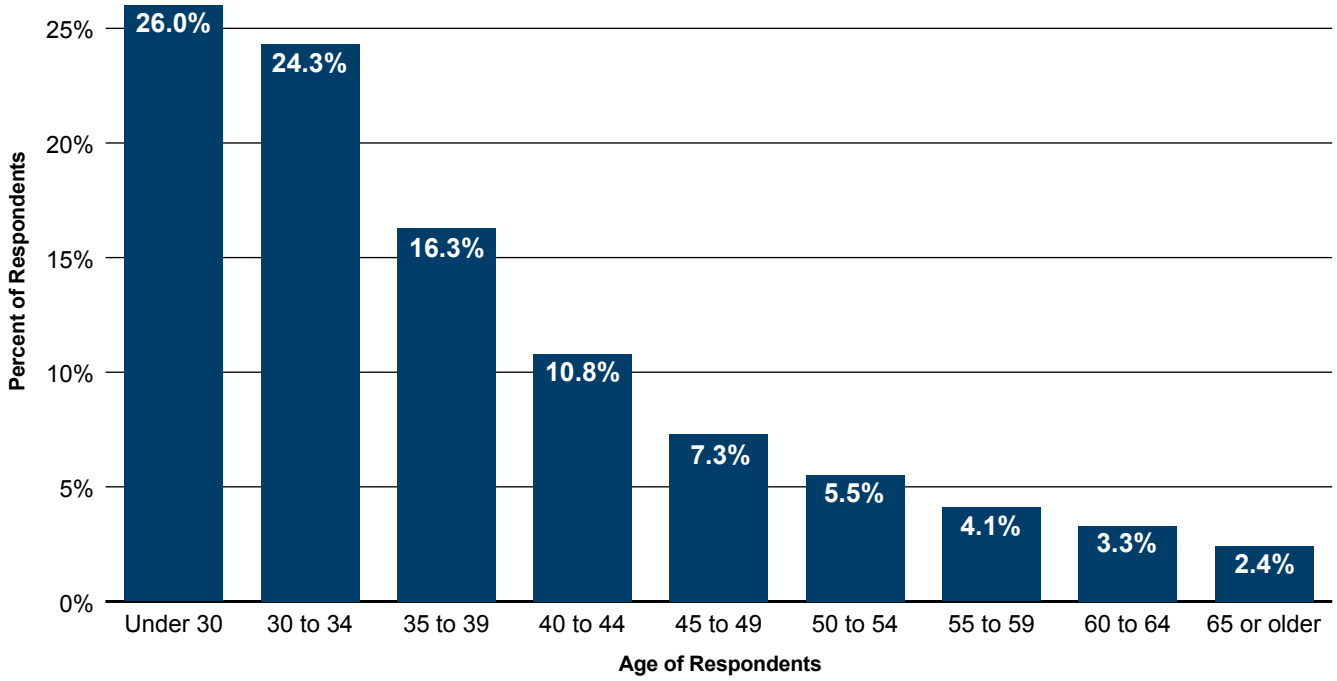
Figure 2. **Distribution of PAs by Race and Ethnicity**

Note: Race and ethnicity were two separate questions on the 2021 AAPA Salary Survey. First, respondents were asked which race best identifies them, and these responses appear in the bars on Figure 2. Then, respondents were asked if they are of Hispanic, Latinx, or Spanish origin.



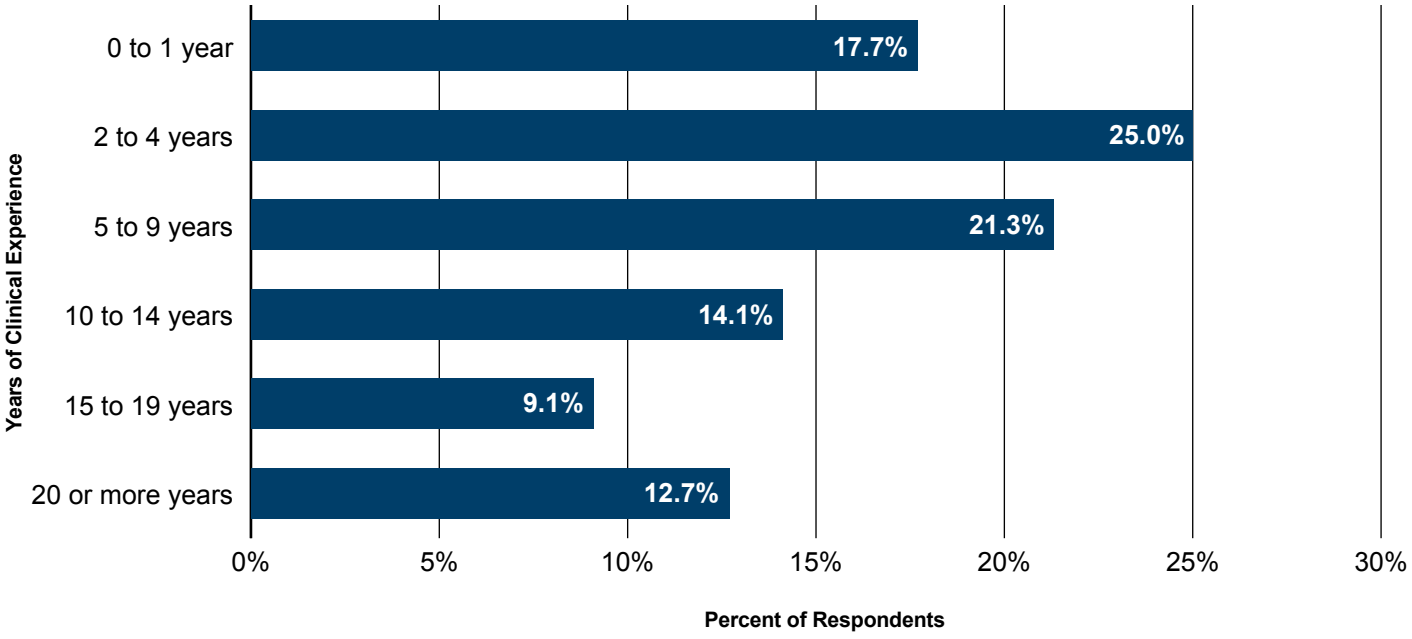
Note: The data reflect all PAs who responded to the 2021 AAPA Salary Survey.

Figure 3. **Distribution of PAs by Age**



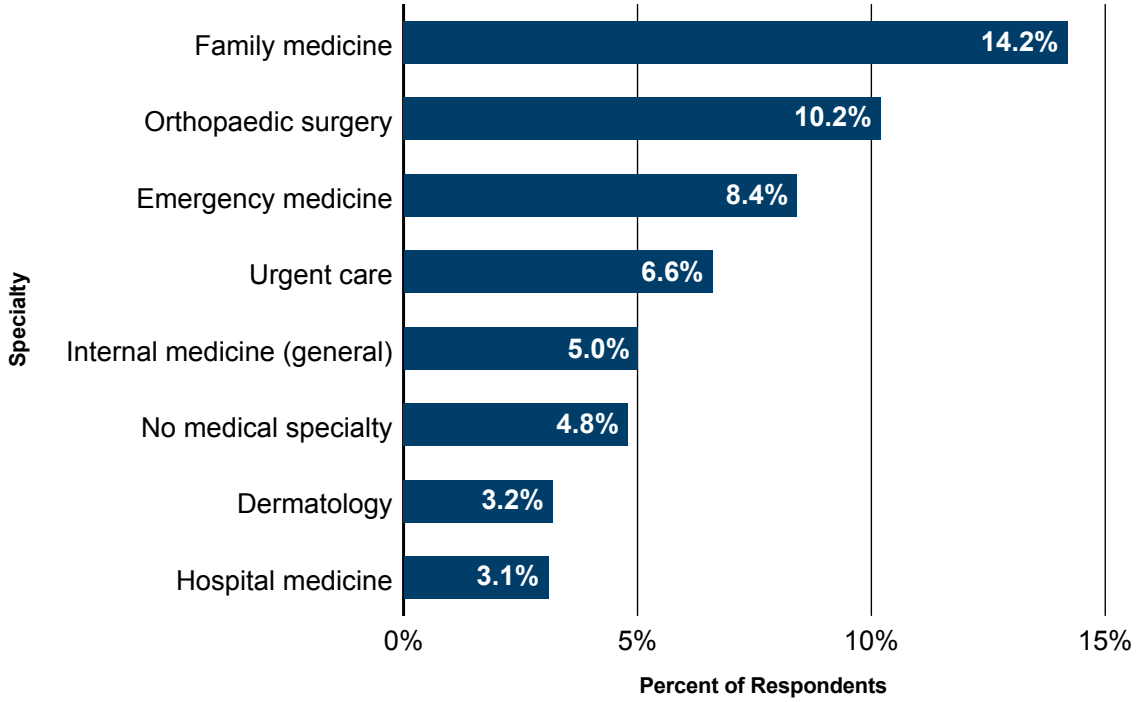
Note: The data reflect all PAs who responded to the 2021 AAPA Salary Survey.

Figure 4. **Distribution of PAs by Years of Clinical Experience**



Note: The data reflect all PAs who responded to the 2021 AAPA Salary Survey. Responses do not sum to 100% due to rounding error.

Figure 5. **Distribution of PAs by Specialty**



Note: The data reflect all PAs who responded to the 2021 AAPA Salary Survey. Only the top eight specialties are listed, including "no medical specialty." The 2021 AAPA Salary Survey allowed PAs who are not in clinical practice (such as PAs who are primarily educators, administrators, and researchers) to respond. AAPA collects "urgent care" as a separate specialty from family medicine and emergency medicine in contrast to NCCPA, and it is the fourth most-reported specialty in which PAs practice. PAs in urgent care are not reported by AAPA as specializing in primary care.

