THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

JANUARY 25, 1989

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"Third Woman Gains Elite Rank of U Acting VP", Minnesota Daily, January 4, 1989
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THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
January 25, 1989
555 Diehl Hall

AGENDA

I.	Approval of the December 21, 1988 Meeting Minutes	Approval
II.	Chairman's Report - Mr. Robert Latz	Information
III.	Hospital Director's Report - Mr. Robert Dickler	Information
IV.	Nominating Committee Report - Ms. Phyllis Ellis	Approval
V.	Special Presentation: "Overview of the Transplantation Program at the University of Minnesota" - Dr. John Najarian	Information
VI.	Committee Reports	
	A. Finance Committee - Mr. Robert Nickoloff	
	1. December 31, 1988 Financials	Information
	2. Regents Audit Committee	Information
	3. Capital Expenditure Report Format	Information
	4. 1989-90 Compensation Planning	Discussion
	5. Second Quarter Bad Debts	Approval
	B. Planning and Development Committee - Ms. Kris Johnson	
	1. MRI II Project Update	Approval
	2. Major Capital Expenditures	Information

C. Joint Conference Committee
- Mr. George Heenan

The Joint Conference Committee did not meet in January.

VII. Other

VIII. Adjournment

MINUTES

BOARD OF GOVERNORS

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

DECEMBER 21, 1988

CALL TO ORDER:

Vice Chairman Robert Nickoloff called the December 21, 1988 meeting of the Board of Governors to order at 2:33 P.M. in 555 Diehl Hall.

ATTENDANCE:

Present:	Leonard Bienias Sally Booth David Brown, M.D. Robert Dickler Phyllis Ellis George Heenan Kris Johnson Jerry Meilahn James Moller, M.D. Robert Nickoloff William Thompson, M.D. Neal Vanselow, M.D.
Not Present:	Carol Campbell Al Hanser Robert Latz Barbara O'Grady

CHAIRMAN'S REPORT:

Mr. Nickoloff reported that on December 9, 1988 the Board of Regents reappointed Mr. Jerry Meilahn and Ms. Barbara O'Grady to 3-year terms on the Board of Governors. In addition, the Board of Regents appointed Mr. Erwin Goldfine to a 3-year term, replacing Mr. Al Hanser, and Mr. David Link to a one-year term, replacing Ms. Sally Booth. All appointments are effective January 1, 1989.

Mr. Nickoloff announced the appointment of the Nominating Committee for the positions of Chair and Vice Chair of the Board of Governors. The Committee includes Ms. Phyllis Ellis (Chair), Ms. Barbara O'Grady, and Dr. James Moller. A Committee report will be made on January 25, 1989.

A luncheon for Dr. Neal Vanselow, Mr. Nickoloff reported, will be held Friday, January 6, 1989 at 11:30 A.M. in the Board Room.

Lastly, Mr. Nickoloff reminded Board members of the Holiday Gathering immediately after the meeting in the 5th floor Library of the Campus Club.

HOSPITAL DIRECTOR'S REPORT:

Mr. Robert Dickler reported that the census continues to run ahead of budget. The length of stay of our patients has been increasing.

Mr. Dickler announced that architects have been selected for the renovation project. Two firms were selected: Setter, Leach & Lindstrom, Inc. and Horty, Elving & Associates, Inc. He anticipates that a contract will be signed in the next week.

Lastly, Mr. Dickler briefly reviewed an article that appeared in the Minnesota Daily on December 2, 1988 incorrectly implied that the Board of Governors had taken action on Dr. Jamieson's appointment. The Daily editors had apparently added the erroneous headline to the article. A letter of apology from the Editor was distributed to Board members.

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of the November 16, 1988 meeting as written.

SPECIAL PRESENTATION:

Mr. Robert Dickler introduced the December enrichment speaker, Ms. Kris Johnson. Ms. Johnson is the Vice President of Corporate Affairs for Medtronic, Inc., a member of our Board of Governors, a member of St. Olaf's Board of Regents, and is currently a member of ProPAC.

Ms. Johnson reported that the Prospective Payment Commission (ProPAC) was established on April 20, 1983 as part of the DRG payment system. ProPAC was created as a body separate and apart from the Health Care Financing Administration (HCFA) and was charged with independently monitoring and evaluating the DRG system. ProPAC was asked to recommend the annual update factors and to recommend modifications to the DRG classifications or categorizations. Additionally, the Commission was charged with evaluating considerations of quality along with cost.

The changes associated with prospective payments, Ms. Johnson reported, are not as significant as early predictions might have indicated. The cost per case continues to rise steadily. No measurable systematic adverse impact on quality or technology development has been identified.

The impact of prospective payments on hospital's operating margins varies significantly. Academic health centers and urban hospitals have, to date, faired more favorably than their rural counterparts.

In coming months ProPAC will devote more attention toward refining a payment system for outpatient services.

JOINT CONFERENCE COMMITTEE REPORT:

The Joint Conference Committee, Mr. Heenan reported, reviewed and endorsed the Credentials Committee report and recommendations. Particular note was made of the resignation of one physician and the termination of appointment/loss of medical staff appointment for another.

The Board of Governors seconded and passed a motion to approve the Credentials Committee Report and Recommendations as submitted.

Mr. Heenan reported that the Committee endorsed the appointment of Dr. Elgene Mainous as Clinical Chief of the Hospital Dental Service. Dr. Mainous is also the Chair of the Department of Oral and Maxillofacial Surgery and was appointed a member of the Medical and Dental Staff at the November Board of Governors meeting. The customary provisional appointment had been waived for Dr. Mainous.

The Board of Governors seconded and passed a motion to approve the appointment of Dr. Elgene Mainous as Clinical Chief of the Hospital Dental Service for an initial term of three years.

Lastly, Mr. Heenan reported that the Joint Conference Committee had reviewed the materials submitted to the Joint Commission in compliance with the written progress report requirement. Overall, the Committee felt it a positive response to the contingencies. Some areas of further discussion were identified and will be pursued in coming months.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

Ms. Kris Johnson reported that Mr. Fred Bertschinger, Director of Development, had provided an update on first quarter contributions, current projects, and a direct mail and telemarketing program being implemented to encourage planned giving.

Mr. Al Dees reviewed the status of the purchase of the second MRI machine for Radiology. The machine UMHC bid included a 2.0 magnet. Since the project was designed, technological advances have led to improved applications at the 1.5 magnet size. Acquisition of this smaller magnet is being considered. The Board will be kept informed whether the machine will be rebid or whether the current purchase agreement will simply be modified.

Mr. Greg Hart reported that, with Board of Governors concurrence, Regental approval will be sought to pursue the purchase of property on Oak Street,

adjacent to the University. A smaller difference between asking price and our appraisal value has renewed the Hospital's interest in purchasing these properties. No specific use for the property has been identified at this time. Any purchase agreement negotiated on the property will be contingent on final Board of Governors' and Regents' approval.

