GREAT BOARDS

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TRENDS

Seven for '07: Key Issues for Boards in the New Year

By Elaine Zablocki and Barry S. Bader

What will be on the radar screens of hospital and health system boards in 2007? We asked some of the nation's most visionary health leaders for their thoughts, and they highlighted these seven trends and issues for the coming year:

1. Return of Healthcare Reform

Richard J. Umbdenstock, chief operating officer and president-elect of the American Hospital Association, predicts that Democratic control of Congress will bring the discussion about healthcare reform center stage again. "Historically the Democratic Party has been oriented toward an inclusive system of access and benefits, while over the last several years the administration has focused more on individual responsibility," he says. "Just about everybody in the equation, from business to government to providers, is interested in reform. The focus for the Democrats in '07 might be on expansion of coverage, especially for kids. Furthermore, (2008) will be a truly wide-open election, a real opportunity for the country to address major issues, and healthcare should be at the top of that list."

National Public Radio's Julie Rovner predicts on NPR's website that in place of GOP-led efforts to expand tax-preferred health savings accounts for individuals and health plans for small businesses, the Democrats' health agenda will include:

- An overhaul of the Medicare prescription-drug benefit, including a pledge to allow Medicare to negotiate prices with drug makers

- Providing coverage for the uninsured, possibly through a purchasing pool similar to the Federal Employee Health Benefits Plan

- Renewal of the popular State Children's Health Insurance Program (SCHIP), which would be a bi-partisan effort.

- Expanded federal funding for embryonic stem-cell research.

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Steven J. Summer, president and CEO of the Colorado Hospital Association, agrees that major change is at least "one Congressional budget cycle away."

"More likely now that Democrats are in charge," he says, will be increased use of "incentive-based payment systems that have the effect of reducing payments without simply cutting the budget to individual providers." The General Accounting Office recommended in November to the new Congress that it "modernize Medicare payment policies to reward quality and efficiency and foster fiscal discipline while preserving access to care."

Umbdenstock doesn't foresee an overhaul of the payment system in this Congress, but rather, the renewal of a broad discussion of how much responsibility individuals, employers and government should shoulder, respectively.
A key to winning support will be that employers who currently offer health benefits continue to do so. "If we are going to reform the healthcare system, we must retain all of the players and funding in the system now, so that we have the resources to work through the reform period, in whatever shape that may take. I don't expect to see a wholesale rush to any single approach, but rather a mixture of approaches."

> **"We do not get the best value for our dollar. There's too much waste in the system. Too many Americans have trouble getting access to health care when they should have it, or if they do they go broke. In 2008, it will be in the presidential debate. Whoever wins will have to do something. It's just a matter of political will and leadership."**
> *— Health economist Uwe Reinhardt on CNN, November 22, 2006*

2. Physician-Hospital Competition Heats Up, But Drives Some Closer

Paul B. Ginsburg, PhD, president of the Center for Studying Health System Change, puts competition from physicians at the top of his 2007 list of trends. "Hospitals need to realize they may do all the right things, and still find themselves losing profitable services to physician competition," he says.

The expiration of Medicare's moratorium on reimbursements for new physician-owned specialty hospitals will re-trigger growth of those hospitals. Technological advances will continue driving growth in outpatient services, and physicians will keep moving more profitable, less complicated procedures to their ambulatory facilities and offices, thus weakening hospitals' financial ability to cross-subsidize less lucrative services. The breakdown of the social compact between hospitals and physicians will also persist, making it difficult for hospitals to get physicians to accept, without market-based compensation, on call coverage in the emergency department and leadership assignments on the medical staff and board.

William F. Jessee, MD, FACMPE, president and CEO of the Medical Group Management Association, says market forces are compelling some physicians to strike out on their own while others seek the shelter of a hospital-owned practice. "Physician payment rates haven't been increasing as fast as operating costs, so physicians are seeking ways to create new income streams. Offering increased ancillary services presents itself as an obvious example." He believes hospitals should be more proactive in reaching out to physicians and seeking joint ventures that "create a win-win solution."

Ginsburg, however, calls joint ventures a "halfway defensive solution," though "they may be the best available option for many hospitals. The focus of joint ventures has been on sharing the profits rather than on effective operating strategies." He notes that some hospitals have taken a more aggressive approach, instituting economic credentialing, which basically tells physicians, "if you compete with the hospital, you're off the staff."