PAs Work Everywhere and via Telehealth, Expanding Access to Care in the Pandemic

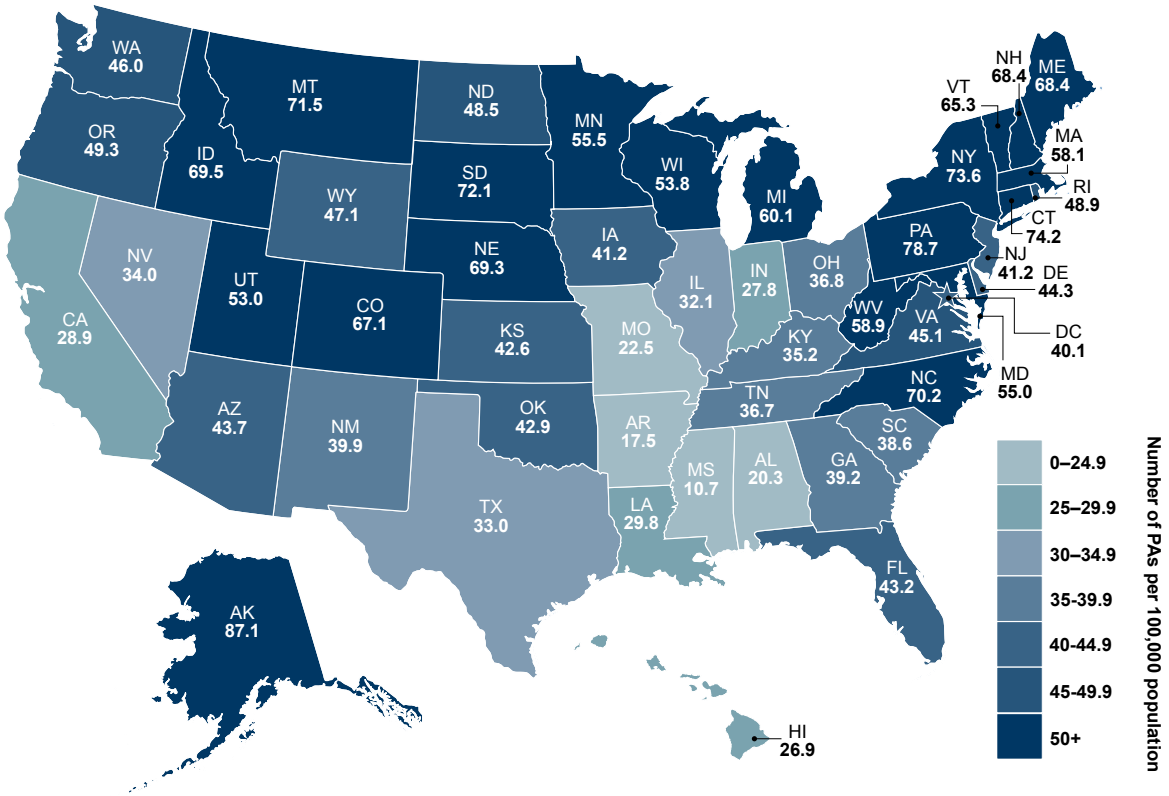
PAs practice across the U.S., although the profession is not uniformly distributed across the country. Some states have much larger PA workforces in relation to the state population than others. Alaska, with 87.1 PAs per 100,000 people, Pennsylvania (78.7), Connecticut (74.2), New York (73.6), and South Dakota (72.1), top the list of states in terms of largest numbers of PAs per capita. With respect to the absolute number of PAs in a state, New York (14,233), California (11,380), Pennsylvania (10,064), Texas (9,697), and Florida (9,381) top the charts. The states with the lowest numbers of PAs per 100,000 population are Mississippi (10.7), Arkansas (17.5), Alabama (20.3), Missouri (22.5), and Hawaii (26.9). States and districts with the lowest absolute number of PAs include Wyoming (274), the District of Columbia (285), Mississippi (318), North Dakota (371), and Hawaii (378). Figure 6 shows the per capita distribution of PAs by state and the District of Columbia.

More than six in seven PAs (86.9%) work in metro areas, with slightly fewer than one in seven (13.1%) working in nonmetro or completely rural areas (see Figure 7). In nonmetro areas, PAs are more likely to specialize in primary care than in metro areas (31.6% versus 19.5%). PAs in nonmetro areas are also more likely to be in physician offices or clinics than PAs in metro areas (61.2% versus 51.7%) and less likely to work in hospitals than PAs in metro areas (27.4% versus 36.8%).

PAs Are Everywhere in the U.S.

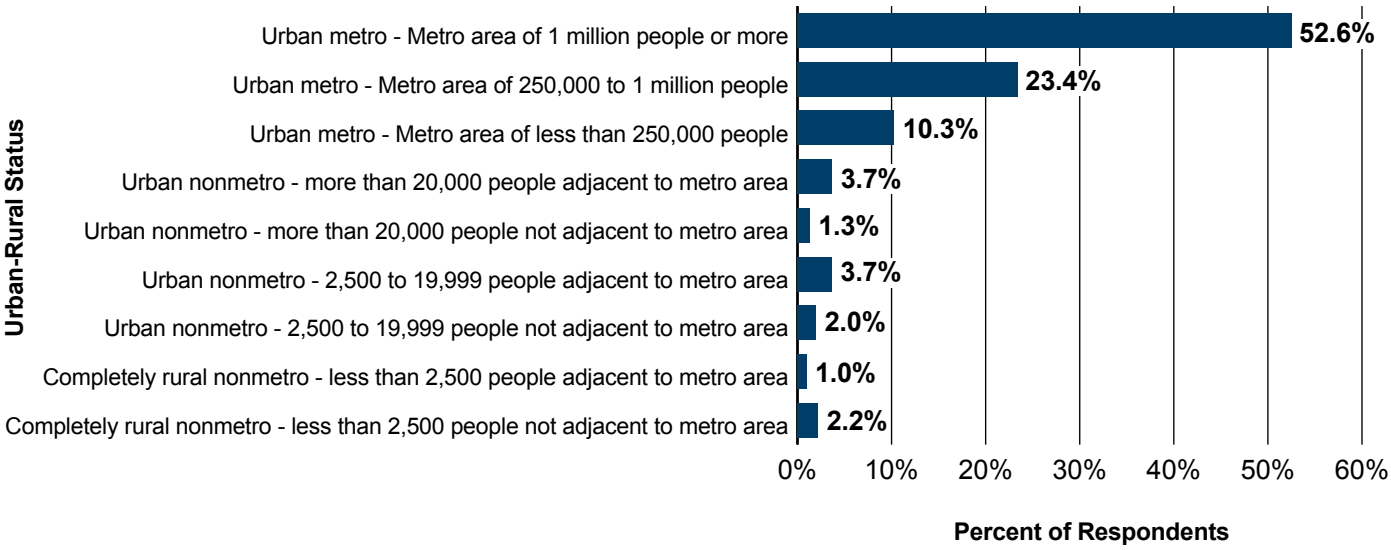
PAs practice all over the U.S. While New York has the greatest number of PAs (14,233), Alaska has the highest number of PAs per capita (87.1 per 100,000 population). Almost one in six PAs work in nonmetro or completely rural areas, and over half currently use telehealth or telemedicine in their clinical practice.

Figure 6. Distribution of Certified PAs per Capita by State



Data source: National Commission on Certification of Physician Assistants, Inc. (2021, July). 2020 Statistical Profile of Certified Physician Assistants: An Annual Report of the National Commission on Certification of Physician Assistants. Retrieved July 19, 2021 from nccpa.net/research.

Figure 7. Geographic Distribution of PAs by Metropolitan Area



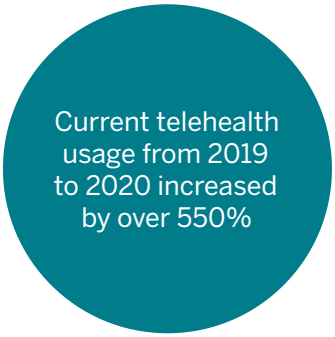
Note: The data reflect all PAs who responded to the 2021 AAPA Salary Survey. Responses do not sum to 100% due to rounding error.

Impact of COVID-19 on PAs' Health, Telehealth, and Access to Care

PAs, healthcare systems, and patients across the globe were overwhelmed by the COVID-19 pandemic. As PAs and other providers were on the frontlines responding to COVID-19, healthcare was forced to rapidly adapt as practitioners helped patients infected with COVID-19 while risking their personal health to serve patients. More than one in seven PA respondents to the survey (14.9%) reported that they became infected with COVID-19 during the pandemic.

In a world where mandated closures became a norm, in addition to the hesitancy toward in-person non-emergent health visits, widespread adoption of telehealth services occurred in 2020. In the 2020 AAPA Salary Survey, which collected data in reference to calendar year 2019, almost 10% of the respondents to the survey (9.6%) indicated that they used telehealth or telemedicine in their clinical practice. Emergency medicine PAs were most likely to report using telehealth (18.8%) in 2019, followed by PAs in both primary care (11.8%) and pediatric subspecialties (11.1%). Among PAs in internal medicine subspecialties, almost one in 12 (8.2%) reported using telehealth in 2019, more than PAs in surgical subspecialties (5.3%). Finally, 10.1 % of PAs in other specialties reported using telehealth in clinical practice in 2019.

The year 2020 was very different from 2019: 62.8% of all respondents to the 2021 AAPA Salary Survey reported using telehealth in their practice in 2020 (53.3% reported still using it, while 9.5% reported using it at some point in 2020 but that they had stopped at prior to responding to their survey). The profession saw telehealth usage increase more than 550% from 2019 to 2020. More than four in five PAs in primary care (80.7%) reported still using telehealth at the time of the survey, followed by more than three in five (60.6%) of PAs in internal medicine subspecialties. Approximately two in five PAs in surgical subspecialties (43.3%) and pediatric subspecialties (39.3%) reported still using telehealth at the time of the survey. Not surprisingly, given the number of emergent COVID-19 cases and deaths in the United States, PAs in emergency medicine were least likely to report using telemedicine or telehealth at the time of the survey (13.5%). AAPA Research published a brief report on aapa.org about the use of telemedicine among PAs in June 2020 that was a based on a small random sample of PAs. Given the huge increase in telehealth use among PAs in the past year, and the likelihood that telehealth is here to stay in healthcare, AAPA will continue to monitor telehealth use, opportunities, and barriers as PAs continue to expand access to care among patients in the United States.



