



HEALTHCARE

# KPMG's Healthcare Business Briefing

KPMG LLP

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## Introduction

This edition represents the fourth anniversary of KPMG's Healthcare Business Briefing, whose principal purpose is to provide timely information on significant and relevant matters to our clients and others in the industry for their consideration and use. As in the past, this Briefing is anchored by matters involving the quality of care, the cost of care, and the access to care in the United States, and emphasizes organizational success factors.

The matters covered here include the fourth annual report on U.S. healthcare quality by the Agency for Healthcare Research and Quality and a report that compares the U.S. delivery system with other countries. Commentary is provided on a current hot topic, reform of our healthcare system, on healthcare spending trends, and on our national economy and federal entitlement programs. The 2007 financial outlook for not-for-profit hospitals and managed care entities is also discussed in this Briefing, together with the CEO as a sales officer; communication with the new healthcare consumer; relationships between the physician and patient as the consumer, the connection between physicians' compensation, quality, and productivity; and the progress being made regarding healthcare information technology.

Because of the critical importance of leadership to the success of all who participate in our delivery system, we begin this edition with two reports concerning governance. The first report, in particular, on building an exceptional board of directors provides a perspective that integrates with many of the other topics covered in the rest of this Briefing.

We trust that our Business Briefings have and will continue to provide information that contributes to your success and the success of your organization.

## Exceptional Governance

Earlier this year, the Center for Healthcare Governance gathered a blue ribbon panel to examine critical issues facing healthcare boards of directors and to identify practices that lead to exceptional governance. In its report, *Building an Exceptional Board: Effective Practices for Health Care Governance*, the panel focused on five areas that it considered critical to effective governance:

- Being an accountable board: earning and maintaining the public's trust
- Building and sustaining a proactive and interactive board culture
- Laying a foundation for effective decision-making: board meetings and information for governing
- Focusing the board on key governance priorities
- Clarifying authority and responsibility: the buck stops where?



In the preface, the panel makes observations that (1) all healthcare organizations must have the trust of their many publics to survive and achieve their mission; (2) the governing board is ultimately accountable for maintaining the public's trust; (3) now is the time for boards, management, and clinical leadership to communicate a clear sense of urgency for change, to strengthen the connection between hospitals and their communities, and to rise to the challenge of transforming healthcare to overcome the many obstacles facing our hospitals and healthcare systems; (4) it is the board that must take the initiative and lead by example, transforming and holding itself to a higher standard of performance by engaging in practices that foster exceptional governance because it's the right thing to do; and (5) evidence suggests that good governance is linked to more effective performance.

While we do not have the space to provide in-depth commentary on all aspects of this report, we do want to brief you on some observations regarding being an accountable board, building and sustaining a proactive and interactive board culture, and focusing the board on key governance priorities.

### Being an Accountable Board

This section of the report begins with the observation that if the purpose of a board is to govern on behalf of an organization's shareholders or stakeholders, then the first task boards must undertake is to identify these "owners" and understand what they need most from the organization. In the case of for-profits, the answer is straightforward: the owners, the shareholders.

However, in considering stakeholders, the answers to both who they are and what are the board's obligations to them are less clear, according to the authors. Hospitals and systems typically have many stakeholders with multiple needs and concerns that often conflict. In an era of governance reform that challenges all boards to raise the bar on their performance and accountability, knowing to whom the board is accountable and what the board is accountable for is more important than ever to good governance.

The panel focused its suggestions on two board practices: understanding traditional and emerging stakeholders and promoting transparency in reporting the organization's performance to its stakeholders. The approaches offered are:

- In identifying key stakeholders, be especially attentive to meeting the needs of underserved populations in your community.
- Build into the board's activities, a periodic review of the entity's current stakeholders, processes for identifying new stakeholders, an examination of the needs of all stakeholders, and how the organization should prioritize and address them.
- Ensure that the organization establishes a working environment that allows it to attract and retain the best employees and maintain productive partnerships with physicians.
- Be mindful of the importance of the board's relationship with the CEO and have formal processes for key board responsibilities such as CEO recruitment, evaluation, compensation, and succession planning.
- Publish quarterly financial reports for financial stakeholders.
- Send internal monthly financial reports to medical staff and department heads.
- Quantify the level of benefit the organization provides to the community each year and publicly report this information.

### Building and Sustaining a Proactive and Interactive Board Culture

The panelists stress that great boards are effective teams that continue to build on their capabilities and focus on: (1) committing to achieve the organization's mission, (2) building trust and candor, (3) fostering a culture of open and respectful dissent, (4) avoiding rigid roles and behavior, (5) requiring individual accountability, and (6) evaluating performance.

