The Changing Landscape of CEO & CFO Compensation

The New Normal

May 11, 2013

Presented to:

Fourth Annual Becker's Hospital Review Meeting

SullivanCotter AND ASSOCIATES, INC.

INTEGRITY INDEPENDENCE INSIGHT INFORMATION

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Jim Rohan is one of the founders of Sullivan, Cotter and Associates, Inc. and serves as Vice President and Managing Director for the Central Region of the firm.

For more than thirty years, Jim has worked with boards of directors and senior management at over 350 health care organizations in the development of executive, physician, broad-based employee compensation programs, and strategic rewards systems.

Jim served for six years on the Federal Reserve Bank of Chicago's Advisory Committee on Agriculture, Labor and Small Business; served two terms as President of the Chicago Compensation Association and more than ten years on its Board of Directors, and is a past member of the Advisory Board for DePaul University's Master's of Science in Human Resources program.

Jim is a member of WorldatWork, the American Society for Healthcare Human Resource Administration, the American College of Healthcare Executives, the Society for Human Resource Management, and the Chicago Compensation Association. He was presented the Lifetime Achievement Award by both WorldatWork and the Chicago Compensation Association.

Jim earned his undergraduate and Masters of Labor and Industrial Relations from Loyola University (Chicago, IL). Jim teaches compensation seminars for the Chicago Compensation Association and was an instructor at the University of Wisconsin.

Discussion

- The New Normal
- Implications of health care reform on CEO and CFO compensation
- Emerging practices related to executive incentive compensation
- Questions and Answers

The New Normal

The Rules of the Game Continue to Change

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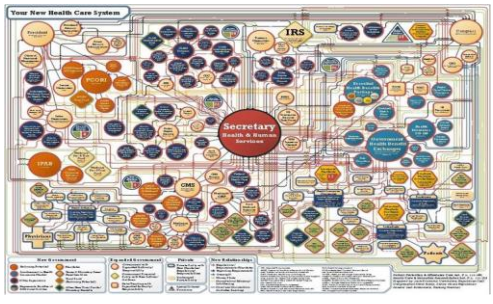
Health Care Reform/PPACA Made Simple



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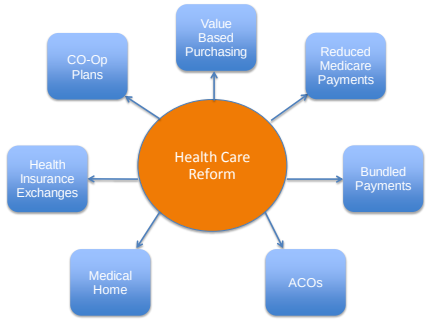

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CMS Goal:
Transform Medicare from a passive payer of claims to an active purchaser of quality health care for its beneficiaries

1. Improve clinical quality
2. Reduce adverse events and improve patient safety
3. Encourage more patient-centered care
4. Avoid unnecessary costs in the delivery of care
5. Stimulate investments in structural components or systems
6. Make performance results transparent and comprehensible to:
   - Empower consumers to make value-based decisions about their health care and
   - Encourage hospitals and clinicians to improve the quality of care

More than 100 million Americans are enrolled in Medicare, Medicaid or the Children's Health Insurance Program (nearly 1/3 of the US population)

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2013 Changes

- Bundled payment models -- national pilot program

2014 Changes

- Insurance mandates for individuals (or pay fine)
- Insurance mandates for employers of 50+ employees (or pay fine)
- Insurance exchanges (open enrollment October 2013)
- Reductions in Disproportionate Share Hospital (DSH) payments (begin in October 2013)

2015 Changes

- Quality payment program for physician groups of 100 professionals or more

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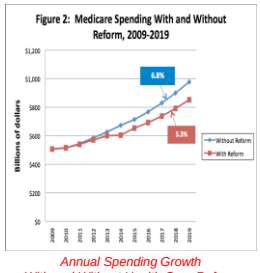
Projected Cost Saving over Next Decade

- Estimated total saving **$575B**
  - VBP - $50B
  - Readmission reduction - $8.2B
  - Meaningful Use - $17B
  - Hospital acquired conditions - $3.2B
  - Ending overpayment to Medicare Advantage Plans - $145B



