



What is the right pay for a Nonprofit Healthcare executive?

A ROUNDTABLE DISCUSSION ON PUBLICLY
ACCOUNTABLE COMPENSATION PRACTICES

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INTRODUCTION

Executive pay levels in the corporate world are under increasing scrutiny, both in the media and among investors. Proponents of today's salary levels argue that pay and other compensation must be high to attract and retain the best candidates. Critics point out that company performance sometimes seems to have nothing to do with how much an executive is paid.

Witness recent headlines such as "My Big Fat C.E.O. Paycheck" in *The New York Times* and "Goodbye to Pay for No Performance" in *The Wall Street Journal*.

Now the attention toward executive compensation is extending to nonprofit organizations. Section 4958 of the Internal Revenue Code, known as intermediate sanctions, governs exempt organizations and allows the Internal Revenue Service to impose a penalty, tax, or both on overpaid CEOs and individual board members who approve the excessive payments.

Steven Miller, IRS director of exempt organizations, is leading an investigation of nonprofit organizations' compliance with the intermediate sanction regulations issued in 2001. Large nonprofit hospitals and health care systems are reported to be receiving priority focus because of their relatively high compensation levels. Executive compensation in specific nonprofit health organizations also has been

under scrutiny by some state legislators, regulators, and media members. The U.S. House Ways and Means Committee and Senate Finance Committee may discuss the issue in oversight hearings this year. Finally, new governance requirements regarding executive compensation being imposed on or recommended for for-profit, publicly traded companies are being touted by some as possible best practices for nonprofit organizations.

The participants in this discussion, held Dec. 4, 2004, were: Ken Ackerman, President of Clark Consulting-Healthcare Group in Minneapolis; Bill Kibler, Vice President of Investments with Smith Barney, and immediate past Chairman of the Board of the AnMed Health System in Anderson, S.C., and its compensation committee; Glenn Steele, Jr., M.D., Ph.D., President and CEO of the Geisinger Health System in Danville, Pa.; Larry Van Horn, Ph.D., Associate Professor of Economics and Management at the University of Rochester in Rochester, N.Y.; and Kathy Swartz, Ph.D., Professor in the School of Public Health at Harvard University and Editor of *Inquiry*. Bruce McPherson, Executive Director of the Alliance for Advancing Nonprofit Healthcare, in Washington, D.C., moderated the session.

Bruce McPherson: Let's start with the basics. To whom do the IRS' intermediate sanctions apply, and what does it take to avoid the sanctions?

Ken Ackerman: This is such an elementary question, yet it is just amazing to us in Clark Consulting-Healthcare Group that there are people not paying sufficient attention to the law. The Taxpayer Bill of Rights, Section 4958 of the Internal Revenue Code, has been around for about eight years, and it is very specific to all nonprofit organizations. Some nonprofit organizations seem to be much more focused on Sarbanes-Oxley (the 2002 federal law is designed to protect investors by improving corporate disclosure practices), which doesn't legally apply to them, than they are on the Taxpayer Bill of Rights. Section 4958, known as intermediate sanctions, provides that the IRS can impose a penalty or tax or both on overpaid CEOs and/or individual board members who approve the excessive payment transaction. Before Congress passed this law, the IRS basically had two options: do nothing or remove the tax-exempt status of the organization. Consequently, in most cases, they did nothing. With the new law the ball game has changed considerably, and the IRS has published final regulations providing a safe harbor, which is a good thing. The

safe harbor for boards and healthcare organizations involves basically three things. First, independence; that is, the governing board has to appoint an independent committee made up of members who have no issues or conflicts of interest. Secondly, the committee needs to hire an experienced independent outside expert to provide the committee with total compensation advice. Many boards seem too focused on the cash side of the equation, when it's all about cash, benefits and perquisites. That's what state attorneys general are interested in, that's what the IRS is interested in, and that's what boards need to be interested in. And thirdly, and this is where most failures occur, the compensation committee needs to contemporaneously document the decision: those present; whether disqualified persons absent themselves during the process; and the rationale for the decisions, especially for any decisions that are outside the payment range. To my knowledge, there has yet to be a single case on record where the IRS has even challenged the compensation decisions of boards when they followed this process.

