4sight Health Roundup Podcast
Where Hospitals Should Be Investing Your Money
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[Intro & outdo music by C. Ezra Lange]

David Burda:
Welcome to the 4sight Health Roundup Podcast. 4sight Health's podcast series for healthcare revolutionaries. Outcomes matter, customers count, and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, July 23rd. Last week, I told you I went on a GLP-1 drug for the first time to lose weight to treat my sleep apnea. This week today is National Vanilla Ice Cream Day. So this is how it's gonna be. Last week, I invested $686 for my first four doses of Zepbound. Today, will I invest at $6.86 for a half gallon of premium vanilla ice cream at my local grocery store? Which one gives me the best return for my money? How hospitals invest their money is the topic of today's show, featuring Dave Johnson, founder and CEO, 4sight Health, and Julie Johnson:, partner of Transformation Capital. Hi, Dave. Hi, Julie. How you two doing this morning, Dave?

David W. Johnson:
I’m going from good to great, man. <Laugh>

Burda:
Excellent. You're moving the needle. Thanks. Julie, how are you?

Julie Murchinson:
Wow, I'm not going from good to great, but <laugh> I'm pretty good. You know, it's been a good summer week. Yeah. Can't complain.

Burda:

Yeah. You're, you're progressing to greatness. That, that's good. Yes, let's put it that way.

Murchinson:

That's good.

Burda:

All right. Before we talk about hospital investment portfolios, let's talk more about ice cream. One of my favorite topics besides pizza. Dave, do you have a favorite flavor or brand?

Johnson:

Salted caramel vanilla ice cream is a hands down favorite for me. Any place that has it, that's what I'm getting.

Burda:

That sounds good. Kinda like your payday bars, right? You got a thing.

Johnson:

<Laugh> Exactly.

Burda:

Yeah, thanks. Julie, how about you? Do you have a favorite ice cream flavor or brand?

Murchinson:

Yeah. So for me, it's not really a brand thing, Dave, even though I do appreciate, like, a really good creamy local Lopez Island, but…. I go one of three ways depending upon the season and just I think how hot it is. Yeah. Either coffee and time of day. Coffee, chocolate, or mint chip.

Johnson:

My God, th- this is like a Michelin rating approach to ice cream. <Laugh> Yeah. Yeah. Impressive.

Murchinson:

Ice cream, serious business.

Burda:

Yeah. Very sophisticated. Well, I'd do just about anything for a good pint of butter pecan from Oberweis Dairy here in Wheaton. <Laugh> And I'm not sure any GLP-1 has power over good butter pecan. So we'll see. This will be a real test. And we'll see how hospital investment portfolios did this year when we closed the books on 2026 and head into 2027. But for now, we'll have to rely on a new study in health affairs by two researchers from the University of Chicago. They crunched 24 years worth of tax returns from 2,666 not - for-profit hospitals. And here's what they found. Their investment portfolios rose 56.6% from $189 billion in 2010 to $296 billion in 2023. Of that 296 billion, two-thirds were in publicly traded securities, and one-third was in other alternative securities like private equity, hedge funds, and venture capital. The average investment management fee paid per hospital rose 86.3% from $300,000 in 2010 to $559,000 in 2023. And there were dramatic swings in return during the study period from a low of minus 16 in 2010 to a high of 113 in 2023. All of that led the researchers to ask four questions. One, should tax-exempt hospitals be permitted to invest so aggressively in high risk alternative assets? Two, should there be limits on the proportion of assets allocated to alternative investments? Three, should investment income be taxed? And four, should hospitals be called upon to prove that the income from their investments supports their charitable mission? Dave, you're a reformed investment banker and a critic of hospital tax exemptions. How would you answer any of those questions? You picked the question.