The point is also made that truly effective boards move beyond fiduciary and strategic governance to a third mode of governing that they call "generative governance," which is a mode of thinking that focuses the board, stakeholders, and other leaders on:

- Making sense of circumstances facing the organization
- Inviting questions and alternative hypotheses
- Shedding new light on perceived problems and opportunities
- Finding and framing problems and opportunities facing the organization in ways that may change values, beliefs, and behaviors

#### Board Culture Comparisons

Characteristics of an Effective Board	Characteristics of an Ineffective Board
Commitment to mission	Lack of commitment to mission
Well-defined government processes	Ineffective meetings, decision-making is pro forma Board has difficulty acting as one body and is top heavy with committees, stultifying board structures
Broad skills and diverse backgrounds	Board members elected based on social status vs. proven skills of value
Strategic and organizational performance focus	Unclear focus
Engaged	Unengaged, disconnected, passive, and reactive
Explicit, high-performance expectations	Personal agendas are played out
Constructive dialogue and debate are welcome	Lack of creativity
Ongoing education	Lack of appreciation by management

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"Exceptional boards make meetings matter."

Board Source, 2005

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"The purpose of a board is to represent and balance shareholder or stakeholder interests. Standing in for those to whom the organization belongs, boards must decide and act as their constituents would if they had the time, energy, experience, and knowledge to do so on their own behalf."

D.D. Pointer and J.E. Orlikoff, 1999

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## Focusing the Board on Key Governance Priorities

Exceptional boards ensure that there is a strong link between the organization's priorities and stakeholders' needs and concerns and that the organization has the necessary infrastructure in place to help the board govern effectively. The panel focused on helping board members become more deeply engaged with suggestions such as:

- Once stakeholders and their needs have been identified, link the organization's and the board's priorities to stakeholders' needs.
- To facilitate discussion and decision-making, provide board members with a concise synopsis of each issue that the board is being asked to address, include questions they should consider, and present options that were evaluated as well as management or committee recommendations.
- Create regular opportunities during board meetings for in-depth discussion on a strategic priority, sometimes referred to as a "deep dive" discussion, that is, physician relationships, consumerism, large providers versus large insurers, the business/charity paradox, and so forth.
- Identify in the hospital or system budget specific funds adequate to support staff, educational, and other resources needed to accomplish the board's work.

For information on the study, including how to purchase it, please go to <http://www.americangovernance.com> or call 888-540-6111.

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## Navigating the Zone of Insolvency

*Navigating the Zone of Insolvency* is a nonprofit trustees' guide to financially troubled healthcare organizations prepared by Cain Brothers, healthcare industry investment bankers, and capital advisers as part of their *Strategies in Capital Finance* series.

In this report, the firm states "Trustees of nonprofit healthcare organizations need to pay attention to the factors that can cause their organization to become vulnerable to financial trouble. External challenges include changes in reimbursement methods, new legislation, local competitive and demographic trends, and even forces of nature. Internal challenges include cost structures, governing board composition, medical staff organization, management structure, and the strategic focus of the organization. External and internal challenges can lead to well-known financial warning signs such as drawing down cash reserves or violating debt covenants."

Cain Brothers indicates that organizations are considered to have entered the zone of insolvency when they can't pay their debts or when liabilities are greater than the market value of assets. The firm also advises that even hospitals with "clean" audit opinions and many hospitals with qualified, going-concern opinions can find themselves in this zone of insolvency, too.

This report refers to seven common internal challenges in hospitals, as identified by Timothy Stack, facing the kind of trouble that led to a turnaround or near turnaround:

- The governing board is too large, its composition is inappropriate to the situation, its actions are passive rather than proactive, and board development is lacking.



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"We recommend that trustees start by becoming more aware of their oversight responsibilities when the first signs of trouble appear. Early and forceful action by the board can often prevent the kinds of deterioration that would ultimately result in a bankruptcy process. Identifying when the organization is first entering the zone of insolvency and getting the right kind of help to make necessary changes can best assure that the organization will successfully regain financial strength."

Cain Brothers, 2007

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- The medical staff leadership is weak, uncommitted to the hospital, and focused on opposing goals rather than mutual goals.
- Executive management is ineffective in fulfilling both its operational and strategic management responsibilities.
- There are too many middle managers, so professionals capable of autonomy are over managed.
- The corporate structure is too tall and top heavy with staff.
- Operational problems are being overlooked because it is more exciting to pursue the latest fad.
- Emphasis is placed on a long-range planning process rather than on actively managing today's strategic issues.

