

Assessing the State of Healthcare: Connecting Today's Priorities to Tomorrow's Promise

February 2013



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Assessing the State of Healthcare: Connecting Today's Priorities to Tomorrow's Promise

Continuing change in the nonprofit healthcare sector—led by mounting pressure on reimbursements—will force small and mid-sized healthcare organizations to adopt more flexible endowment management practices.

Introduction

Nonprofit healthcare organizations are confronting an unprecedented series of challenges as they strive to maintain positive operating margins in the face of declining reimbursement from insurance companies and governmental payers. The crisis is particularly acute at smaller and mid-sized organizations. Having played a major role in their communities for decades, they are finding that the healthcare business model is changing. Medical practice models are being upended as many doctors are closing their independent clinical practices and becoming hospital employees in response to decreasing reimbursement levels and ever-greater demands for capital investment, and in pursuit of a more manageable professional lifestyle. In hospitals and clinics, the old-style model of brick-and-mortar buildings located in major urban centers is being challenged by new delivery systems such as suburban mall-style “big box” shell structures with flexible wards that can easily be changed in response to the advent of new equipment and practices, free from the strictures of plaster walls and concrete slabs.

Although these challenges are being accelerated and intensified by the regulatory and payment changes mandated by the Patient Protection and Affordable Care Act, they are not new. In fact, healthcare organizations have worked for years to cut costs and maximize operating efficiencies. Larger organizations and networks, with substantial endowments to support their operations, have been better prepared financially to adapt to the more stringent demands of the coming environment

and have been more successful in reducing costs and tightening their organizational structure. Small and mid-sized healthcare providers, however, lack the economies of scale necessary to achieve meaningful cost reduction. For these, the way forward may include merging or affiliating with other organizations to form more competitive networks. With or without these operational steps, it will be essential that small and mid-sized healthcare organizations strengthen their resource base by improving their endowment management skills and strengthening their ability to attract gifts and donations.

This paper will argue that healthcare organizations must consider adopting the endowment management model that has been developed over the last three decades by educational institutions and increasingly copied by other types of nonprofits. The fact that it will take healthcare organizations several years to implement these changes and begin to reap their benefits makes this task all the more urgent. Along the way, leaders of healthcare organizations will need to consider the following questions:

- What is the role of the endowment in our healthcare organization?
- How do actual and potential donors evaluate our skill in managing our present endowment?
- How can we make the case for larger endowments – and contributions – at a time of fiscal uncertainty?

The Healthcare Business Model and the Margin Squeeze

Nonprofit healthcare organizations commonly operate with razor thin margins, or even at a deficit. Every day they provide crucial services to patients and the larger community, for which they incur substantial operating costs. To offset this expense, they seek to obtain revenue from three major sources.

First comes reimbursement from federal, state, and local governments. These amounts are, by far, the largest income source for healthcare providers. The second source is income from private insurers and self-pay patients. Finally, and at a considerably lower level for most healthcare organizations, comes support from donations or via transfers from any endowment that the organization may have.

The excess, if any, of the first two categories of revenue over costs is the operating margin. An analysis of operating margins in the healthcare industry shows how thin the line is that divides surplus from loss. The 2012 Commonfund Benchmarks Study® *Healthcare Report*—a nationwide survey of 86 nonprofit healthcare organizations—reported a median operating margin in FY2011 of 4.1 percent. This figure was unchanged from FY2010 and just 0.1 percent lower than FY2009's 4.2 percent, but much higher than the 2.9 percent reported in FY2008, which seems to have marked the low point from which healthcare organizations have been able to recover somewhat. These recently-expanded margins are indicative of an increased dynamic of cost-cutting that appears set to continue across the industry over the next several years. Large healthcare organizations have made the greatest progress with this cost-containment process, but smaller organizations are catching up, as their FY2011 margins increased to 4.0 percent, up strongly from 2.3 percent in FY2010.

Large institutions were able to take an early lead in widening their operating margins not because reimbursement increased, but because they realized that they would have to reduce operating expenses and took steps to change their cost structures to capture greater economies of scale. Following their lead, smaller healthcare organizations have taken what actions they could to lift their previously low—or even negative—operating margins.