Johnson:

Well, not surprisingly think since I think all nonprofit hospitals and health systems should pay all taxes. I'll take number three. Should investment income be taxed? , You won't be surprised my answer is an overwhelming yes, but let's, let's, let's take a journey to get there. Yeah. , the right way to frame this question is to delineate the different operating profiles of nonprofit and for - profit health systems. And the easiest way to do this is to think of non-profit health systems as cash accumulators and for - profit health systems as cash deployers, accumulators versus deployers. , So how does this prove itself out? All you have to really do is look at the, the credit metrics. So cash to debt, the ratio of how much cash an organization has to how much debt it carries in nonprofit land is 100 to 250%. Ascension carries two and a half times, its debt balance in investments. , Common spirit not as strong a credit is at 85%. , A typical for - profit is not 100 to 250%, it's one to 5%. , HCA is extreme. It is 0.2%. So basically two cents of investment coverage, for every dollar of debt. , Very extreme difference. Days cash on hand, in the nonprofit world, the typical days cash on hand is 150 to 250 days of operations. So literally, not a penny comes in that could cover 150 to 250 days of operating costs. In the for - profit world, it's five to 15 days. Debt service coverage three times to 10 times. That's the ratio of cashflow to annual debt, payments, interest and principle. , In for - profit, one and a half to two and a half times. And debt to cashflow, sort of that same pattern. Nonprofits it's two to four times less debt to its cashflow. And for - profits, it's three to four and a half times. So how does this manifest itself, in, in operations? , Well, probably the most obvious difference is in the margins. , Operating margins, for nonprofit health systems tend to be negative two to 3%. For-Profits tend to be 10 to 14%. And cashflow margins, when you, you take the operating margin and add back in depreciation, taxes, depreciation, and amortization, in nonprofit, they're four to 8%. And in for - profit, 18 to 20%. So much more operating profitability inherently built into the for - profit structure in part because they have to pay taxes on their operations. , And for many nonprofits, all of their margins, particularly operating margin, but also some with, EBITDA margin are coming from investments. Labor costs, much

higher percentage of, revenues or operating expenses in nonprofit health systems than in for - profits. So labor costs or revenues in non-profit health systems, 52 to 58%. , For - profit, 42 to 45%. Now, interestingly, you can say, okay, you pay less for labor. , That's gotta manifest itself in, lower quality scores, higher readmission rates, and so on. And it turns out that when analysts adjust for geography for location, no difference at all. , So for - profits are achieving the same quality and outcome metrics, age caps, readmission rates, so on, as nonprofits and spending anywhere from 10 to 15%, less on labor costs. , And you mentioned I was a, an investment banker to health systems for most of my career. So when I started out, you know, sort of early 90-ish timeframe, days cash on hand for an A - rated nonprofit hospital or health system was 60 days., There's been enormous grade inflation. So today, days cash on hand for an A - rated hospital or health system around 150 days, two and a half times what it was, you know, in the '90s. , So consequently, just by virtue of the numbers, when you got that much more cash, managing investments and generating returns from those investments has become a much larger component of the fiscal, management, financial management of nonprofit hospitals and health systems. More time and attention needs to go into the investment portfolio relative, today relative to where it was in the early 1990s. Is that really where we want management focusing its attention? , So just to wrap it all up, there will be howls. The AHA will have protests, but taxing investment returns a positive first step in creating more equilibrium between nonprofit and for - profit operating models. Let's do it.

Burda:

Accumulators versus deployers. I see a column there, Dave. <Laugh> You really are.

Johnson:

Mine or yours?

Burda:

Yours. It's just, I'm a student. You're the teacher on this, on this business. No, that was great. Thank you. Julie, any questions for Dave?

Murchinson:

So, Dave, I remember when banks went through this big shift where they separated investment banking from analysts. Do you think health systems should separate their clinical and purchasing leadership from its venture arm or something similar that would make a difference? Or is just, is that not really what it's about?