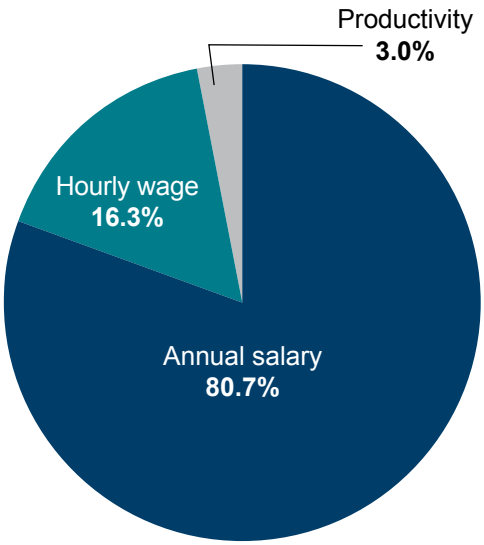
PA Compensation Varies by Multiple Factors, Including COVID-19

In 2020, four in five full-time PAs (80.7%) reported that they were paid an annual base salary; 16.3% received an hourly wage, while 3.0% were paid based on productivity, either entirely or in combination with a guaranteed minimum base compensation (Figure 8). The median annual base salary was $110,000, reflecting no change from 2019. The median hourly wage was $61.00, down from $62.73 in 2019. Median productivity-based compensation was $144,000, down from $145,000 in 2019. Overall, the total median compensation across all compensation types was $110,000 (with annualized base wage), down from $111,000 in 2019. Among full-time PAs, about half (48.7%, down from 50.1% the previous year) received a bonus, and for those that did, the median bonus was also less than the previous year: $4,500, down from $5,500. The amount of PA compensation, as well as the extent to which it increased from last year, varies by work setting, employer type, and major specialty area. (See Figures 9, 10, and 11.)

PA Compensation in 2020

Compensation in 2020 decreased from the prior year in the PA profession, and this may be in part due to the COVID-19 pandemic. For the full profession, across compensation types, median compensation was $110,000, down from $111,000 in the prior year. Among full-time salaried PAs, median annual base salary was $110,000, steady from the prior year. PAs who reported receiving an hourly wage reported earning a median of $61.00 per hour, down from $62.73 per hour the prior year, and productivity-compensated PAs reported a median compensation of $144,000, down from $145,000 the prior year. About half (48.7%) of full-time PAs received a bonus, in comparison to 50.1% the previous year. Among respondents who received a bonus, half reported a bonus of $4,500 or more, down from $5,500 in the prior year.

Figure 8. Distribution of PAs by Mode of Compensation



2020 Median PA Compensation:

Base salary: $110,000

Hourly wage: $61.00

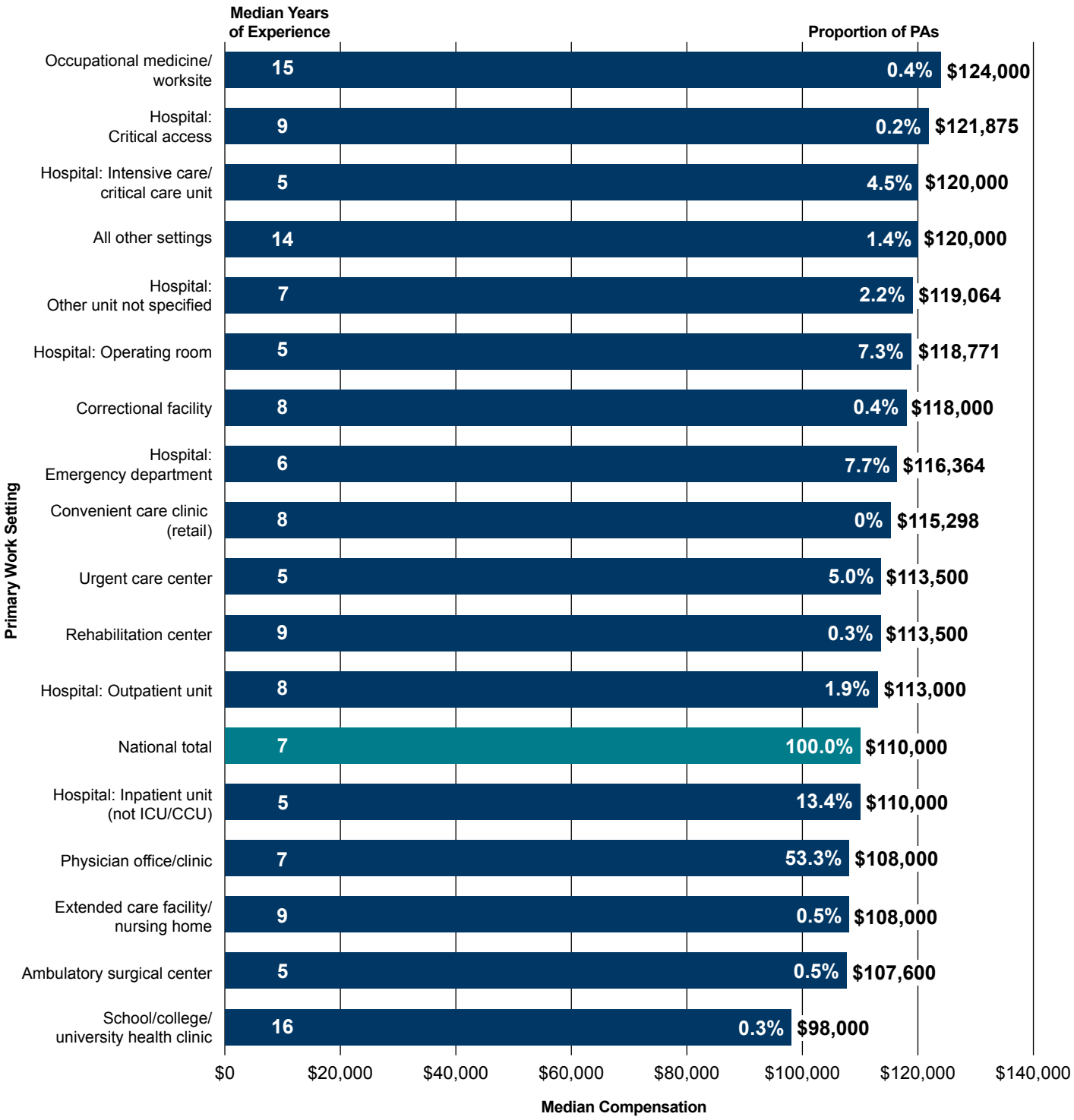
Productivity pay: $144,000

Profession-wide compensation: $110,000

Annual bonus: $4,500

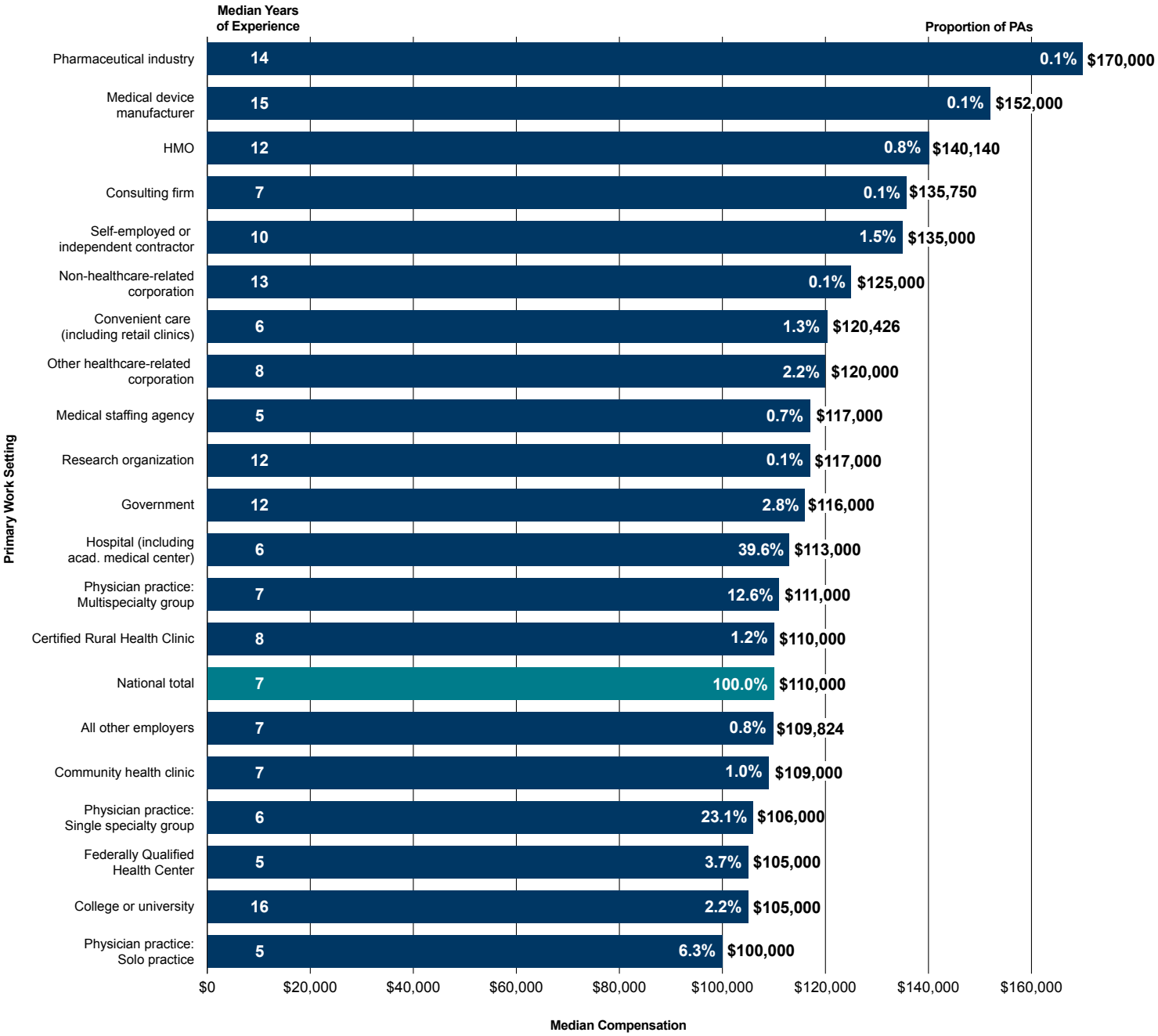
Note: The data reflect PAs who worked 32 hours or more per week in 2020.