Some hospitals are becoming more attentive to physicians' needs, offering more efficient operating room schedules and better-equipped facilities, Ginsburg says. "They are trying to make themselves more attractive workshops for physicians, because physicians now have alternatives."

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In fact, some physicians are seeking an even closer relationship with hospitals. Jessee observes that today “a growing number of physicians come to the hospital saying 'give me shelter.’ They aren't looking for a windfall. They’re looking for protection from an increasingly difficult economic environment.” These physicians include specialists as well as primary care physicians, he says. They want to practice their profession without coping with all the business details involved in managing a practice, and they're willing to accept production-based compensation.

While some hospitals have a strategy that welcomes new physician partners to hospital-affiliated practices, others barely have a toe in the water. Jessee predicts more physicians will come knocking, and boards need to be sure they have a rational plan to respond.

Umbdenstock adds that this a generational issue, with many younger physicians seeking a closer relationship with the local hospital because they have a different view of their preferred lifestyle. "The appropriate response is highly dependent on your specific marketplace and the age and specialty mix of your medical staff," Umbdenstock says. "This trend presents both challenges and opportunities. The challenge is, is the hospital prepared to enter the field of physician practice management? The opportunity is a chance to further integrate what have been separate parts of the system. Of course this trend must be examined on a business basis, but it is also a delivery system opportunity."

> “A growing number of physicians come to the hospital saying ‘give me shelter.’ They aren't looking for a windfall.”
>
> *— William F. Jessee, MD, MGMA*

3. Consumer-Directed Health Plans Start to Affect Hospitals

A recent study in Health Affairs, based on spring 2006 data, found that about 4 percent of employees are enrolled in high deductible health plans with savings options. However, the plans are growing steadily and could eventually impact hospitals financially. In 2005, Wal-Mart Stores announced a new high-deductible health care plan with monthly premiums as low as $11 per pay period. About 70,000 Wal-Mart workers who previously waived healthcare coverage have signed up, said a company spokesman.

CHA’s Steven Summer predicts that the changing nature of insurance will have significant consequences for hospitals, as individuals assume more risk and decision-making power through the growing phenomena of health savings accounts, high-deductible policies, and flex accounts. He believes as a result hospitals are already experiencing increased bad debt, as well as a much more complicated billing process. “We’re asking, how do we begin educating our business office people to deal with this?,” he says. “Because of the nature of a hospital, we can’t check someone's credit report before repairing their broken leg.”

Increased consumerism also will have hospitals looking to improve price transparency, for example, with clearer and more accurate cost estimates to assist savvy health shoppers and more understandable bills after treatment.

Steven T. Valentine, president, The Camden Group, Los Angeles expects to see “much greater pressure for transparency in pricing.” Due to high deductible health plans, people are far more price sensitive when it comes to outpatient services. “It’s worth shopping around when you're paying the full bill.” As a result, “hospitals not only need to be transparent about prices, they also need to be competitive about prices. That means they need to get their costs down in the outpatient services arena.”

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4. Renewed Focus on Business and Strategic Discipline

In 2005, the most current year available, community hospitals reported operating margins of 2.8%, their best year since 2001, according to Fitch Ratings, while AHA reported a total margin of 5.3%. So what's the worry?

Continuing below-cost payments from Medicare and Medicaid, aggressive health plan contract negotiations, and increasing competition from physician enterprises will keep relentless pressure on the bottom line. Meanwhile, hospitals' expenses keep marching higher, driven by capital needs, aggressive labor unions, and higher costs for technology and supplies.

> "Consumers will be more inclined—some might say motivated—to research what things cost and increasingly able to weigh both cost and quality for different services."
>
> — Ann Mond Johnson, president of Subimo LLC, a marketer of consumer health information

Hospitals and health systems need to maintain strong strategic and business discipline based on solid metrics. Yet, "most hospitals don't even know where their profits are coming from," says Nathan S. Kaufman, managing director of Kaufman Strategic Advisors. He recommends that hospitals routinely track critical performance indicators such as operating margin, Medicare margin, percentage of net revenue spent on supplies, bad debt as a percentage of net revenue, the percentage of unnecessary inpatient days, and market share for surgery, cardiology, and emergency services. "Hospitals typically have 40 to 100 different sources of revenue; it is one of the most complex areas in a hospital. Track your revenue cycle in detail to ensure that the hospital is actually paid for the services it provides."