FINANCE COMMITTEE REPORT:

Mr. Cliff Fearing reported that admissions for November were 3.8% above budget. The overall average length of stay was 7.9 days. Patient days for November were 905 days over budget. The average daily census was 440. The average daily census for the first two weeks of December was 439. Outpatient clinic visits for November were 8.8% over budget. The Hospital's Statement of Operations shows total revenue over expense of $4,365,004 for a favorable variance of $2,620,958. Lastly, Mr. Fearing noted that the Accounts Receivable seem to be plateauing out at approximately 100 days.

Mr. Greg Hart reviewed the preliminary considerations for the employee 1989-90 compensation plan. The endorsement of compensation plan principles will be sought in January for incorporation into the budget development in February and March. The significant issues include: 1) the AFSCME contract to be negotiated this spring which typically keys off the State of Minnesota AFSCME union settlement and the issue of pay equity for the union; and 2) contract negotiations by the community hospitals with the Minnesota Nurses Association, and its effect on other non-nursing employee compensation plans at the community hospitals. Other internal issues include: 1) pay equity; 2) progression increases; and 3) merit pay. The compensation plan will be discussed at the Finance Committee and then presented to the Board for approval.

OTHER BUSINESS:

Mr. Robert Nickoloff presented a plaque to Ms. Sally Booth, recognizing her contributions as the student representative to the Board of Governors during 1988. Mr. George Heenan commended Sally for her valuable input as a member of the Joint Conference Committee during 1988.

ADJOURNMENT:

There being no further business, the December 21, 1988 meeting of the Board of Governors was adjourned at 3:50 P.M.

Respectfully submitted,

Kay F. Fuecker

Kay F. Fuecker
Board of Governors Office

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

January 25, 1989

TO: Members of the Board of Governors

FROM: Nancy C. Janda
Associate Director and
Secretary to the Board of Governors

We are honored to have Dr. John Najarian as our enrichment speaker this month. Dr. Najarian is the Regents Professor and Chairman of the Department of Surgery and Jay Phillips Distinguished Chair in Surgery. He will be speaking to the Board of Governors about the Transplantation Program at the University of Minnesota.

This presentation is another in a series of presentations designed to broaden or enhance the Board of Governors familiarity with current issues at The University of Minnesota Hospital and Clinic.

NCJ/kff

Attachment

CURRICULUM VITAE

ON

JOHN S. NAJARIAN, M.D.

REGENTS' PROFESSOR

JAY PHILLIPS CHAIR IN SURGERY

JOHN S. NAJARIAN, M.D.

CURRICULUM VITAE

Personal Statistics:

Date of Birth - December 22, 1927
Place of Birth - Oakland, California
Marital Status - Married, four children

Education:

University of California, Berkeley, 1945-1948, A.B. with Honors
University of California, San Francisco School of Medicine 1948-1952, M.D.

Military Service:

Division Surgeon, 34th Air Division (DEF) USAF, 1953-1955 Albuquerque, New Mexico

Post Doctoral Training:

Internship - straight surgical, University of California Medical School, San Francisco, 1952-1953
Residency - surgical, University of California Medical School, San Francisco, 1955-1960

Research Training:

Surgical Physiology, University of California, San Francisco School of Medicine, 1955-1956
Immunopathology, University of Pittsburgh Medical School, Special Research Fellow, NIH, 1960-1961
Tissue Transplantation Immunology, Scripps Clinic and Research Foundation, La Jolla, California, Senior Fellow and Associate, NIH, 1961-1963

Visiting Professorships:

Winnipeg General Hospital, Winnipeg Manitoba, Canada - 1967
Johns Hopkins University, Baltimore, Maryland - 1968
Marquette School of Medicine, Milwaukee, Wisconsin - 1969
Ohio State University, Columbus, Ohio - 1969
University of California, Los Angeles, California - 1969
Massachusetts General Hospital, Boston, Massachusetts - 1969
Rochester School of Medicine, Rochester, New York - 1970
Harvard University Medical School, Boston, Massachusetts - 1970
Balfour Visiting Professor of Surgery, Mayo Clinic, Rochester, Minnesota - 1970

Visiting Professorships: continued:

St. Mary's Hospital and Medical Center, San Francisco, California - 1971
University of Cincinnati Medical Center, Cincinnati, Ohio -1973
University of Arkansas, Little Rock, Arkansas - 1975
Wayne State University, Detroit, Michigan - 1975
Memorial Hospital for Cancer and Allied Diseases, New York, New York - 1975
University of California Medical School, San Diego, California- 1979
Rives Visiting Professor, New Orleans, Louisianna - 1979
Renee Tanger-Lowenberg Memorial Foundation Lectureship, Atlanta, Georgia - 1980
New York University Medical Center, New York, New York - 1980
Milton S. Hershey Medical Center, Pennsylvania State University Hershey, Pennsylvania - 1980
Mercy Hospital and Medical Center, Metropolitan Group Hospitals, Abraham Lincoln School of Medicine and University of Illinois, Chicago, Illinois - 1981
State University of New York at Stony Brook, Stony Brook, New York - 1981
College of Physicians and Surgeons, Columbia University, New York, New York - 1982
University of Manitoba, Winnipeg, Canada - 1983
Benjamin Park Visiting Professor and Lecturer, New York Hospital-Cornell Medical Center, New York, New York - 198
Gothenburg University, Gothenburg, Sweden - 1985
University of Iowa, Iowa City, Iowa - 1985
Brown University, Providence, Rhode Island - 1986
Mt. Sinai Medical Center, New York - 1986
North Dakota Orator, North Dakota Medical Society Grand Forks, North Dakota - 1987
Long Island Jewish Medical Center New Hyde Park, New York - 1987

Named Lectures:

William C. Beaumont Memorial Lecturer, Wisconsin Medical Society - 1968
Sommer Memorial Lecturer - 1969
Twenty-fourth Annual Strauss Lecturer - 1973
Masauki Hara Lecturer, University of Arkansas - 1975
Morita Day Memorial Lecturer, William Beaumont Hospital, Royal Oak, Michigan - 1978
McGraw Lecturer -Joint Meeting of Detroit Surgical Association and Academy of Surgery, Detroit, Michigan - April, 1982
Reinhoff Lecturer, Johns Hopkins Hospital, Baltimore, Maryland - May, 1982
William C. Beaumont Memorial Lecture, Wayne County Medical Society, Detroit, Michigan - 1984
J. Donald Babb Memorial Speaker, Joseph F. Mulach Medical Lecture Series, St. Clair Memorial Hospital, Pittsburgh, Pennsylvania - 1985
R. Tait McKenzie Lecture, University of Wisconsin, Madison, 1985
Hale-McMillan Lecturer, Meharry Medical College, Nashville Tennessee - 1985

Named Lectures: continued

18th Annual E.C. Janes Memorial Lecture in Surgery, The Hamilton Academy of Medicine, Hamilton, Ontario - 1985
The Second Gelin Memorial Lecture on Transplantation Gothenburg University, Gothenburg, Sweden - 1985
Willard E. Goodwin Address, Harbor-UCLA Medical Center Los Angeles, California - 1986
Samuel L. Kountz Lecture Brooklyn Surgical Society - 1987
Edward R. Woodward Visiting Professor University of Florida, Gainesville - 1987
Leon Ginzburg Lecture, Beth Israel Medical Center New York City - 1987
First Annual Kerkhof Lecture, Metropolitan Medical Center Minneapolis, Minnesota - 1987
Max Broedel Lecturer, Association of Medical Illustrators Minneapolis, Minnesota - 1987
A.J. Grace Memorial Lecture, Southwestern Ontario Surgical Society London, Ontario - 1987
The 1988 J.W. Johnson Lecture, Scripps Memorial Hospitals La Jolla, California - 1988