Figure 9. Median Compensation From Primary Employer by Primary Work Setting



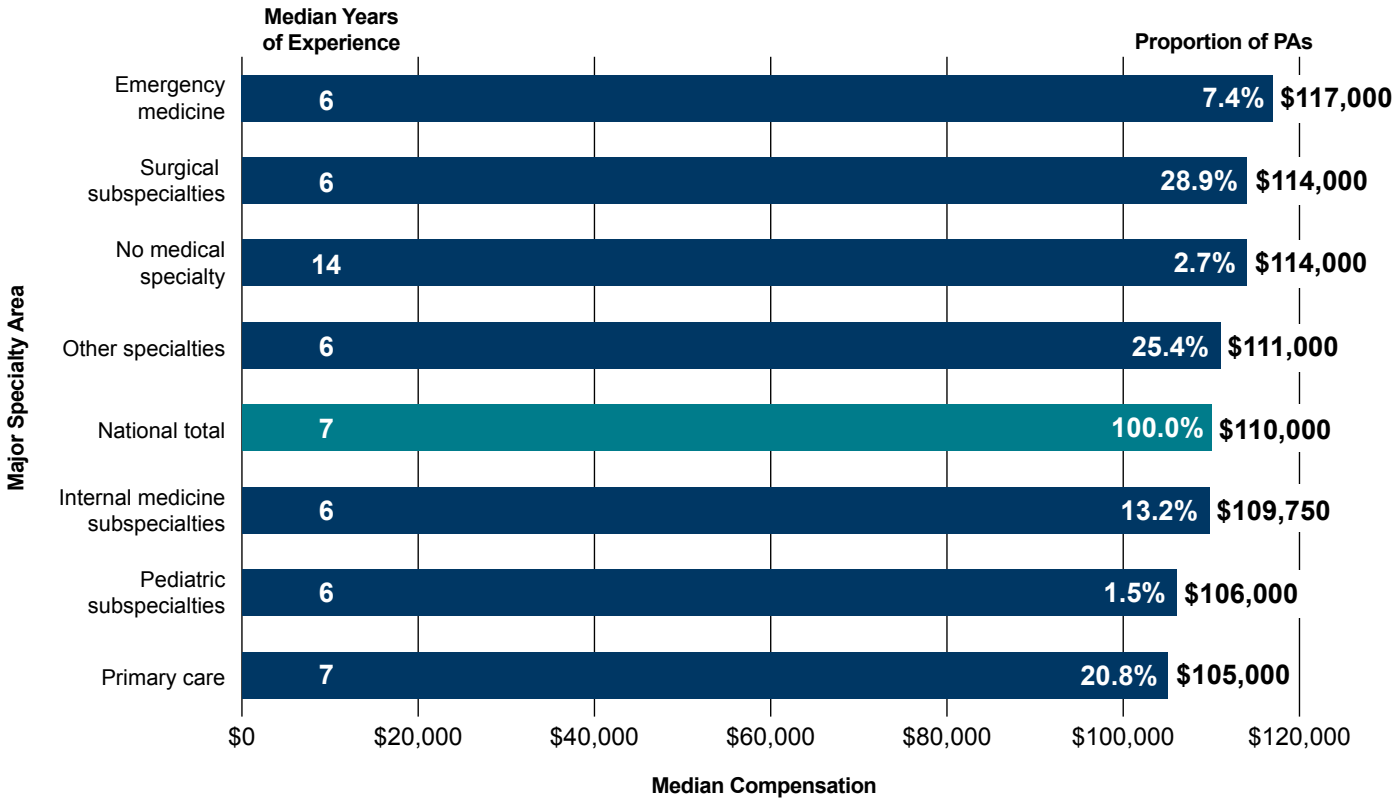
Note: The data reflect PAs who worked 32 hours or more per week in 2020. "Compensation" includes all compensation types: base salary, annualized hourly wage, and productivity pay. Percentages inside bars indicate the percentage of PAs who report that employer type as their primary employer type. The percentages and median years of experience may slightly differ from the profession-wide percentage as they reflect full-time PAs who provided their compensation in the 2021 AAPA Salary Survey. Responses do not sum to 100% due to rounding error.

Figure 10. Median Compensation From Primary Employer by Employer Type



Note: The data reflect PAs who worked 32 hours or more per week in 2020. "Compensation" includes all compensation types: base salary, annualized hourly wage, and productivity pay. Percentages inside bars indicate the percentage of PAs who report that employer type as their primary employer type. The percentages and median years of experience may slightly differ from the profession-wide percentage as they reflect full-time PAs who provided their compensation in the 2021 AAPA Salary Survey. Responses do not sum to 100% due to rounding error.

Figure 11. Median Compensation From Primary Employer by Major Specialty Area



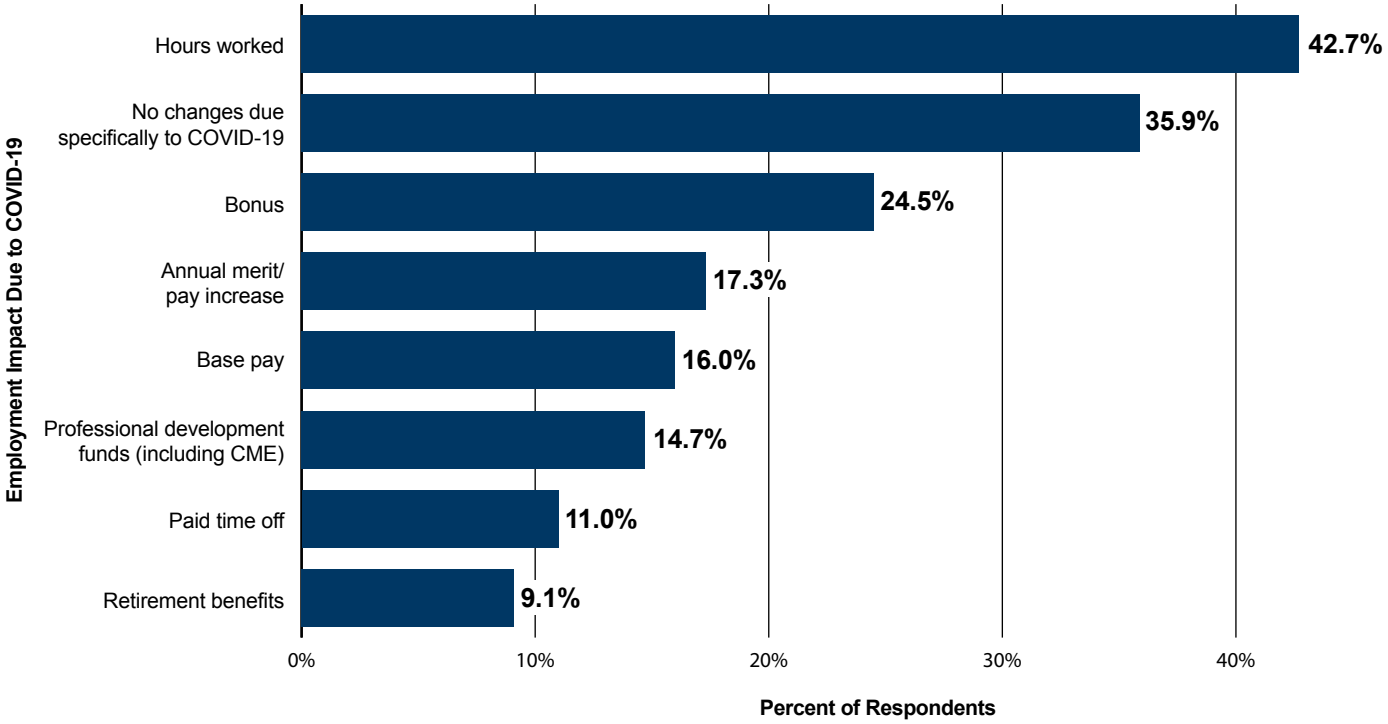
Note: The data reflect PAs who worked 32 hours or more per week in 2020. "Compensation" includes all compensation types: base salary, annualized hourly wage, and productivity pay. Percentages inside bars indicate the percentage of PAs who report that employer type as their primary employer type. The percentages and median years of experience may slightly differ from the profession-wide percentage as they reflect full-time PAs who provided their compensation in the 2021 AAPA Salary Survey. Responses do not sum to 100% due to rounding error.

Both where a PA works (work setting - Figure 9) as well as for whom a PA works (employer type - Figure 10) are associated with compensation. PAs who work in hospitals (regardless of type) reported median compensation of $112,914, down from $115,000 in 2019, but work settings within hospitals varied substantially. PAs in school/college/university health clinics ($98,000), ambulatory surgical centers ($107,600), and extended care facilities/nursing homes, as well as physician offices or clinics ($108,000), reported the lowest median compensation. PAs in occupational medicine/worksites ($124,000), critical access hospitals ($121,875), and hospital ICU/CCU ($120,000) reported the highest median compensation (Figure 9). See Tables 20 and 21 for more information.

PAs whose employer is a physician practice (solo practice, $100,000), a college or university ($105,000), or a Federally Qualified Health Center ($105,000), reported the lowest median compensation; these PAs comprised 12.2% of respondents and in two of the three employer types, median years of experience was below the national median. PAs who are employed by the pharmaceutical industry ($170,000), a medical device manufacturer ($152,000), or an HMO ($140,140), reported the highest median compensation (Figure 10), though these PAs comprised under 1% of respondents to the survey and their median years of experience were substantially above the national median (seven years). For more information, see Tables 23 and 24.

PAs who practice emergency medicine as their major specialty area earned more than PAs in other major specialty areas ($117,000; Figure 11), although some surgical subspecialties are paid far more than emergency medicine. Primary care (defined as family medicine, general internal medicine, and general pediatrics) is the lowest-paid major specialty area ($105,000). See Tables 10 and 11 for more information.

Figure 12. **Employment Impacts in 2020 Due Specifically to COVID-19**



Note: The data reflect all PAs who responded to the 2021 AAPA Salary Survey. Respondents were able to select multiple impacts, so percentages do not sum to 100%.
Question: "Did any of the following change at your primary employer (increase or decrease) at some point in 2020 as a result of the COVID-19 pandemic?"