Glenn Steele: In the first element of the safe harbor, the independent compensation committee must document advance approval, not after-the-fact approval of executive compensation.

Ackerman: Also, Len Henzke of the IRS (a tax law specialist in the Exempt Organizations Division) recently was speaking to a group of health lawyers and made a very specific point about the need for absolute independence in the relationship between the compensation committee and the outside third party expert.

McPherson: Regarding the use of independent consultants and independent committee members for executive compensation, what is the current status?

Ackerman: There are literally hundreds if not thousands of hospitals that are still behind the curve. In many cases, they're probably smaller hospitals. The larger you are, however, the bigger the target you are. The more aggressive your compensation package needs to be to attract the right kinds of people, the more at risk you are, vis a vis the media, unions, state attorneys general who are getting very aggressive around this subject, and the IRS. We've got the soft audits going on with the IRS now, and undoubtedly there's going to be some egregious pay practices that will surface and become a big issue.

Van Horn: Ken, can you shed some light on the IRS evaluation of levels of compensation, as opposed to the structure of that compensation, such as contingent payments, bonuses, and the like?

Ackerman: The IRS doesn't have any trouble with any of the structure as long as it is considered in the context of total compensation. Short-term incentives, long-term incentives, retention bonuses, performance bonuses—all of that just needs to be within the context of total compensation. Then the issue of reasonable peer comparators comes into play.

McPherson: Are there other emerging best practices in this area that nonprofit healthcare organizations should be pursuing?

Ackerman: Compensation decisions need to be based on a well thought out compensation philosophy, specific to the organization. It gets all of the board members on the same page in terms of the basis for a competitive pay system to attract and retain the best senior executives. There are various pieces of a compensation philosophy. There is nothing more important than peer comparators.

Van Horn: This is fundamental to attract or retain top managerial talent. The question is, what is the right market for this managerial talent? Do nonprofit hospital CEOs not go to for-profits, and do for-profit hospital CEOs not go to the nonprofits? We certainly see evidence of people going back and forth, and to attract and retain the highest quality managerial talent the pool might be nonprofits, but it might also be for-profits. So conceptually I think about for-profit hospitals' CEOs as being potential candidates and potential valuable managerial assets for a nonprofit hospital.

Ackerman: A key question in peer comparators is whether you're using local, state, regional, or national data. That's driven by whom the board sees as competitors. Are you competing on a national basis and recruiting nationally? Many smaller organizations are competing and recruiting within a state or a region.

Bill Kibler: We compare ourselves nationally, and to institutions that are similar in terms of revenue, beds, and mission. We compare ourselves to nonprofits only.

Steele: With some notable exceptions, we do not have for-profits in our peer groups. The compensation models

in for-profits have been quite different. A large amount of compensation is or has been based on stock options, something that is not available to us. That's the primary reason. The other important reason, again, is that we are mission driven. Our mission goes beyond earnings and does not involve the distribution of earnings for the benefit of stockholders.

On the other hand, an example of leadership candidate pools where we do include for-profits as well as nonprofits is our insurance company, which is a 501(c)(4). We have not lost our ability to attract these candidates based on our present benchmarking. Nor have we lost any key candidates to for profit. If we started seeing that kind of a dynamic then we'd really question the outside executive compensation consultant and our compensation committee about our benchmarking parameters.

For sizing our peer groups for benchmarking, our consultant Mercer goes directly to the top line—the revenue line. There are also some interesting aberrations. For instance, in an organization that has academic aspirations, whether or not connected to a medical school, you have a number of people who are in your top executive group who are also heads of their discipline-based departments or divisions. To try to peer comparators for those folks you may have to go to different benchmarking, such as the American Association of Medical Colleges.

Another issue, and of course the compensation committee and I, as CEO, talk about this, is that we're not simply wanting to establish a de facto strategy of increasing our size in order to get into a bigger, higher paying peer group.