Annual Spending Growth
With and Without Health Care Reform

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Commercial Payors

- Adopting their own version of health care reform including
  - Penalties for hospital-acquired conditions (HAC)
  - Infections
  - Preventable readmissions
  - Bundled payments [including medical homes and acute care episodes (ACEs)]

The New Normal

Impact on Financials

- How health care reform will impact financials
  1. Increased demand (both inpatient and outpatient)
  2. Reduced revenue per unit of service
  3. Risk-based payment systems (e.g., ACOs)
  4. Shift from volume to value
     - Incentives for quality, cost and service
  5. Further reimbursement cuts – 2013 and beyond

Implications

Implications

Executive Talent Redefined

- Lower reimbursements and cost cutting pressures will **test** the management **skills** of **CEOs** and **CFOs**
  - The **transformation** of the health care industry **may require different skill** sets
    - Building, managing, and succeeding under shared risk arrangements (e.g., ACOs, Medical Home, Bundled Payments)
    - Managing costs and productivity of large numbers of employed physicians

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Implications

Executive Talent Redefined

- Strong demand for highly-skilled executives who can address the complex issues facing health care providers
  - Executives with proven experience and performance commanding a premium in the market
  - Regardless of economic conditions, **proven performers are expensive**

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Implications

Talent Market

- Increased competition for proven executive talent
- Limited supply of top executives that can run $3.0B+ health care systems
- Increased **CEO turnover** and **retirements** over last few years
  - Health care organizations saw the heaviest CEO turnover among all sectors in 2011, as 187 CEOs left their posts, an average of nearly 16 per month (Challenger, Gray & Christmas)
  - Average age of CEOs approximately 58

- More executives will have two commas on their W-2
- Succession planning top priority of boards

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Implications

Growth of CEO and CFO Cash Compensation (2009-2012)

- Salary and total cash compensation growth **has moderated** despite
  - Market pressures
  - Increased demands and challenges
- This is especially true when compared to growth in the early 2000s

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Implications

Growth of CEO Cash Compensation (2009-2012)

CEO Salary Data				Base Salary P50 2009	2010	2011	2012	3 Yr % Change	Avg Annual % Change
Hospital	CEO	Free Standing	$300M+ Rev	$617.0	$623.1	$625.0	$685.5	11%	4%
Hospital	CEO	System Owned	$300M+ Rev	$395.0	$406.3	$420.9	$409.2	4%	1%
Health System	CEO	----	$700M-$2.0B	$753.0	$775.0	$776.1	$810.0	8%	3%
Health System	CEO	----	$1.5B+	$951.0	$960.0	$982.3	$994.8	5%	2%

CEO Total Cash Compensation				TCC P50 2009	2010	2011	2012	3 Yr % Change	Avg Annual % Change
Hospital	CEO	Free Standing	$300M+ Rev	$688.0	$718.3	$724.9	$783.3	14%	5%
Hospital	CEO	System Owned	$300M+ Rev	$499.0	$519.3	$529.1	$507.1	2%	1%
Health System	CEO	----	$700M-$2.0B	$880.0	$897.6	$894.6	$963.7	10%	3%
Health System	CEO	----	$1.5B+	$1,287.0	$1,306.0	$1,259.0	$1,345.8	5%	2%

Source: SullivanCotter's Manager and Executive Compensation in Hospitals and Health Systems

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Implications

Growth of CFO Cash Compensation (2009-2012)

CFO Salary Data				Base Salary P50 2009	2010	2011	2012	3 Yr % Change	Avg Annual % Change
Hospital	CFO	Free Standing	$300M+ Rev	$350.0	$357.1	$375.0	$384.1	10%	3%
Hospital	CFO	System Owned	$300M+ Rev	$240.0	$249.0	$245.0	$250.9	5%	2%
Health System	CFO	----	$700M-$2.0B	$413.0	$410.0	$421.5	$431.7	5%	2%
Health System	CFO	----	$1.5B+	$504.0	$513.0	$503.3	$520.2	3%	1%