PAs were asked as part of the 2021 AAPA Salary Survey whether any of the following changed (either an increase or a decrease) at their primary employer as a result of the COVID-19 pandemic: hours worked, bonus, annual merit/pay increases, base pay, professional development funds, paid time off, and/or retirement benefits. Among all respondents to the survey, 64.1% were impacted in one or more ways with a change to their hours worked (42.7% of respondents), bonus (24.5% of respondents), annual merit/pay increase (17.3% of respondents), base pay (16.0% of respondents), professional development funds (14.7% of respondents), paid time off (11.0% of respondents), and retirement benefits (9.1% of respondents).

To understand the nature of these changes, it is important to understand these data in the context of the type of impact (increase or decrease) that

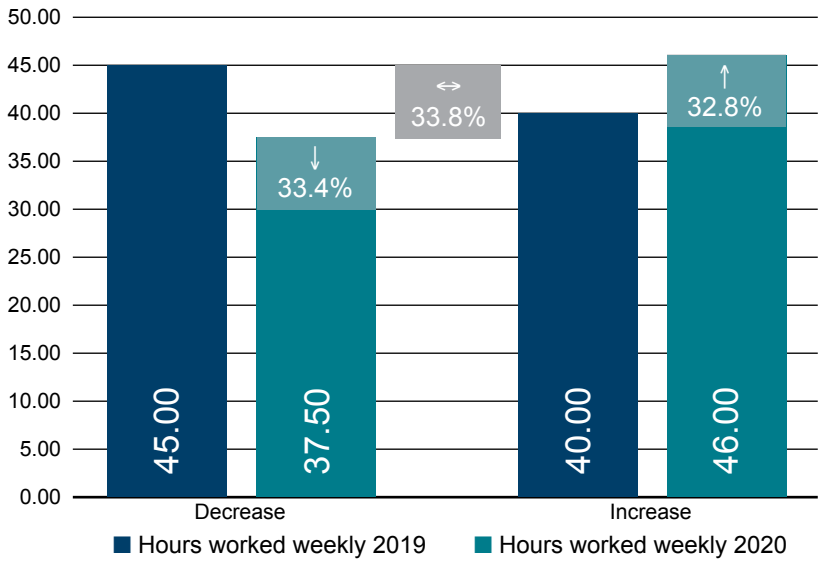
occurred specifically due to COVID-19. To do this, we asked PAs who indicated that their base pay or bonus changed due to COVID-19 to respond to additional questions in the 2021 AAPA Salary Survey. Specifically, they were given follow-up questions to our typical compensation questions in relation to 2020 and were also asked about their compensation in the prior year, 2019, before COVID-19's impact was widespread. These questions were optional, but among all respondents who provided data from 2019 and 2020, a few themes emerged.

Among PA respondents who worked 32 or more hours per week in 2020, base salary, hourly wage, productivity, and bonuses showed patterns that may partially explain why compensation in the profession slightly declined in 2020. While some PAs reported they had reductions in hours worked, compensation, and benefits, other PAs reported increases in these.

To classify whether hours worked, base salary, hourly wage, or bonus increased, decreased, or remained the same, AAPA Research used the data provided by PAs for both 2020 as well as 2019 to create new data points. Subtracting 2019 values from 2020 resulted in a positive or negative number (or zero), and was categorized as an increase, decrease, or no change.

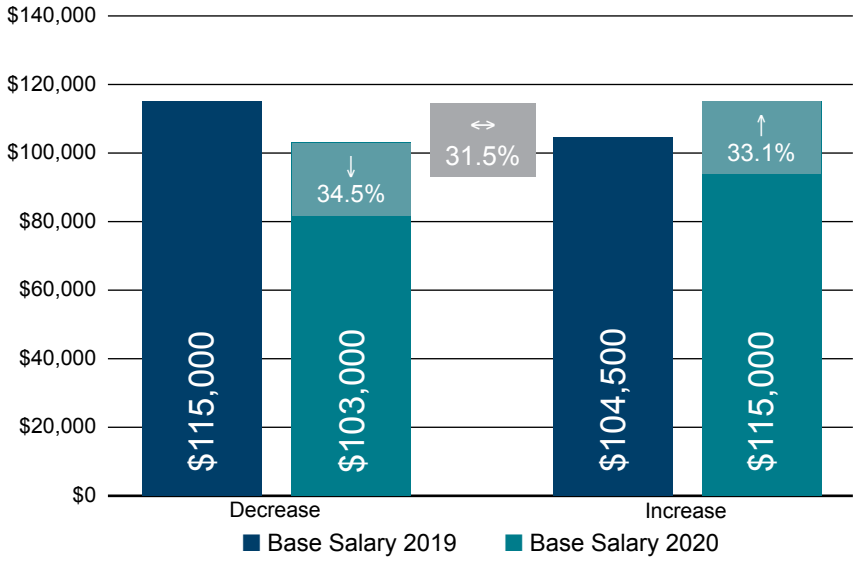
The following tables present hours and compensation among full-time PAs who provided these data, categorized by the nature of change. It is important to note that some PAs reported their hours or compensation were impacted as a result of COVID-19, but there may not have been a measurable change from the number provided for 2019. This could be a result of multiple factors, including that there were ultimately increases or decreases for other reasons as well, masking any change that occurred as a result of COVID.

Figure 13. Median Hours Worked Weekly in 2019 Versus 2020 by the Type of Impact Experienced Due Specifically to COVID-19



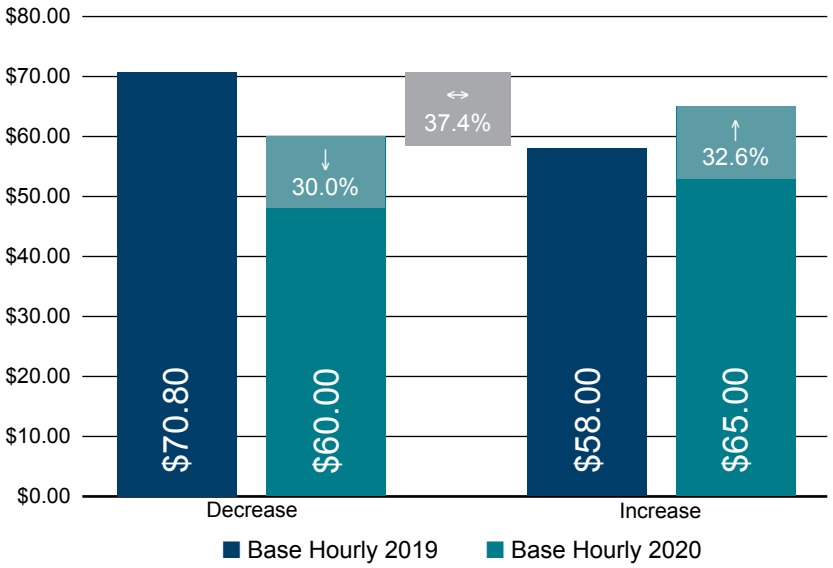
Note: The data reflect PAs who responded to the 2021 AAPA Salary Survey and worked 32 or more hours per week in 2020. The data display 2019 versus 2020 hours worked weekly among respondents who indicated their hours worked were impacted at some point as a result of COVID-19. Data are displayed for PAs who provided their hours worked. Among respondents who indicated their hours worked were impacted and provided 2019 and 2020 data, 33.4% of respondents had a decrease in average weekly hours worked in 2020 versus the hours they reported for 2019, 33.8% reported the same number of hours both years, and 32.8% had an increase in the average weekly hours worked in 2020 versus the hours they reported for 2019.

Figure 14. Median Base Salary in 2019 Versus 2020 by the Type of Impact Experienced Due Specifically to COVID-19



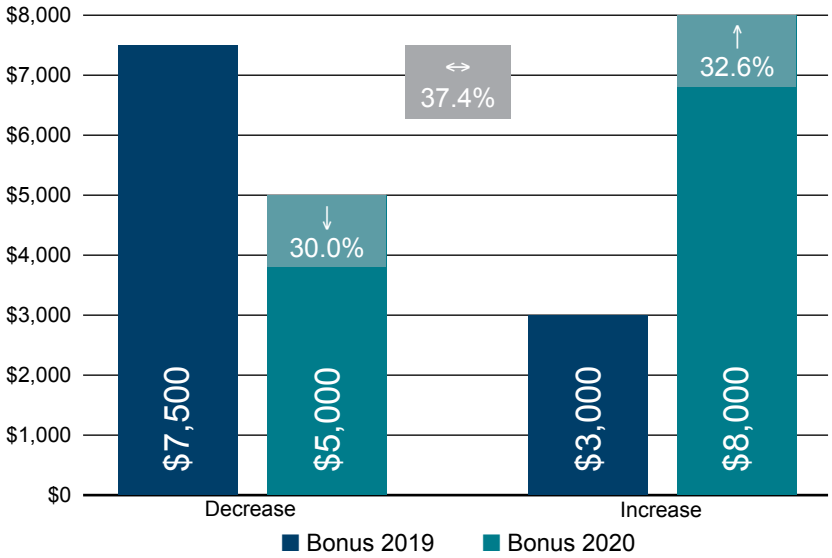
Note: The data reflect PAs who responded to the 2021 AAPA Salary Survey and worked 32 or more hours per week in 2020. The data display 2019 versus 2020 base salary among respondents who indicated their base pay was impacted at some point as a result of COVID-19. Data are displayed for PAs who provided their base salary. Among respondents who indicated their base pay was impacted and provided 2019 and 2020 data, 35.4% of respondents had a decrease in base salary in 2020 versus the base salary they reported for 2019, 31.5% reported the same base salary for both years, and 33.1% had an increase in base salary in 2020 versus the base salary they reported for 2019. Responses do not sum to 100% due to rounding error.

Figure 15. Median Hourly Wage in 2019 Versus 2020 by the Type of Impact Experienced Due Specifically to COVID-19



Note: The data reflect PAs who responded to the 2021 AAPA Salary Survey and worked 32 or more hours per week in 2020. The data display 2019 versus 2020 hourly wage among respondents who indicated their base pay was impacted at some point as a result of COVID-19. Data are displayed for PAs who provided their hourly wage. Among respondents who indicated their base pay was impacted and provided 2019 and 2020 data, 30.0% of respondents had a decrease in hourly wage in 2020 versus the hourly wage they reported for 2019, 37.4% reported the same hourly wage for both years, and 32.6% had an increase in hourly wage in 2020 versus the hourly wage they reported for 2019.