Ackerman: We see revenue as a common measure in looking at comparative size. Complexity is also a major issue. The kind of organization that Glenn Steele is leading, a \$1.5 billion enterprise, is a very different kind of organization, with a large integrated multi-specialty group practice, the Geisinger Health Plan insurance piece, as well as multiple sites and multiple organizations. So we try to measure that. It becomes difficult. A lot of compensation consultants don't do it because they don't have the data. As far as the IRS is concerned, it's acceptable to use for-profit data. We do it only if the client really wants to use it, and it's usually specifically targeted to executives responsible for insurance products, or for information technology and sometimes finance. It's interesting

how the base cash compensation is generally a non-issue when you compare the two. Nonprofit executive base salaries more often than not will be in the ballpark, but it's around the stock options and other incentives that the executives on the investor-owned side differ.

Steele: Organizational complexity is a huge factor that must be considered here. Not only the organization but also the definition of the job and the complexity of the mission are central to defining an appropriate level of compensation.

McPherson: Beyond establishing peer comparators that accurately reflect the market in which you are competing for talent, what other considerations must be addressed in a compensation philosophy?

Ackerman: There are several other pieces. What is base salary? Are there short-term incentives, and if so, what are they? Are there long-term incentives? What about benefits? Here I am talking about the costs per dollar of benefits. Too often boards are looking at only prevalence information; for example, 75% of executives having long term care insurance. That tells you nothing about the specific breadth and depth of such coverage or the costs involved. Perquisites get you quickly into quicksand, and we caution our clients to be very careful about perks of any kind.

A compensation philosophy is also about establishing where the healthcare enterprise wants to be: at the 50th percentile for the CEO and senior executives, at the 65th, 75th, at the 90th – we see it all. And that's OK. Some want to be at the 75th percentile with benefits but at the 65th percentile for cash.

Steele: As you take an organization from one stage to another, the compensation philosophy is extraordinarily important to articulate and, in fact, to disseminate. For instance, we have moved at Geisinger to a much more incentive-based compensation. Our philosophy is to set the base salaries at a lower target, at the 50th percentile. But we have overall ambitions that our integrated health system, whether on a financial or programmatic basis, is going to be at the 75th or 80th percentile of performance in our cohort. Thus, as our organization performs well, our total cash compensation is going to be ramped up.

For positions in our insurance company where we had excellent

candidates from both nonprofits and for-profits, it was a challenge to figure out comparable incentive tools and leverage in negotiating relationships with those who had the incentive of an equity-based compensation model. But it was doable.

Ackerman: There's certainly a trend in nonprofit health care organizations' executive compensation towards more leverage and that's what Glenn is describing—more pay is at risk. About 80% of the nation's nonprofit healthcare organizations have short-term incentive plans in place. Long-term incentive plans are skewed to larger organizations. I think somewhere in the neighborhood of 18, 20, 22% of healthcare enterprises have long-term incentive plans.

Van Horn: Our research shows a strong relationship between objective measures of financial performance and CEO compensation in nonprofit hospitals, as much as you'd see in a set of for-profit hospitals. The difficulty in nonprofit pay-for-performance is trying to relate compensation to objective, non-financial community measures. Yet they should be part of a compensation philosophy. The other thing we observe is a significant difference in job attributes across CEOs. For example, if a CEO is also chairman of a board, with different job attributes, you would expect compensation to vary. As a final point, since nonprofit hospitals can't use compensation as a disciplining device to the degree that for-profits can with contingent payoff mechanisms like stock options, we see a particularly strong relationship between CEO turnover and performance in nonprofit hospitals, in contrast to for-profit hospitals or the investor-owned sector more generally.

Kibler: Our board links our CEO's incentive pay to both financial and non-financial measures. Finances are important, but we also try to align incentives with goals that are good for patients and our community. Patient satisfaction is one of our measures. We also score our CEO on the success of our strategic plan, which includes many community benefits.

Steele: In Pennsylvania we have a limit on how much incentive can be based on financial performance. It forces us in our incentive component of the compensation philosophy to look at exactly what Bill is talking about—patient satisfaction across the entire company, accomplishment of strategic aims, access, quality. I think things are moving in a direction where we can actually measure the non-financial endpoints, and we're compelled to do so.

