Executive Pay and the High Cost of Healthcare

Two recent articles examined hospital executive pay. One was “Bitter Pill: Why Medical Bills Are Killing Us” from Time magazine (1). We reviewed this article in our “March 2013 Critical Care Journal Club” (2). The other is a more recent article from Kaiser Health News (3). The later is particularly intriguing since it discusses healthcare executive compensation. We thought it might be of interest to examine executive compensation from selected nonprofit hospital tax returns from Arizona, New Mexico and Arizona. (Table 1).

Table 1. Financial information from Southwest hospitals latest year tax return as listed by GuideStar (4).

Hospital	Total Revenue	Total Expenses	Net Assets
Banner Health	4,221,287,426	3,925,202,020	2,721,618,423
Centura Health Corporation	186,466,985	176,749,965	94,912,380
Dignity Health	9,211,708,211	8,701,072,466	4,130,566,978
Exempla Inc FKA Lutheran Hospital	661,832,660	625,107,763	404,250,761
Flagstaff Medical Center	354,802,853	318,746,741	315,532,227
John C Lincoln	480,948,959	460,016,947	260,821,971
Mayo Clinic Arizona	938,570,495	867,156,380	532,702,920
Presbyterian Healthcare Services	1,323,374,057	1,266,392,139	609,037,202
Scottsdale Healthcare Hospitals*	1,004,726,248	970,514,461	454,271,625
Tucson Medical Center	422,018,475	409,187,507	143,035,265
University Medical Center Corporation	617,408,880	597,199,795	237,184,294
Verde Valley Medical Center	148,447,732	139,153,687	140,769,987
Yavapai Community Hospital Association	259,495,565	228,699,731	183,936,890

*Includes Scottsdale Healthcare Corporation

These Southwest hospitals appear to be doing quite well. Overall they had combined incomes of $19,831,088,546, assets of $ 10,228,640,923 and profits of $1,145,888,944. None lost money. Although the data from organizations such as Dignity, Banner, Scottsdale Healthcare, Exempla, and Presbyterian Healthcare include several hospitals, they are doing well, especially for “nonprofit” hospitals.

The CEOs were also doing well (Table 2).

Table 2. CEO and executive compensation from Southwest hospitals latest year tax return as listed by GuideStar (4).

Hospital	CEO/President	CEO Compensation	Average Executive Compensation*
Banner Health	Peter S Fine	2,967,079	1,101,719
Centura Health Corporation	Gary Campbell	1,551,409	703,921
Dignity Health	Lloyd A Dean	5,136,883	1,176,435
Exempla Inc FKA Lutheran Hospital	Robert Ladenburger	1,171,455	492,591
Flagstaff Medical Center	William T Bradel	645,690	478,591
John C Lincoln	Rhonda Forsyth	874,062	442,965
Mayo Clinic Arizona	Shirley Weis	1,094,659	541,036
Presbyterian Healthcare Services	James H Hinton	2,125,443	538,755
Scottsdale Healthcare Hospitals**	Thomas J Sadvary	1,154,891	390,042
Tucson Medical Center	Judith Rich	713,466	284,214
University Medical Center Corporation	Gregory Pivirotto	3,493,507	645,370
Verde Valley Medical Center	James Bleicher	516,848	495,934
Yavapai Community Hospital Association	Timothy J Barnett	894,906	399,466

*Includes employees listed on Form 990.
**Includes Scottsdale Healthcare Corporation

The CEOs were paid an average of $1,718,484 and the average executive made $591,618. Not bad for being paid by a “nonprofit” organization. The CEO pay is nearly 8 times and the executive pay is nearly 3 times the slightly over $200,000 average Southwest pulmonary and critical care physician received in 2011 (5).

The Kaiser Healthcare News article went on to point out that boards at nonprofit hospitals are often paying hospital administrators much more for boosting volume than delivering healthcare value (3). Hospital administrators agreed but were quick to point out that compensation is increasingly being determined by healthcare performance incentives. However, James Guthrie, a hospital compensation consultant for Integrated Healthcare Strategies stated about administrative compensation, "What you're seeing is incentive plans that look pretty similar to what they looked like five years ago or ten years ago…they're changing, but they're changing fairly slowly."

Two of the local executives mentioned in the Kaiser Healthcare News article were Lloyd Dean and Peter Fine, heads of Dignity Health and Banner Health respectively. Incentive goals for Dean included unspecified "annual and long-term financial performance” (4). Dean's bonus for 2011 was $2.1 million. Fine speaks of "an unwavering commitment to improve clinical quality and efficiency" but Fine's long-term incentive goals included profits and revenue growth (4).

"Boards of trustees in health care are oriented around top-line, revenue goals," said Dr. Donald Berwick, who was CEO of the Institute of Healthcare Improvement (IHI) and later the Administrator for the Centers for Medicare and Medicaid Services (CMS) (Figure 1).

Figure 1. Dr. Donald Berwick

"They celebrate the CEO when the hospital is full instead of rewarding business models that improve patients' care." Such deals undermine measures in the 2010 health law that aim to cut unnecessary treatment and control costs, say economists and policy authorities (3).