Consistent with specifying internal challenges, the report provides questions that board members can use to help determine when their hospital should be "turned around":

- Has the hospital operated with an operational loss for two or more consecutive years?
- Are activity trends significantly worse than those in competing hospitals?
- Are trustees holding private meetings to discuss "concerns" or hiring outside management consultants to evaluate the CEO's performance?
- Has market share declined for two or more consecutive years?
- Is the hospital always responding to marketing initiatives of competing hospitals, rather than the other way around?
- Are physicians controlling policy decisions because of a weak board and management?
- Are competing hospitals or a chain offering to buy or merge with the hospital?

If you would like to receive the study, please contact Cain Brothers at <http://www.cainbrothers.com>.

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## Healthcare Quality Reports

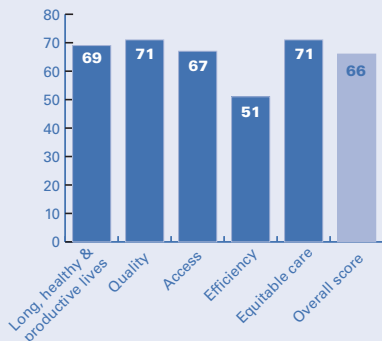
In the fourth annual National Healthcare Quality Report (NHQR) by the Agency for Healthcare Research and Quality (AHRQ), four themes emerged regarding the status of the U.S. delivery system in 2006:

- Most measures of quality are improving.
  - Of the 40 core measures with trend data, 26 showed significant improvement, 2 showed significant deterioration, and 12 showed no change.
  - Relative to last year's NHQR, a greater percentage of measures moved from the "no significant change" category to the "improvement" category.
  - The median annual rate of change for core measures is a 3.1 percent improvement, which has been consistent for the past three years.
- Quality improvement varies by the setting and phase of care.
  - Hospital measures of quality improved at a median rate of 7.8 percent.

**Hospital Measures Showing the Most Care Improvement (Rate per year)**

Heart Attack	15.0%
Pneumonia	11.7%
Heart Failure	8.4%
Postoperative Safety	7.3%

According to the 2006 National Scorecard on U.S. Health System Performance, the United States scored only 66 out of 100 points when comparing our nation's average performance against benchmarks set either within the U.S. or abroad. The composition of the U.S. scores is:



- The hospital measures improved at a much higher rate than did measures for other settings of care, including ambulatory care (3.2 percent) and nursing home and home health care (1 percent).
- Improvements in hospital care may have resulted from public reporting of health quality measures, focused quality improvement programs, and policies that support improvement initiatives.
- Acute care measures' median rate of improvement was 4.3 percent, about twice as high as preventive care (2.4 percent) and chronic care (1.8 percent).
- Variation in healthcare quality remains high.
  - The measure with the greatest degree of variation is the percentage of chronic nursing home patients who were physically restrained.
  - Other core measures with at least a three fold variation across the country are hemodialysis, pediatric admissions to hospitals, prenatal care in the first trimester, appropriate heart attack care, and the suicide rate.

The report can be accessed at: <http://www.ahrq.gov/qual/nhqr06/nhqr06report.pdf>

The messages from those involved in preparation of the scorecard are that the U.S. must:

- Simultaneously improve access, quality and efficiency
- Ensure universal participation in healthcare and reduce disparities
- Reduce costs
- Coordinate and integrate care
- Improve its capacity which will require a highly motivated workforce, more research on evidence-based medicine and innovative delivery models, greater investment in information technology, and improved capacity to measure quality

Seven strategies suggested to yield better future results are:

- Universal access
- Increased transparency and reporting of quality and costs
- Implementation of proven quality and safety improvements
- Reorganization of healthcare delivery emphasizing patient-centered primary care
- Expansion of the use of information technology
- Rewarding quality and efficiency
- Encouraging public-private collaboration

## Quality Data Could Result in New Government Enforcement Actions

Earlier this year, Jim Sheehan, an associate U.S. attorney who has been very active in healthcare-related government actions over the years, indicated that his office is continuing to focus on ensuring that healthcare providers that are receiving federal

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“We are reviewing assorted sources of quality information on your facility to see what it says and if it is consistent...”

James G. Sheehan, Associate  
U.S. Attorney

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care funds give patients high-quality care as Medicare changes its reimbursement system to one based on outcomes. In essence, as these changes take place, new enforcement action that targets lapses in the delivery of quality care will be developed by regulatory and oversight agencies from data-mining activities as well as from information provided by regulators, whistle blowers, media, and others.

