Trustee Insights

TRANSFORMING GOVERNANCE

# Board Compensation: The Emerging New Normal

## What to make of the increase in boards that compensate their members

BY JAMIE ORLIKOFF

Should board members of not-for-profit, charitable hospitals and health systems be compensated? This debate has raged for the past 30 years, and the question was relevant as the number of health systems and hospitals that compensated their board members remained relatively static. However, a recent dramatic uptrend in board compensation has rendered the question moot.

The most striking results of the recent AHA triennial survey of health care boards relate to the exponential growth in the number of boards that provide cash compensation to their members. The overall percentage of boards (hospitals and systems) that compensate their members more than doubled in 2022 compared to 2018, growing from 13% to 27% (AHA Governance Report 2022, Figure 4.4). By comparison, the growth in compensation from 2014 to 2018 was a modest 3.0 percentage points, from 10% in 2014 to 13% in 2018.

The most explosive growth in compensation was found in system boards, with 56% providing some type of compensation to their members (AHA Governance Report 2022, Figure 4.4). Thirty four percent of system boards reported payment of an annual fee to their members in 2022, an order of magnitude increase from the 3% of systems that did so in 2018 (AHA Governance Report 2022, Figure 4.6). That a majority of system boards have suddenly embraced a practice that is still regarded as controversial is quite significant, and has reframed the debate away from the theoretical "should we compensate" to the more practical issues of "why and how should we compensate?"

### Probable Drivers of Compensation

#### Growing System and Health Care Field Complexity

Governing a system of hospitals is much more complex than governing a stand-alone hospital. The larger the system, the greater the complexity. And most large systems are now comprised of more than just hospitals, including different organizations and businesses such as medical groups, insurance companies, skilled nursing facilities, ambulatory surgery centers and others. Governing such an integrated delivery system is even more complex than governing a multi-hospital system. Added to this is the growing complexity and challenges of the health care field. This is a reason for both the growth

of and rationale for compensation of board members of systems: it is an increasingly complex and demanding job that requires board members with specific and uncommon skill sets.

**Shrinking Talent Pool**

Increasingly, system and hospital boards compete with for-profit corporations for the same limited talent pool of qualified candidates. These candidates are also serving on fewer boards than in the past. The recent concept of "director distraction" rules that restrict individuals from serving on multiple boards emerged from pension funds, activist investor groups and regulators. These groups scrutinize boards of publicly traded companies to assure that their members do not serve on an excessive number of boards, including not-for-profit health care boards, as they cannot do so and be expected to fulfill their fiduciary duties. As recently as 20 years ago, it was common for individuals to serve on eight or more corporate boards simultaneously. With the passage of the Sarbanes Oxley Act in 2002, and the growth of corporate governance best practices and board member accountability, this practice is increasingly monitored and discouraged. Compensation enables not-for-profit health systems to compete more effectively for the recruitment and retention of qualified board candidates who are both in greater demand and who serve on fewer boards.

**Groucho Marx Paradox**

Groucho famously said, "I would never belong to a club that would have me as a member." Increasingly the most desirable potential board members are also likely to be the most difficult to recruit. The growing liability and reputational risk for board members, in addition to a polarized political environment that has penetrated many board rooms, has caused individuals to be much more discerning in assessing and accepting invitations to join both publicly traded corporate boards and boards of not-for-profit health care systems, further constraining the pool of potential board members. Compensation is a variable in the decision calculus of these individuals that can help tip the balance in favor of joining a health system board.

**Increasing Time, Pressure and Other Demands**

As systems and hospitals struggle to achieve post-pandemic sustainability, and as CEO turnover rates remain high, serving on their boards requires a growing amount of time, energy, effort and emotional resilience. Compensation can… well, compensate for that.

**Diversity**

Health care boards are aging faster than the general population (AHA Governance Survey 2022, Figure 3.4). They are not meeting their goals for diverse membership in ethnicity, gender or age. Compensation may not only make it easier to attract and retain the most qualified individuals, but it also may make it easier to attract qualified, diverse candidates who are both in demand and might otherwise not consider joining an unpaid board due to lost income opportunity costs. This is especially true for younger generations facing more challenging economic circumstances than did their predecessors.

**More Accountability**

Compensation makes it easier to develop higher standards of board performance and to hold board members accountable to those standards. It facilitates the development and use of formal board norms and expectations. Equally important, compensation can then facilitate the regular performance evaluation of individual board members against these norms and standards, as well as dispassionate decisions about whether to reappoint each member to additional terms or not. Similarly, compensation can drive the willingness and rigor of a board to remove one of its own members mid-term for cause. It is culturally much easier for a board to "fire" a compensated board member than a volunteer. Compensation is thus a key factor in creating and sustaining a board's move away from a volunteer culture.

**Facilitating Better Governance**

When boards do their job well, they add tremendous value to the hospital or system. Conversely, when governance is suboptimal it contributes to organizational decline and even failure. The uptrend in board compensation is more than simply a tangible way for hospitals and systems to reward board service; it may be an effective and necessary lever to facilitate better governance.