Ackerman: In our jargon this is called a balanced scorecard approach. We caution any of our clients when they start getting north of a 40% to 50% focus on financial performance. It needs to be balanced to be a good program.

Steele: The American Medical Group Association did a benchmarking study. It was remarkable to me how few organizations achieved best practice in this particular area. I'm sure best practice is not widely disseminated.

Van Horn: Looking at nonprofit hospitals in the United States in the early-to-mid '90s, we found that the average percentage of CEO compensation tied to financial performance, going from the worst hospitals to the best hospitals, was still only around 8%. So we're nowhere near the mark that Ken is suggesting, at least not as of the mid-'90s.

McPherson: Ken, do you also try to counsel your clients on the degree to which they are focusing on short-term versus longer-term performance?

Ackerman: We do, and in fact long-term incentive programs are very difficult to manage. So we begin by saying, "Get your house in order. Be comfortable with what you're doing with short-term incentive plans. Make sure it's working well, and is thoroughly understood by the board and by executive management, before you even consider longer-term incentive plans."

Steele: I want to add an internal management truth that has become apparent to us at Geisinger. When an organization moves from losing money to making money on operations, it is interesting how valuable communication within the company family becomes. When you lose money on operations there is little need to justify nonprofit status. As you achieve robust operations, folks at every level of our organization need to understand the process and cost of recruiting and retaining the best and the brightest, and how the board benchmarks the process.

McPherson: What I am hearing, then, is that benefits provided to the community need to be built into both pay-for-performance and communications?

Ackerman: I think that some boards are very in tune with this and are demonstrating internally as well as to their communities the measurable contributions they're making. The *(Minneapolis) Star Tribune* released an article on the Fairview

hospital system, as a result of a 28-page report by Minnesota Attorney General Mike Hatch. The title of the article was, "While Execs Got Bonuses, Fairview's Low Income Patients Got Bill Collectors." That gets back to your point. It is increasingly important that boards focus on community benefits.

McPherson: What about fund-raising? Is that also frequently a key differentiator in the performance goals and compensation for a nonprofit versus for-profit CEO?

Ackerman: My bias is that philanthropy is the future of nonprofit healthcare. It's certainly a very important element that's been ignored way too long. Some organizations have done a great job with it; others are just barely getting started with it. You do see it sometimes tied to a CEO's incentive plan, but it's infrequent. There's no doubt that whatever is tied to the short-term or long-term incentives will drive performance.

Kibler: We don't use fund-raising as a criterion to measure our CEO's performance. We have just begun to embrace philanthropy in a bigger way, and our CEO has been a leader in that process. But the current board doesn't assign an incentive to his fund-raising efforts. In fact he doesn't solicit donations from board members, or keep track of what we give. I'm sure he wants us to give, and give generously, but we don't want that to cloud the governance/CEO relationship.

Van Horn: Our research has found that the board structure itself can have a significant impact on the ability of the organization to be successful in raising donations. The CEOs who are more powerful on their boards appear to be able to significantly increase the donations. At the same time, there are other things that seem to make organizations less able to recruit donations. Most notably, significant physician participation on the board tends to reduce the level of donations and the ability of the CEO to recruit donations.

McPherson: Do you think the compensation expectations of executives in nonprofit health care organizations have changed over time? For instance, as a product of the '60s, I started my career in 1970, driven by a desire to apply business knowledge and skills to nonprofit health care organizations with a social mission. I was interested in making a decent living, but also wanted the psychological rewards of doing good work. Also, the health care world of the 1970s was a lot less challenging in terms of competition, regulation, and payment.

Steele: Having been in and around academics for 27 years, in Chicago, Boston, and now in Pennsylvania with differing organizational structures and aspirations, I have not seen health system leadership career paths primarily driven by what people think they are going to make. I've just never talked to anybody who has gotten into a leadership position where compensation was the driving force.

The complexity of the jobs has increased dramatically as has the expectation for formal training. There are not many people like me, I think, who will learn it on the street in the future. Formal business training is now a predicate and that is a good thing.