Median Operating Margin for Fiscal Years 2006-2011

Fiscal Year	Numbers in Percent (%)		Investable Assets		
	Total Organizations	Over \$1 Billion	\$501 Million-\$1 Billion	\$251-\$500 Million	Under \$251 Million
	86	32	25	15	14
2006	3.6	4.2	2.9	3.4	3.7
2007	3.6	4.2	4.1	3.0	2.9
2008	2.9	3.2	3.0	3.3	2.6
2009	4.2	4.1	4.3	4.8	2.3
2010	4.1	4.4	4.4	3.4	2.3
2011	4.1	4.9	3.8	3.6	4.0

Source: Commonfund Benchmarks Study of Healthcare Organizations

Constraints Faced by Healthcare Endowments

The world of healthcare organizations is thus increasingly being shaped by pressures affecting both the revenue and expense sides of the income statement. On the revenue side, these pressures take the form of tighter standards for government and insurance reimbursement. On the expense side, healthcare organizations have already carried out cost-cutting steps but it is clear that the larger organizations, with their ability to spread cost reductions over a wider patient and constituent user base and to weather reimbursement reductions, are the first movers and will reap greater benefit than the smaller and mid-sized organizations with their proportionately higher fixed cost base. In this environment, the conclusion seems inescapable that there will be greater reliance by these organizations on the third revenue source, endowment, to enhance surpluses and make up for losses.

Enhancing returns from endowment will, however, not be a simple task. Healthcare organizations continue to face constraints in optimizing the return from their endowments. This is because their facilities – both inpatient and outpatient and related medical equipment – have a relatively short lifespan, as advances in healthcare treatment and technology accelerate their obsolescence and mandate renovation or rebuilding on a regular basis.

As institutional nonprofits, most health systems make use of bond issues to fund brick-and-mortar construction projects and improvements. A successful bond offering depends in large part on the ability of the bonds to earn a high rating from the bond rating agencies, which look not only to the ability of the healthcare provider to generate cash flow but also to the liquidity of its endowment's financial assets as a potential backstop source of repayment. Indeed, liquidity measures have come to form a key metric in determining bond ratings.

Bond Ratings* for Fiscal Year 2011

	<i>Numbers in Percent (%)</i>			
	<i>Total Organizations</i>	<i>Investable Assets</i>		
		<i>Over \$1 Billion</i>	<i>\$501 Million-\$1 Billion</i>	<i>Under \$251 Million</i>
	86	32	25	14
Highest or high grade	45	69	56	7
Upper medium grade	36	25	36	29
Medium grade	6	0	0	21
Not rated	11	3	8	36
No answer/uncertain	2	3	0	7

*Moody's, S&P and Fitch ratings were used to determine investment grade.
Source: 2012 Commonfund Benchmarks Study of Healthcare Organizations

For this reason, the asset allocations of healthcare endowments have tended, on average, to be more heavily weighted toward cash and fixed income investments than those of other types of nonprofits. The following table compares healthcare organizations' dollar-weighted asset allocations to those of foundations and operating charities as of December 31, 2011, as reported in Commonfund Benchmarks Studies for the relevant sector (direct comparison with educational institutions is not possible due to their June 30 fiscal year end):

Asset Allocations* for Fiscal Year 2011

<i>Asset Class/Strategy</i>	<i>Numbers in percent (%)</i>		
	<i>Healthcare</i>	<i>Foundations</i>	<i>Operating Charities</i>
	86	179	68
Domestic equities	20	24	25
Fixed income	36	13	22
International equities	15	12	16
Alternative strategies	21	43	28
Short-term securities/cash	8	8	9

*Dollar-weighted

Source: 2012 Commonfund Benchmarks Studies of Healthcare Organizations, Foundations and Operating Charities

As the table shows, the major differences among the three types of endowment lie in the allocations to fixed income investments and alternative strategies. Healthcare organizations and foundations are at opposite ends of the spectrum with respect to these allocations, while operating charities (cultural, religious and social service organizations) occupy the middle ground. The liquidity required by rating agencies accounts for a good measure of healthcare organizations' high allocation to fixed income securities and their correspondingly low allocation to the relatively illiquid group of alternative strategies.

Yet this preference comes at a cost. It has long been accepted by investment professionals that asset allocation decisions account for the vast majority of the variation in an investor's portfolio returns. The original, and still authoritative, studies on the subject¹ found that 91.5 percent of the variation in returns could be explained by asset allocation policy choices as opposed to other types of activity such as security selection or market timing.

As a consequence of their bias away from the traditional equity orientation favored by other types of nonprofits, healthcare endowments have generally returned less per year than other nonprofits – a heavy burden to bear, and one which has left them worse off compared to their foundation and operating charity peers. Given the other stresses that the healthcare sector is experiencing, this practice seems increasingly to resemble a luxury that will eventually become unsustainable as other sources of revenue for healthcare organizations continue to diminish. The following table shows how, over the last eight years, a hypothetical \$100 million investable asset pool would have performed, based on average returns from the Commonfund Benchmarks Studies. Over this period, absent spending, a foundation or operating charity would have added over \$7 million more to its endowment than the average healthcare organization.