CFO Total Cash Compensation				TCC P50 2009	2010	2011	2012	3 Yr % Change	Avg Annual % Change
Hospital	CFO	Free Standing	$300M+ Rev	$396.0	$399.6	$410.0	$427.2	8%	3%
Hospital	CFO	System Owned	$300M+ Rev	$274.0	$302.4	$285.9	$293.6	7%	2%
Health System	CFO	----	$700M-$2.0B	$447.0	$465.0	$490.0	$487.4	9%	3%
Health System	CFO	----	$1.5B+	$638.0	$625.0	$649.5	$664.2	4%	1%

Source: SullivanCotter's Manager and Executive Compensation in Hospitals and Health Systems

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Implications

Growth of Cash Compensation (2009-2012)

- **Scrutiny** of executive compensation **has not subsided** and is **moderating** growth in cash compensation
  - Enhanced disclosure on **990s** and related public scrutiny
  - Spotlight on **health care reform**
  - IRS's 990 (normative) database and related **risk profiles**
  - Selected state attorneys general (Massachusetts and New Hampshire) are actively working in the area
  - **States efforts to limit** executive compensation in tax-exempt organizations (California and New York)

Compensation Committees' Challenges
Balance public pressure to moderate executive compensation with need to attract and retain executive talent

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Implications

CEO and CFO Retention

- Boards and Compensation Committees focusing on **retention** of key leaders:
  - More executives are **willing to move** for new opportunities
  - Market **consolidation** has made executives **feel less secure**
- Use of **retention incentives** has grown dramatically as industry consolidates, including
  - Stay bonuses
  - Retention incentives
  - Bonuses for deal completion

Boards are requiring formal succession plans for all key executives as part of their executive recruitment and retention strategies

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Implications

Executive Benefits and Perquisites

- Tax gross-ups and **perquisites** are being eliminated and supplemental benefits **scaled back**
  - Often accompanied by salary increases
  - When perquisites are provided, based on 'business need'
- Supplemental executive retirement plans (SERPs) are being revised
  - Moving from DB to DC approach
  - Avoiding split dollar life insurance
  - Committees/Boards sensitive to 'cash flow' and 990 reporting implications

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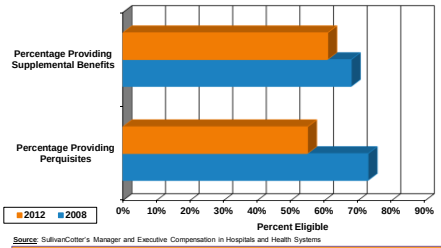
Implications

Executive Benefits and Perquisites

- Prevalence of executive benefits and perquisites in health systems



Source: SullivanCotter's Manager and Executive Compensation in Hospitals and Health Systems

Details on most prevalent supplemental benefits/perquisites provided on next pages

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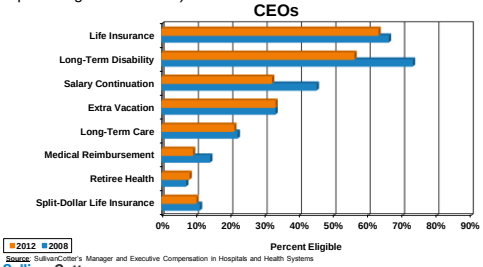
Implications

Executive Benefits and Perquisites

- Prevalence of supplemental benefits in health systems (amongst those providing to executives)



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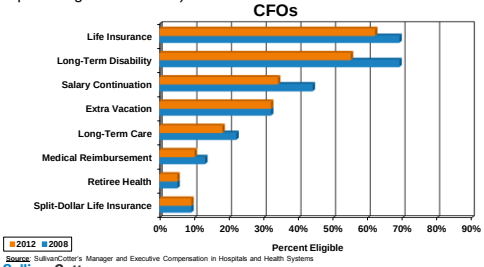

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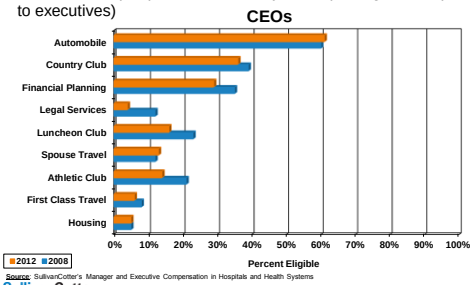