Figure 16. Median Bonus in 2019 Versus 2020 by the Type of Impact Experienced Due Specifically to COVID-19



Note: The data reflect PAs who responded to the 2021 AAPA Salary Survey and worked 32 or more hours per week in 2020. The data display 2019 versus 2020 bonus among respondents who indicated their bonus was impacted at some point as a result of COVID-19. Data are displayed for PAs who provided their bonus. Among respondents who indicated their bonus was impacted and provided 2019 and 2020 data, 30.0% of respondents had a decrease in bonus in 2020 versus the bonus they reported for 2019, 37.4% reported the same bonus for both years, and 32.6% had an increase in bonus in 2020 versus the bonus they reported for 2019.

Among full-time respondents who said their hours worked were impacted as a result of COVID-19 and provided their hours worked data, PAs saw increases as well as decreases in hours worked. One in three respondents whose hours were impacted (33.4%) had a decrease (from a median of 45 to a median of 37.5) in average weekly hours worked in 2020 versus 2019, 33.8% had no change, and 32.8% had an increase in 2020 versus 2019 (from a median of 40 to a median of 46 - Figure 13). For PAs who reported their hours were impacted due to COVID-19 but there was no difference from 2019 to 2020, there may have been other changes in hours worked that masked an increase or decrease.

Among full-time respondents who said their base pay was impacted as a result of COVID-19 and provided their base salary, more than one in three respondents (35.4%) had a decrease in base salary (from a median of $115,000 in 2019 to a median $103,000 in 2020) and three in 10 (30.0%) had a decrease in hourly wage (from a median of $70.80 in 2019 to a median $60.00 in 2020). More than three in 10 salaried PA respondents (31.5%) of and more than one in three respondents (37.4%) paid an hourly wage saw no change in their annual pay, perhaps due to other changes in hours worked that masked an increase or decrease. Finally, of the respondents who said their base pay was impacted due to COVID-19, almost one in three salaried PAs (33.1%), as well as hourly PAs (32.6%), had an increase in pay (from a median of $104,500 in 2019 to a median $115,000 in 2020 for salaried PAs, and from a median of $58.00 in 2019 to a median $65.00 in 2020).

Finally, among full-time respondents who said their bonus was impacted as a result of COVID-19 and provided details of their bonus, 74.1% had a decrease in bonus (from a median of $7,500 in 2019 to a median $5,000 in 2020). One in 20 (5.1%) had no change in their bonus amount, and one in five (20.8%) had an increase (from a median of $3,000 in 2019 to a median $8,000 in 2020 - Figure 16).

Compensation and Cost of Living Vary by State for PAs

While it is generally true that states with a higher cost of living enjoy higher compensation, this is not always the case. Some states with high compensation have a high cost of living, giving their dollar "less bang for the buck," while others have a low cost of living, making dollars go further.

Understanding how far salary or hourly wage will go in a state is vital, particularly if a PA wishes to move to another state and maintain a similar standard of living. AAPA provides cost-of-living adjusted compensation data to PAs, both at the state and local levels. Using cost-of-living data calculators, such as the one found on AAPA's website, a PA can determine the compensation needed to maintain the same standard of living in a different location. Please note that cost-of-living adjusted compensation in the AAPA Salary Report is the state-level buying power that median salary or hourly wage in the state has and is helpful to compare state to state in terms of what an equivalent salary or hourly wage to have an equivalent buying power are.

In 2020, the median PA salary in the United States was $110,000, and the median hourly wage was $61.00. Figures 17 and 19 display actual median base salary and hourly wage for each state and the District of Columbia. Figures 18 and 20 display the cost-of-living adjusted base salary and hourly wage. In many of the states where PAs reported lower compensation, PAs will find they have more purchasing power than their compensation suggests. Likewise, states with higher compensation tend to have a higher cost of living, so PAs' dollars may not go as far as their paycheck may suggest.

While Alaska, California, and Washington have the top three base salaries, and California, Maine, and New Mexico have the top three hourly wages nationally (Figures 18 and 20), this does not account for the cost of living in each of these states. Once the cost of living is considered, the three states with the highest base salaries are Oklahoma, Michigan, and Texas (Figure 17). The top three for hourly wage (Figure 19) are Kentucky, Oklahoma, and Kansas. All of these states have a cost of living that is lower than the national average, resulting in higher buying power than their median compensation would suggest. For a state-by-state comparison of actual versus cost-of-living adjusted base salary and hourly wages, see Charts 2 and 3.

How Far Does A Dollar Go?

A larger paycheck does not always translate to more buying power. AAPA has partnered with the Council for Community and Economic Research to make cost-of-living data adjusted compensation data available to PAs in order to understand just how far your dollar will go in comparison with national cost averages.

Figure 17. **Median Base Salary by State Rankings**

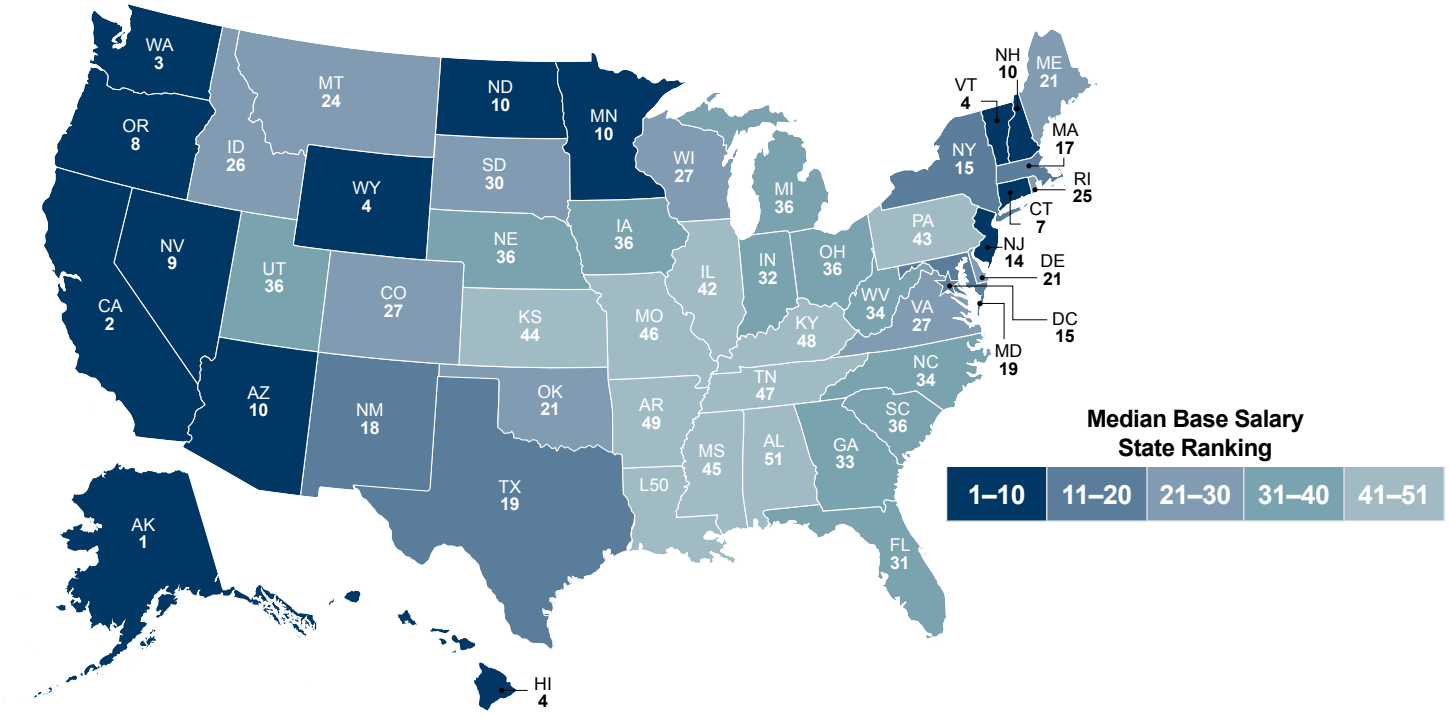


Figure 18. **Cost-of-Living Adjusted Salary by State Rankings**

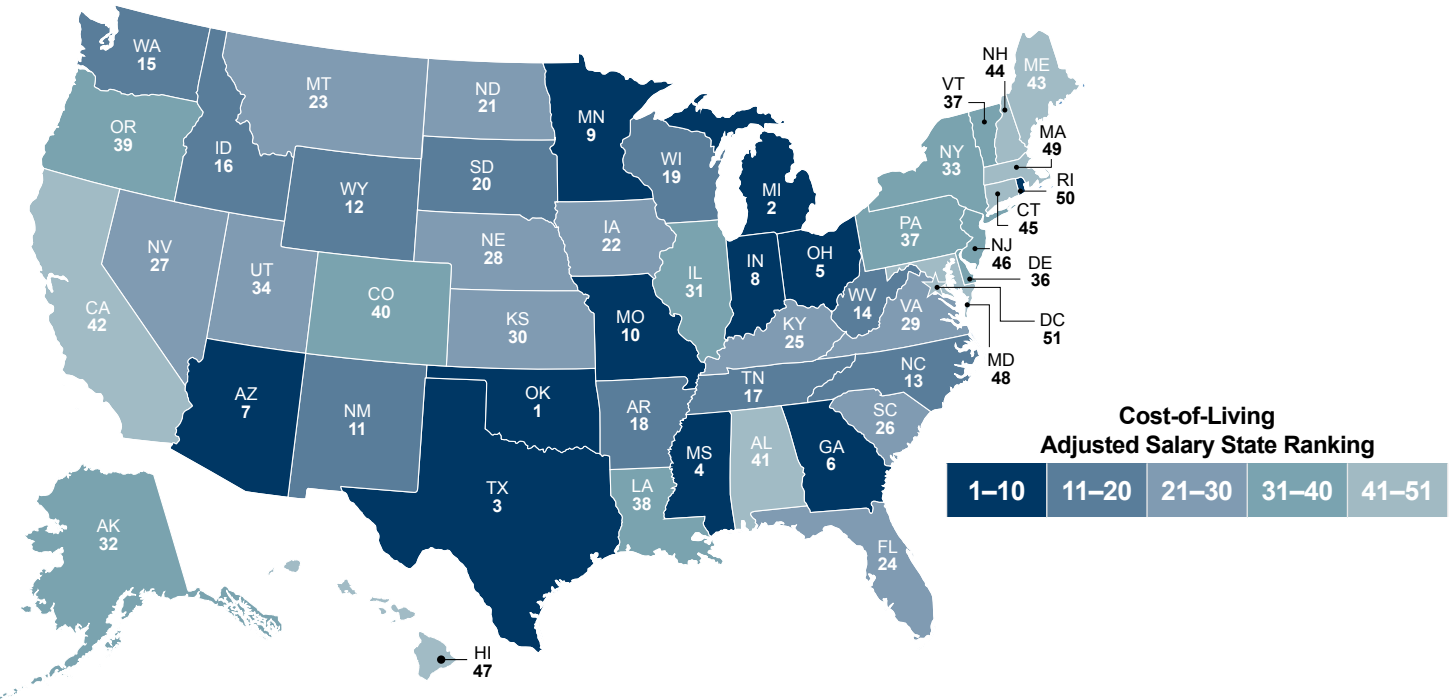


Chart 2. Actual and Cost-of-Living Adjusted Median Base Salary and Rankings by State

