Trustee Insights

INTERVIEW

A Taxonomy of Health Care Boards

Jamie Orlikoff, national adviser on governance to the AHA, helps demystify the types of boards and their differences

BY SUE ELLEN WAGNER

There are many types of boards in health care and each type of board varies in how it is structured and how it functions. Sue Ellen Wagner, vice president of trustee engagement and strategy at the American Hospital Association, talks with Jamie Orlikoff, president of Orlikoff & Associates, Inc. and national adviser on governance and leadership to the AHA, to gain a better understanding of the taxonomy of health care boards.

Sue Ellen Wagner: *Can you describe the different types of health care boards and how each is structured?*

Jamie Orlikoff: Certainly. First, it is important to remember that the origin of boards tracked directly with the origin of corporations. Prior to the concept of the corporation there really wasn't the need for the concept of a legal board. The reason that's worth knowing is because different types of corporations have different types of boards.

There are three broadly different types of health care delivery corporations, and so each has a different type of board. Each of these three types of board have different legal requirements that determine or influence their structure, how they are composed and how the board operates.

What are those three models?

- There is the for-profit company.
- There is the not-for-profit charitable company, which is what most hospitals and health systems are. That is a 501(c)(3) corporation under the Internal Revenue Service code.
- There are governmental entities which are public, state, county, district or authority types of organizations.

Each of those entities has a distinctly different type of board:

- **For-profit Board.** For-profit companies can either be privately owned or publicly owned. If it is privately owned, the board is typically composed of the owners of the corporation or several individuals who the owners select. If the company is publicly owned, it is a publicly traded company and

then the boards are elected by the shareholders of the company. In this model of "one share, one vote," if an institutional investor owns a significant amount of stock, they then get a disproportionate amount of say in which individuals are elected to serve on the board. Board members of these companies will be listed in the public disclosure documents required by the Securities Exchange Commission, or SEC, and they'll have to comport with all the government regulations about how publicly traded companies must function. That includes the Sarbanes-Oxley regulations, which were passed after notable corporate governance failures, SEC regulations and the laws of the state in which the corporation is legally incorporated.

• **Not-for-profit boards.** The most common type of health care delivery corporation is the private, not-for-profit, tax-exempt organization. This is what is known as the 501(c)(3) organization under IRS code. The reason that these corporations are tax exempt is because they provide a service to society. To qualify for and maintain that tax-exempt status, their boards are subject to IRS rules and requirements, as well as those of states and other regulators.

Society, in the form of the IRS, regards the services provided by these types of hospitals and health systems as so important that they're worthy of certain tax exemptions to help them provide the service. So, they are charitable entities, and the IRS then has significant influence over how these boards are composed and how they operate.

These boards can appoint their own members, but under the IRS regulations, at least 51% of the members of a not-for-profit charitable board must meet the IRS definition of independence. This means that these board members must be independent of direct economic relationships with the organization and not have direct family members who work for the organization. This is one way that the IRS tries to ensure that the board is loyal to the charitable mission of the organization. So, a very important distinction between the public boards and the private, not-for-profit boards is that the missions of the organizations are different. The mission of a publicly traded corporation is to return economic value to their shareholders, and that is the primary fiduciary focus of that board. On the other hand, the mission of a not-for-profit, 501(c)(3), charitable hospital or system is to provide a benefit by providing health care services to the community to help improve the health of the community. The board of a 501(c)(3) organization must be primarily focused on the fulfillment of the charitable mission, not on generating profit for its own sake.

A hospital or health system can be either of these two types of corporations and that is a very important distinction which is reflected in very different governance requirements and structures. Now, in these two types of organizations (publicly traded and private not-for-profit) we see two very different structures and methods of board composition. In publicly traded, for-profit corporations, board members are elected and removed by shareholders of the company. In private, not-for-profit 501(c)(3) companies, the members of the board tend to be self-selected by the other board members. This becomes one of the key functions of a 501(c)(3) company board: the board selects its own members and can also remove them for cause. This is a key defining structural characteristic and crucial function of an effective private, not-for-profit board. The reason I mention that is because it brings us into the third category of boards.