An explosion of medical regulatory groups have arisen to improve quality, including Berwick's IHI. These regulatory groups have often produced guidelines embraced by hospital administrators as improving healthcare. However, the administrators are often self-servingly paid bonuses for guideline compliance. Because nearly all the regulatory organizations are "nonprofit" like the hospitals, surely they would have more modest profits (Table 3).

Table 3. Financial information of healthcare regulatory organizations from latest year tax return as listed by GuideStar (4).

Organization	Total Revenue	Total Expenses	Net Assets
American Board of Internal Medicine	49,304,645	51,037,791	-45,394,162
Institute of Healthcare Improvement	42,591,359	40,450,171	73,139,508
Joint Commission on Accreditation of Healthcare Organizations	138,788,431	122,317,981	95,021,325
National Academy of Sciences (Institute of Medicine)	359,039,858	345,428,611	440,265,540
Phoenix Pulmonary & Critical Care Research & Education Foundation	4,000	2,936	26,046

We are happy to report that the regulatory organizations had much more humble finances compared to the Southwest hospitals. Overall the four we examined totaled incomes of $589,724,293, assets of $563,032,211 and profits of $30,489,739. Only the American Board of Internal Medicine lost money with a loss of $-1,733,146 on income of nearly $50 million. For comparison, we added the Phoenix Pulmonary and Critical Care Research and Education Foundation to Table 3. It is the financial source behind the Southwest Journal of Pulmonary and Critical Care.

Executive pay was also more modest than Southwest hospital administrators (Table 4).

Table 4. CEO and executive compensation from healthcare regulatory organizations latest year tax return as listed by GuideStar (4).

Organization	CEO/President	CEO Compensation	Average Executive Compensation*
American Board of Internal Medicine	Christine Cassel	786,751	344,406
Institute of Healthcare Improvement	Maureen Bisogano	979,333	271,228
Joint Commission on Accreditation of Healthcare Organizations	Mark Chassin	989,190	446,357
National Academy of Sciences (Institute of Medicine)	Harvey Feinberg	788,477	466,044
Phoenix Pulmonary & Critical Care Res & Ed Foundation	Richard A Robbins	0	0

*Includes employees listed on Form 990.

The CEOs were paid an average of $885,938 and the average executive made $382,009. Although much lower than the average $1,718,484 and the $591,618 paid to Southwest hospital CEO and executives, these salaries are still not bad for a “nonprofit” organization.

The only regulatory organization to lose money was the American Board of Internal Medicine. Either an increase or revenue or a decrease in expenses will eventually be necessary. The major source of income for the American Board is test revenue and increasing the fee for certification or the frequency and/or fees for maintenance of certification may be necessary. Alternatively, they could pay their CEO less than $786,751, eliminate the CEO’s spousal travel benefits, or lower the compensation for general internists such as Eric Holmboe from $417,945 to be more in line with the $161,000 average income of general internists in the mid-Atlantic region (4,5).

Donald Berwick has a good point and is correct. Hospital administrators need to be rewarded more for improving healthcare and less for keeping the hospital full and profits high. However, in 2009 while CEO at IHI Berwick was compensated $920,952 (4). This is almost 7 times the compensation of the average pediatrician in New England (5). Included were $88,200 in bonuses. It is unclear from the tax return what justified these bonuses (4).

Executive pay for both hospital and regulatory administrators is too high and contributes to the high cost of healthcare. We find no evidence that either type of administrator contributes much to improved patient-centered outcomes. Quality care continues to rely on an adequate number of good doctors, nurses and other healthcare providers. If anyone should be paid bonuses for healthcare, it is those providing care, not administrators.

Present bonus systems for healthcare administrators are perverse. As noted above these include bonuses for keeping the hospital full and profits high, neither consistent with what should be the goals of a nonprofit organization. Furthermore, increasing pay for supervising an increased number of administrative personnel will only add to the increasing costs. If administrators

must be paid a bonus let them be paid for performance directly under their control. This could include ensuring that adequate numbers of good doctors and nurses are caring for the patients and improving administrative efficiency. These should result in better care but lower numbers of administrators consuming fewer healthcare dollars.

Last Friday, June 14, the Medicare Payment Advisory Commission, or MedPAC released their recommendations to Congress (8). These include recommendations that may be relative to hospital administrative pay. One is for "site-neutral payment". Currently Medicare pays hospitals more than private physician offices for many services. MedPAC recommended that Congress "move immediately to cut payments to hospitals for many services that can be provided at much lower cost in doctors' offices." The commission said that "current payment disparities had created incentives for hospitals to buy physician practices, driving up costs..." This will increase the hospital's bottom line, and therefore, the administrators' bonuses. We agree with MedPAC's recommendation.

MedPAC also told Congress that "the financial penalties that Medicare imposes on hospitals with high rates of patient readmissions are too harsh for hospitals serving the poor and should be changed." Based on this and data that higher mortality is associated with lower readmission rates, we agree (9). Rewarding hospitals for potentially harmful patient practices that increase the hospital's bottom line are not appropriate. Financial incentives for reducing readmissions should only be part of a more global assessment of patient outcomes including mortality, length of stay and morbidity. Regulatory administrators need to become more focused on patients and less on an endless array of surrogate markers that have little to do with quality of care.

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*The opinions expressed are those of the authors and not necessarily the Southwest Journal of Pulmonary and Critical Care or the Arizona, New Mexico or Colorado Thoracic Societies.