STATE	ACTUAL MEDIAN BASE SALARY	MEDIAN BASE SALARY STATE RANKING	COST-OF-LIVING ADJUSTED BASE SALARY	COST-OF-LIVING ADJUSTED STATE RANKING
Alabama	90,000	51	102,521	41
Alaska	137,000	1	111,095	32
Arizona	115,000	10	120,394	7
Arkansas	97,000	49	115,625	18
California	130,000	2	102,387	42
Colorado	108,000	27	103,448	40
Connecticut	119,128	7	100,302	45
Delaware	110,000	21	107,111	36
District of Columbia	113,000	15	77,855	51
Florida	107,247	31	113,738	24
Georgia	106,000	33	121,660	6
Hawaii	120,000	4	94,673	47
Idaho	108,700	26	116,208	16
Illinois	104,000	42	111,367	31
Indiana	107,060	32	120,254	8
Iowa	105,000	36	114,303	22
Kansas	102,000	44	111,447	30
Kentucky	98,134	48	113,419	25
Louisiana	96,500	50	106,234	38
Maine	110,000	21	100,830	43
Maryland	112,000	19	94,528	48
Massachusetts	112,957	17	92,625	49
Michigan	105,000	36	124,091	2
Minnesota	115,000	10	120,148	9
Mississippi	101,500	45	123,193	4
Missouri	101,000	46	120,145	10
Montana	109,820	24	113,741	23
Nebraska	105,000	36	112,272	28
Nevada	117,500	9	112,805	27
New Hampshire	115,000	10	100,629	44
New Jersey	114,000	14	100,125	46
New Mexico	112,207	18	119,926	11
New York	113,000	15	108,132	33
North Carolina	105,500	34	118,342	13
North Dakota	115,000	10	114,495	21
Ohio	105,000	36	121,670	5
Oklahoma	110,000	21	126,261	1
Oregon	118,000	8	104,756	39
Pennsylvania	103,000	43	107,924	35
Rhode Island	109,500	25	92,323	50
South Carolina	105,000	36	112,961	26
South Dakota	107,900	30	115,326	20
Tennessee	100,000	47	116,000	17
Texas	112,000	19	123,848	3
Utah	105,000	36	108,093	34
Vermont	120,000	4	106,448	37
Virginia	108,000	27	111,499	29
Washington	125,000	3	117,460	15
West Virginia	105,500	34	118,142	14
Wisconsin	108,000	27	115,545	19
Wyoming	120,000	4	119,661	12
U.S.	110,000			

Note: Rankings were determined by salary/wage, in descending order. Where there were ties, each state was assigned the same ranking, and states were listed in alphabetical order. Following a tie, states were assigned a rank indicating the position out of 51 possible ranks. For example, for actual median base salary, there was a three-way tie for fourth rank, so the subsequent state was ranked seventh.

