Session 27AB
Refining Your Executive Compensation Program

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Refining Your Executive Compensation Program

Disclosure of Relevant Financial Relationships

The following faculty of this continuing education activity has no relevant financial relationships with commercial interests to disclose:

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- **John J. (“Jack”) Lynch, FACHE**, President & CEO
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- **Christine Schuster**, President/CEO
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Learning Objectives

• Learn how to win support of the board and compensation committee for transforming and refining the executive compensation program
• Learn how to overcome obstacles to getting an effective executive compensation program
• Learn how to reshape executive compensation to support transformation, clinical integration, accountable care, population health management

Agenda

• Challenges
• The Committee’s role and perspective
• Board’s role and perspective
• Compensation policy and philosophy
• The full picture
• Case studies
Challenges

• Era of unprecedented change
  – Uncertainty about future
• Need to manage operations even better while changing risk-averse organizations
• Public thinks executive pay too high
  – Boards represent their communities
• Boards and committees exercising more influence
• Turnover on compensation committee
• Boards don’t always trust committee

Unprecedented Change

• Medical model to health model:
  – promoting and managing health, not just acute care
• Consumer-driven: choice, access, cost, transparency
• Increased financial risk for providers
• Physician integration and alignment essential
• Physician leadership more important than ever
• Scale: getting bigger to manage risk and share costs
• Clinical informatics: to identify best intervention
• New competitors: retailers and insurers; outsiders moving into primary market
• Technology: telemedicine, remote monitoring, virtual appointments
• Declining reimbursement: boomers moving to Medicare; high-deductibles leading to write offs

Increasing complexity requires more sophistication in managing clinical integration, technology, virtual networks, financial risk, disease management, and population health. Overall leadership skills will trump technical competencies in leading change successfully.
Manage operations and change at same time

- Need to move the entire organization and manage into the future
- Even while rewards come only from managing operations well
- Need to learn how to manage risks in value-based contracts and accountable health
- Organizations need to change

Public: executive pay is too high

- Intense criticism makes it hard to deal with executive compensation issues
- Board representatives vs. executive pay: community values vs. fiduciary responsibility
- Size of executive team and its payroll cost rising as systems add new positions to lead change
- Regulation makes executive compensation risky
- Boards questioning whether pay in healthcare isn’t higher than in general industry
- Ongoing Operations
Boards and committees exercising more control

- Boards and committees no longer committed to past policies and approaches
  - Questioning compensation philosophy, peer group, and structure of program
- New board or committee chair aim to influence policy and/or structure of program
- CEO turnover gives committees opportunities to rethink past approach

Turnover on board and committee: problem and opportunity

- Turnover on board and committee often leads to re-opening questions about compensation policy
  - New members have no commitment to past decisions
- Getting the right members on the compensation committee is essential to having an effective compensation program
- Consistent leadership over time from same chair helps keep compensation program effective
  - But it may take a new chair to refine the program
Boards don’t always trust committees

- Boards should delegate oversight, within a policy approved by board
- Boards tighten control (demand right of approval) if uncomfortable with committee decisions or if left in the dark
- Important to maintain board’s trust in compensation committee

Committee’s role and perspective

- Who’s on the committee?
- Who’s leading the committee?
- What can the committee approve on its own?
- Does committee understand difficulty of recruiting and retain high-caliber executives
  - Goal of program should be recruiting and retaining
- Does committee support pay-for-performance?
- Is committee committed to making each part of package competitive?
Winning committee approval

- Spend time with chair to win his support
- Preview your recommendations with the opinion leaders on the committee
  - Let them know how much you care, and why
- Explain rationale for salary increases, discretionary adjustments (e.g., performance, retention)
- Set proposed incentive goals in context (e.g., past performance, industry benchmarks, best practices)
- Plan to spend several meetings on major new proposals
  - Deal with objections at first meeting, move toward acceptance in 2nd or 3rd meeting

Dealing with Nay Sayers

- Every board and committee has one
  - But s/he usually gives in to the majority
- Get the chair to deal with the nay sayer
  - Committee will generally follow the chair
  - If chair supports your recommendation, it will be difficult for nay sayer to prevent approval
- Be persistent and patient
  - Work with the chair and committee over time
Patterns in general industry

- Committee members often suggest following patterns in for-profit sector
  - Lower salaries, higher incentive opportunity
  - Long-term incentives, too
  - Modest benefits
- Private firms pay less than nonprofit hospitals and health systems
- Public firms pay lower salaries and benefits but much richer annual and long-term incentives
- Can you justify using for-profits in your peer group?
- Be wary of incentive designs from for-profit sector

Compensation policy/philosophy

- What’s the right peer group?
- How competitive should it be?
- What’s the right mix of fixed and variable pay?
- What’s the right balance between pay and benefits?
Getting the policy right

• Getting the compensation philosophy right is a big step in the right direction
  – Start with getting the peer group right
  – Define how competitive total pay should be when performance is good
  – Make sure it says benefits must be competitive
  – Maintain commitment to the philosophy by reviewing and reaffirming it (and peer group) regularly

Getting the peer group right

• What’s the right peer group?
  – Organizations like yours in size and other characteristics?
  – National or regional?
  – Public vs. private not-for-profit?
  – Special focus (e.g., academic, children’s, rehab)
  – Best performers?
Choosing peer group wisely

• Get to know what the organizations in your peer group do
  – Who has LTI or SERP
• Make sure the peer group includes organizations that could recruit you or your team members away
  – Bigger, higher-paying organizations
  – Organizations with LTI or SERP
• Most prestigious organizations in your region

How competitive?