Honors:

Alpha Omega Alpha
California Trudeau Society Award - 1962
Markle Scholar of Academic Medicine, 1964-1969
University of California Football Alumnus of the Year - 1967
University of California, Berkeley, Alumnus of the Year - 1975
University of California Medical School, Alumnus of the Year, San Francisco, California - 1977
Annual Brotherhood Award, National Conference of Christians and Jews - 1978
Award for Distinguished Achievement, Modern Medicine - 1978
Walter A. Gordon Distinguished Citizen - Athlete Award - 1979
International Great American Award, B'nai B'rith Foundation, October 31, 1982
Kabakjian Award - 1983
Man of the Year, WCCO Radio, Minneapolis, 1983
Distinguished Alumnus of the Year, Oakland High School - 1984
Golden Key National Honor Society, University of Minnesota - 1985
Distinguished Minnesotan Award, Bemidji State University, Bemidji, Minnesota - 1985
Uncommon Citizen Award, Greater Minneapolis Chamber of Commerce, Minneapolis - 1985
Regents' Professor, University of Minnesota - 1985
1986 FDR Memorial Award: March of Dimes - 1986
Man of the Year Award, Armenian Professional Society - 1986
Honorary Membership, Minnesota Chapter of Mortar Board - 1986
Outstanding Minnesotan Award, Minnesota Broadcasting Association - 1986
Jay Phillips Distinguished Chair in Surgery, University of Minnesota - 1986
Sir James Carreras Award, Variety Clubs International - 1987
Silver Medal, IXth Centenary of the University of Bologna, Italy - 1988

Honorary Degrees:

Honorary Doctorate, University of Athens - November 6, 1980
Honorary Doctor of Science Degree, Gustavus Adolphus College - May 31, 1981
Honorary Doctor of Humane Letters, California Lutheran College, Thousand Oaks, California - May 22, 1983
Honorary Fellowship in The Royal College of Surgeons of England - 1987

Editorial Boards:

American Journal of Nephrology, 1980 -
American Journal of Surgery, 1967 -
Associate Editor, 1982 -
Annals of Surgery, 1972 -
Health Today, 1984 -
Hippocrates, 1986 -
Journal of Surgical Oncology, 1968 -
Journal of Surgical Research, 1968 -
Kidney International, 1981-
Minnesota Medicine, 1968 -
Surgery, Associate Editor, 1971 -
Surgery, Gynecology & Obstetrics, 1985 -
Surgical Techniques Illustrated, 1973 -
Transplantation, 1970 -
Transplantation Proceedings, 1970 -
Board of Clinical Editors, 1981-84
World Journal of Surgery, 1976 -
Yearbook of Surgery, 1970 - 1985
Clinical Transplantation, 1986 -
Editor-In-Chief

Other:

Special Consultant, United States Public Health Service, National Institutes of Health, Clinical Research Training Committee, Institute of General Medical Sciences 1965-1969
Consultant, United States Bureau of the Budget, 1966-1968
Member, Scientific Advisory Board, National Kidney Foundation 1968
Member, Advisory Committee on Hemodialysis and Renal Transplantation, Department of Public Welfare, Minnesota State Medical Association
Consultant, Upper Midwest Chapter of the National Kidney Foundation
Council Member, Midwinter Conference of Immunologists
Member, Board of Directors, Variety Club Heart Hospital, University of Minnesota
Member, Board of Trustees, Minnesota Medical Foundation
Member, Committee Regarding Ethical Problems, International Transplantation Society, 1970
Member, Legislative Liaison Committee of the National Kidney Foundation, 1970
Chief of Hospital Staff, University of Minnesota Hospital, 1970-71
Member, Surgical Study Section A, Division of Research Grants,

Other: continued

Member, Scientific Advisory Committee of the National Council on Tissue Utilization and Transplantation, 1970
Chairman, Renal Transplant Advisory Group, Veterans Administration Hospital, 1971
Member, Board of Scientific Consultants, Sloan-Kettering Institute for Cancer Research, 1971-1978
Neutral Arbitrator for the National Football League, 1971
Member, Screening Committee for the Dernham Postdoctoral Fellowships in Oncology (administered by the California Division of the American Cancer Society)
Board of Directors, Variety Club Heart Hospital, 1972
Member, Honorary Advisory Board, Association of Kidney Patients, Inc., 1973
Member, State and Provincial Advisory Committee, American College of Surgeons
Board of Directors, Vikings Childrens Fund, 1978
Chairman, Organ Transplantation Committee, Central Veterans Administration, Washington, D.C., 1985
Board of Directors, Metropolitan Boys Choir of the Twin Cities, 1985
Board of Scientific Advisors, Farmacon Research Corporation 1985
Blue Ribbon Advisory Council: Campaign for Child Survival, 1986
Consultant to Bureau of Standards Development in Health Care for New York State, 1986
Honorary President, Commission for Research and Organ Transplants, Ararat International Academy of Sciences, 1987
Honorary Council, National Conference of Christians and Jews - 1987
Founding Member, The Panamerican Society for Dialysis and Transplantation, 1988
Treasurer, Board of Directors, Upper Midwest Organ Procurement Organization, Inc., 1988

Professional Organizations:

American Association for the Advancement of Science
American Association for Laboratory Animal Science
American Association of Immunologists
American Board of Surgery, Diplomat
    Member of the Board, 1982-88
    In-Training Examination Committee, 1985-86
    Committee on Credentials, 1985-86
    Director, 1982-1988
American College of Angiology, Honorary Member, 1983
American College of Surgeons, Fellow
American Diabetes Association
American Heart Association
American Medical Association
American Society for Experimental Pathology
American Society of Nephrology - Council Member, 1972
American Society of Transplant Surgeons - President, 1977-1978;
    Chairman, Education Committee, 1980-1988
    Member, Advisory Committee on Issues - 1987

Professional Organizations: continued

American Surgical Association
Committee on Honorary Fellowships, 1984--
Committee on Advisory Memberships, 1988-1989
President, 1988-1989
Association for Academic Surgery - President, 1969
Central Surgical Association
Columbian Society of Nephrology - Honorary Member, 1981
Council on the Kidney in Cardiovascular Disease
Hagfish Society (Immunology)
Halsted Society
Hennepin County Medical Society
Howard C. Naffziger Surgical Society
Italian Surgical Research Society - Correspondent Member
International Society of Nephrology
International Society of Surgery
Kansas City Surgical Society
Minneapolis Surgical Society
Minnesota Academy of Medicine
Minnesota Medical Association
Minnesota Medical Foundation
Minnesota State Medical Society
Minnesota Surgical Society
Portland Surgical Society
St. Paul Surgical Society
Sigma Xi
Society for Experimental Biology and Medicine
Society of Clinical Surgery
Society of Surgical Chairmen
Society of University Surgeons
Surgical Biology Club
Transplantation Society - Council Member, 1971 and 1982
Vice President (Western Hemisphere), 1984-86