> "Most hospitals don't even know where their profits are coming from."
>
> — Nathan S. Kaufman, Kaufman Strategic Advisors

Hospitals need to be more aware of which services are profitable, more disciplined about the products and services they offer, and more ready than in the past to jettison those that are not profitable, says Kaufman. Valentine says hospitals need to diversify their revenue streams. "Hospitals need to move into the outpatient side of the business more aggressively than in the past," he says. "Otherwise you will find that much of your volume has moved to outpatient and you're still an inpatient-oriented facility."

Kaufman also urges hospitals to take a much stronger negotiating stance with private insurers. "You have to use your contracts with insurers to subsidize under-funding from the government," he says. "The only area where hospitals have the ability to negotiate is with managed care providers. That's where the action is."

A hospital's success ultimately depends on just two things, he argues, its ability to produce measurable quality and to negotiate profitable contracts. Without adequate payment, they can't deliver top quality. "To my mind, it is absolutely critical for the board to understand that sometimes you have to turn down a contract with a major payer," he says. "The for-profit hospitals have done this for years, but many of the not-for-profits haven't."

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5. Quality at a Crossroads

Medicare will continue expanding pay-for-performance initiatives, which have demonstrated improved quality scores for acute myocardial infarction (heart attack); pneumonia; coronary artery bypass graft; and hip and knee replacement. "Hospitals are already acting differently because they're reporting quality data to CMS and to the Joint Commission on Accreditation of Healthcare Organizations," Ginsburg says. "They believe in the future this information will influence insurer and patient decisions, and they're already placing greater priority on improving those quality scores."

CMS is developing quality measures for the outpatient setting and in October announced a four-state pilot program to extend pay-for-performance to small and medium-size physician practices, with payouts of up to $50,000 per physician annually. Hospitals will begin training and "dry runs" en route to reporting results of a 27-item patient experience survey to a Medicare database. Consumers will be able to compare patients' ratings of communication with doctors and nurses, responsiveness of hospital staff, cleanliness and quietness of hospital environment, pain management, communication about medicines, and discharge information.

A new study on hospital-acquired infections may trigger nation-wide reporting and prevention efforts, The Commonwealth Fund predicts. Nationally, 400,000 cases of hospital-acquired infections occur each year, resulting in 50,000 deaths and $20 billion in payments for treatment, according to the Pennsylvania Health Care Cost Containment Council. For example, hospitals lose an average of $26,839 per case in which patients develop a "central line infection." But improvement efforts are paying off.

More than 3,000 hospitals joined the Institute for Healthcare Improvement's 100,000 Lives campaign and reported more than 122,000 lives saved as of late November. IHI will announce new initiatives for 2007 at its annual meeting on December 12. The Joint Commission has expanded its national patient safety goals for 2007 to include patient involvement in care and assessment of patients at risk for suicide and other dangers.

So far, hospitals have been rewarded for just "showing up," i.e., reporting data on quality initiatives. At some point, the honeymoon may end and real accountability will begin, with poorer performers paid less and attracting fewer patients.

Will the carrot will be replaced by the stick? "CMS is now talking about 'value-based purchasing,'" says Kaufman. "The success of Premier's pay-for-performance demonstration project combined with the extremely wide variation of care recently reported by the Dartmouth Health Atlas will accelerate the implementation of the government's pay-for-quality-performance program over the next 3-5 years, he says.

> "This one here is for the taking—and it's billions and billions of dollars."
>
> — Marc P. Volavka, executive director of the Pennsylvania Health Care Cost Containment Council, on the benefit of reducing hospital infections

6. Hospitals Seek Renewed Community Credibility and Support

Efforts to broaden reporting of hospitals' community benefits and demonstrate why they should be tax-exempt will continue, even with the Congressional changes. Senator Charles F. Grassley (R-Iowa), who has been leading the charge, will no longer chair the Senate Finance Committee in January, but Senator Max Baucus, (D-Montana), who will take over as chair, has supported the committee's initiatives.

"Regardless of congressional activity, the issue will continue be discussed given that it is also on the radar screen of the IRS," Umbdenstock says. He calls concerns about hospitals' contributions to their communities

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"the broad background music of hospital governance," and notes that they are not going away. As we advised in the fall issue of Great Boards, governing boards need to be proactive in defining community benefit, setting strategic goals within their resources, and telling their stories more transparently to their communities and to legislators.

7. Governing Boards Get their Houses in Order

The final theme for boards in 2007 may well be governance itself. A new White Paper (by Barry S. Bader, Edward A. Kazemek and Roger W. Witalis) from The Governance Institute says a "tipping point" has arrived for charitable organizations to demonstrate their "institutional integrity" or risk losing the public's trust and tax-exempt status.

