HEALTHCARE INVESTMENT PORTFOLIOS GOVERNANCE AND STAFFING

NEPC Healthcare Team

Introduction

Healthcare's juggling act has become a risky one. Keeping the operations, finance and investment "balls" aloft just got harder. Now, healthcare is charged with juggling balls of fire where only the adept and the careful will avoid getting burnt. It is not enough that healthcare is dealing with a shifting operating environment and constrained access to capital. Healthcare now contends with increasingly complex investment portfolios and higher reporting hurdles.

Until recently, healthcare's overall mission rarely integrated investment strategy and risk, despite the large investment assets. This nonintegrated approach was not problematic, investments were rarely scrutinized by bond holders or even rating agencies. These investment portfolios are no longer a passing notation in a healthcare's strategy. Traditional healthcare revenue models are under greater pressure, increasing the importance of investments. Consequently, these investment pools have a growing role in healthcare's ability to support and extend its mission. Unfortunately, the investment complexity and risk make appropriate oversight even more critical.

To help our clients address these key issues, NEPC conducted a survey of healthcare investment professionals. The goals were to understand healthcare investment portfolios' governance structure, staffing models, resources and complexity. While responses varied, two themes emerged: dissatisfaction with current staffing and the need for more investment expertise.

A Changing World

For years, many healthcare institutions have gravitated to the endowment and foundation investment model. It made perfect sense. In many cases, healthcare assets dwarfed almost all but the largest endowments or foundations. Historically, healthcare CFOs, Treasurers and committees largely believed their assets would never be tapped and a substantial cushion over debt covenants was standard. Therefore, adopting a more complex, illiquid structure was not problematic and, in fact, often produced superior returns at lower risk.

HEALTHCARE INSTITUTIONS REPORTED A DESIRE FOR GREATER INTERNAL AND EXTERNAL INVESTMENT EXPERTISE.

The events of 2008 and 2009 changed all of that. It challenged the wisdom of accepted capital structures and forced awareness of implicit liquidity events. It tested the assumption of asset "surplus" and the ability to take on greater and greater levels of illiquidity. Suddenly access to capital was the number one priority, and the inability to take realized losses for fear of violating bond covenants was a very real concern for many.

The result was the realization that healthcare deserves its own investment "model." Yes, most systems can tolerate some illiquidity and yes, portfolio complexity can be beneficial. With these factors, however, comes a greater need for expertise. More resources are needed and

investment acumen is valued. In other words, healthcare is challenging the investment portfolio's oversight.

Appropriate portfolio oversight is being discussed in board meetings, among committee members and at conferences – all, for good reason. It seems that everyone is looking for that "magic bullet" to figure out the optimal governance and staffing solution.

So how should a CFO determine the right investment governance and staffing? The answer – and there is one – begins by assessing the enterprise's risk tolerance. This enterprise risk should capture the changes in the operating, finance and investment landscapes. The staffing and governance decision should then be made within the context of an enterprise risk assessment. While this paper is not designed to address enterprise risk, it is an integral component in understanding the desired portfolio complexity and the optimal oversight structure for your institution.

The balance of this paper reports the results of the survey. The key areas of focus are:

Respondent Profile

KEY TOPICS

Portfolio Complexity

Current Staffing Models and Intended Changes

Resources and Support for Investment Portfolio

Committee and Staff Governance Structures

The survey included almost 50 healthcare institutions representing more than $75 billion in assets and a variety of different investment pools. Exhibit 1 illustrates the percentage of responses according to size.

The investment pools include operating assets, retirement plans, self insurance, foundation, and construction pools. To illustrate the complexity and scope of healthcare investments, 85% of the

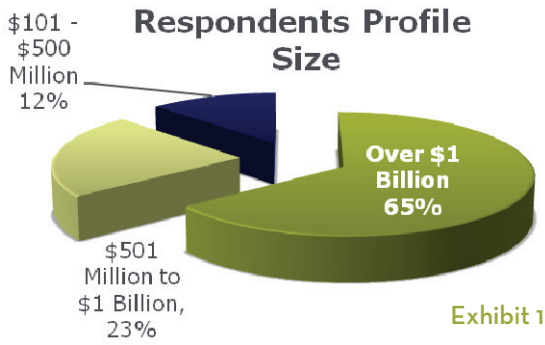


Exhibit 1

respondents reported three or more investment pools. Almost 30% of the respondents had four or more investment pools. Notably 90% of the respondents had operating assets and 86% had defined benefit pension plans. Foundation and Self Insurance pools were also represented as they were found with 77% and 71% of the organizations that replied to the survey, respectively.