## Compensation Caveats

It is important to note that even though compensating board mem-

bers of not-for-profit, tax-exempt organizations is legal, it is subject to the same federal requirements as compensation provided to executives. Specifically, the Internal Revenue Service Intermediate Sanctions rules require that any compensation provided to board members meet their definition of "reasonable." So, just as with executive compensation, board compensation must be implemented with a structured and documented process that includes appropriate comparison cohorts. Further, as board members will likely vote on their own compensation, and as they are defined by the IRS as "disqualified persons," the rebuttable presumption of reasonableness safe harbor from the IRS would not apply, increasing the importance of a thorough and structured process to determine the appropriateness of adopting board compensation, compensation amounts and eligibility criteria.

Board compensation also removes any protection provided by federal and state statutory immunity from liability. For example, the Federal Volunteer Protection Act of 1997 provides certain limited immunity from liability for board members of not-for-profit, charitable organizations who are "volunteers" defined as receiving less than $500 per year in compensation. Most states have similar statues, but with a much lower threshold of "any" compensation in a given year. If a board member receives compensation above these thresholds, they lose this statutory immunity from liability. And "compensation" does not just mean a monetary payment but includes free or discounted medical services and other considerations. Even though the liability protections of these federal and state laws have significant limitations, their loss should be considered as part of a thoughtful decision to both adopt board compensation and to set the amount of the compensation.

Even with the explosive growth of health care board compensation, there are still many residual concerns about the practice. Common arguments against board compensation include:

- Compensation can call into question board members' duty of loyalty. Are the compensated board members acting in the best interests of the organization or in their own financial interest? Similarly, it can also raise conflict of interest concerns.
- It can blur the distinction between not-for-profit systems and for-profit systems and increase the scrutiny and challenge of tax-exemption for systems and hospitals.
- It may present issues with the media and public perception as it is inconsistent with the long volunteer tradition of not-for-profit hospital board service as a civic duty.

Notwithstanding these caveats and arguments against board compensation, the practice has suddenly become the norm for health systems. It is reasonable to assume that this trend will continue to grow. It is also likely the explosive growth in compensation of not-for-profit health system board members portends more significant changes ahead. It may herald the death of the traditional model of hospital governance.

This model, going back to the days of Ben Franklin, has several implicit components, with voluntary (uncompensated) board members at its very foundation. Other components of the old governance model include: community-based governance (no outside board members); minimal-to-manageable time commitments ("all you have to do is come to the meetings"); lack of standardized or mandatory training ("come to the educational course if you want, or pick another one, or don't bother"); diffuse and variable accountability of both boards and their members ("some board members do the work, some don't"); long tenure and lack of term limits ("Jamie has been on the board for more than 20 years"); and a tolerance for conflicts of interest on the board in service of community relationships. As health care systems evolved directly from hospitals, they naturally adopted this traditional model of governance into initial models of system governance.

But the fact that a majority (56%) of not-for-profit health system boards now compensate their members strongly suggests that this old model is not conducive to the effective governance of modern systems. Further, it is highly likely that compensation for board members who were traditionally expected to serve as volunteers is only the first of many changes to come in the creation of a new, more professionalized model of health care governance.

But, even if the sudden growth in system board compensation does portend the emergence of a new model of governance, it still begs the question: will board compensation stimulate better governance? There is no data to suggest that

board compensation in and of itself will improve the function and outcomes of governance. In fact, some still argue that compensation could paradoxically weaken not-for-profit health system and hospital governance by diverting board member loyalty away from the mission and the fulfillment of fiduciary duty, and toward seeking and maintaining financial reward for serving on the board.

However, it is logical to assume that compensation in exchange for performance accountability can drive more effective system governance. And this may be part of the emerging new model of governance: the routine and robust evaluation of the performance of individual system board members pursuant to the renewal of their terms. In other words, if boards are willing to pay their members, they may also be more willing to both hold them accountable to higher standards of performance and to "fire" them for substandard performance. This implies the further professionalization of the role of governance of the system, and a willingness via board member and leader job descriptions, performance objectives and evaluation, and formal feedback to terminate or not reappoint to additional terms of office for failing to fulfill defined duties.

The issue of not-for-profit health system and hospital compensation of board members is complex, challenging and is still controversial even as it becomes the norm. Many argue that the volunteer board inherently has more integrity, ethics and purity of purpose than the paid board. Increasingly, that view is seen as a quaint vestige of earlier, simpler times, and one that is detrimental to effective governance in today's rapidly changing and radically challenging health care environment. Also, the notion that a board is "pure" simply because it is not compensated has been severely damaged by the many recent high-profile cases of uncompensated boards tolerating lucrative and blatant conflicts of interests among their members.

More important than chasing or hiding behind this mythical advantage is creating consistently effective, focused governance that achieves the mission and long-term success of the system or hospital.

There is only one legitimate rationale for board compensation: enhancing board performance and oversight of organizational success. In today's challenging and chaotic health care environment, board compensation is emerging as a key component of a new model of effective, professionalized governance.

---

**Jamie Orlikoff** (j.orlikoff@att.net) is president of Orlikoff & Associates, a consulting firm specializing in health care governance and leadership. He is the national adviser on governance and leadership to the American Hospital Association. He is the chair of the board of the St. Charles Health System in Bend, Ore.

---

*Please note that the views of authors do not always reflect the views of the AHA.*