Mr. Sheehan stressed that his office will focus criminal investigations only on the most egregious cases of failure of care. The basic approach is to give voluntary compliance efforts a chance to work, but if that doesn't work, his office is prepared to act otherwise. He also indicated that the development of programs designed to assess and maintain compliance in the quality of care arena is paramount.

According to Mr. Sheehan, questions that his office will ask to determine whether prosecution is appropriate are:

- Was there a systemic failure by the institution's management and the board of directors to address quality issues?
- Did the institution make false reports about quality or fail to file mandated reports?
- Has the institution profited from ignoring poor quality or ignoring providers of poor quality?
- Have patients been harmed by poor quality care or been given false information about it?

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## Healthcare Reform

Until recently, reform of the U.S. healthcare delivery and payment system had been largely out of the national spotlight for nearly 15 years. It has returned to the national scene now due, in part, to various initiatives in many states as described in KPMG's March 2007 *FlashPoint* and to attention being brought by the myriad of candidates or possible candidates for the presidency in 2008. In addition, and perhaps more important to the new focus, is the level of concern about healthcare and its costs and the "push" for reform by business; the private sector, including insurers; and by governors in states across the country.

Approaches to reform generally fall into three categories: fundamental reform of the insurance system, expansion of existing public insurance programs, and strengthening employer-based health insurance. With the exception of federal-state partnerships to expand coverage, current proposals would transform the traditional role of employers in time by scaling back or eliminating the extent to which they contract directly for health insurance coverage. Most would also require persons to have insurance with individuals and employers sharing in the cost, provide subsidies to people with lower incomes to help defray the cost, pool risks into large groups to equalize premium costs across families regardless of health risk, and increase efficiency in insurance administration.

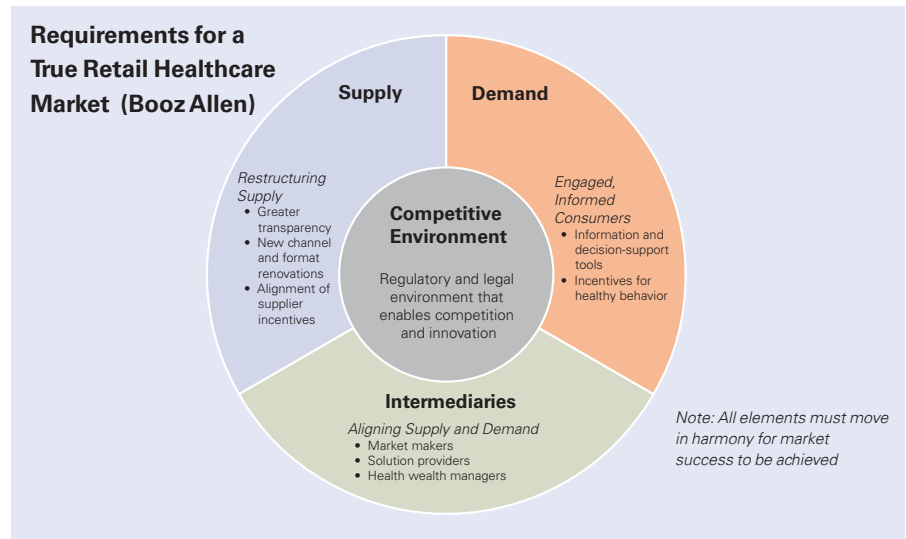
Proposals to expand existing public programs include Medicare buy-in for adults age 55 to 64, elimination of the two-year Medicare waiting period for the disabled, universal coverage for children, and Medicaid expansions.

As for strengthening employer-based coverage, proposals include an employer mandate for large employers (those with 50 or more employees) and improving the affordability of health insurance for small employers.

# Consumers and Physicians in the Healthcare Market

Booz Allen Hamilton, in an article entitled *Consumer and Physician Readiness for a Retail Healthcare Market—Changing the Basis of Competition*, examines the physician community's response to consumer-directed health plans and the interplay of supply and demand in developing a successful consumer-centered marketplace. In the executive summary, Booz Allen says that its research suggests that people with greater cost responsibility (those enrolled in high-deductible health plans or with associated savings vehicles such as health savings accounts or health reimbursement arrangements) are beginning to act like true retail consumers by becoming more aware of both cost and quality differences, shopping for products and services, and expecting competition among providers and suppliers.

Booz Allen goes on to say that the country is in the early stages of this transition and for many products and services, consumers lack the ability to compare options easily. Consumers appear encumbered by a lack of trusted health information and advice and they appear to have different views from physicians concerning the role of physicians and other industry participants in providing that information. For a copy of this report, please go to <http://www.boozallen.com/publications.article/33114276?lpid=66005>.