Exhibit 2 shows the types of investment portfolios.

As NEPC analyzed the data, it became clear that the data should be assessed not only in aggregate but according to size *and* the presence of an internal Chief Investment Officer ("CIO"). This resulted in three categories:

- Assets *with less* than $1 billion and no CIO 33% of observations;
- Assets *with more* than $1 billion and no CIO 54% of observations; and
- Assets with an internal CIO[1] 13% of observations.

[1]Only one respondent with an internal CIO has assets of less than $1 billion.

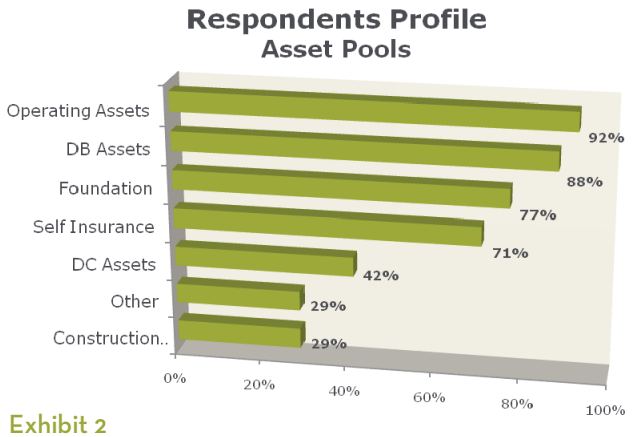


Exhibit 2

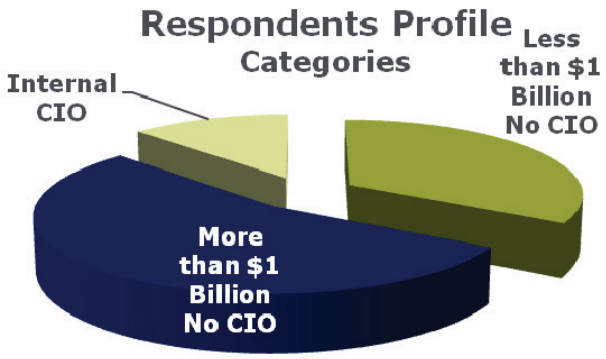


Exhibit 3

Throughout this analysis we will compare across these three categories and within each category. Given the small sample size of respondents with internal CIOs, broad conclusions regarding this category are limited. One interesting observation about this group, however, is that four of the six respondents with internal CIOs added that position within the last two years, suggesting an important trend.

The survey questions (a copy of the survey is in the Appendix) and responses can be grouped into four broad areas:

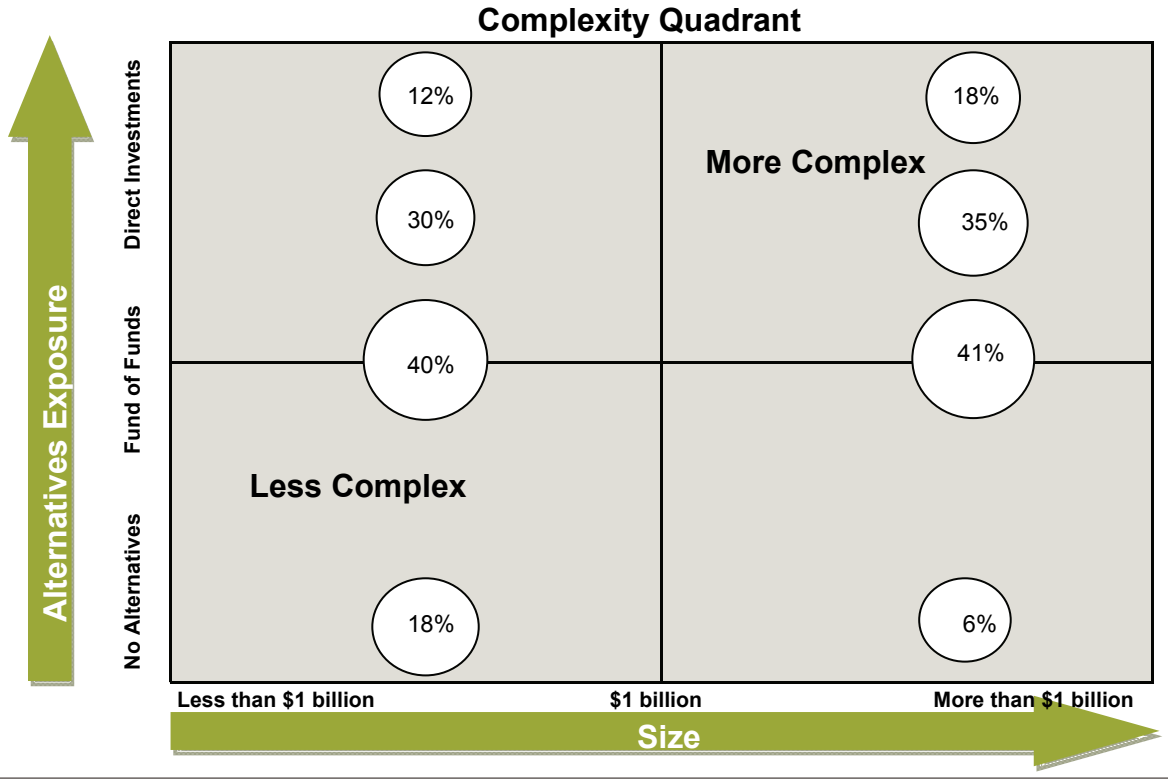
- Investment Pool Complexity,
- Staffing and Proposed Changes,
- Resources and Support, and
- Governance.

Complexity

Too often, investors equate size with complexity. While they often go hand in hand, they do not need to do so. Staffing structure should not depend simply upon the amount of assets. Large pools of assets invested in traditional investment managers and fund of fund structures for alternatives require modest investment expertise on the part of staff and governance structure. Large pools with little traditional manager exposure and significant direct investment in alternatives require greater staff and governance investment expertise. While this intuitively makes sense, we reviewed the responses to see what factors might contribute to staff size, resources, committee governance etc. As we suspected, the two most dominant factors in determining structure were size *coupled* with direct alternatives[2] investment programs.

Having said this, size did NOT necessarily determine complexity. Exhibit 3 depicts the interplay of those two elements. We have plotted the respondents by size and investment in alternatives. The number within the circle is the percentage of health systems at that level.

[2]Alternatives includes all non-traditional investments (e.g., hedge funds, private equity, real estate, real assets, etc.)



Of the three systems that were less than $1 billion and contained no alternatives, two indicated they are seeking to add them to the portfolio. Of the two systems greater than $1 billion with no alternatives, one system is prohibited from investing in alternatives by law.

Clearly alternatives, in one form or another, have a place in healthcare investment pools. Surprisingly, the decision to invest in alternatives via a fund of funds or direct investing is **not** size related. All three investment pool sizes had at least one respondent with no alternatives or with direct investing.

While this is the current investment structure, planned changes and additional comments from survey respondents indicate that several plans are considering moving to a direct program requiring greater oversight. In fact, all respondents with internal CIOs reported some form of direct investment program.

Staffing and Proposed Changes

NEPC asked which professionals are involved with the investment portfolio. The goal is to understand differences in staffing as it relates to size and complexity.

As shown in Table 1, the number of Treasurers involved in the investment portfolios without CIOs was high. The CFOs involvement is the most notable difference between plans under a billion versus over a billion. In pools with more than one billion in assets, the number of plans reporting involvement by the CFO is significantly less.

The respondents with internal CIOs reported the most noteworthy change in senior management's involvement with the investment pool. The CFO still retained some involvement but the Treasurer's involvement dropped sharply. This change can be at least partially attributed to the reporting structure of the organization. The CIO most often reported directly to either the CFO or the board. This suggests the CIO role is considered a peer of the Treasurer's role, explaining the drop in Treasurer's involvement where a CIO is present.

