# Assessing the State of Healthcare

A Commonfund Whitepaper

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## About the Author

William F. Jarvis, Executive Director, Commonfund Institute, leads Commonfund's educational, research and professional development activities. Bill is the managing editor of Commonfund Institute's series of proprietary studies of nonprofit investment and governance practices and the author or co-author of numerous white papers and articles. He speaks at Commonfund's annual Endowment Institute and Commonfund Forum as well as at other nonprofit and industry conferences. A financial services executive and attorney, Bill served as Commonfund Institute's Head of Research from 2006-2015. His career prior to joining Commonfund included working 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. He also 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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Commonfund Institute houses the education and research activities of Commonfund and provides the entire community of long-term investors with investment information and professional development programs. Commonfund Institute is dedicated to the advancement of investment knowledge and the promotion of best practices in financial management. It provides a wide variety of resources, including conferences, seminars and roundtables on topics such as endowments and treasury management; proprietary and third-party research such as the NACUBO–Commonfund Study of Endowments; publications including the Higher Education Price Index (HEPI); and events such as the annual Commonfund Forum and Commonfund Endowment Institute.

# Assessing the State of Healthcare

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.

## Introduction

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 (ACA), they are not new and, we believe, will continue despite any repeal or replacement of the ACA. 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 2014–2015 Commonfund Benchmarks Study® of Healthcare Organizations[1]—a nationwide survey of 73 nonprofit healthcare organizations—reported a median operating margin in FY2015 of 3.7 percent. This compares with a median operating margin of 4.3 percent reported in the Study for FY2013 and 4.1 percent reported for FY2012. Although lower than other recent years, FY2015's 3.7 percent median operating margin is a significant improvement over 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; although smaller organizations have made progress, they still lag. For example, in the Study for FY2008, the largest organizations had a median operating margin of 3.2 percent versus 2.9 percent for the smallest participants. For the FY2015 Study, the largest organizations reported median operating margin of 3.7 percent versus 3.2 percent for the smallest respondents.

1 The Commonfund Benchmarks Study of Healthcare Organizations was published on a annual basis from 2003-2013 with a skip in 2012. The series was resumed in 2016 addressing fiscal years 2014 and 2015. This study is referred to hereafter as "Study."

Large institutions were able to take an early lead in widening their operating margins not because reimbursement levels 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.

## 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, liquid-

ity measures have come to form a key metric in determining bond ratings.

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 community foundations and educational endowments, as reported in the most recent Commonfund studies[2] for the relevant sector. (Note that data from healthcare organizations and community foundations are as of December 31, 2015, while data from educational endowments are as of June 30, 2015. Educational institutions' fiscal year typically runs from July 1 to June 30 of the following year.)

### COMPARISON OF HEALTHCARE ORGANIZATIONS' DOLLAR-WEIGHTED ASSET ALLOCATIONS

Numbers in percent

| Asset Class/ Strategy | Healthcare Organizations | Educational Endowments | Community Foundations |
|---|---|---|---|
| Domestic equities | 19 | 16 | 33 |
| Fixed income | 28 | 9 | 16 |
| International equities | 19 | 19 | 22 |
| Alternative strategies | 29 | 52 | 25 |
| Short-term securities/cash | 5 | 4 | 4 |

Source: CCSF, NACUBO, Commonfund Institute

As the table shows, there are major differences in asset allocations among the three organizational types, particularly in fixed income and alternative strategies. Healthcare organizations have the largest allocation to fixed income—more than three times that of educational endowments and 75 percent larger than that of community foundations. Community foundations have the largest allocation to traditional domestic equities—more than double that of educational endowments and more than half again as large as that of healthcare organizations. Community foundations also show the smallest allocation to alternative strategies.

Indeed, it could be said that, notwithstanding their different allocations to domestic equity and fixed income, healthcare organizations and community foundations seem to take a similar approach to portfolio liquidity.

Healthcare organizations' focus on maintaining their bond ratings, and the attendant balance sheet liquidity required by the rating agencies, will likely keep their allocations to fixed income securities comparatively high in the future. Nevertheless, the trend over the past several years among healthcare organizations has been to increase allocations to alternative strategies.