Major findings by Booz Allen are:

- Consumers with greater cost responsibility are more aware of cost and quality differences in health products and services, but are only beginning to act upon this information.
- There are indications that consumers in plans with health savings vehicles are significantly more likely to expand their planning horizons in terms of future medical expenses and are more willing to spend now to potentially avoid health complications later.
- Consumers expect supply-side participants to compete but in different ways depending on the product or service offered. Physicians and other service

providers are expected to compete primarily on quality; health plans primarily on price; and pharmaceutical companies primarily on price and, to a lesser extent, quality.

- While consumers expect supply-side participants to compete, they lack the information and advice needed to compare alternatives and make informed choices. Complicating this situation, consumers and physicians have different emerging views of the most trusted and reliable sources of information.
- Physicians place consumerism at the top of the list of issues that will affect their practices over the next three to five years, equal to or higher than the much talked about pay-for-performance programs and evidence-based medicine. However, fewer than 20 percent believe that consumerism will produce better outcomes or more rewarding patient-physician relationships.
- There is a disconnection between the robust information that consumers expect physicians to provide and what physicians themselves are willing or able to offer. The reluctance or inability of physicians to provide the cost, quality, and service information that consumers expect may give rise to opportunities for new intermediaries.



## Physician Incentive Compensation

The Center for Studying Health System Change released a report earlier this year that showed that while the proportion of physicians in group practice whose compensation is based in part on quality measures increased from 17.6 percent to 20.2 percent in 2004–05, far more physicians face financial incentives tied to individual productivity (52 percent of the total.) Nearly three in four of those physicians facing productivity-based incentives view such incentives as a very important factor in determining their compensation. In contrast, 44 percent of physicians subject to quality-related incentives view these incentives as very important to their compensation.

Other findings include:

- About one in four physicians in non-solo practice do not have their compensation tied to any explicit financial incentives.
- Other incentives used by physician practices include tying individual physician's base compensation and/or bonuses to results of patient satisfaction surveys, and profiling to compare a physician's pattern of medical resource use with that of other physicians. In 2004–05, 24.6 percent of physicians faced financial incentives related to patient satisfaction surveys and 13.9 percent had their compensation tied to profiling.
- Quality-related compensation is more common among primary care physicians and among those, more common among physicians treating adults than pediatricians.
- Physicians in larger group practices as well as hospital, medical school, or other institutional practices are more likely to be compensated in part based on quality than those in small or medium-sized practices.
- Compensation of physicians on the basis of quality is nearly three times as prevalent in practices that receive 20 percent or more of their revenue in capitated payments.

The study can be accessed at: <http://www.hschange.org/CONTENT/905/?PRINT=1>.

## The CEO as Chief Sales Officer

David Bodel, president of Bodel & Associates in Chicago, wrote an article last year whose premise is that hospitals' CEOs reap rewards for time spent selling their organizations to physicians and others in the community. His conclusion is based on research by Solucient indicating that, since 2003, many hospitals have lost outpatient market share even while they have seen an increase in outpatient volume. Other providers, including nonhospital providers, are drawing patients away by creating the impression of delivering more customer-oriented service and by disproportionately serving more of the well-insured.

He goes on to indicate that since more than 40 percent of hospital revenue is tied to outpatient services, which are reimbursed better than inpatient services, failure to keep up with market growth is a significant missed opportunity. He contends that CEOs can improve their outpatient and inpatient market share if they adopt the approach that they are not just the CEO but also the chief sales officer of the organization. Actions that he believes CEOs/chief sales officers can take to build goodwill and create market demand include:

- Investigate what operational barriers can be removed to pave the way for a more satisfying patient and physician experience.
- Discuss ideas for clinical service quality and efficiency improvements.
- Learn what motivates physicians and drives their business—understand their stresses and get to know their staff who are key to outpatient registration.
- Look for opportunities to make introductions and establish connections between primary care physicians and specialists.
- Educate others and brag about outstanding services offered at the hospital, the great physicians on staff, the caring nurses, and the recently solved problems.
- Outside the hospital, communicate regularly about the hospital's vision and commitment to the community good, and have senior hospital leaders and board members make visits into the community on behalf of the hospital.
- Build personal relationships that ensure the hospital will be at the table early in planning discussions for new service locations and delivery ventures.
- Gather market intelligence by listening carefully to physicians as they comment on competitors' plans and developments and learn what they like and dislike about key competitors.
- Actively engage local employers as well as civic and community leaders, communicating genuine interest in community health needs as well as their concerns.
- Share anecdotes and statistics that reflect the hospital's commitment to caring for people without insurance.
- Demonstrate candor and transparency about hospital performance.