Staff Positions:

Assistant Professor of Surgery, Director of Surgical Research Laboratories and Chief, Transplantation Service, Department of Surgery, University of California School of Medicine, San Francisco, California, 1963-1966; Professor and Vice Chairman, Department of Surgery, University of California School of Medicine, San Francisco, California, 1966-1967

Professor and Chairman, Department of Surgery, College of Medical Sciences, University of Minnesota, Minneapolis, Minnesota, July 1967 to present

Regents' Professor and Chairman, Department of Surgery, College of Medical Sciences, University of Minnesota Minneapolis, Minnesota, June 1985 to present

Jay Phillips Distinguished Chair in Surgery and Regents' Professor of Surgery, University of Minnesota Hospital, October 1986 to present

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS FINANCE COMMITTEE
December 21, 1988

MINUTES

ATTENDANCE:

Present:	Edward Ciriacy, M.D. Robert Dickler Clifford Fearing Jerry Meilahn Robert Nickoloff
Not Present:	Elwin Fraley, M.D. Barbara O'Grady Roger Paschke Vic Vikmanis
Staff:	Al Dees Kay Fuecker Greg Hart Nancy Janda Nels Larson Dan Rode

CALL TO ORDER:

On December 21, 1988 the Finance Committee was called to order by Mr. Robert Nickoloff at 12:15 P.M.

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the minutes of the October 26 and November 16, 1988 meetings as written.

PEAT MARWICK AUDIT FOLLOW-UP:

Mr. Steve Laible and Mr. Tim Franz from Peat Marwick, reviewed the UMHC audit and its findings. They emphasized the one identified weakness from prior

years, the reconciliation process between the Hospital and the University has been substantially fixed. No substantial weaknesses were found during the 1988-89 audit. The management letter from the auditors will be sent to the hospital in the near future.

JULY 1, 1988 THROUGH DECEMBER 31, 1988 FINANCIALS:

Mr. Cliff Fearing reported that admissions for November were 3.8% above budget. The overall average length of stay was 7.9 days. Patient days for November were 905 days over budget. The average daily census was 440. The average daily census for the first two weeks of December was 439. Outpatient clinic visits for November were 8.8% over budget. The Hospital's Statement of Operations shows total revenue over expense of $4,365,004 for a favorable variance of $2,620,958. Lastly, Mr. Fearing noted that the Accounts Receivable seem to be plateauing out at approximately 100 days.

BOARD OF REGENTS AUDIT PROCESS:

Mr. Fearing reviewed the proposed relationship between the Regents Audit Committee and the Board of Governors. The Regents Audit Committee is in the process of developing a new process to review the various University and UMHC audits, the associated recommendations and the implementation or dissolution of the recommendations. The Regents Audit Committee will receive the auditors reports directly from the auditors. Under the proposal, the significant changes affecting UMHC are: 1) the Board of Governors will have responsibility for resolution or implementation of all UMHC audit recommendations and for reporting to the Board of Regents Audit Committee on the resolution of or dissolution of these issues; 2) the creation of a compliance officer's office; and 3) a quarterly status report is to be presented by the compliance officer to the Board of Regents and the Board of Governors.

The Committee discussed the need for a new Board of Governors Audit Committee and concluded that under the Board of Governors Bylaws the Finance Committee has the responsibility to review the audits and, therefore, there was no need to create another committee.

BOARD OF GOVERNORS STATEMENT OF FINANCIAL POLICIES AND REQUIREMENTS:

Mr. Cliff Fearing presented the first topic for inclusion in the revised Board of Governors Statement of Financial Policies and Requirements. The first issue to be addresses is reserves. Management is recommending that the Board designated reserves be separated into more specific function reserves such as working capital reserves, internal debt service reserves, and capital reserves.

Mr. Fearing suggested the following designation: the working capital reserves should equal 7% of budgeted operating cash expense or $16 million for 1988-89; internal debt service reserves should be maintained equal to one year's annual

debt service, or $13 million for 1988-89; and the remaining revenues should be dedicated to capital needs. Management is also recommending that spending from reserves be restricted to its specific purpose. Expenditure of internal debt service reserve funds and the capital equipment and facility reserves should require prior Board of Governors authorization.

The issue of reserves was for information only and will be brought back to the Committee in January, 1989 for endorsement.

1989-90 EMPLOYEE COMPENSATION PLANNING:

Mr. Greg Hart reviewed the preliminary considerations for the employee 1989-90 compensation plan. The endorsement of compensation plan principles will be sought in January for incorporation into budget development in February and March. The significant issues include: 1) the AFSCME contract to be negotiated this spring which typically keys off the State of Minnesota AFSCME union settlement and the issue of pay equity for the union; and 2) contract negotiations by the community hospitals with the Minnesota Nurses Association, and its effect on other non-nursing employee compensation plans at the community hospitals. Other internal issues include 1) pay equity; 2) progression increases; and 3) merit pay. This topic will be an on-going issue with endorsement sought in February or March.

MRI II PROJECT UPDATE:

Mr. Al Dees reviewed the status of the purchase of the second MRI machine for Radiology. The machine UMHC bid included a 2.0 magnet. Since the project was designed, technological advances have led to improved applications at the 1.5 magnet size. Acquisition of this smaller magnet is being considered. The Finance Committee will be kept informed whether the machine will be rebid or whether the current purchase agreement will simply be notified.

ADJOURNMENT:

There being no further business, the December 21, 1988 meeting of the Board of Governors Finance Committee was adjourned at 2:10 P.M.

Respectfully submitted,

Kay F. Fuecker

Kay F. Fuecker
Board of Governors Office

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

January 25, 1989

TO: Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period **July 1, 1988 through December 31, 1988**

The Hospital's operations through the month of December reflect both inpatient admissions and outpatient visit activity that were above budgeted levels. Ancillary and routine revenue were also above budgeted levels.

INPATIENT CENSUS: For the month of December, inpatient admissions totaled 1,522, which was 103 above budgeted admissions of 1,419. Our overall average length of stay for the month was 8.0 days. Patient days for December totaled 12,576 and were 1,618 days over budget. The increase in admission levels over budget was primarily in the areas of Medicine, Pediatrics, and Urology.

To recap our year-to-date inpatient census:

	1987-88 Actual	1988-89 Budget	1988-89 Actual	Variance	% Var
Admissions	9,539	9,159	9,552	393	4.3
Patient Days	75,934	71,217	79,968	8,751	12.3
Avg Length of Stay	7.9	7.8	8.3	0.5	6.4
Avg Daily Census	412.7	387.0	434.6	47.6	12.3
Percent Occupancy	71.0	67.1	74.5	7.4	11.0

OUTPATIENT CENSUS: Clinic visits for the month of December totaled 20,482 which was 490, or 2.3%, under budgeted visits of 20,972. Areas in which actual visits were significantly under budget included OB/GYN, Medicine, and Ophthalmology. Community University Health Care Center (CUHCC) visits for the month of December totaled 3,959, which was 9, or .2%, under budgeted visits of 3,968, while Home Health visits of 1,142 for the month were 327, or 40.1%, above budgeted visits of 815.