• **Governmental Entity Boards.** These are boards of hospitals or health care organizations that are owned by a state, county, district, or, in the case of the Veterans Administration, owned by the federal government. For example, the U.S. Congress is legally the board of directors for the Veterans Administration hospitals. That aside, there are state hospitals, county hospitals, district authority hospitals, and each of these boards are either elected by the members of the district or the county in a direct election process; or, more often, they are appointed by the county commissioners or by the governor or by another elected governmental body. These boards are unique for a variety of reasons. First, they cannot select the members of the board. Second, they cannot remove their own members. You can have a board member who is breaking every rule that the board has, and the board can do nothing about it because only the electing or appointing authority can remove a board member. The other challenge facing a public entity board is it must meet the state's open meeting law requirements. These meetings must largely be held open to the press and the public, and there are very few times when these boards may

go into executive session. It may be permitted when they're dealing with a personnel issue or a medical malpractice issue. The rules vary by state, and that makes the governance of that type of organization much more challenging. Another unique governance characteristic of these types of boards is that the size of the board is quite small, usually around five or six members, and rarely more than nine members.

Broadly speaking, a hospital may be any one of these three types of entities: a not-for-profit, charitable organization; a for-profit organization; or a public entity. Each type of organization will have a very different governance model in terms of mission focus, accountability, board composition methods, board size, open meeting requirements and other structures and functions.

Wagner: *Can you discuss the composition of the different boards that you previously mentioned in a bit more detail?*

Orlikoff: Certainly. A unique characteristic of public or governmental entity boards is their size tends to be much smaller than their not-for-profit cousins. Many of these boards have four or five board members and they rarely go above nine members. Their average size tends to be around six, and that typically is required by legislation, so they don't have the ability to say, "oh, we need a larger board," or "the board should be smaller," unless the state law, often called the enabling legislation, is changed. Another common composition requirement of governmental entity boards is board members must live within the borders of the district, county or state. That means it is not possible for these boards to recruit a single outside board member, which is a recognized governance best practice.

Publicly traded boards also tend to be smaller than boards of not-for-profit organizations. Their size has increased recently because of changing corporate accountability standards, but they tend to be in the range of nine to 11 members. Again, publicly traded company boards are elected by the shareholders of the company, and so the nominations and election process are highly regulated and orchestrated and are very public. These types of organizations also tend to have greater executive participation in governance than boards of not-for-profit or governmental organizations. For example, it used to be a standard practice for publicly traded company boards to have the company CEO also serve as the chair of the board, although this is much less common today due to Sarbanes-Oxley legislation and the standards of activist shareholder organizations.

On the other hand, the board of a not-for-profit, charitable 501(c)(3) organization can be whatever size it wishes, if it meets the state legal requirements for a minimum size, usually three members. AHA research has shown over the last 30 years that the size of not-for-profit hospital and health system boards has been consistently declining. For example, in the 1980s, the average size of a not-for-profit hospital board was well over 25, and today the average size is around 13. So, a typical not-for-profit board will have around 13 members, a typical publicly traded elected-by-the-shareholder board will be around nine members and the typical public entity board will be around six members.

This brings us to a very interesting aspect of governance, which is unique to the health care world. In the publicly traded world, you have very large multinational, corporations that are governed by a single board. But in the private, not-for-profit health care space it is very common to have multiple boards, especially in health care systems.

Any time there is more than one board within an organization or system, even just two, there is the concept of subsidiarity, which means that one board is the parent board and the other is subsidiary, or subordinate, to the parent board and reports to that board.

In any system where there's more than one board, one of the jobs of the parent or the system board is to oversee and coordinate all the boards that are subsidiary and that report to it. That is one of the unique governance characteristics of not-for-profit health systems: multiple boards and boards reporting to other boards. As we think about the governance taxonomy of these types of not-for-profit systems with multiple boards, there are basically four models of governance which apply

The first one is called organizational specific governance, and that's where every separate organization in the system will have its own board. So, let's say a health system has four hospitals and a medical group. There will be six different boards, one board for each

organization and then the parent or system board. Now the problem with that model is if the system grows, the number of boards will also grow. When you start getting to be a health care system with 10 hospitals and several medical groups, not to mention an insurance company, a nursing home and a durable medical equipment company, you start having systems which may have more than 20 or 30 boards! That can be unwieldy at best and dysfunctional at worst. When systems start to encounter that unique phenomenon, they typically will go through governance restructuring efforts to try to redesign their model of governance, reducing the number of boards to make it more manageable and less unwieldy at a minimum, and to increase governance effectiveness as a nobler goal.