Johnson:

Well, it's a really interesting question. And Julie, my answer's gonna be as nuanced as yours was for how you, choose your ice cream flavor depending on time of day and season. But, I think that the way to think about this is, too many, hospitals and health systems run their investment portfolios like university endowments. , They're completely separated from operations. So they look at the investment portfolio in isolation to determine targeted return, risk preferences, that type of thing. And this occurs despite the fact that healthcare operations are a very volatile business. So one of my mantras, when I was a banker, and I continue to believe this, this should be true, if I were running financial affairs for large health systems, it, I would want to see much more correlation between investment portfolio and operations so that in the natural course of, business swings, the, there would be cushion, cash cushion from operations to cover the, the blow periods in, in the business cycle. I would not separate that type of investment from operations. Indeed, it's, it's tied to operations. , But when you get into, more speculative areas, venture funding, private equity and so on, I think there's real [00:39:00] merit in thinking about separating, or walling those off entirely from, from operations. , That's, that's play money at that point. And, you know, it should probably be treated differently.

Burda:

Right hand, meet left-hand, right?

Johnson:

Exactly.

Burda:

Interesting. Thanks, Dave. All right Julie, you're an investor. What do you think of how hospitals are investing their money? Should they be doing anything different to spark more market innovation?

Murchinson:

That's not quite the hill I choose to die on like Dave does, but - <laugh>... You know, I, I do have some opinions, I guess. So Brody, you mentioned that portfolios rose 57% over, you know, some 15-year period, but you didn't mention that number right next to it, that net patient revenue growth over the same period is basically flat. Yeah. And so many of the points that Dave just made are, <laugh> are, this is the problem. So when the system was a blowout year or a brutal one, it's, it's not because they got better or worse, right? It's the, this is masking what's going on in the core business. It's, you know, performance is becoming basically just lame to the SMP. And that's actually, you know, it's not a, it's not a motivator, for, for change, that's for sure. And, you know, that University of Chicago researcher, I think, put it pretty bluntly that most people think that nonprofit hospitals are a charitable institution that, you know, takes patient revenue and spends it on care. And what they don't realize is that these institutions are now sitting on portfolios that look like a financial firm. So Dave makes some really great points, I think, in how he talked about it. I, I do think, to be fair though, there is a bit of a bull case because, these businesses are hard. They're community, services. So this is a bit of a hedge, which I think, you know, is useful for the broader community potentially. But I agree that ta- taxation is an issue. And the other bold case, I guess, is a bit self-serving, but it's true.

A slice of that money in venture specifically, healthcare venture specifically, can really help the health system with market intelligence. It's an early look at the digital health and AI tools that might reshape their cost structure or might disrupt them entirely. It's not just a return stream. So I think there's a defensible strategy there in theory. The problem might be the in theory part. You know, you cited the 86% jump in fees with those massive swings from minus 16 to plus 113. And if you put all that together, it stops looking like a, you know, a discipline hedge. And it just looks like, you know, fee extraction dressed up as a strategy. And with, I, from what I can tell, no disclosure requirements at all, right? So it's, the devil's in the details in terms of what's wrong with some of the models that are, being practiced today. And I do think hospitals should be looking at doing something different to spark market innovation with this money. You know, if you're gonna be an LP anyway, you should be a strategic one and redirect, you know, your asset allocation into mission aligned either venture care delivery infrastructure, things that move your own cost curve instead of, you know, anonymous funds you don't control. So right now, hospitals are really LPs and other people's innovation and they should be thinking about how do they fund their own with this money? And, and boards should be able to help, you know, go there and prove it.

Burda:

Yeah. More strategic investment. Makes sense to me. Thanks, Julie. Dave, any questions for Julie?