To recap our year-to-date outpatient census:

	1987-88 Actual	1988-89 Budget	1988-89 Actual	Variance	% Var
Clinic Visits	130,043	131,092	134,391	3,299	2.5
CUHCC Visits	24,646	24,802	23,081	(1,721)	(6.9)
HHA Visits	4,306	4,839	5,942	1,103	22.8

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows total revenue over expense of $2,830,288, a favorable variance of $2,533,479.

Patient care charges through December totaled $155,105,513, which was 12.0% over budget. Routine revenue was 15.6% over budget and reflects our year-to-date favorable patient day variance.

Ancillary revenue was $11,099,064 above budget (10.8%) and reflected the favorable variance in both admissions and clinic visits. Inpatient ancillary revenue has averaged $8,738 per admission compared to the budgeted average of $7,982 per admission. Outpatient revenue per clinic visit has averaged $225 which agrees with the budgeted average per clinic visit.

Operating expenditures through December totaled $135,718,839 and were $6,332,203 (4.9%) over budgeted levels of $129,386,636. The overall unfavorable variance relates primarily to the increased demand for patient services, and is reflected in higher personnel costs and patient care supplies (drugs, blood, and medical supplies and services).

ACCOUNTS RECEIVABLE: The balance in patient accounts receivable as of December 31, 1988, totaled $91,572,577 and represented 105.7 days of revenue outstanding. The overall increase in our patient receivables in December of 4.2 days occurred primarily in Medicare, Champ, Blue Cross, and Commercial Insurance.

CONCLUSION: The Hospital's overall operating position is positive and above budgeted levels. Both inpatient and outpatient census levels are above budget. We continue to monitor our demand for service closely and make those operating changes that are necessary and appropriate.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1988 TO DECEMBER 31, 1988

	1988-89 Budgeted	1988-89 Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$138,426,644	$155,105,513	$16,678,869	12.0%
Deductions from Charges	23,[illegible]913	32,123,300	$8,182,387	34.2%
Other Operating Revenue	4,290,610	4,743,687	$453,077	10.6%
Total Operating Revenue	118,776,341	127,725,900	8,949,559	7.5%
Total Expenditures	129,386,636	135,718,839	6,332,203	4.9%
Net Operating Revenue	(10,610,294)	(7,992,939)	2,617,355	24.7%
Non-Operating Revenue and Expenses	10,907,103	11,823,227	916,124	8.4%
Revenue Over/Under Expense	$296,809	$3,830,288	$3,533,479	

	1988-89 Budgeted	1988-89 Actual	Variance Over/-Under Budget	Variance %
Admissions	9,159	9,552	[illegible]3	4.3%
Patient Days	71,217	79,968	8,751	12.3%
Average Daily Census	387.0	434.6	47.6	12.3%
Average Length of Stay	7.8	8.3	0.5	6.4%
Percentage Occupancy	67.1	74.5	7.4	11.0%
Outpatient Clinic Visits	131,092	134,391	3,299	2.5%

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

January 19, 1989

TO: Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director and Director of Finance

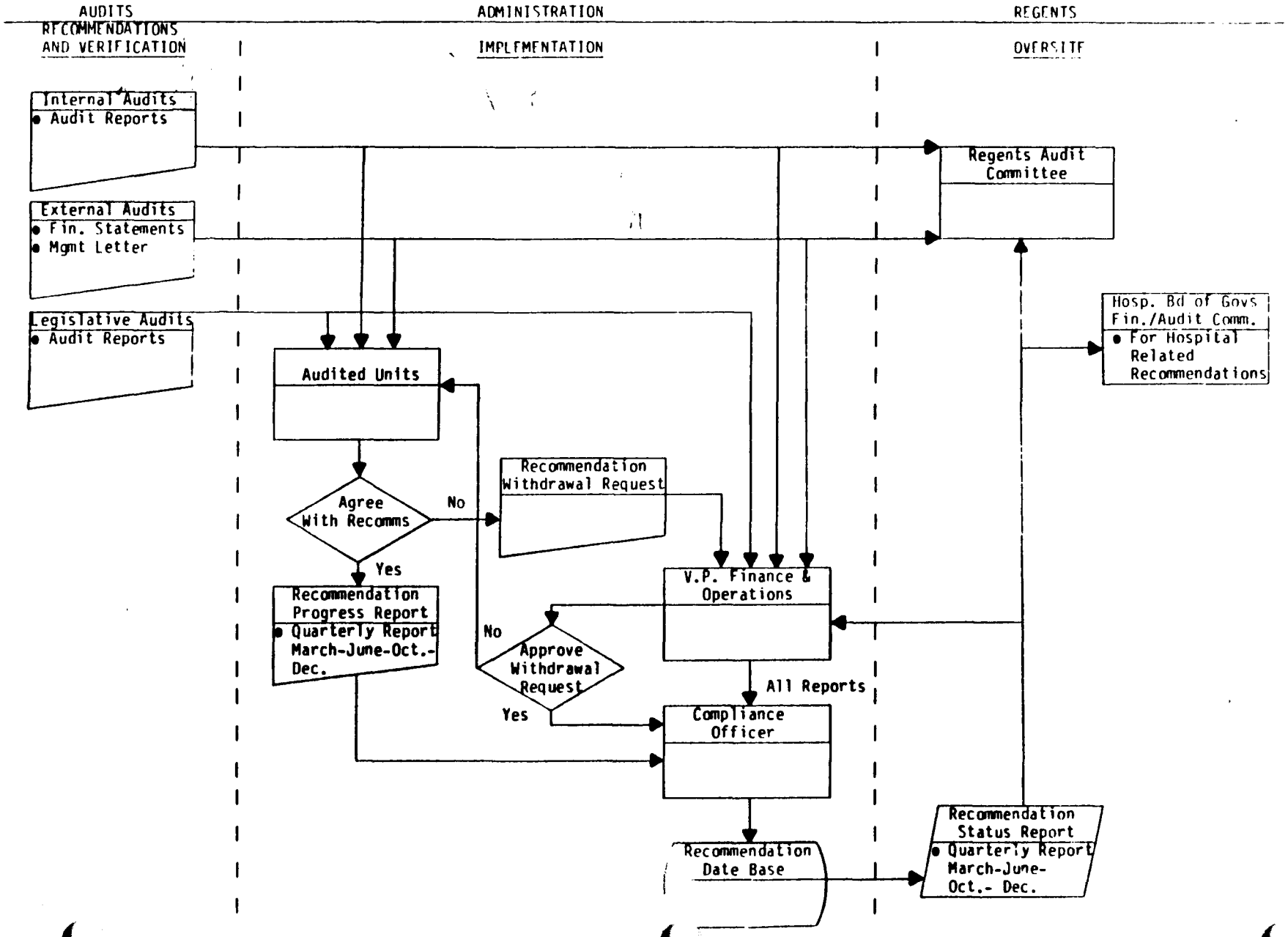
SUBJECT: Status Board of Regents Audit Committee Proposal for implementation of Audit Recommendation and dissolution Process

As we discussed at the December meeting, the Board of Regents Audit Committee has been developing a revised process for reviewing all university audits and their associated recommendations and the implementation or dissolution of the recommendation. Although the entire process will affect UMHC, the most significant component of the proposal is that the Board of Governors will have the responsibility to review and monitor audit results and be responsible for assuring UMHC resolution or dissolution with audit recommendations and subsequent reporting thereof to the Board of Regents Audit Committee.