> "A hospital's board of directors should have clear oversight over the development and monitoring of the charity care policy.
>
> The board should link the policy to the hospital's mission and evaluate whether it reaches those it is designed to serve."
>
> — *Price Waterhouse Coopers' report, My Brother's Keeper*

The White Paper, entitled *Emerging Standards for Institutional Integrity: A Tipping Point for Charitable Organizations*, offers 72 recommended practices in six areas:

- Measuring and demonstrating community benefit
- Financial integrity, transparency and corporate compliance
- Conflict of interest and director independence
- Oversight of executive compensation
- Transparency of quality, safety, customer service and pricing information
- Governance practices and board culture.

Some boards face stronger pressures than others from aggressive state attorneys general and local tax agencies. They will need to be more proactive, but all boards need to prepare for a new era of increased accountability and transparency.

Michael W. Peregrine, partner at McDermott Will & Emery LLP, Chicago, is still mulling over his "top ten" governance trends for 2007, but as we go to press he informally shared his thoughts with us. "Boards will focus on charitable mission and evaluate to what extent operations are consistent with the mission," he says. "Expect continued concern over defining, monitoring and explaining how the hospital offers community benefit and justifies its tax exempt status."
Peregrine also sees continued scrutiny of executive compensation by an IRS armed with information from its compliance check surveys and a GAO study. New rules from the Securities and Exchange Commission and high profile scenarios such as the Dick Grasso/New York Stock Exchange case will prolong media interest, says Peregrine, and have spillover effect on not-for-profit healthcare.
In general, the role of the compensation committee is becoming more difficult, he says.

He also predicts a continued focus on full disclosure of potential conflicts of interest and on board management of conflicts which are waived. The law allows a director to provide services to the hospital under certain circumstances, so the board needs to define an appropriate process to determine whether the relationship is reasonable and fair. But even when the relationship is legally impeccable, it still creates a public perception risk, says Peregrine.

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Directors who are also vendors can be a lightning rod for scrutiny in the press, and ultimately by the state attorney general.

> "The genie is out of the bottle ... The integrity of not-for-profit hospitals and health systems can no longer be taken for granted."
>
> — The Governance Institute, White paper on Institutional Integrity

The Long View

It remains to be seen whether 2007 also will see any major developments on the longer term issues facing U.S. healthcare. The nation faces shortages of nurses, physicians and other healthcare workers. Hospitals' expense control initiatives will fuel labor activity by national unions who see healthcare as a membership growth opportunity. Capital needs are huge for facilities and technology to meet the demands of the baby boom generation and new bio-medical advances. The digitization of healthcare holds the promise of increased efficiency and quality improvements, but only if information technology can be integrated into patient care processes without increasing overall costs.

The U.S. lacks a coordinated approach and adequate payment for chronic care. Medicare, Medicaid and Social Security need fundamental reform to achieve fiscal solvency. The insured population keeps growing. The elephant in the room is the growing share of the economy consumed by healthcare, about 16% today, but projected to reach 20% or more as baby boomers live longer. Can the U.S. economy afford it, or at some point, does healthcare self-destruct the economy by devouring it?

"Our health system is the size of the Chinese economy and growing at a comparable rate," says futurist Jeff Goldsmith. "We have an open cash register and an unlimited appetite for services. We're not making value-for-money decisions when it comes to using health care; we're using Dad's money."

It's unlikely any of these long-term issues will be resolved in 2007, but jockeying for the 2008 elections suggests healthcare issues will return to the national scene in the months ahead.

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Emerging Standards for Institutional Integrity: A Tipping Point for Charitable Organizations, The Governance Institute, (877)712-8778, www.governanceinstitute.com

Best Practices for Board Oversight of Executive Compensation

By Barry S. Bader and Elaine Zablocki

It's 7:30 am, and your board's executive compensation committee is meeting. Do you know what they're doing?

In the past, most directors who weren't on the compensation committee knew little or nothing about the committee's work or how much the CEO earned. Boards believed executive compensation was best treated confidentially, and they entrusted a few board members with the responsibility. Asking too many questions was frowned upon.

That's history. In an era of heightened accountability and transparency, executive pay has become a high visibility issue:

- Some newspapers publish hospital CEOs' salaries using publicly available data from a hospital's own Form 990.

- The Internal Revenue Service (IRS) is ramping up its scrutiny of executive compensation at tax-exempt organizations and plans to broaden disclosures required on the Form 990. Last summer IRS sent a 9-page, 80-item "Compliance Check" survey focusing on executive compensation to 550 organizations.