Johnson:

Yeah. Julie, great answer. , Particularly the idea of, market intelligence and, getting ahead of the curve and, and, being more strategically offensive, as the market shifts. All, all great points. , I, but I do wonder about the trade-offs of a health system, investing in companies and then, needing a return from those companies. And there are kind of two sides to that and I'd love to get your take on it. One would be the health

system is the perfect incubator laboratory for testing out some of these technologies. And if they work, the company that succeeds, within the health system gets the equivalent of a good housekeeping seal of approval and presumably can go market itself, more broadly, generate a higher return, higher valuation, and so on. All for the greater good of the health system. On the other hand, you might end up with health systems pushing a mediocre product because they have an ownership stake in it. I just wonder how you think about the trade-offs between health systems owning and promoting their portfolio investments.

Murchinson:

Yeah. It's a tough one. I mean, it obviously helps the companies, but it can cut both ways. I've seen it cut both ways. Like that sale approval buys a startup a faster first sale, but not a faster 10th one. Like, it's a distribution headstart.

Murchinson:

More than anything else. And I mean, there are some real pros, right? Like, they've been either been born of or co-developed with a health system. So it's real world validation, not just a logo. But, I think there's also a lot of, I don't know if I'd call it competitive suspicion or the kind of the not invented here bias that can keep some health systems from wanting to buy that tool just because it was born out of a certain system. There's always some weird infighting when it happens. And I think that it is real because the systems that, that birth these tools have real skin in the game and they work really hard to make it work. And sometimes it actually takes it down a path of, you know, being too fit for that system. And other times, it masks what the solution really needs to do to be, you know, a commercially scalable solution that's applicable to multiple systems. So it's, it's a double-edged sword.

Burda:

I didn't realize that dynamic was in play. That's like where you went to school, right? Oh, yeah. Wow. Interesting. Thanks, Julie. Well, you know, it's just too bad hospitals can't make ends meet on their core business of providing patient care. So I get that they need investment income. But on the other hand, I don't want a big bet on Cal Sheer Polymarket deciding whether a burn unit stays open at my local hospital, right? <Laugh>

Murchinson:

Oh my God.

Burda:

What an industry. Thanks, Dave. Thanks, Julie. Now let's, let's talk about other big healthcare news that happened this week. Julie, what else happened that we should know about?

Murchinson:

Well, I read a bunch of these, you know, forecasts that people like Dave used to write. And I saw one this week that I though was interesting from Vizient, because I'm finding that Vizient is just playing, you know, an increasingly large role in influencing the market given what they're doing in health systems today. So they are forecasting big rapid growth in home health, outpatient behavioral not surprising, and community oncology not surprising. Home health has been a hot potato, so I was interested in that.

Burda:

Good point about Vizient. They've acquired a lot of market intelligence firms. Thanks, Julie. Dave, what's your big healthcare news of the week? <Laugh>

Johnson:

Well, for the fourth consecutive week, I'm going to set my sights on Verona, Wisconsin. So my first observation was that Epic was threatening to sue ONC, watering down the exemptions for information blocking, big time threat for lawsuits. And then the last couple of weeks, really prominent departures from Epic in their senior leadership team and the people leaving, associated more with positive interoperability <laugh> strategy than a negative one. And this week, what I'm hearing lots of rumblings that the FTC has begun an investigation of Epic, into anti-competitive practices. So that story just continues to develop and data wants to be free, data libre. And let's see; I think the government, the Trump administration is very serious about data interoperability and, maybe it will manifest itself as an antitrust case. We'll see.

Burda:

Wow. Wow. That is -

Murchinson:

That would be so exciting. <Laugh>

Burda:

I think we'd be talking about that on the show. <Laugh>

Murchinson:

I think that if this administration gets where they need to play at creating the interoperability rules, not just, you know, broad, but exactly where it needs to happen in the tech stack. And that's what's starting to really become an issue for Epic.

Burda:

Right. They, they know who didn't sign that interoperability pledge, right? Thanks, Dave. And thank you, Julie. That all the time we have for today. If you'd like to learn more about the topics we discussed on

today's show, please visit our website at 4sighthealth.com. You also can subscribe to the Roundup on Spotify, Apple Podcasts, YouTube, or wherever you listen to your favorite podcast. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.