The Board of Regents Audit Committee received this proposal for information in January without any major changes recommended. The proposal is intended to be acted on in February. We will let you know the outcome of their action so we can implement the appropriate review process within UMHC.

The proposal being reviewed by the Regents Audit Committee is attached for your review.

AUDIT RECOMMENDATIONS - DISTRIBUTION AND FOLLOW-UP



UNIVERSITY OF MINNESOTA
AUDIT RECOMMENDATION FOLLOW-UP
SUMMARY OF RESPONSIBILITIES

Auditors

- Complete audits and distribute to appropriate personnel and compliance officer
- Rate significance of recommendations: one (useful), two (significant), or three (critical)
- Do follow-up audits to verify compliance

Compliance Officer

- Maintain recommendation data base
- Contact units to get current status of recommendations
- Prepare quarterly reports for management and audit committee

University Administrators

- Identify who will implement recommendations, appoint unit coordinator, and establish time frame
- Complete quarterly progress reports
- Initiate withdrawal request forms when there is a disagreement with recommendations

Vice President for Finance and Operations

- Review status reports and take appropriate action
  - determine reasons for delayed recommendations
  - request additional audit work
  - request early follow-up of selected recommendations
- Sign off on withdrawal requests for level two and three recommendations

Regents

- Review status reports and take appropriate action
  - review excessively delayed recommendations
  - request additional audit work
  - request early follow-up of selected recommendations
- Sign off on withdrawal requests for level three recommendations

Level: of Audit Recommendati:rs

To help assure that important audit recommendations get the proper attention and action, a rating system has been developed. In the future, we will categorize all our recommendations into three levels:

1. Useful
2. Significant
3. Critical

The following pages summarizes the criteria that will be used to rate each recommendation. While there may be some disagreements on how particular recommendations are rated, the following general definitions may help in identifying differences:

Useful - Recommendation is usually common to many units, involves a basic issue, and normally is easily correctible within 6 months.

Significant - Recommendation is usually unique to a particular unit, involves a difficult issue, and may take more than 6 months to implement.

Critical - Recommendation usually would affect many University units, involves a complex issue, and could take a year or more to implement.

The recommendations may not always fit the general criteria. Sometimes special circumstances may dictate the rating level. The more detailed definitions and examples attached provide further background on evaluating recommendations.

DEFINITION	EXAMPLE	MONITORING OF COMPLIANCE	LEVEL OF REPORTING
1. USEFUL			
Resolution would help improve controls and avoid problems in the unit's operations	• Job duties should be separated in the payroll or revenue collection process • Money should be deposited in a timely manner as required by U of M policy • Screen design standards should be established for new computer systems to avoid data entry errors	Compliance Officer Quarterly status report to VP for Finance and Regents Audit Committee Audits Standard follow-up 12-18 mos. after audit	Standard
Comments: This group is generally basic in nature and usually easily correctible by the unit within 6 months. Approx. 55% of our recommendations are in this category. Recommendations are usually common to many units.			
2. SIGNIFICANT			
Resolution would help avoid a potentially significant negative impact on the unit's assets, financial information, or ability to comply with important laws, policies, or procedures	• Some faculty members were not being notified of their eligibility in the faculty retirement plan • Drawdowns of cash from outstate banks could be improved by revising procedures • A computer system is not thoroughly documented which would increase the chances of incorrect system changes	Compliance Officer Quarterly status report to VP for Finance and Regents Audit Committee Audits Standard follow-up 12-18 mos. after audit unless specific follow-up is requested by VP-Finance or Regents Audit Comm	Standard
Comments: This group has the potential to cause significant operating problems. Implementation is more difficult and time consuming. Approximately 30% of our recommendations are in this category. Recommendations are usually unique to one unit.			
3. CRITICAL			
Resolution would help avoid a potentially critical negative impact involving loss of material assets, reputation, critical financial information, or ability to comply with the most important laws, policies, or procedures	• The University does not have a complete and widely distributed financial policy and procedure manual • The University needs to have a more highly computerized Purchasing system • The security of the payroll system does not prohibit unauthorized changes to the payroll files	Compliance Officer Quarterly status report to VP for Finance and Regents Audit Committee Audits Standard follow-up 12-18 mos. after audit unless specific follow-up is requested by VP-Finance or Reg. Audit Comm.	Standard and status is hilited in annual report to Audit Committee
Comments: These recommendations are the most critical and often the most difficult to resolve. Implementation sometimes may take years. Approx. 15% of our recommendations are in this category. Recommendations usually would affect many University units.			

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

January 18, 1989

TO: Members of the Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: Capital Expenditure Reporting

The recently passed Board of Governors' policy on capital expenditures requires quarterly budget comparison reporting. Attached please find the format we would propose to use to meet this requirement, utilizing November year-to-date expenditures.

We would appreciate your reaction to this format, and will plan on regular quarterly reporting in the future, beginning with December, 1988 information.

GH/kj

attachment

CAPITAL EXPENDITURES
7-1-88 THRU 11-30-88

	ANNUAL BUDGET	ROLL FORWARD FROM 6-30-88	TOTAL	5-MONTH BUDGET	EXPENDITURES 87-88 ROLL FORWARD	EXPENDITURES 88-89 BUDGET	TOTAL
EQUIPMENT PURCHASES	6,718,513.00	2,847,693.00	9,566,206.00	3,985,919.00	549,066.00	1,182,269.00	1,731,335.00
REMODELING PROJECTS	1,272,650.00		1,272,650.00	530,271.00	82,488.00	39,435.00	121,923.00
	7,991,163.00	2,847,693.00	10,838,856.00	4,516,190.00	631,554.00	1,221,704.00	1,853,258.00
PRINCIPLE PAYMENTS							
CT SCANNER	179,800.00			74,917.00			73,400.00
COMPUTER EQUIP	665,795.00			343,415.00			297,988.00
LITHOTRIPTOR	288,405.00			120,169.00			118,075.00
	1,134,000.00			538,501.00			489,463.00
							2,342,721.00
BOND PAYMENTS	2,815,000.00			(DUE FEB. 1,1989)			

CAPITAL PROJECTS

	AUTHORIZED BUDGET	EXPENDITURES 1988-89	TOTAL EXPEND. TO DATE
MRI II	3,600,000.00	53,034.00	53,034.00
DERMATOLOGY	630,000.00	32,928.00	93,822.00
MAYO 4 SURG	1,029,350.00	3,150.00	3,150.00
CUHCC	1,350,000.00	308,131.00	308,131.00
MASONIC HOSP	600,000.00	710.00	710.00
COMPUTER UPGRADE	850,000.00	--	--
NEURORADIOLOGY UPGRADE	909,000.00	--	--
TOTAL	8,968,350.00	397,953.00	458,847.00
MISC. CAPITAL EXPEND		47,649.00	
		445,602.00	

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

January 19, 1989

TO: Members, Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: 1989-90 Compensation Planning

As we indicated last month, we are planning on focusing more attention at an earlier stage than usual on employee compensation planning for the 1989-90 fiscal year. The marketplace will be more dynamic than usual this year, especially given the upcoming Minnesota Nurses Association negotiations in the community hospitals. In addition, there are other compensation issues, including pay equity, progression, and merit pay, which will be important variables from a compensation and budget planning perspective. We would like to focus on these latter issues this month.