1 Brinson, Hood and Beebower, "Determinants of Portfolio Performance". Financial Analysts Journal, July/August 1986, pp. 39-44 and Brinson, Singer and Beebower, "Determinants of Portfolio Performance II: An Update". Financial Analysts Journal, May/June 1991, pp. 40-48.

Average Annual Total Net Returns

Numbers in percent (%) and dollars (\$) in millions

Fiscal Year	Foundations	\$100mm Example	Operating Charities	\$100mm Example	Healthcare	\$100mm Example
		\$100.0		\$100.0		\$100.0
2004	11.3	111.3	12.0	112.0	8.2	108.2
2005	7.9	120.1	8.9	122.0	6.3	115.0
2006	13.7	136.5	13.0	137.8	10.6	127.2
2007	9.9	150.1	10.1	151.7	8.0	137.4
2008	-26.0	111.0	-25.8	112.6	-21.2	108.3
2009	20.9	134.3	21.5	136.8	18.8	128.6
2010	12.5	151.0	11.6	152.7	10.9	142.6
2011	-0.9	\$149.7	-1.8	\$149.9	0.0	\$142.6

Source: 2012 Commonfund Benchmarks Studies of Foundations, Operating Charities and Healthcare Organizations

The Dangers of Indebtedness

Nor are these low endowment returns a theoretical matter only, as they provide in many cases a key source of funds for debt repayment. Debt plays a major role on healthcare organizations' balance sheets, and healthcare organizations have until very recently assumed greater debt each year. Data from the 2012 Commonfund Benchmarks Study Healthcare Report show that for five consecutive years, from FY2005-FY2010, participating healthcare organizations reported a higher average debt level each year. Overall, debt rose to an average of just over \$1 billion in FY2010 from \$395 million in FY2005. Only in FY2011 did the direction finally reverse, with average debt declining to \$763 million – still nearly double the level of FY2005.

Average Total Debt for Fiscal Years 2004-2011

Dollars (\$) in millions

Fiscal Year	Total Organizations	Over \$1 Billion	\$501 Million-\$1 Billion	\$251-\$500 Million	Under \$251 Million
2004	413	1,463	371	205	95
2005	395	1,096	371	219	101
2006	509	1,397	371	240	106
2007	580	1,432	384	251	151
2008	681	2,206	480	316	171
2009	903	2,625	466	319	187
2010	1,011	2,118	447	313	130
2011	763	1,391	494	308	137

Source: Commonfund Benchmarks Study of Healthcare Organizations

Rebalancing the Relationship

Rating agencies, bondholders and healthcare organizations have a common interest in seeing that the sector is able not only to survive the coming period of stress and transition but to thrive beyond it. To that end, a renegotiation of the strictures on asset allocation and liquidity will be necessary.

One important reason for rethinking high fixed income allocations is that, in a crisis, bonds provide poor protection against portfolio loss. This statement seems contrary to finance textbook theory, but its truth was demonstrated in the crucible of the 2008-09 financial market crisis. In FY2008, healthcare organizations reported net investment returns of -21.2 percent while foundations reported returns of -26.0 percent and operating charities reported a nearly-identical result of -25.8 percent. Healthcare organizations thus lost some 460-480 basis points less than the other two types of nonprofits, but it is impossible to say that this represented any kind of triumph of investing, particularly given the consistent and compounded underperformance of the cash- and bond-laden portfolios of the healthcare organizations during the years prior to the downturn. Furthermore, in the recovery period of FY2009-FY2010, healthcare organizations have continued to underperform. Even assuming no spending from these endowments, healthcare organizations have recovered a smaller percentage of their FY2007 endowment than either of the other two types of nonprofits.

Effect of Fiscal Year 2009-2011 Returns on Foundations, Operating Charities and Healthcare Organizations

Numbers in percent (%) and dollars (\$) in millions

Fiscal Year	Foundations	\$100mm Example	Operating Charities	\$100mm Example	Healthcare	\$100mm Example
		\$100.0		\$100.0		\$100.0
2009	20.9	120.9	21.5	121.5	18.8	118.8
2010	12.5	136.0	11.6	135.6	10.9	131.7
2011	-0.9	\$134.8	-1.8	133.2	0.0	\$131.7

Source: 2012 Commonfund Benchmarks Studies of Foundations, Operating Charities and Healthcare Organizations

The second reason that a readjustment of asset allocations will be required is that, in the current interest rate environment, a portfolio of medium- to long-duration fixed-rate bonds—whether U.S. Treasuries or corporate credits—is extremely vulnerable to changes in the yield curve. Should 10-year interest rates rise even modestly, from the current level of below 2 percent to 4 percent or so, the adverse effect on the value of healthcare organizations' large bond portfolios would be severe.