Mr. Bodel also emphasizes that cultivating physician relationships is central to the "sales role" since patients are nearly twice as loyal to their physicians as they are to a hospital, evidenced by their greater willingness to switch hospitals more than physicians.



## Communicating with the New Consumer

The president and CEO of Press Ganey Associates Inc., Melvin Hall, has recently written an article discussing four trends in healthcare that require hospitals to change the way they deal with the new healthcare consumer. They are:

- **Consumer-directed health plans:** Higher deductibles and co-pays together with less coverage mean higher out-of-pocket costs for consumers. Putting consumers in charge of the first \$1,000, \$5,000, or \$10,000 of their healthcare costs will ignite demand for customer-perceived value in return for healthcare dollars.
- **Employers changing the game:** Employer-based insurance is eroding overall and through increased cost-sharing, leaving more of the costs for employees to cover themselves. In addition, employers and business coalitions continue to demand better quality outcomes.
- **Transparency:** CMS currently reports clinical quality data and will soon add patient satisfaction information, allowing customers to compare hospitals. People will demand a better mix of technology, cost, service, and clinical quality.
- **Pay-for-performance:** CMS pay-for-performance projects continue to prove that offering incentives for key aspects of care improves patient outcomes.

Mr. Hall notes that the new healthcare consumer is accustomed to finding detailed information on everything of value and is, therefore, likely to “do homework” on hospitals, physicians, illnesses, and conditions. As a result of having such information, the healthcare consumer demands and receives more control over provider choice. Mr. Hall also concludes that leading healthcare organizations create a culture of responding to patients’ questions, anticipating patients’ needs, and proactively providing information. He cites Dartmouth-Hitchcock Medical Center, a KPMG audit client in New Hampshire, as an example of a provider that is going out of its way to get desired information into the hands of the new consumer. The medical center has voluntarily posted its quality reports on its external Web site for three years and has also published its service charges for the last two years.

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“Consumption is the sole end and purpose of all production; and the interest of the producer ought to be attended to only so far as it may be necessary for promoting that of the consumer.”

Adam Smith, 1723-1790

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## The Economy

A Blue Chip Economic Indicators survey of top economic forecasters released in April indicates that the estimate of 2007 economic growth has been lowered—GDP is now predicted to increase at a rate of 2.3 percent for the year versus 2.8 percent when we last briefed you six months ago, and is one percentage point less than the 3.3 percent growth experienced in 2006. The odds of a recession in the next 12 months were put at one in four, and also, the new economist of the International Monetary Fund said in April that he doesn't expect a U.S. recession in 2007.

In comments that invoked entitlements, the director of the Congressional Budget Office (CBO) said in March that relying on tax increases “exclusively or perhaps even primarily” to fix the long-term imbalance in Medicare and Medicaid could pose problems for the economy given the size of the increase that would be necessary.

He went on to say, "The economic effects of revenue increases would depend in part on the specific measures adopted; however, especially in light of the scale of projected increases in spending over the long term, a policy that relied exclusively or perhaps even primarily on increased revenues to restore fiscal balance could significantly impair economic growth by distorting economic decisions and reducing incentives for people to work and save....[and] The aging of the population is not the primary factor affecting the growth of entitlement programs, however. Instead, the most important cause is the projected increase in healthcare costs."

In the CBO's *The Budget and Economic Outlook Fiscal Years 2008 to 2017*, the agency states, "because the cost of healthcare is likely to continue rising rapidly, spending for Medicare and Medicaid is projected to grow even faster—in the range of 7–8 percent annually. Total outlays for those two healthcare programs are projected to more than double by 2017, increasing by 124 percent, while nominal GDP is expected to grow only half as much, by 63 percent. Consequently, under the assumptions of the CBO's baseline, spending for Medicare and Medicaid and Social Security will together equal nearly 11 percent of GDP in 2017, compared with a little less than 9 percent this year."

The Outlook also indicates that "with respect to Medicare and Medicaid, and to a lesser extent Social Security, either a substantial reduction in the growth of spending, a significant increase in tax revenues relative to the size of the economy, or some combination of spending and revenue changes will be necessary to promote the nation's long-term fiscal stability."

In the CBO director's opinion, "one option for discouraging overuse of care under Medicare's fee-for-service system is to shift the method for compensating physicians, moving the system toward payments tied to quality or efficiency...another option involves grouping physicians into multispecialty units that would share some financial responsibility with Medicare for the utilization of care by patients served by the group."