Pay Equity

In 1985 the Board of Governors extensively reviewed and discussed the issue of pay equity, or comparable worth. At that time the Board of Governors approved a four-year plan, with the intent that additional decisions would be made in 1989. The 1985 Board of Governors resolution on comparable worth and a summary of the approved plan are attached.

In each of the past four years the Hospital has increased the salary ranges and salaries of employees in the classes identified as needing comparable worth adjustments. It was known in 1985, and continues to be true, that additional adjustments would be needed to fully achieve pay equity. The issue at hand is thus whether we should continue with pay equity implementation and, if so, at what pace.

This issue continues to be a priority for the State of Minnesota, and the University last year initiated a plan to "complete" its comparable worth process by 1990-91. The University's plan will affect Hospital employees in University-dominated classes (secretarial staff, data processing, etc.) and will cost the Hospital $250,000 for each of the next two years.

For employees in Hospital-dominated classes, pay equity adjustments will cost an additional $750,000 for each of the next two years, assuming that we would "complete" the Hospital pay equity plan on the same schedule as the University. A substantial amount of these dollars, however, will likely need to be spent regardless of pay equity, in order to stay competitive from a

marketplace perspective. Most notably, about $415,000 of the annual increases would go to general staff nurses and related classes. It is very probable that these classifications would receive above-average salary increases regardless of pay equity. Factoring out this and similar considerations for AFSCME classifications, the estimated incremental cost for pay equity is about $190,000 per year for each of two years.

Given this more limited view of the cost of pay equity, and given the University's plan to complete its pay equity plan in the next two years, we would recommend that the Hospital also complete its pay equity plan over the next two years, and that the 1989-90 budget be developed accordingly.

Progression

We have found that we have a growing problem in salary competitiveness for experienced employees, particularly in numerous health care professional areas. The nature of the problem is demonstrated by the attached graphs portraying occupational therapy positions. The problem is a result of a multi-year practice within the University of not including advancement within the salary range, or progression, as part of the University pay plans. The Hospital has budgeted limited funds to solve this problem in the past two years, but the problem is growing increasingly broad and acute. The University, similarly, has recognized this problem and has submitted a legislative request for special salary progression funding.

In order to maintain our ability to recruit and retain experienced employees, we are recommending that progression increases be a major compensation priority in 1989-90. It is unlikely that we can fully solve this problem in one year, however. More specific costs and recommendations relative to progression will be brought to the Board of Governors in March.

Merit Pay

The Board of Governors approved inclusion of a merit pay component in each of the last two years' pay plans. Our limited application of a merit pay plan has met with, at best, mixed results. This is, we believe, largely a factor of the existence of the progression problem referenced earlier. Managers have had to use limited merit pay dollars to try to solve a broader marketplace progression problem. In short, we have been trying to achieve too many compensation objectives with the limited merit pay dollars available.

While we continue to fundamentally believe in the objectives associated with merit pay, the realities of the need to stay competitive from a salary range and progression perspective will likely be such that we will not be able to afford merit pay as an additional component of the pay plan in 1989-90. We are thus recommending that consideration of additional implementation of merit pay be delayed at least one year. Because this is a change in direction from our current practice, we would like to communicate that change as quickly as possible to our employees. We are thus particularly eager to get Board feedback and endorsement in this area.

Summary

It is recommended that 1989-90 compensation planning and budgeting include the following principles:

1. Implementation of pay equity will be continued, over the next two years, with achievement of pay equity targets by 1990-91.

2. Initiation of a progression plan, that is, movement of individuals through salary ranges, will be a high priority compensation objective for 1989-90.

3. Continued implementation of merit pay will be delayed for at least one year, and not incorporated into the 1989-90 compensation plan and budget, given other compensation priorities.

GH/kj

attachment

Board of Governors

Resolution on Comparable Worth

April 24, 1985

Whereas, the State of Minnesota and University of Minnesota have made a commitment to pay equity in compensation practices, and

Whereas, consistent with that commitment, University Hospitals has completed a job evaluation study and comparable worth analysis, and

Whereas, the findings of the job evaluation study and comparable worth analysis suggest that certain adjustments may be appropriate, and

Whereas, the objective of the Board of Governors is to take action consistent with those adjustments,

Therefore be it resolved, that the Board of Governors endorse the direction outlined in the five point plan recommended by hospital administration (attached), and

That the Board of Governors instruct hospital administration to incorporate the comparable worth plan into the Hospitals' financial planning process for fiscal year 1985-86, and

That the Board of Governors instructs hospital administration to continue to provide the Board with information, and recommendations where appropriate, on any modifications to this plan which may be considered based upon Federal action, State action, Board of Regents action, the results of the comparative Hospital/University job evaluation study, or other factors which may arise in the future.

University Hospitals and Clinics

Comparable Worth Plan Summary

1. The male market line, established as part of University Hospitals' job evaluation and comparable worth study, shall be the pay line which shall be targeted for purposes of the Hospitals' compensation practices.

2. The use of the targeted pay line shall be applied to female dominated, male dominated and balanced job classifications.

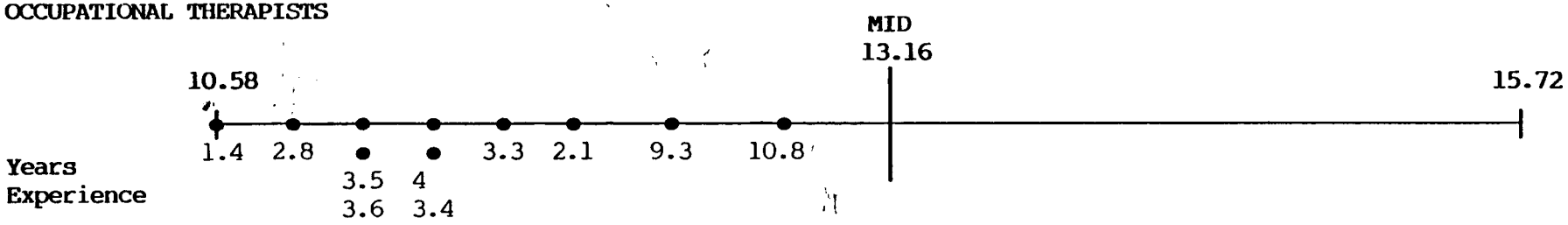
3. The initial phase of implementation shall be structured such that the affected job classifications which are more than 5% away from the targeted pay line shall be brought to within 5% of the targeted pay line.