- The General Accounting Office (GAO), at the request of the chairman of the House Ways and Means Committee, sent a survey asking about executive compensation practices to 100 not-for-profit health systems.

- Outgoing Senate Finance Committee Chairman Charles Grassley criticized the independence of hospitals' board compensation committees, their lax oversight of personal entertainment expenses, and their use of supplemental executive retirement plans (SERPs).

- The new Democratic majority in Congress is unlikely to reverse course on increased scrutiny of tax-exempt organizations, Washington observers say.

"From a public policy perspective, effective board oversight of executive compensation is increasingly viewed as fundamental to non-profit, exempt organization status," concludes a new White Paper from The Governance Institute, co-authored by lawyers from McDermott Will & Emery and compensation experts from Sullivan, Cotter and Associates.

The Board's Responsibility

A board is responsible for attracting and retaining a highly qualified chief executive and senior management team to carry out the mission of the organization. Under IRS regulations, the board is responsible for seeing that executive pay and benefits are consistent with the organization's charitable mission and are reasonable compared with fair market value in the industry.

The central regulatory guidance for oversight of executive compensation is Section 4958 of the IRS Code. On one hand, it authorizes "intermediate sanctions" in the form of penalties and excise taxes if IRS finds excessive compensation or self-dealing and misuse of charitable resources by trustees or officers.

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On the other hand, Section 4958 describes three conditions for boards to create a "rebuttable presumption" that executive pay is reasonable:

- Compensation is reviewed and approved in advance by a board or committee of “disinterested” board members, i.e., members who are not in a position to benefit personally from compensation decisions.

- The board or committee relies on independent sources (not management) for information on compensation at comparable organizations in the industry

- The board or committee makes a contemporaneous, written record that clearly documents its thoroughness and the rationale for its decisions.

Achieving these conditions is getting harder. Paper compliance won’t do. Boards need to tune-up the practices of their executive compensation committees and increase the transparency of the committee’s work with the full board – and to a lesser but critical extent, with the public.

Recommended Practices

Here are the practices compensation and legal experts are recommending:

1 **Basic education.** The full board should be educated and updated annually about its executive compensation responsibilities, including IRS Section 4958.

2 **Independent committee mechanism.** The board should have a committee comprised of “disinterested” directors to oversee executive compensation. Who is disinterested? At best, committee members would have no conflicts of interest. At a minimum, they should meet a “de minimis” definition for director independence, meaning they or their families or businesses may provide a small amount of goods or services, but they have no “material” economic relationship with the organization.

3 **Charter and delegation of authority.** The board should approve a charter specifying the responsibilities of the executive compensation committee and require an annual report to the board, so that all board members are aware of the committee’s work. The charter or a separate policy should specify the committee's authority, including which decisions must be approved by the board and which can be made by the committee.

4 **CEO's role.** The CEO should be a non-voting member or attend compensation committee meetings only to provide and discuss information concerning the senior management team. The CEO should be excused when his or her evaluation or compensation are discussed.

5 **Independent advice.** The committee should engage an independent compensation consultant or firm to provide education, advice, and comparability data. The committee also needs access to legal counsel, as necessary.

6 **Executive sessions.** The compensation committee should meet periodically in executive session with its independent advisers.

7 **Engagement.** The committee should not be a rubber stamp; members should be informed and engaged, raising tough questions and exercising rigorous oversight.

8 **Compensation philosophy and incentive compensation plan.** The committee should recommend a compensation philosophy and incentive plan to the full board for approval. This philosophy and plan provide a framework for determining executives' base pay, incentives and benefits (see box for key provisions). Without this context, salary figures are orphan data that leave the board ill-equipped to assess whether compensation is reasonable and competitive.

9 **Benefits.** The compensation committee should seek independent, expert assurance that deferred compensation arrangements, other benefit programs, and any “executive perks” such as automobiles, spouse travel reimbursement, and country club memberships, are consistent with current IRS rules. The committee also shoud require an audit of executive travel and other expenses to ensure that executives are acting appropriately.

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Board education and approval. The full board should review and approve the committee's recommendations. (Except in rare circumstances, the full board does not rehash or redo the executive compensation committee's work.) To make an informed approval, the full board needs education to understand how the compensation philosophy and incentive plan have been applied. It should understand the process the executive compensation committee conducted. Members should know the CEO's compensation package and the compensation for other members of the executive team. Members should be briefed on and understand the form 990 disclosure statement every year before it is filed.