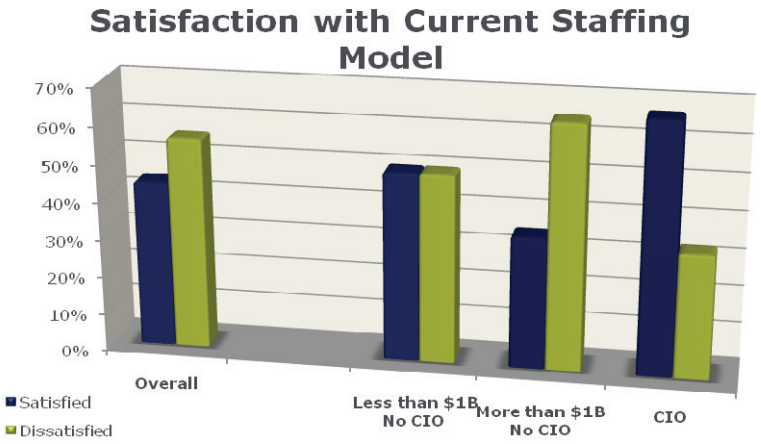


Exhibit 4

A significant number of respondents expressed dissatisfaction with their current staffing model. In particular, respondents with greater than $1 billion with no CIO expressed the highest level of **dissatisfaction** at 65%. Interestingly enough, healthcare with CIOs reported a high degree of **satisfaction** at 67%.

Current Staffing						
	CFO	Treasurer	CIO	Portfolio Manager	Analyst	Other
Overall	65%	81%	13%	19%	56%	35%
Less than $1B – No CIO	88%	81%	0%	6%	31%	38%
More than $1B – No CIO	58%	96%	0%	23%	77%	31%
CIO	33%	17%	100%	33%	33%	50%

Table 1

Planned Action by those Dissatisfied with Staffing				
	Expand Staff	Use Consultant More	Outsource	Hire CIO
Overall	81%	19%	15%	7%
Less than $1B – No CIO	88%	25%	25%	13%
More than $1B – No CIO	76%	18%	12%	6%
CIO	100%	0%	0%	0%

Numbers do not sum as multiple responses were permitted.

Table 2

We asked those respondents reporting dissatisfaction to provide information on planned changes (the details are in Table 2). Of the respondents with greater than $1 billion with no CIO, 88% reported the goal of adding staff, however only 6% intended to hire a CIO. In addition, this group did not indicate significant planned outsourcing or consultant use.

While the respondents with less than $1 billion and no CIO reported less dissatisfaction than their larger counterparts, they planned to take more action. A greater number reported the intention to expand staff. In addition, this group was looking for external support – either by utilizing their consultant more or outsourcing some functions. In addition, 13% reported plans to hire an internal CIO.

For those organizations with internal CIOs that reported dissatisfaction, the only identified future change action was to expand the current staff.

Resources and Support

The respondents of this survey control very large investment portfolios with the median assets exceeding a billion dollars. In order to execute a successful investment program, we believe hiring the right people and providing the right tools go hand in hand. Therefore, NEPC requested information on investment support beyond internal staffing.

The survey indicated that traditional consultant roles are used relatively consistently regardless of plan size or internal staffing. An emerging role for consultants is that of an outsourced CIO (either for one pool or the entire investment program). Overall, 17% of respondents use their consultant in an outsourced CIO capacity. This result did not vary by plan size or the presence of an internal CIO.

Consultant Use – Strategy			
	Asset Allocation	Policy	Outsourced CIO
Overall	98%	98%	17%
Less than $1B – No CIO	100%	100%	19%
More than $1B – No CIO	100%	100%	15%
CIO	83%	83%	17%

Table 3

Consultant Use – Portfolio Construction				
	Manager Selection	Performance Reporting	Direct Investment Programs	Custodian Selection
Overall	98%	94%	75%	46%
Less than $1B – No CIO	100%	100%	69%	63%
More than $1B – No CIO	96%	88%	77%	38%
CIO	100%	100%	83%	33%

Table 4

Portfolio construction services are used across plan regardless of size. Manager Selection and Performance Reporting also are utilized regardless of category. Surprisingly, a significant number of respondents reported using consultants for their direct investment program, even in programs in which there was an internal CIO.