To that extent, it appears that healthcare organizations are being influenced by the "endowment model", characterized by the pursuit of total return through a high degree of asset class diversification, the acceptance of lower portfolio liquidity in pursuit of both diversification and higher returns, and the adoption of a perpetual investment horizon, which forms the basis of asset allocation policies for educational institutions and foundations.

Nevertheless, healthcare organizations' greater emphasis on balance sheet liquidity 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 subject[3] 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 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 educational endowment and foundation 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.

2 Educational endowment data are from the NACUBO-Commonfund Study of Endowments (NCSE) while foundation data are based on the Council on Foundations-Commonfund Study of Foundations (CCSF).

3 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.

The following table shows how, over the last 10 years, a hypothetical $100 million investable asset pool would have performed, based on average healthcare, private and community foundation net investment returns as reported in the relevant Commonfund Benchmarks and CCSF studies.[4] Over this period, absent spending, a typical community foundation would have added over $68 million to its endowment and a private foundation would have grown its endowment by more than $71 million. A healthcare organization, on the other hand, would have added an average of just over $59 million to its endowment, lagging the private foundation by nearly $12.5 million over the 10-year period.

## The Dangers of Indebtedness

Nor are these lower 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 Study shows 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. Debt levels were not included in the most recent Study; instead, average debt-to-capitalization ratios were reported. In this case, the average 2015 debt-to-capitalization ratio for all participating institutions was 26.5 percent, and ranged up to 30.2 percent for Institutions with assets over $1 billion.

## 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

**10-YEAR COMPARATIVE RETURNS (HYPOTHETICAL)**

| | Private Foundations | | Community Foundations | | Healthcare Organizations | |
|---|---|---|---|---|---|---|
| **2005** | $100,000,000 | | $100,000,000 | | $100,000,000 | |
| **2006** | 113,700,000 | 13.7% | 113,600,000 | 13.6% | 110,600,000 | 10.6% |
| **2007** | 125,411,100 | 10.3% | 123,596,800 | 8.8% | 119,448,000 | 8.0% |
| **2008** | 92,929,625 | -25.9% | 90,843,648 | -26.5% | 94,125,0 24 | -21.2% |
| **2009** | 111,980,198 | 20.5% | 110,920,094 | 22.1% | 111,820,528 | 18.8% |
| **2010** | 125,977,723 | 12.5% | 124,785,105 | 12.5% | 124,008,966 | 10.9% |
| **2011** | 125,095,878 | -0.7% | 126,532,097 | 1.4% | 124,008,966 | 0.0% |
| **2012** | 140,107,384 | 12.0% | 141,969,013 | 12.2% | 137,401,934 | 10.8% |
| **2013** | 161,964,136 | 15.6% | 163,548,303 | 15.2% | 155,126,784 | 12.9% |
| **2014** | 171,843,948 | 6.1% | 171,398,621 | 4.8% | 161,952,362 | 4.4% |
| **2015** | 171,843,948 | 0.0% | 168,313,446 | -1.8% | 159,361,124 | -1.6% |

Source: Commonfund Institute

4 Returns for these organizations, which have a December 31 fiscal year, are not comparable with those of educational institutions, which have a June 30 fiscal year.

returns of -21.2 percent while foundations reported returns of -26.0 percent and educational endowments reported returns averaging -18.7 percent for their 2009 fiscal year.[5] Healthcare organizations thus lost some 480 basis points less than foundations, 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 continued to underperform. As of December 31, 2015, healthcare organizations' returns lagged those of community foundations, albeit moderately, for the trailing three- and five-year periods. For the trailing 10-year period, healthcare organizations' average annual returns lag those of community foundations by 50 basis points annually—which, compounded over the years, adds up to a significant difference.

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, slightly over 2 percent, and exceed 4 percent or more—something that could happen if the Trump administration issues new Treasury debt to invest in infrastructure—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.[6]

## The Donor Dynamic

These factors have not gone unnoticed by donors. As we have noted elsewhere[7], 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 30 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.

## 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.

5 As we have noted, healthcare organizations and foundations operate on a December 31 fiscal year, while educational institutions' fiscal year ends on June 30 of the following year. A survey sample of educational institutions for the period July 1, 2008 to December 31, 2008—the height of the financial crisis—showed returns of -24.1 percent.

6 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 2015 NACUBO-Commonfund Study of Endowments, pp. 33-38.

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

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