In addition, the CBO director states, "Systems for shifting incentives toward higher value care would require better information, which could be generated by two changes to the underlying health infrastructure. The first is an information infrastructure to collect data on patients' conditions, the services ordered by physicians, and health outcomes and to distribute information back to individual doctors or groups. The second is an adequately funded effort, whether inside the government or outside it, to analyze the data, evaluate comparative effectiveness, and perhaps design and implement payment systems that reward the more efficient practice of medicine."

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## Healthcare Spending

According to The Centers for Medicare & Medicaid (CMS), growth in national healthcare spending is projected to slow slightly from 6.9 percent in 2005 to 6.8 percent in 2006, the fourth consecutive year of this slowing trend. While healthcare's share of the GDP is expected to hold steady in 2006, at 16 percent, it is then expected to resume its historic upward trend, reaching 19.6 percent of GDP in 2016.



In March, a Watson Wyatt Worldwide/National Business Group on Health survey of 573 large companies reported that the percentage of employers offering consumer-directed health plans (CDHP) continues to grow, from 33 percent in 2006 to 38 percent in 2007. Forty percent of employers now offer or plan to offer health savings accounts and 26 percent plan to offer a health reimbursement account.

However, employee enrollment in CDHPs remains low at 8 percent, an increase of only 1 percentage point from 2006. Employers with 10 percent or more of their covered population in a CDHP are holding their healthcare cost increase to 6.5 percent in 2007, which is less than other employers as the overall average increase was 8 percent in 2007 and is expected to increase 8 percent again in 2008. The survey also found that companies that were most successful in trimming their healthcare costs usually used a multipronged approach with programs in five areas:

- Appropriate financial incentives
- Effective information delivery
- Quality care
- Data and metrics
- Health and productivity

With respect to retiree health benefits, a Kaiser Family Foundation/Hewitt Associates survey of large private sector employers with 1,000 or more employees that offer retiree health benefits reported:

- Total retiree health costs (employer and retiree contributions) increased by 6.8 percent, on average, between 2005 and 2006.
- The average increase in retiree contributions to premiums was higher for newly retired people under age 65 (15.1 percent) than for newly retired people over 65 (9.6 percent).
- The majority of firms do not pre-fund retiree health benefits; 25 percent do.
- In 2007, 78 percent of the surveyed employers intend to provide drug coverage to Medicare-eligible retirees and take the 28 percent tax-free subsidy; 14 percent intend to supplement Medicare drug coverage, contract with a Medicare drug plan, or become a Medicare drug plan; and 8 percent say they will not provide drug coverage.
- Employers offering retiree health coverage are split on the question of whether the federal government should play a larger role than it does today in financing retiree health benefits for retirees under age 65.

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## 2007 Outlook for Not-for-Profit Hospitals and Managed Care Organizations

In its *2007 Outlook*, Fitch Ratings' prognosis for nonprofit hospitals and healthcare systems is stable, with slight improvements expected in the operating performance of its rated hospitals as well as continued improvement in the ratio of downgrades to upgrades.

## Industry Pressures and Risks

- Regulatory changes
- Capital needs
- Volume trends
- Rising expenses: bad debts, labor, and pensions
- Physician competition
- Project management and construction costs
- Transparency

Source: Fitch Ratings

Medicare reimbursement is expected to remain adequate for most hospitals; however, there is also an expectation that reimbursement for hospitals that specialize in services such as cardiology could be negatively affected in the short to medium term. Medicaid is also expected to be fairly stable "as most states are reporting a stable to improving revenue environment; however, as medical costs continue to increase, many states could look to contain costs through the implementation of more Medicaid managed care programs..." Reimbursement from managed care entities is expected to be favorable as well this year, in particular those with strong market positions, but double-digit increases experienced in recent years are not anticipated.

The firm looks favorably at hospitals that: (1) provide better management of their supply chain; (2) successfully manage all aspects of their physician relationships, (3) are preparing for greater consumerism from consumer-directed health plans, pay-for-performance measures with payors and employed physicians, and public disclosure of quality measures; and (4) invest in projects related to quality and patient safety.

Fitch also expressed concern related to trends such as (1) insufficient capital spending by most hospitals in the recent past as increased demands for capital continue, especially given the need to invest in high-priced technology, and (2) short-term volatility in volume trends.