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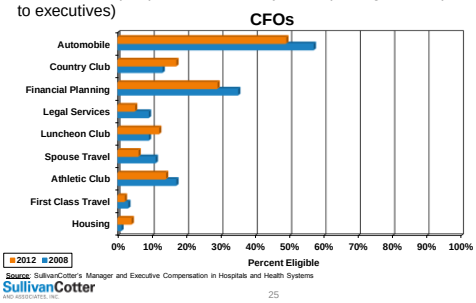

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Implications

Executive Benefits and Perquisites

- **Other changes** related to industry consolidation
  - Revisiting **severance** plan provisions:
    - Change in control
    - Good reason termination
  - Revising **SERPs** and vesting provisions related to change in control

Consolidation resulting in executives feeling less secure

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Implications

Other Emerging Practices

- Use of **custom peer** groups
  - Key competitors
  - High performing organizations
- Increasing use of **for-profit market data**
  - For-profit health care increasing its footprint, NFPs need to be able to compete for executive talent
  - New skills sets required in health care (SVP Supply Chain; National Brand Manager, SVP Sales, etc.)

The IRS has expressed concern about the use of for-profit market data, even though Intermediate Sanctions does not prohibit its use

Implications

Other Emerging Practices

- Increased interest in **long-term incentive** plans
  - Still a minority practice minority practice (20% to 30%)
  - Increased prevalence with larger health care systems and for-profit health care organizations
  - Some considering using LTIP in place of SERPs
    - Performance based retention
    - Better optics on Form 990

Implications

Industry Consolidation Impact on Compensation

- Health systems becoming **more centralized** with goal of improving operating effectiveness and efficiency
  - With consolidation, executive positions being consolidated
    - Decreasing demand
    - Increasing supply
    - Reducing executives' autonomy and responsibilities
      - Move from free-standing to subsidiary entity
  - Impacts growth of compensation

CEOs and CFOs in system-owned hospitals experienced 1% and 2% annual growth in cash compensation between 2009-2012

Implications

Industry Consolidation Impact on Compensation

- Because of **consolidation**, the **market value** of certain executive positions are **being examined**, e.g.,
  - CEOs in system-owned hospitals
    - If a hospital CEO reports to a "Regional CEO" or has significantly reduced board responsibilities, is he/she still a CEO?
  - CFOs in system-owned hospitals
    - In a health system, where all key financial decisions are made at corporate office, is he/she still a CFO?

These dynamics are true of many executive positions outside the corporate office, especially in highly centralized/integrated health systems

Implications

CEO and CFO Pay-for-Performance

- **Greater emphasis** on incentive plans and performance, with particular focus on
  - Cost reduction
  - Quality
  - Patient satisfaction
  - Integration
  - Network development
- Prevalence
  - Short-term (annual) incentive plans – majority practice (80% to 90%)
  - Long-term incentive plans – minority practice (20% to 30%)
    - Increased prevalence with larger health care systems and for-profit health care organizations

Implications

Executive Pay-for-Performance

- Incentive Compensation
  - Compensation Committees and Boards are increasingly active in the goal-setting process
    - More demanding and are **challenging the status quo**
    - Requiring a **greater ROI** on incentive dollars
    - **Rethinking performance metrics** in incentive plans

Implications

Executive Pay-for-Performance

- Incentive Compensation: **Past Practice**

1) Typical goals
- Operating margin
- Revenue growth
- Patient satisfaction (e.g., Press Ganey)
- Employee satisfaction
- Employee turnover/retention
- Quality

2) Metrics are symmetrical, e.g.,
- Goal: Operating margin
- Metrics:
  - Threshold: 1.5%
  - Target (budget): 2.5%
  - Exceptional: 3.5%

3) Limited use of industry benchmarking

4) Alignment of executive pay and performance not always demonstrated

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Implications

Executive Pay-for-Performance

- Mandates for Change
  - Maintaining **status quo is not an option** under health care reform
  - Compensation committees and boards are under **intense pressure** to justify executive pay (in all industries)
  - **Incremental improvement** may not be enough

Public Perception of Executive Pay

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Implications

Executive Pay-for-Performance – Board Governance

1. Are committees **asking enough questions** about the goals and results presented to them for review and approval?
2. Do committees **understand the goals/metrics** presented (i.e., what is being measured and why is it important to the organization)?
3. Do committees **understand the context** of the proposed goal/metric (e.g., how does it compare to industry benchmarks and/or the historical performance of the organization)?
4. Is there **enough 'stretch'** in the proposed goals/metrics/ numbers?
5. Are the results achieved **audited**?
6. Do committees rush through meetings and **simply rubber-stamp** proposed goals/metrics and/or results achieved?