The next model of governance is called the regional model of governance. That's where very large systems that cover a state or multiple states will frequently divide their system into regions and have a different board govern each of the different regions. So, you might have 20 or 30 hospitals and multiple medical groups in addition to other entities, yet this system might only have, say, four boards, one for each region, plus a parent board.

The third and far less common model is what is called the functional model of governance. In this model, governance is organized around the functions that naturally aggregate and lend themselves to being governed by a single board. For example, in this model you could have one board govern all the hospitals in the system and one board govern all the medical groups in the system. It theoretically wouldn't matter how many hospitals are in the system — you could just have one board that governs all of them. So, in the functional model the subsidiary boards are few, and then of course there is the parent board.

That brings us to the fourth model, which combines all the three previous models. In this model, every organization has its own board, and the organizations are divided into regions. Each region has a board which oversees all the boards in that region. There are a few organizations that provide functions to the whole system, like insurance, which have their own boards; and then, of course, there is a parent board — the head of the octopus. This is the least effective and most cumbersome structural model of system governance.

The other interesting and unique thing that's being introduced in several of these models is the concept of layers of governance; where boards report to other boards. In some systems, there might be three or four layers of governance where one board reports to another board, which in turn reports to another board, which then reports to the parent or system board. Understanding this taxonomy gets to the more important aspect of the question: What's the difference in what these boards do? And, how can governance function most effectively?

No matter the model of governance, if there is more than one board, then clear distinction of roles and responsibilities between boards is absolutely crucial for effective governance of the health system or organization. This is also crucial as it is unique to health care, meaning it is very rare to have multiple boards in other types of large, for-profit corporations. While many of the board members of hospitals and health systems have experience in the corporate governance world, they rarely have any experience in a multiple-governance organizational model. So, clarity in the number, role and function of these multiple boards is critical, as is the rationale for the particular model of governance (organizational, regional, functional or combined) for effective governance function.

Finally, because of the uniqueness of the multiple-board model in health care, it must be understood that all boards can have fiduciary duty, not just the parent board. Many board members with non-health care corporate governance experience tend to believe that if a board does not have certain authorities (like CEO oversight, audit and budget) then it is not a "real" board. But that is not true! A subsidiary board in a system that governs a hospital has crucial fiduciary duties in the areas of safety and quality, medical staff credentialing, community health assessment and regulatory compliance. This board still has critical duties, responsibilities and liabilities even though it has no responsibility to hire and fire a CEO, or for audit or for budget. While unique to health care and outside the experience of many board members, this is a crucial concept of effective governance of health systems with

multiple boards.

Now there is one more "board" that we need to discuss in our taxonomy: the advisory board. This is an oxymoron and I strongly recommend that groups do not use that term. If a group is a legal board that means that it has some legal authority and fiduciary duty. An entity that is advisory may at most make recommendations but has no authority, and in my view, should not be referred to as a board.

Call it an advisory committee, or an advisory council, or an advisory group, but whatever you call it, please do not call it an advisory board. Why? Because language matters and it is common that the members of "advisory boards" will start acting as though they are on a real board and will try to make decisions and try to assert authority which they do not have. And this can create all types of problems for the health system.

So, in this taxonomy of governance, it is important to distinguish subsidiary boards from "advisory boards." Someone who is a member of a subsidiary or subordinate board has real authority, fiduciary duty and very important governance responsibilities, as well as potential liability. But someone who is a member of an "advisory board" belongs to a group that has none of these authorities, fiduciary duties, responsibilities or potential liabilities. This is a very important distinction, and one of the reasons I am opposed to the use of the term "advisory board."

There is an old saying that especially applies to governance of systems and hospitals: Where there is mystery, there is no mastery. Hence the critical importance in understanding the taxonomy of boards in creating a foundation for governance mastery.

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