NEPC surveyed the amount of analytical tools available. Respondents reported a surprising lack of direct technological resources. Of the most common analytical tools and risk systems used to evaluate or manage assets of this size, only three are used. With the exception of one system, the only analytical tool reported is Bloomberg and only 23% of the respondents reported having this resource.

Presumably, technical support for staff is provided by the investment consultant. This may be an area of investment to consider as it is unlikely that any of the investment staff can utilize their consultant's analytical tools directly. As such, staff must rely upon the consultant's analysis or conclusions to assess the portfolio. There was no indication, however, that respondents intended to increase their technology support in the near future.

Governance

During the last few years, one important change is in committee structure and decision making. Investment committees have been formed and the members' qualifications have changed. Whereas it was common to comprise a committee with only board members, it is now more common to have outside experts at the table. Seventy-one respondents indicated they have intentionally added committee members with investment expertise. There was not a significant differentiation by size of plan (see Table 5).

Committee Structure and Outcomes	
	Added Committee Members
Overall	71%
Less than $1B – No CIO	75%
More than $1B – No CIO	69%
CIO	67%

Table 5

Just how big are these committees with the new experts? The number of committee members was surprisingly similar regardless of respondent type.

Committee Size				
	0-4	5-9	10-15	Too Many
Overall	8%	67%	25%	0%
Less than $1B – No CIO	6%	69%	25%	0%
More than $1B – No CIO	12%	65%	23%	0%
CIO	0%	67%	33%	0%

Table 6

While the committee size didn't vary significantly, there were a significantly greater number of experts on the committees with internal CIOs. A good portion, if not the majority, of committee members are experts in those systems with internal CIOs. This may indicate that the roles of these committees vary.

Number of Experts on Committee				
	0-4	5-9	10-15	Too Many
Overall	58%	33%	6%	2%
Less than $1B – No CIO	69%	31%	0%	
More than $1B – No CIO	62%	27%	8%	4%
CIO	17%	67%	17%	0%

Table 7

The addition of investment experts begs the question "Have the investment outcomes changed?" Of course, this is a difficult question to answer empirically since it is impossible to compare the portfolio with experts and without experts in identical conditions. Nevertheless, NEPC solicited *opinions* regarding decision processes and perceived outcomes.

The respondent indicated the investment decisions are the same or better than before experts were added. No respondent indicated the decision quality had declined. Also, 86% of the respondents said the amount of time for a decision either stayed the same or declined. Only 14% reported the amount of time required for a decision is higher.

Ultimately, the respondents did not report a decline in decision quality and there may have been an improvement.

While the decisions may be vetted better, did the investments actually improve? Half of the respondents reported felt their investment returns were probably higher with experts added. For healthcare less than a billion, 60% felt the return was probably the same as before the experts were added. Despite the split vote on investment returns, respondents overwhelmingly thought the addition of experts decreased the portfolio's risk.

Ultimately, the addition of the experts to the committees causes NEPC to ask the question "who has the decision making authority?"

Committee Structure and Outcomes with Experts Added					
	Same Decisions	Better Decision	Shorter Time	Same Time	More Time
Overall	29%	69%	29%	54%	14%
Less than $1B – No CIO	17%	83%	33%	42%	25%
More than $1B – No CIO	39%	61%	28%	61%	11%
CIO[5]	25%	75%	25%	75%	0%

Table 8

Committee Structure and Outcomes with Experts Added				
	Same Returns	Higher Returns	Lower Risk	Same Risk
Overall	49%	49%	71%	26%
Less than $1B – No CIO	58%	42%	83%	17%
More than $1B – No CIO	44%	56%	72%	28%
CIO	50%	50%	50%	50%

Table 9

[5]The return and risk information reported by the plans with CIOs are from a very small sample set and are more of an example than a representation of the entire universe.