Ackerman: Because of the complexity and enormous change that we've all seen over the last 30-plus years in health care, the best of the best are required in health care management. With that have come changes in what that kind of leadership needs and deserves in the way of compensation.

Van Horn: While I can't speak to the motivation issue, I would underscore what Ken and Glenn have laid out here. Not only have the organizations become much more complex, but I would argue that the value of managerial talent in those positions is much greater today than it was 20 years ago. The need for keen decision-making ability to chart the path of these organizations is much greater, and it's only logical from our perspective that greater compensation flow from that.

Kibler: It's important for boards to compensate talent. Ten years ago our system's compensation philosophy was loosely structured. The executive committee of the board would hold a meeting in December, guess at the inflation rate for the next year, and give the CEO a commensurate raise. If the bottom line was good, and things were running smoothly, we'd also give a bonus. When we adopted a more disciplined philosophy, we found that we were actually underpaying our very talented CEO. If I were the prospective CEO of a nonprofit health system, I would want my board to adopt a disciplined approach to recognizing and rewarding talent.

Kathy Swartz: From the Harvard School of Public Health perspective, in my Department of Health Policy and Management there are two tracks that the two-year students can pursue, and to a limited extent this is also true of the one-year M.P.H. program for physicians. The ones who are interested in management attend the Harvard Business School

for quite a number of their courses in their second year. They come back shaking their heads, in part because they realize that the other students in the business school courses are in fact going to go out and earn huge amounts of money. Our students view themselves as people who will go do good for the world and are highly unlikely to earn huge amounts of money, unless they rise to the top and become CEOs of health plans or hospitals. We also have created a mid-career program that is largely targeted at physicians in hospitals who want to take on management roles. I think they recognize that the business schools don't always offer them the context that they need for accounting practices, management practices, whatever it is. So I agree with what Bruce and Glenn were saying. We can look back 30 years ago to when we all were in school, and I still think it's true now.

Van Horn: I support some of Kathy's comments based on our experience with University of Rochester's Simon Graduate School of Business Health Care MBA program. A frustration of mine over the last 10 years in producing managerial talent for healthcare delivery settings is that typically the salary structures there are relatively flat until you get to the very top levels of the organization. Salaries below the top are not meeting the requirements or expectations of a lot of today's talented MBA students with health care experience and knowledge. So, many of our students go into healthcare consulting for a number of years, establishing relationships with delivery systems and then transferring into them.

Ackerman: You're absolutely right. There's been a very interesting transformation in graduate schools of health care management over the last 30 years. Thirty years ago, when Bruce and I were in school, essentially 100% of our classmates would go into the provider side at some entry-level position in hospital management. Today you'll find some programs where 50%, 60%, 70%, 100% of those students are going to corporate America -- drug companies, consulting, and investor-owned for-profit organizations.

Steele: I think there are ways that you can structure your compensation program and disseminate it down into the organization to help that middle management compression challenge that Larry is talking about. It has to do with our overall strategic goal. We carry our Mercer benchmarking and incentive compensation down to our top 125 managers. It's part of our basic philosophy and expectation. We actually celebrate the exporting of potential new leaders out to other

organizations. Part of what I found remarkable about Geisinger was how many terrific people came through here and then made leadership contributions elsewhere.

McPherson: We've just been talking about extending executive compensation philosophy and practices down into the organization. What about internal equity? What happens to morale when managers and employees at all levels perceive that executives' compensation is off the charts compared to their own? And what about external perceptions?

Steele: Every year our local newspaper publishes all our doctor and top administrative leadership salaries. Whomever we recruit we warn that someday when they're walking into the Giant food store somebody is going to know exactly how much they make. So we're basically functioning under the assumption that if there is anything that we don't want to have published, we'd better not do it. In addition, we stress internally and externally that we are competing in a national market. We have to compete using national benchmarks or clinical programs will deteriorate very quickly. You've got to be sure that everyone, both internal and external audiences, understand how you benchmark and your formal process. There are still going to be people that try to demagogue it, but I think as long as you know you're doing the right thing you've got a better starting point for your story.