What's Next? Proxy Statements and Tally Sheets

In July 2006, the U.S. Securities and Exchange Commission (SEC) adopted changes to the rules for publicly owned companies requiring disclosure of executive and director compensation, related person transactions, director independence and other corporate governance matters. The outcome is greater disclosure, and as a result, publicly traded companies such as IBM and Altria are posting complete descriptions of their executive compensation philosophy, oversight process and determinations on their web sites. The SEC requires disclosure of the total value of all elements of compensation, including retirement liabilities and severance, in exhibits that tally everything up.

Not-for-profit organizations face no such mandate – at least not yet – but the SEC's rules are a clear sign of the need for increased rigor and transparency. Members of many boards are already asking for "tally sheets" disclosing all elements of total compensation.

How Much Does the Full Board Need to Know?

In an era of increased accountability and transparency, a fiduciary board is responsible for and should know the compensation of its top executives. The board may delegate the details to an executive compensation committee, but it ultimately must oversee the committee's work and review or approve its recommendations.

"The IRS recently said that while it is okay for the board to delegate oversight of compensation to a committee, it cannot ignore executive compensation," says David Bjork, PhD, Managing Director at Clark Consulting, Minneapolis. "They (directors) can delegate the administrative task; they cannot delegate the responsibility for seeing that it is appropriately performed."

In some states, the board is legally required to approve hospital executives' compensation. However, when possible, Bjork prefers to use language such as "the board accepts the committee's recommendation", or "the board ratifies the committee's decision." His argument: the IRS requires that the body approving compensation for top executives must obtain and rely upon appropriate comparability data on total compensation and must articulate the rationale for its decisions. The executive compensation committee takes time to review this data in detail, and debates the issues before making its decision. The Board rarely has the time to review the data in similar detail... and in any case, why should it duplicate the committee's work?

Some boards are concerned that some trustees - especially physicians - would violate confidentiality and leak the CEO's salary, creating misunderstanding and dissension among those who don't understand the rationale for seemingly high salaries. The answer is clear: breeches of confidentially are grounds for removal, but fear of breeches does not justify keeping the entire board in the dark.

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For some boards, openness about executive compensation will be business as usual. For others, it will be a difficult change. Greater transparency does open a cloistered process to the risks of inappropriate tinkering and breaches of confidentiality. Board education, clear policies, and rigorous enforcement of confidentiality can mitigate the risks. Gradual implementation may be appropriate.

A board of directors deserves information that will soon be in the public domain, available to the press and accessible to regulators and legislators.

In an age of accountability and transparency, the board needs to know. With hospitals' charitable tax status on the line, it's time for boards to open a window to all directors on the work of their executive compensation committees.

Compensation Philosophy and Incentive Plan Checklist

Does Your Compensation Philosophy:

- Explain how executive compensation is linked to achieving the charitable mission? ❑ yes ❑ no

- Articulate that executive compensation decisions are made by the board and not management? ❑ yes ❑ no

- Require and describe the board's executive compensation oversight process for creating a "rebuttable presumption" of reasonableness or at least complying with laws and regulations? ❑ yes ❑ no

- Define the organization's peer groups for comparison purposes and its targets (e.g., 60th percentile)? ❑ yes ❑ no

- Articulate the underpinnings of the organization's approach to compensation, which may include: pay for performance; percentage of pay at risk; multi-year (as opposed to only annual) goals; and the intent to include a range of mission-based measures (not just financial) in determining compensation? ❑ yes ❑ no

- Describe benefits and deferred compensation, so the total possible compensation of each executive is clear? ❑ yes ❑ no

Does Your Incentive Plan:

- Re-articulate the rationale and basis for determining incentive awards and total compensation for the CEO and senior executives? ❑ yes ❑ no

- Establish incentive award opportunities, often at three levels: minimum threshold, targeted incentive opportunity, and maximum incentive opportunity or "stretch goal"? ❑ yes ❑ no

FOR MORE INFORMATION

Is the Job Getting Harder?
White Paper from The Governance Institute, November 2006
Members: $19 per copy (download PDF free)
Non-Members: $76 per copy

Red Flags: When to Probe Deeper on Executive Compensation

What are the red flags that should alert a board or compensation committee to pay closer attention?

We asked three compensation consultants:

Jim Rohan, Vice President and Managing Director, Sullivan, Cotter and Associates, Chicago, IL; David Bjork, PhD, Managing Director at Clark Consulting, Minneapolis, MN; and Lindalee Lawrence, President of Lawrence Associates, Wellesley, MA.