Staff Decision Making Authority				
	Asset Allocation	Manager Selection	Policy	Direct Investing
Overall	4%	19%	2%	19%
Less than $1B – No CIO	13%	19%	6%	13%
More than $1B – No CIO	0%	12%	0%	15%
CIO	0%	50%	0%	50%

Table 10

Table 10 reveals some interesting results. For example, staff for assets less than $1 billion and no CIO had more decision making authority than the other categories. Not surprisingly, half of the organizations with internal CIOs had the authority to approve manager decisions and execute direct investing.

Conclusion

The survey reveals a shifting approach to investment portfolio execution and staffing for healthcare institutions. Ultimately, it is important to consider the components necessary to create a successful investment portfolio. The following questions should be considered when thinking about investment portfolio oversight:

- How much overall risk can your organization assume (considering operational environment and access to capital) and how much of that risk can be allocated to the investment program?
- What is the allowable level of investment portfolio complexity given the risk allocation and asset size?
- Based upon this complexity level, what internal or external support is needed to be successful?
- Does this model fit with the organization's culture and view of the investment portfolio?

These are not easy questions. As healthcare is facing its most challenging environment in years, investment oversight will be critical to supporting and growing its mission.

NEPC believes understanding the shifting healthcare world is critical to constructing a successful investment portfolio for our healthcare clients. Adapting to their changing investment needs is just one component to that support. Assisting our clients as they determine the risks they can assume and the governance needed to navigate the risks safely is another. We believe that a staffing framework which incorporates investment portfolio risk *with* operating and financial structure risk is necessary. Taking this holistic approach, CFOs will make better decisions about investment portfolio staffing and governance, ultimately providing better solutions for their institution.

NEPC, LLC is the largest independent investment consulting firms in the industry, servicing 285 retainer clients with over $350 billion in assets. NEPC has been consulting to Healthcare clients since the firm's inception over 24 years ago. NEPC currently consults to 28 healthcare related institutions, representing $27 billion in assets.

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Appendix

Staffing Investments For Healthcare Institutions

NEPC is writing a paper on staffing investments for healthcare institutions. We have surveyed foundation and endowments and would like to gather information from you regarding your staffing.
We know, we know. You are thinking – *"Not another survey!!!!"*

Please don't panic. It is easy and we will give you Starbucks gift card. I know, how cool is that? All you have to do is answer a few easy questions about staffing. We will then send you the passport to the caffeine that you know you want.

As a bonus, you will receive an advance copy of the paper which analyzes optimal Healthcare staffing structures. Okay. It's not as good as Starbucks but you really need this for your job.

Welcome to the Survey!

Please answer the following questions by Wednesday, June 30th and you are on your way to an alert and happy morning. Press the button below to begin the survey.

STAFFING INVESTMENTS FOR HEALTHCARE INSTITUTIONS

Contact Information

Please enter the information below before answering the survey.

*First Name:

*Last Name:

*Email Address:

Submit

Staffing Investments For Healthcare Institutions

0% Complete
Thank you for verifying the below information.

First Name:
Last Name:
Email Address:

1. Please estimate your total investment pool (include operating, pension, and foundation) as of June 30, 2009.

- ☐ Over $1 Billion
- ☐ $501 Million - $1 Billion
- ☐ $101 - $500 Million
- ☐ $51 - $100 Million
- ☐ $50 Million or less

2. Please check all the plans that you are including in that asset pool:

- ☐ Operating Assets
- ☐ Defined Benefit Pension Assets
- ☐ Defined Contribution Pension Assets
- ☐ Self Insurance
- ☐ Construction Pools
- ☐ Foundation
- ☐ Other

3. Please provide the number of full-time equivalent (FTE) employees for each category dedicated to investments (fraction of a FTE is permitted).