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Emerging Practices

Incentive Compensation Practices and Processes

Emerging Practices

1) **Realign** incentive goals/metrics

- Align with **payors' expectations**
  - CMS value-based purchasing
  - Other payors' metrics (Anthem)
- Quality
  - Measures are changing
  - **More weight** assigned to **quality** than before, as it impacts
    - Reimbursement
    - Organization's reputation (increased transparency via CMS's Hospital Compare)
- Alignment of executive and MD metrics

Emerging Practices

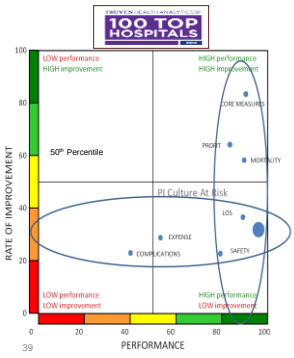
2) Ensure **goals/metrics stretch** the organization/individual

- Moving from symmetrical to asymmetrical measures
  - Metrics:
    - Threshold: 1.5%
    - Target (budget): 2.5%
    - Exceptional: 6.0% ← "Stretch performance"

Emerging Practices

3) Use industry **benchmarks**

- Available sources
  - *Truven Top 100 (Health Analytics)*
  - *Moody's\Standard & Poor's*
  - *University Hospital Consortium (AMCs only)*
- Provide necessary information for Committees to make informed decisions



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Emerging Practices

3) Use industry **benchmarks**

- Allows for alignment of executive pay with performance
- Boards/committees can justify pay
  - *We pay at the 75th percentile for 75th percentile performance*

Pilot Studies

SullivanCotter and Truven are conducing pilot studies with select clients to assist board compensation committees in determining the alignment of our client's compensation strategies, actual executive pay levels, and organizational performance using national and custom peer group performance data.

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Emerging Practices

4) Provide committees with appropriate information to make **informed decisions**

EXAMPLE

OPERATING MARGIN (_____% weight)			
As defined in the financial statement. Net operating income (loss) exclusive of unrestricted gifts, special charges, and investment income reported as non-operating revenue.			
	Threshold	Target	Maximum
Goal	$	$	$
Strategic Plan (if possible)			
2013 Budget: $_____			
2014 Budget: $_____			
2010-2012 Performance			
	Budget		Actual
2010 Actual Performance	$_____		$_____
2011 Actual Performance	$_____		$_____
2012 Actual Performance	$_____		$_____
Benchmark Information on Peers – as Available			

SullivanCotter suggests one page of information per incentive goal/measure

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Emerging Practices

5) Move **away from incremental** improvement

- Incremental improvement vs. benchmarks
  - Goal: Decrease 30-day readmission rates
  - Prior Year's Performance: 24.8%

Performance Metric	Incremental Improvement	Industry Benchmark
Threshold	23.5%	50th Percentile: 20.9%
Target	22.5%	75th Percentile: 20.7%
Exceptional	21.0%	90th Percentile: 20.6%

  - What might have appeared to be a moderately aggressive goal
    - Represents below market performance
    - May take several years of incremental improvement to reach median performance
    - Bar rises every year under Value-Based Purchasing

Emerging Practices

5) Move **away from incremental** improvement

- Value-Based Purchasing (VBP):
  - Every hospital is assessed relative to other hospitals
  - 2013: VBP score of 41 earns 100% of your withholdings (break-even)
- Break even-score increases year after year
  - The bar is constantly rising
  - 2017: Break even-score is 85 (hospitals need to do better than 84% of other hospitals to earn back their withholdings)

Closing Thoughts

Culture of Performance Excellence

Closing Thoughts

American Hospital Association's 2013 Environmental Scan

- **High performing** health systems
  - Have a culture of performance excellence and accountability
  - Focus on continuous improvement
  - Drive towards dramatic improvement or perfection (vs. incremental improvement)
  - Are patient centered
  - Embrace internal and external transparency

The NEW NORMAL
Executive compensation will need to recognize and reward high performing organizations and executives (vs. incremental performance)

Questions & Answers