Big Numbers

Executive compensation must be reasonable in relation to market data from appropriate peer groups. “Most organizations carefully manage total compensation to ensure it does not exceed the 75th percentile of market comparability data,” says Rohan. “In some cases hospitals may need to pay above the 75th percentile for a particular business reason, and that's fine as long as the decision is approved by an independent compensation committee and the rationale is well documented.”

“If they’re paying above the median, then it becomes even more important to state why this is needed for their particular organization and is consistent with their charitable mission,” says Bjork. “Often it comes down to an argument that you need first rate talent to carry out your mission, and top people have many other opportunities elsewhere.”

The higher the compensation, the more a board must be prepared to document its reasonableness. “Boards should be sure they have satisfied the IRS intermediate sanctions safe harbor, so that the IRS must prove its case, rather than vice versa,” Lawrence says. “An inquisitive press and a state attorney general with strong oversight increase the odds that an organization will be looked at. Behavior that flaunts pay, benefits or perks can prompt outside scrutiny. Substantial year-to-year changes in compensation can also trigger questions.”

Executive pay in healthcare is increasing only four or five percent per year, Bjork points out, not much faster than general inflation in the cost of living. Everyone strives to pay enough to attract talented executives, he says. "A good third of the universe wants to pay at the 75th percentile. More than half want to pay at median, so everyone is chasing the middle of the market. That contributes to continued growth in compensation levels."

Rural hospitals and small community hospitals don't necessarily need to pay at the median to attract executive talent, he says. Surveys show that small rural hospitals tend to pay well below national norms, though they are competitive on a regional basis. “If you can recruit and retain, you are paying enough, even if you are 10 percent below the national median,” Bjork says. But if good CEOs are leaving every few years for greener pastures, or if a hospital can’t recruit top notch chief financial and chief nursing officers because of sub-par pay, a higher percentile may be justified.

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> “An incentive plan should be so clear that a board member who sees it once a year can understand it on its face.”
>
> — David Bjork

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Vague or Confusing Explanations

Boards should expect straightforward explanations and clear answers to their questions. Vague or confusing explanations are signs that there is something the board ought to dig into. An incentive plan should be so clear that a board member who sees it once a year can understand it on its face, says Bjork. "If you ever sense that management or your consultant is treating you like an amateur and not giving the board enough information, that would make me suspicious – they could be hiding something."

If a board isn't being educated about current developments in regulation of executive compensation, that itself is a "red flag" for the board, adds Lawrence.

Inappropriate Comparison Group

Make sure you are getting data from comparable organizations. The IRS expects boards to insist on getting data on like jobs, from like organizations, in like circumstances. If you're a children's hospital, define whether your peer group is other children's hospitals, or is a combination of community hospitals and children's hospitals, and explain why.

State explicitly whether you are looking at a national, regional or local peer roup, and why. The IRS is beginning to suggest hospitals should use regional or local data. This makes no sense, says Bjork, since the labor market for executive talent isn't local or regional. At present almost all hospitals use national data (with the exception of California and certain large east coast cities) so they should explain why in their compensation philosophy, says Bjork.

Lawrence says looking at regional or local comparisons can be relevant. Although an organization may recruit nationally, the CEO lives locally, and regional or local patterns of compensation differ depending on cost of living and other factors.

Over-reliance on Financial Incentives

Incentive plans should include a balanced set of measures including financial performance, community benefits, strategic growth, patient access, patient satisfaction, and quality of care. The IRS has expressed reservations about too large a share of total incentives being based strictly on financial performance, says Rohan. The incentive plan should set reasonable limits in terms of incentives as well as potential impact on total compensation.

Extras Not Included

Boards should insist on getting full disclosure on all elements of executive compensation, including all perquisites and the ultimate liability for retirement benefits and severance. When determining executive compensation, boards should look at each element in the context of total compensation.

For example, Rohan says, "Let's assume an organization pays its executives total cash compensation at the upper end of the market (i.e., above the 75th percentile). Then based on current market practice, it adds a rather aggressive supplemental executive retirement plan (SERP). This organization would need to determine if its current cash compensation plus the new SERP results in total compensation that is reasonable."