It can thus be seen that the asset allocation choices forced on the healthcare sector by the bond rating agencies are not only failing to provide the protections to bondholders that are presumably intended, they have also failed to enable the organizations themselves to benefit fully from the market recovery.²

The Donor Dynamic

These factors have not gone unnoticed by donors. As we have noted elsewhere³, the profile of the typical contemporary donor is that of a self-made, capable businessperson who is able to assess the relative wealth-generation and wealth-preservation capabilities of the nonprofits to which he or she contributes. Organizations that have demonstrated an ability to maintain the real value of their endowment while fulfilling mission goals are more likely to receive endowed gifts; those that have not will receive gifts for current use or none at all. These donors, whether or not they are investment professionals, may also inquire why their college or university endowment has a low allocation to fixed income while the local healthcare organization has allocated nearly 40 percent of its portfolio to the asset class, and may compare the relative long-term investment results of each type of institution when considering where to bestow an endowed gift.

² The absence of high levels of portfolio liquidity has not prevented colleges and universities from making use of the debt market, even in today's constrained credit environment. See, e.g., Ch. 4, "Debt", in 2011 NACUBO-Commonfund Study of Endowments, pp. 23-29.

³ Griswold and Jarvis, "Essential Not Optional: A Strategic Approach to Fund-raising for Endowments", Commonfund Institute, 2012.

Conclusion

It is in the interest of healthcare organizations, rating agencies, and donors that healthcare endowments evolve toward becoming more like those of other long-term nonprofit institutions. The nature of many alternative investments, with their limited partnership structures, and the imperative to diversify among strategies and vintage years, means that this will be a slow process, perhaps taking as much as a decade. But, particularly for small and mid-sized healthcare organizations that lack the ability to spread costs over a wider patient base, a greater degree of reliance on endowment income appears inevitable, and there is little time to lose.

The Endowment Model

The term “endowment model” refers to a set of principles guiding the management of perpetual (or very long-term) institutional pools of capital. The endowment model originated in the 1990s at colleges and universities and subsequently expanded to other endowed institutions. In investment terms, it combines the use of a highly diversified portfolio of uncorrelated assets with a willingness to accept illiquidity in exchange for higher long-term return.

The first characteristic of the endowment model is a structural bias toward equities. This bias is based on the economic reality that equity ownership of assets is the best way to benefit from the fundamental economic growth that is the source of long-term real (i.e., net of inflation) investment returns. Debt securities, in contrast, pay only a current return for the use of financial capital. Equity ownership should therefore offer higher real returns than lending over the long term, albeit at the cost of higher volatility of returns and the (usually remote) possibility of permanent loss.

The second characteristic of the endowment model is a perpetual time horizon that, in principle, is longer than that of any other type of investor. This positions the endowment to take maximum advantage of the time value of invested capital. Because the future is uncertain, the longer an investor is willing to commit capital, the greater should be the return expected in order to compensate for the risk of volatility

and loss. Investors with a perpetual horizon are less likely to be driven by, or forced to react to, relatively short-term market gyrations.

A corollary to the perpetual time horizon of these investors is their ability to exploit market inefficiencies in sectors of the capital markets such as private capital, natural resources and hedge funds that suffer from a scarcity of capital owing to their illiquid nature and long-term uncertainty. It is in these sectors that risk can often be mispriced. The risk premium to be earned from supplying “patient capital” to such less efficient sectors can be significant.

The third principle is that a high degree of portfolio diversification is essential. Some investment risk is systemic to the market and cannot be diversified away, but non-systemic risks can be lowered by diversification. Long-term investors diversify away as much of this type of risk as possible, while also seeking strategies that protect against or hedge other fundamental risks, notably inflation and deflation.

Taken as a whole, the endowment model has historically produced higher returns with lower volatility than investment strategies based on liquid, public market securities. Institutions pursuing such a model, however, must find resources to conduct due diligence and monitoring of managers, both before and after they are hired. Internal staff are frequently viewed as too expensive, so most committees supplement their staff with a consultant or use an outsourced chief investment officer structure.



About the Author

William F. Jarvis

William F. Jarvis is Managing Director of Commonfund Institute, responsible for the Institute's research, written analysis and client publications. A financial services executive and attorney, Bill has worked with J.P. Morgan, where he spent 13 years as an investment banker in New York and Tokyo; Greenwich Associates, where he advised leading investment management firms and led the fielding of the first Commonfund Benchmarks Study; and Davis Polk & Wardwell, where he provided legal advice to global banks and securities firms. Prior to joining Commonfund in 2006, Bill served as Chief Operating Officer of a privately-held hedge fund manager based in New York City. Bill holds a B.A. in English Literature from Yale University, a J.D. from the Northwestern University School of Law, and an M.B.A. from the J.L. Kellogg Graduate School of Management.

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