Figure 19. **Median Hourly Wage by State Rankings**

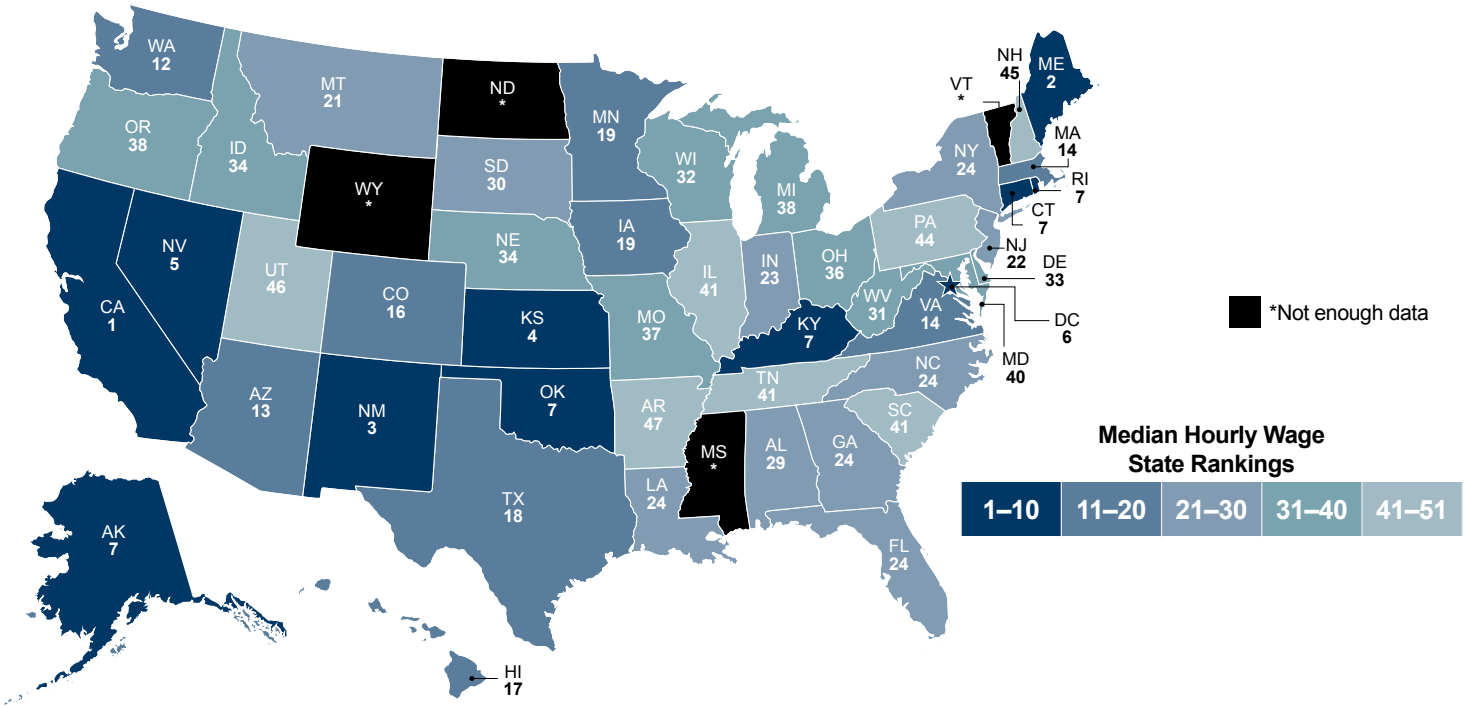


Figure 20. **Cost-of-Living Adjusted Hourly Wage by State Rankings**

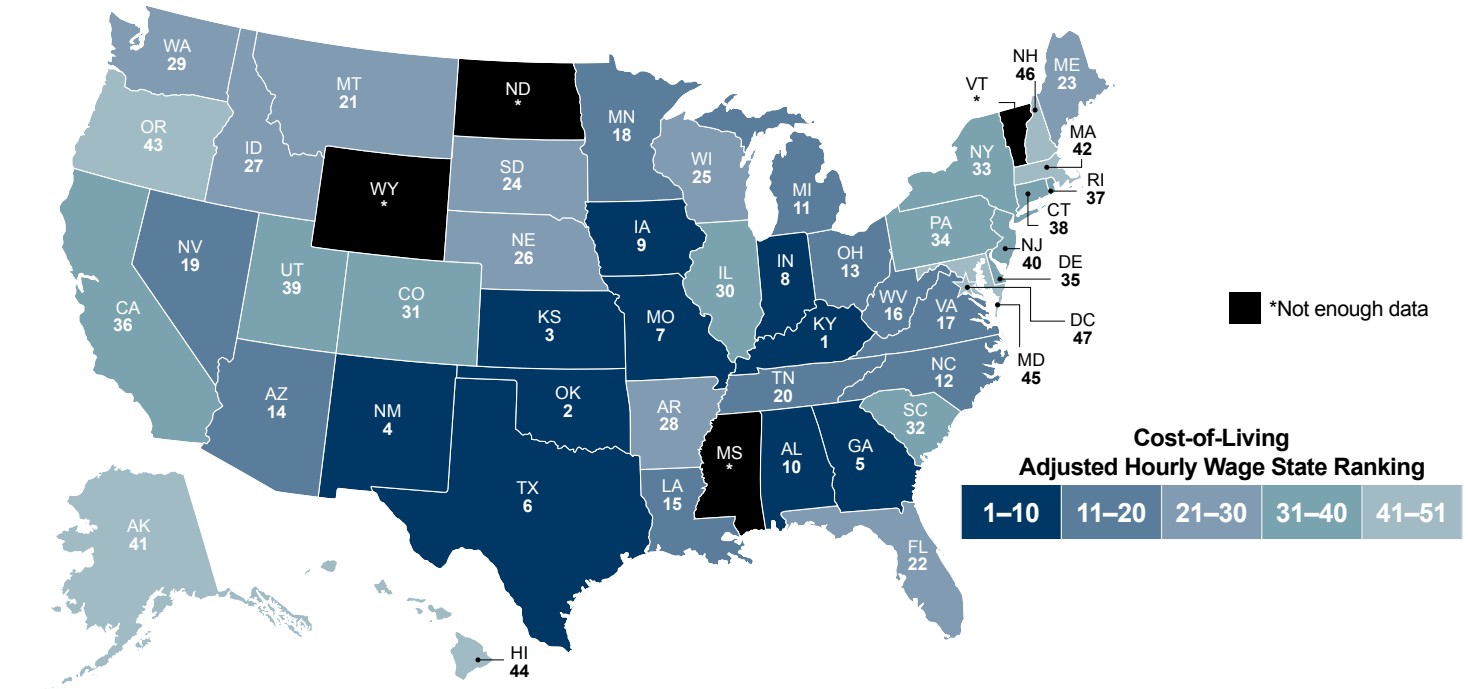


Chart 3. Actual and Cost-of-Living Adjusted Hourly Wages and Rankings by State

STATE	ACTUAL MEDIAN HOURLY WAGE	MEDIAN HOURLY WAGE STATE RANKING	COST-OF-LIVING ADJUSTED HOURLY WAGE	COST-OF-LIVING ADJUSTED STATE RANKING
Alabama	59.24	29	67.48	10
Alaska	65.00	7	52.71	41
Arizona	63.50	13	66.48	14
Arkansas	51.61	47	61.53	28
California	70.00	1	55.13	36
Colorado	62.52	16	59.88	31
Connecticut	65.00	7	54.73	38
Delaware	58.13	33	56.60	35
District of Columbia	65.50	6	45.13	47
Florida	60.00	24	63.63	22
Georgia	60.00	24	68.86	5
Hawaii	62.50	17	49.31	44
Idaho	58.00	34	62.01	27
Illinois	56.00	41	59.97	30
Indiana	60.40	23	67.84	8
Iowa	62.00	19	67.49	9
Kansas	67.00	4	73.21	3
Kentucky	65.00	7	75.12	1
Louisiana	60.00	24	66.05	15
Maine	69.00	2	63.25	23
Maryland	56.18	40	47.42	45
Massachusetts	63.00	14	51.66	42
Michigan	57.00	38	67.36	11
Minnesota	62.00	19	64.78	18
Mississippi	*	*	*	*
Missouri	57.50	37	68.40	7
Montana	61.55	21	63.75	21
Nebraska	58.00	34	62.02	26
Nevada	66.84	5	64.16	19
New Hampshire	53.00	45	46.38	46
New Jersey	60.50	22	53.14	40
New Mexico	67.60	3	72.25	4
New York	60.00	24	57.42	33
North Carolina	60.00	24	67.30	12
North Dakota	*	*	*	*
Ohio	57.56	36	66.69	13
Oklahoma	65.00	7	74.61	2
Oregon	57.00	38	50.60	43
Pennsylvania	54.17	44	56.76	34
Rhode Island	65.00	7	54.80	37
South Carolina	55.00	41	59.17	32
South Dakota	59.17	30	63.24	24
Tennessee	55.00	41	63.80	20
Texas	62.25	18	68.84	6
Utah	52.39	46	53.93	39
Vermont	*	*	*	*
Virginia	63.00	14	65.04	17
Washington	64.50	12	60.61	29
West Virginia	58.75	31	65.79	16
Wisconsin	58.17	32	62.23	25
Wyoming	*	*	*	*
US	61.00			

Note: Rankings were determined by salary/wage, in descending order. Where there were ties, each state was assigned the same ranking, and states were listed in alphabetical order. Following a tie, states were assigned a rank indicating the position out of 47 possible ranks. Four states did not have enough respondents to be ranked. Wages in states with fewer than five respondents are not displayed.

Frequently Asked Questions About the AAPA Salary Report

One of AAPA's important responsibilities is to collect and analyze data to track growth and change in the PA profession. The 2021 AAPA Salary Report includes more detailed PA compensation and benefits information than ever before. We've compiled this list of questions PAs and employers often ask, and the corresponding answers. Please contact us via email with more questions. We are here to help.

Is this year's report useful, given the COVID-19 pandemic?

The 2021 AAPA Salary Report reflects data from the entire calendar year of 2020, which was met with widespread employment, work effort, and wage impacts in the PA profession and other professions. Because so many PAs saw hours worked, base pay, bonuses, and benefits impacted, there were unsurprising dips in compensation and benefits for some PAs.

Interestingly, base salary (the method in which four out of five PAs are compensated) remained steady from 2019 to 2020. However, PAs paid an hourly wage or based on productivity saw decreases in pay, and this is a reason that compensation across the profession decreased. AAPA Salary Survey data reflect the state of the profession in the prior calendar year, and workers across the United States saw employment impacts.

While the data reflect the state of PA compensation and benefits in 2020 during the COVID-19 pandemic, for historical context, prior AAPA Salary Reports are available on aapa.org.

Why does the Bureau of Labor Statistics show that compensation is up among PAs, even in the pandemic?

BLS data are reported by employers for a given point in time and are averaged over several years and adjusted, based on changes in wage over time. BLS is a good resource for PAs who are interested in what PAs in major metropolitan areas earn from a single employer, or for those who are interested in wage estimates based on employer-reported wages.

It is important to note that the Bureau of Labor Statistics compensation estimate was produced by BLS using data collected in the May 2020, November 2019, May 2019, November 2018, May 2018, and November 2017 semiannual panels. Five of these six panels occurred before the COVID-19 pandemic, so only the most recent (May 2020) survey panel would reflect changes related to the COVID-19 pandemic, and thus any increase or decrease because of COVID-19 may be masked since data are collected on a rolling basis. NCCPA also collects compensation data on a rolling basis, perhaps causing their number to appear higher as well..

There are many salary surveys available. Why should I use the AAPA Salary Report?

AAPA Salary Report data is based on thousands of responses from full-time PAs. The AAPA Salary Report is the only resource that provides detailed information on salary, bonuses, and hourly wages, broken out by state, experience, specialty, setting, and employer type. These are all factors that will impact a PA's base salary or hourly wage. The report also provides in-depth national- and state-level information on compensation for taking and being available for call, as well as for profit sharing and other kinds of compensation and benefits available to PAs. No other salary survey provides the breadth of information contained in the AAPA Salary Report.

I am trying to negotiate a higher salary, but the employer does not want to accept AAPA data, saying that it is not objective or accurate. Can you help me explain why it is a valid data source?

AAPA frequently hears the myth that its data cannot be valid as it is self-reported. However, we benchmark our data against other available salary data and have found that we are consistently within a reasonable range of other salary sources, given the differences in what is considered "salary" or "compensation."

For example, the base salary data in the AAPA Salary Report is very close to data released by the Bureau of Labor Statistics, which is employer-reported based on annualized hourly wage. PAs reference the Medical Group Management Association (MGMA) as a source of salary benchmarking. However, MGMA data are based on salary data reported to MGMA by a small group of their member organizations, and the breakouts needed to accurately determine a PA's base compensation are limited due to the small sample sizes.

Do you collect salary and data in ranges like other salary surveys do?

The AAPA Salary Survey collects actual salary data rather than asking respondents to select a range in which their salary falls. Many salary surveys collect data in categories, such as $90,000 to $99,999, $100,000 to $109,999, etc. They then assume that the midpoints of the range are the salaries of every PA who selected the category. The advantage of this approach is that participants may feel more comfortable providing their information. The disadvantage is loss of accuracy. AAPA, on the other hand, asks the PA to report their actual salary to the nearest whole number. AAPA data are also collected at the start of the year, when W-2s for the year in question have been released and PAs can refer to them for accuracy. While we may deter some from responding due to the sensitive nature of the information collected, the data we do collect is more accurate.

What is a percentile? When do I use them?

A percentile is the point at or below which a given percentage of respondents fall. For example, the 10th percentile is the value at or below which 10% of the respondents fall — a 10th percentile salary of $80,000 means that 10% of all the respondents made $80,000 or less. Conversely, the 90th percentile salary of $120,000 means that 90% of the respondents made $120,000 or less. You can use percentiles to approximate an appropriate value within any given table. For example, if you are a PA with 25 years of experience and are looking at a table that lists only state and specialty, you may want to use the 90th percentile to determine your ideal salary to account for your experience. Conversely, if you have one year of experience, you may want to use the 10th percentile, while the 50th percentile may be more appropriate for those with 10 years of experience.

Where is the average salary listed?

We find that the median is a better measure of the "middle salary" than the mean, as it is not impacted by outliers — those responses that are on the far extremes of a normal response. We do not report the mean or "average" salary, but the median is a good number to think of as a "typical" PA within that category.

Why do you list salary and bonuses separately? What total compensation should I expect?

When negotiating for a job, PAs need to know what salary or hourly wage is appropriate for their position, separate from whatever bonus might also be offered. Because salary is generally negotiable, along with some benefits, while bonus is typically not, we keep these separate to facilitate the negotiation process. You will notice in our report that bonuses are included in the salary tables rather than in hourly tables. While this may seem as though we only report annual bonuses for salaried workers, these numbers reflect bonuses of all PAs, regardless of base compensation type.

I am a PA in Montana working in a critical access hospital. I do not see my information in the Salary Report. Why not? And who has that information for me?

Salary information is presented by specialty, setting, experience, and other categories to provide the most detailed information possible for PAs. But to maintain the trust and anonymity of those who take our surveys, as well as the integrity of the percentiles we calculate, we do not show any data points based on fewer than five respondents. So, for PAs in states with relatively few PAs, or in uncommon settings or specialties, this detailed information is not made available by AAPA.

I am a PA in Scottsdale, Arizona and I have been in a urology practice for two years. I do not see this information in the AAPA Salary Report. Is there any way I can use the AAPA Salary Report to understand whether I'm being paid appropriately?

In this example, we have information on PAs in urology with two to four years of experience, and PAs in Arizona in all surgical specialties combined. Using the percentiles available within the report, you can approximate a reasonable salary range to negotiate the best rate of pay. In Arizona, salaries are higher than in the U.S. overall. Where we would normally recommend that someone with fewer years of experience compare themselves to the 10th to 25th percentiles, with the higher salaries in Arizona, one might estimate a negotiating salary at closer to the 50th to 75th percentiles of any national tables, at the 25th of the Arizona tables as a whole, and at the 50th for PAs in Arizona with two to four years of experience.