• What’s enough to recruit and retain?
  – Can’t recruit experienced executives at median pay
• What do major competitors pay?
• How to deal with perceptions based on 990s?
• What about the outliers? (High and low)
Compensation Philosophies at Nonprofit Health Systems

• More than half of all systems position salaries at median—but more than half position total compensation above median (i.e., at P60, P65, or P75)

Compensation Philosophy in the Northeast Region

• More than half the systems in the Northeast region position total compensation at P75:
What’s the right mix?

• High base or total pay with generous incentives?
• Long-term + annual incentives or rich annual incentives?
• More pay while working or better retirement benefits?
  – Lifetime annuity worth more than generous pay for 5 to 10 years
• Adequate protection against loss of income (death, disability)
• P75 is 20% > P50; P90 is 30-40% > P50

What matters most?

• Turnover may be the determining factor
  – How much recruiting do you need to do?
  – Is turnover excessive due to inadequate compensation?
• Other circumstances affect answer, too
  – Age of executives, years until retirement
  – Incentives that don’t pay awards don’t work
Age of Executives

Impact of CEO Turnover

• Hospital CEO turnover in 2015 remained elevated at 18%, same as 2014\textsuperscript{1}

• Record High of 20% in 2013\textsuperscript{1}
  – Due to:
    • 16% involuntary termination\textsuperscript{2}
    • Trend of Consolidations\textsuperscript{1}
    • New Models of Care\textsuperscript{1}
    • Retirement of Baby Boomer Era, etc.\textsuperscript{1}

Source\textsuperscript{1}: ACHE March 2016
Source\textsuperscript{2}: The Impact of Hospital CEO Turnover in U.S. Hospitals: Final Report,\textsuperscript{1} prepared for the American College of Healthcare Executives, 2014
Impact of CEO Turnover

- New CEOs tend to retain less than 30 percent of their senior executives\(^1\)
- When a new CEO is hired\(^2\):
  - Almost 50% of CFOs, COOs and CIOs are fired within 9 months
  - 87% of CMOs are replaced within 2 months

Source\(^1\): The Impact of Hospital CEO Turnover in U.S. Hospitals: Final Report, prepared for the American College of Healthcare Executives, 2014
Source\(^2\): 10 Statistics on CEO Turnover, Recruitment, Becker's 12/18/13

The full picture

- Compensation philosophy
  - Right peer group, how competitive
- Salary vs. variable pay
  - Right mix
- Annual incentive vs. annual + long-term or retention incentive
- Basic benefits
- Supplemental benefits, including SERP
- Perquisites
- Severance
Refining the compensation program

• What needs to be refined?
• Develop a plan
  – Recognize it may take several years
• Start with the highest priority
• Start with rationale and prevalence
  – Needed to achieve strategic plan
  – Needed to recruit and retain
• Build a commitment to achieving competitive position outlined in compensation philosophy

Case studies

• System A
  – Positioned salaries and total at median, relative to regional competitors
  – Recruited new CEO first, then many other new executives
  – Embraced transformation and clinical integration
    • Changed peer group to leading national integrated systems
  – Got board to position total at P75 to recruit and retain
  – Won approval of supplemental life and disability
  – Won increase in annual opportunity (to get to P75)
  – Introduced LTI (to get to P75 of new peer group)
  – Introduced new DC SERP to bring retirement benefits up to competitive level
Case studies

• System B
  – New system in NE region formed through merger
  – New committee needed to shape new program
    • Considerable variation in legacy programs
    • Large committee: 1-5 representatives of each affiliate
  – Policy set salary midpoints at median of national peer group
    • Lowered ranges at flagship and for all affiliate “CEOs”
    • Implication of lower ranges for other affiliate executives, too
  – Incentive opportunity raised for most but not all affiliates
  – Executive benefits still need to be standardized
    • Committee surprised by degree of variation

Case studies

• System C
  – Public hospital system with conservative board and conservative program
    • Salaries below median
    • No incentives or supplemental benefits or severance
  – Announced intent to merge or sell
  – Executives started leaving for jobs elsewhere
  – Committee saw light and held onto remaining executives
    • Salary increases and annual incentives
    • Retention incentives and severance
What does it take to retire comfortably?

- Financial planners say it takes 60% of pre-retirement pay to maintain standard of living
- It takes a lump sum of 11-12 X annual income to produce a lifetime stream with 6% post-retirement investment earnings
- If post-retirement investment return is only 5%, it takes a lump sum of y-z X annual income

What’s a good retirement benefit?