> "Boards should be sure they have satisfied the IRS intermediate sanctions safe harbor, so that the IRS must prove its case, rather than vice versa."
>
> — Lindalee Lawrence

The IRS can fine executives for being paid too much, and require repayment of any amount over fair market value or any amount not disclosed as compensation. Boards should protect executives and themselves by approving total compensation and

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seeing that it is accurately disclosed on form 990. “Make sure you have full disclosure on perquisites and all contractual terms,” says Bjork. “If you are paying for country clubs or an automobile, that should be disclosed to the board every year.”

It is essential that the IRS form 990 capture all forms of compensation, including perks such as executive expense accounts, personal use of employer-owned cars, cell phones, or home computers. Compensation committee and board decisions about total compensation levels need to match the actual payments reported on the 990. The IRS is looking closely at these forms, and underreporting compensation is a serious violation.

“If you inadvertently pay two bonuses in the same fiscal year, or if severance pay shows up on the form, that can create a problem,” says Lawrence. “Historically there have been a number of cases where the board was not aware of total compensation levels, because an executive was compensated through various subsidiaries, and this has led to regulatory problems.”

Passive Process

“We see executive compensation committees becoming much more careful and deliberate as they carry out their governance responsibilities. They’re asking senior management much tougher questions,” Rohan says.

If board members aren’t asking questions about executive compensation, or if they let the CEO dominate the discussions, be wary, says Bjork. If they don’t “quiz consultants on the reliability of their data, watch out.”

At a minimum, the compensation committee should meet twice a year, says Bjork. First, it reviews and approves incentive plan goals and measures. At the close of the fiscal year, the committee meets again to review performance against goals and determine actual incentive award levels.

Management Influence

The board or compensation committee should choose its executive compensation consultant and directly supervise his or her work. Any evidence that management is excessively involved undermines the credibility of the external advisor, our experts agree.

Management may identify a list of potential firms and draft a request for proposals, but the committee itself needs to listen to presentations, choose the consultant and direct his or her work. Management also may assist with data collection. “The IRS has also said that compensation consultants are supposed to collect all our data through the committee members, but that is almost impossible – it is not an effective use of their time,” says Bjork. “Compensation consultants need direct access to management to gather detailed information about the hospital's past compensation practices.”

Outside advisors should be vetted for other business they do with the organization. “If the committee advisor also has a book of business that senior management controls (e.g. an outsourcing contract), the question has to be asked – which master is the advisor serving? Is it the board/committee or senior management?” Rohan says. “Can the advisor be accused of making recommendations to the committee that he/she might not otherwise make to protect the other business?”

Board Conflicts of Interest

Ideally, members of the compensation committee should have no conflicts of interest. At a minimum, they should meet the organization’s definition of an “independent director.”

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“Most organizations carefully manage total compensation to ensure it does not exceed the 75th percentile of market comparibility data.”

— Jim Rohan

FOR MORE INFORMATION

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"It is often assumed that members of the committee don't have conflicts, but when you go through a formal review process, you do discover potential conflicts," says Rohan. "This committee must be free of conflicts if the organization is to qualify for the "rebuttable presumption" available under intermediate sanctions." That will generally rule out physician board members who serve on the medical staff.

Skimpy Documentation

The compensation committee should keep detailed minutes and records. Several years ago, those minutes might be one or two pages at most; today they tend to be eight or nine pages long. "They should contain enough detail so that a reader can follow the thread of the committee's conversation and decision-making process," says Rohan.

The executive compensation committee also should receive needed data well ahead of decisions. "Getting materials at the last minute on significant issues is a definitely red flag," Rohan says.

Paying too little

Paying too little can be a problem, too. In small communities where the hospital is the largest, most complex enterprise around, the CEO may be paid more than anyone else in the board room. The local farmer, store owner, or teacher may react from a personal viewpoint and question why anyone is worth so much, experts say. On public hospital boards that are appointed or elected, executive pay may acquire political overtones. "Some boards are reluctant to pay competitively, and don't think executives could get better paying jobs. They find out," says Bjork, "when an executive leaves that they generally have to pay more to recruit a replacement."

Education and open discussion can help the board act objectively, not emotionally. Does the hospital seek an executive from the local community, or does it recruit regionally or nationally for healthcare management professionals? If a hospital wants the best talent, it needs to establish compensation based on regional or national benchmarks.

"This can be a difficult discussion," Rohan says. "It probably takes one or two meetings for the board to come to terms with the compensation levels it needs to pay to attract top talent to its community. After appropriate education and discussion, board members generally reach consensus on appropriate pay levels. This consensus opinion requires a sensitivity to community perceptions and a public communications plan to describe how compensation is set and why executive pay is merited.