Beyond 2007, Fitch has concern about the sustainability of current trends due to uncertainty around revenue constraints from the rate of growth of managed care, Medicare and Medicaid reimbursement and volume growth, increased scrutiny by legislators regarding tax-exempt status, the number of uninsured and underinsured, and increasing consumerism.

Fitch also says it "strongly believes that hospitals that focus on improving quality, strengthening internal controls over financial reporting, containing costs, and improving transparency may be able to offset possible negative effects of these uncertainties. Additionally, investment in technology and information systems to support these areas will be differentiating factors for hospitals and health systems going forward."

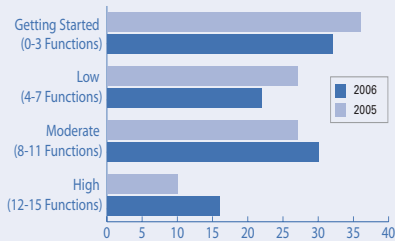
The Fitch report can be accessed at [http://www.fitchratings.com/corporate/reports/report\\_frame.cfm?rpt\\_id=309142](http://www.fitchratings.com/corporate/reports/report_frame.cfm?rpt_id=309142).

Regarding the managed care segment of the industry, in late 2006, Deutsche Bank Securities, Inc. offered comments including:

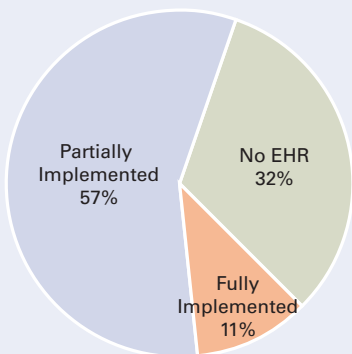
- Initial guidance suggests that 2007 is "shaping up to be another year of double-digit earnings growth..."
- Pricing in 2007 should remain relatively consistent with 2006 levels resulting in premium yields averaging 6.5 percent–7.5 percent.
- Enrollment growth at managed care organizations has generally been in line with expectations.
- As expected, Medicare Part D premium yields should "moderate" in 2007 due to vigorous product competition and favorable claims experience in 2006.
- Robust cash flow is expected to continue in 2007.

### Hospital Use of IT

Levels of Health IT Use (percent)



### EHR Implementation Percent of Hospitals Reporting EHRs in 2006



## Information Technology

*Continued Progress: Hospital Use of Information Technology 2007* was released by the American Hospital Association in late February of this year and can be accessed at <http://www.aha.org/aha/content/2007/pdf/070227-continuedprogress.pdf>. Key findings include:

- Over two-thirds of hospitals have either fully or partially implemented electronic health records (EHRs) in 2006. Those that fully implemented EHRs were more likely to be large, urban, and/or teaching hospitals.
- Health information technology (IT) use is increasing. In 2006, 46 percent of community hospitals reported moderate growth of high use of health IT, compared with 37 percent in 2005.
- Computerized physician order entry is gaining traction: in 10 percent of hospitals, physicians routinely ordered drugs at least 50 percent of the time in 2006; in 16 percent of hospitals, physicians routinely placed orders electronically for lab and other tests at least half of the time.
- Hospitals reported significant increases in the use of computerized alerts to prevent negative drug interactions. In 2006, 51 percent of hospitals used real-time drug interaction alerts versus 23 percent in 2005.
- Larger hospitals, those in urban areas, teaching hospitals, and hospitals with positive profit margins used more IT.
- Hospital spending on IT is viewed as high and increasing.
- The most common barrier to IT adoption continued to be cost.
- About half of hospitals shared electronic patient data with others in both 2005 and 2006.
- Accelerating IT adoption will require a shared investment among providers, payors, and purchasers per the AHA. When looking to finance health IT adoption, policymakers should give special attention to hospitals with less stable finances and smaller and rural hospitals. Other barriers to adoption include the lack of systems that share data easily, challenges in managing work process changes, and lack of trained IT staff.

## Personal Health Topics

- According to the Centers for Disease Control and Prevention, only one in seven Americans exercises enough and eats enough vegetables and fruits. Overall, 14.6 percent of Americans met both benchmarks, including 12.4 percent of men and 16.6 percent of women.
- Harvard Medical School researchers have reported that high-deductible health insurance plans often cost women more than men, largely because women need more routine medical exams such as mammograms, Pap tests, and birth control services. The median expense for men under age 45 in such plans was less than \$500 compared to \$1,200 for women in the same age group. Only one third of insured men in that age group spent more than \$1,050 in annual medical costs, while 55 percent of the women did.
- A new pneumonia vaccine by Wyeth (pneumococcal conjugate) has significantly reduced hospital admissions for U.S. babies and toddlers.

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