- With no inflation and no raises, annual contributions 10% of salary for 25 years should generate a retirement income of 60% of salary (with 7% return pre-retirement, 6% post-retirement)
  - But with 3% salary increases, annual contributions need to be 15% of salary to get there in 25 years
  - And to get to 60% of final total pay (salary plus bonus), it would take annual contributions of 15% of total pay
- But with pre-retirement returns of 6% and post-retirement returns of 5%, it would take annual contributions of x% of pay for 25 years to generate a retirement income of 60% of final pay
7 Steps to Success

1. Educate board and committee on competitive practices
2. Use compensation philosophy to shape program and maintain consistency
3. Take it one step at a time, and persevere
4. Hold several committee meetings each year
5. Choose a consultant you trust and let the consultant meet alone with committee
6. Set proposed goals in context (benchmarks, baseline)
7. Bring proposed goals as drafts to get feedback before asking for approval

Presenter Biography & Contact Info

David A. Bjork, Ph.D.


Dr. Bjork has presented at ACHE conferences each of the past few years, as well as at Health Insights, Becker’s Healthcare Conference, Health Management Academy Forum for Chief Human Resource Leaders, several state hospital associations, and LEAP HR Conference. He earned an A.B. at Harvard, and M.B.A. in finance from the University of Chicago, and a Ph.D. from the University of California at Berkeley.

Presentations made to ACHE audiences:
- ACHE Congress, March 2016
- ACHE Congress, March 2015
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Toni has over 25 years’ experience working with health care organizations on executive compensation issues and now advises boards of some of the country’s largest health systems on executive compensation strategies. Toni earned her undergraduate degree in accounting from Moorhead (MN) State University.

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Kevin leads the total compensation consulting practice at Integrated Healthcare Strategies and oversees its consulting relationships with over 300 clients. Kevin has 15 years’ experience consulting on executive compensation and now advises the boards of some of the country’s largest health systems on executive compensation strategies. Kevin has presented at a regional ACHE meeting, Health Insights, IHES, and various state hospital associations. He received a Masters of Business Administration from the Carlson School of Management at the University of Minnesota and completed his Bachelor of Science degree at the United States Naval Academy.

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As president and CEO of Scripps Health, Chris Van Gorder has led the nearly $3 billion integrated health care system from the brink of disaster to one of the most noted health care systems in the nation.

Van Gorder’s rise to health care executive has been unconventional. A former cop critically injured in the line of duty, his journey began as a hospital patient. After a lengthy recovery, he continued his education in health care management and rose to levels of increased responsibility.

This year Modern Healthcare magazine once again named Van Gorder one of the “100 Most Influential People in Health Care.” His first book – The Front-Line Leader – was released in November 2014.

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John J. (“Jack”) Lynch, FACHE
John J. (Jack) Lynch III has served as president and CEO of Main Line Health since 2005, providing executive leadership to suburban Philadelphia’s most comprehensive health care system. Main Line Health is comprised of four of the region’s respected acute care hospitals—Lankenau Medical Center, Bryn Mawr Hospital, Paoli Hospital and Riddle Hospital—as well as one of the nation’s premier facilities for rehabilitative medicine, Bryn Mawr Rehab Hospital; Mirmont Treatment Center, one of the leading addiction treatment programs in the Northeast; the Lankenau Institute for Medical Research; and the Home Care Network, which provides at-home nursing and hospice care throughout the five county region. Prior to joining Main Line Health, Lynch served nearly 20 years as an executive with the St. Luke’s Episcopal Health System in Houston, Texas, where he advanced to the position of Executive Vice President and Chief Operating Officer for the system, as well as CEO of the system’s flagship facility, St. Luke’s Episcopal Hospital. While residing in Houston, Lynch served on the boards of a wide variety of professional associations, including the Texas Hospital Association, the Greater Houston Hospital Counsel and the United Way. A native of Washington, D.C., Lynch received his undergraduate degree from the University of Scranton in Pennsylvania and his Master of Health Administration degree from the Washington University School of Medicine in St. Louis, Missouri. As former Governor of the American College of Healthcare Executives, Lynch serves on the boards of the Delaware Valley Healthcare Council, the United Way of Southeastern Pennsylvania, and the Haverford School. A former Chairman of the Institute for Diversity in Health Management, Lynch currently serves as a board member. In 2008, he served as Chairman of the American Heart Association of Southeastern Pennsylvania’s Heart Walk.

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Christine Schuster

Ms. Christine C. Schuster has been Chief Executive Officer and President of Emerson Hospital, Inc. since July 2005. Ms. Schuster is a Registered Nurse who headed Quincy Medical Center Inc. She served as the Chief Executive Officer and the President of Quincy Medical Center Inc. Ms. Schuster served as the Chief Executive Officer and the President of Athol Memorial Hospital and also served as a Vice President and as the Chief Operating Officer of the Tenet Saint Vincent Healthcare System in Worcester, Mass. Ms. Schuster served as a Director of critical care services at the New England Deaconess Hospital. She also served for five years as a healthcare management consultant with Coopers and Lybrand. She serves as a Director of Emerson Hospital, Inc. Ms. Schuster received an MBA with honors from the University of Chicago Graduate School of Business and a BS in nursing from Boston University.

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