CFO	
Treasurer	
Chief Investment Officer	
Portfolio Manager	
Analyst	
Researcher	
Other Investment Professional	

4. Are you satisfied with your current staffing model?

- ☐ Yes
- ☐ No

5. Do you have alternatives in your portfolio?

- ☐ Yes
- ☐ No

6. If you have a Chief Investment Officer, to whom does he* report?

- ☐ Chief Executive Officer
- ☐ Chief Financial Officer
- ☐ Treasurer
- ☐ Other

7. Please list the systems to which you subscribe for investment support.

	Yes	No
BARRA	☐	☐
Bloomberg	☐	☐
eVestment	☐	☐
Factset	☐	☐
MeasureRisk	☐	☐
PerTrac	☐	☐
Riskmetrics	☐	☐
Venture Economics	☐	☐
Yield Book	☐	☐
Other	☐	☐

8. Please indicate the categories in which you use a consultant.

	Yes	No
Asset allocation/rebalancing	☐	☐
Manager selection	☐	☐
Policy review	☐	☐
Performance attribution and measurement	☐	☐
Direct investment programs	☐	☐
Outsourced CIO services	☐	☐
Socially Responsible Investing (SRI) review	☐	☐
Custodian	☐	☐
Other	☐	☐

9. How many people sit on your investment committee?

- ☐ Too many
- ☐ 16 - 20
- ☐ 10 - 15
- ☐ 5 - 9
- ☐ 0 - 5

10. How many of your investment committee members have meaningful investment experience?

- ☐ Too many
- ☐ 16-20
- ☐ 10-15
- ☐ 5-9
- ☐ 0-5

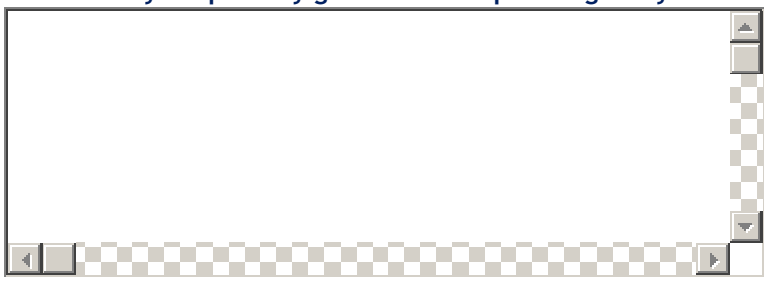
11. Were members added for expertise? If members were added for expertise, what has been the outcome? (Please select one answer in each category).

- ☐ Yes (Please answer the questions below regarding the outcome)
- ☐ Members were not added

12. Who has ultimate decision making authority for the following:

	Board	Finance Committee	Investment Committee	Staff	Outsourced Fiduciary
Asset Allocation	☐	☐	☐	☐	☐
Manager Selection	☐	☐	☐	☐	☐
Policy Review	☐	☐	☐	☐	☐
Performance	☐	☐	☐	☐	☐
Direct Investments	☐	☐	☐	☐	☐

13. What are your primary goals for the upcoming 1-2 years?



14. Please make any final comments in the box below.

Thank you for your time. We know how busy you are and we appreciate the information.

Sincerely,

The NEPC Healthcare Team

**For purposes of simplicity, male pronouns (he and him) are used throughout this document to denote the person in that position. If the person in that position is a woman, we will give you credit for 1.7 FTE since we all know that women can multi-task.*

NEPC would like to thank the following firms for their participation and insights in our study

Adventist Health Care
Alexian Brothers Health System
Allina Health System
American Hospital Association
Ascension Health
BJC Health System
Banner Health
Baptist Health Care Corporation
Baylor Health Care System
Bon Secours Health System, Inc.
Boston Medical Center
Catholic Health East
Catholic Healthcare Partners
Catholic Healthcare West
Christiana Care Health System
Cleveland Clinic
Community Health Network, Inc. & Affiliates
Fairview Health Services
HealthPartners, Inc.
Hoag Memorial Hospital Presbyterian
Lakeview Health System
Lifetime Healthcare Companies
MaineGeneral Health
Memorial Healthcare System
Methodist Health System
Montefiore Medical Center
Moses Cone Health System
North Memorial Health Care
North Shore - LIJ Health System
Northwestern Memorial HealthCare
NorthShore University HealthSystem
Norton Healthcare
OhioHealth Corporation
Partners Healthcare
Premier Health Partners
Presbyterian Healthcare Services
ProMedica Health System
Regions Hospitals
Rochester General Health System
Rush University Medical Center
Scripps Health
Sisters of Charity Levenworth Health System
St. Joseph Health System
The Reading Hospital and Medical Center
Tri Health - Bethesda Services
Trinity Health
University Hospitals Health System
William Beaumont Hospitals