Van Horn: It's difficult, whether you are in a community of 5,000 or over one million, as in Rochester, Syracuse, or Buffalo. Every spring the papers come out publishing salaries and raising this issue. Our friends in the nonprofit insurance sector, because of New York State filings, need to make public the compensation of anyone in the organization making more than \$100,000. So it goes very deep. I also think that there is a longstanding tension between medical staff and administration, with the medical community not fully appreciating the value that managerial talent brings to the table. Many physicians don't seem to understand why executives of third-party payers or executives who are leading large medical facilities should be paid the sums they receive, compared to their own. That tension is going to exist.

Kibler: We operate in a smaller community and we're the largest employer in that community. We employ about 4,000 people. Our community's financial health depends upon the viability of our healthcare system, so the community should expect qualified, well-paid leaders of its health system. I think

the medical staff probably feels the same way. They want to work in a well-managed facility. It really is a community benefit to have good leaders in place, and good leaders should be compensated fairly.

Steele: Bill and his other directors are making the case in their community that their medical center represents a major engine of economic growth in addition to care-giving. But all it takes is one egregious situation, and all of us are behind the eight ball for a while, like the public allegations of executive compensation excesses in the attempted conversion of CareFirst (a nonprofit health insurer in Maryland) to for-profit status.

Van Horn: We want valuable managerial talent, and if the CEO of a \$4 billion company that drives employment in the community is making a million dollars, I'd probably want to pay him more. He affects livelihoods and drives a lot of the economic engine in the community.

Ackerman: Because healthcare enterprises are often the major employer in many of our communities across the country, they're big targets. This requires ongoing education. It isn't a story or message you can tell once. It's something I think the boards, compensation committees and leadership need to be proactive about. They need to think about the message that they want to get out and how they want to get it out. People need to understand the process: it involves a compensation committee made up of independent directors and not involving management; the board seeks expert advice and data so that it can make wise decisions to recruit and retain the best; and there are complicating factors that must be considered. These include management challenges, scope of responsibilities, size and complexity of the organization, and the competitive marketplace they're in and from which executives have to be recruited.

Steele: There's one other helpful approach. We recruit a lot of executives from outside our region. And, it is our explicit expectation that they spend a significant amount of time working in the community. My suspicion is that over time this will help break down a lot of the natural polarization.

Ackerman: My bias is that there has to be more education of boards on greater transparency over CEO and senior executive compensation. It's amazing that a cloistered group of directors might still be approving compensation packages for senior

executives with the rest of the board not knowing anything about it. In this day and age, with 990s (annual IRS reports for nonprofit organizations) and easy public access, with the aggressive state attorneys general and aggressive media in some communities, it is amazing that there are still nonprofit health care organizations not making it a practice to annually report senior executive compensation. That's a time bomb just waiting to go off.

McPherson: How prevalent is it for compensation committees to be engaged in performance assessments and compensation for executives other than the CEO?

Steele: We do that as part of our practice. In fact, we have a board rule that if there's more than a certain percentage change in anyone's compensation, even within our associate group, which is what we call our doctors, advance approval by the board is required.

Ackerman: What Glenn is describing is best practice. The old way was, " Mr. or Ms. CEO, we'll review your performance and compensation. You make all the decisions relative to your executive team, and we don't care if we ever see the data." That's history. That's not the way to do it today.

Kibler: We apply the same general compensation philosophy to the senior VPs that we apply to the CEO. They're all working on the same goals.

McPherson: In recruiting and retaining executives for non-profit health care organizations, is it currently a seller's or buyer's market, and how is that impacting compensation levels?

Ackerman: The short answer is that it is resoundingly a seller's market, especially for larger, more complex organizations where there is a lot of competition around a relatively small cohort of talent. Also, when you take into consideration executive turnover in healthcare enterprises, which has been running somewhere between 14% to 19% for the last several

years, we find organizations paying somewhere between 15% to 20% above the median of the market to replace their CEOs from the outside. The average tenure for a CEO of a health care enterprise is only about four years.

McPherson: So, by implication, the way to get around this is good succession planning?

Ackerman: You're absolutely right. This is another difficult area where organizations need to do better.