4. The initial phase of implementation shall be four years in length.

5. During the four year initial implementation period, and at the end of the four year implementation period, continued comparable worth analyses will be conducted. Additional adjustments may be necessary after the initial four year period if there continues to be a differential between the target payline and the female internal payline.

ACTUAL SALARY POSITION WITHIN RANGE

OCCUPATIONAL THERAPISTS



SR. OCCUPATIONAL THERAPISTS

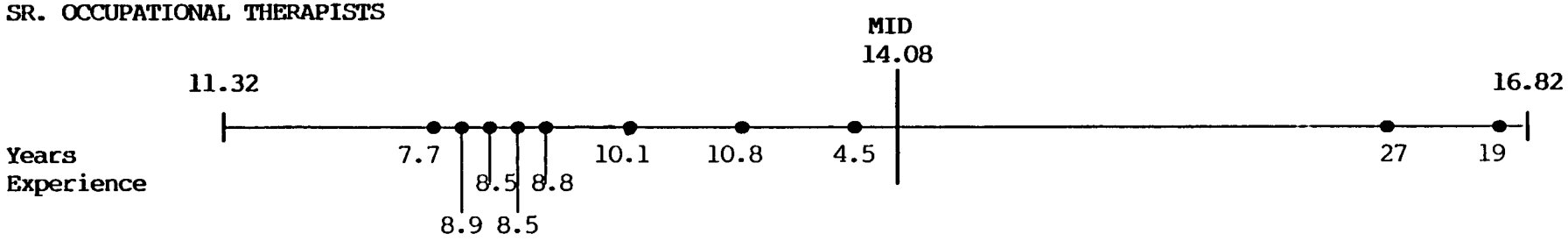
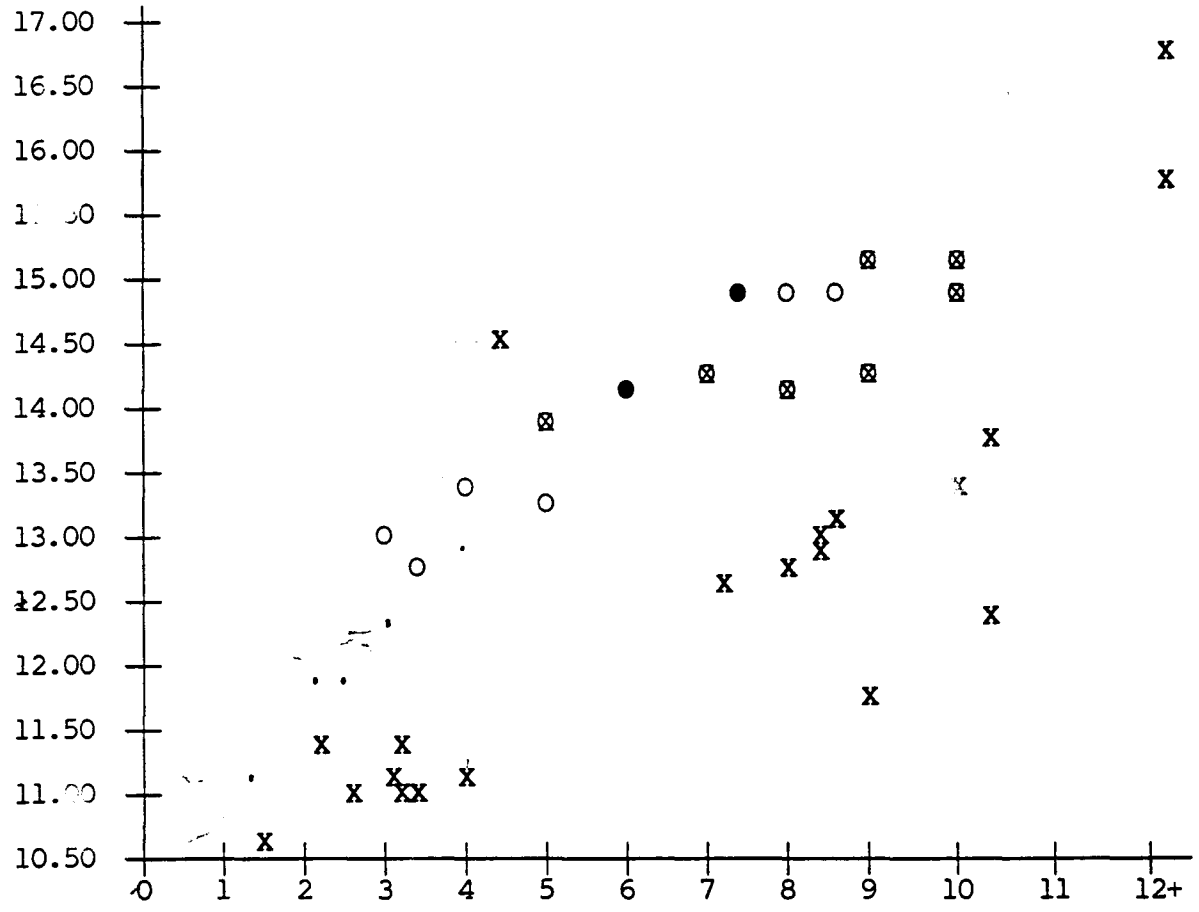


EXHIBIT C

SALARY COMPARISONS BASED ON
YEARS OF EXPERIENCE AS AN OTR
(Fiscal Year 1988)



⊗ Abbott Northwestern

O Fairview Riverside

● Ramsey Medical Center

X UMHC

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

SUBJECT: Bad Debts - Second Quarter Fiscal Year 1989 DATE: January 17, 1989

TO: UMHC Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director, UMHC

The total amount recommended for bad debt for Hospital and Clinic accounts receivable during the second quarter of 1988-89 is $687,303.14 represented by 1570 accounts. Bad debt recoveries during the period amounted to $31,118.46, leaving a net charge-off of $656,184.68.

The net bad debts of $656,184.68 for the quarter were 0.86% of gross charges. This compares to a budgeted level of bad debts of 1.42% ($710,088.00)

A statistical summary is attached along with a detailed description of losses over $2,000.00 and recoveries over $200 for each month of the second quarter.

Year-to-date bad debts have amounted to $1,081,953.20 represented by 2930 accounts. Recoveries during this first half of this fiscal year amount to $43,784.16, leaving a net charge-off of $1,038,169.04.

The net bad debts of $1,038,169.04 for the two quarters were 0.67% of gross charges. This compares to a budgeted level of bad debts of 1.42% ($1,459,705.00).

Along with a year-to-date statistical summary, we have also included reports with a breakdown of bad debts by residence and by the clinical services.

CPF:slw

Attachments

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

OCTOBER 1988 THROUGH DECEMBER 1988

	Less Than $2000	# of Accounts	More Than $2000	# of Accounts	TOTAL AMOUNT	TOTAL # of ACCOUNTS
INPATIENT						
Bad Debt (701) Write-Offs	50,838.49	110	256,269.00	29	307,107.49	139
Bad Debt (702) Charity Care	20,444.65	34	97,427.70	14	117,872.35	48
Total	71,283.14	144	353,696.70	43	424,979.84	187
Recoveries	(605.12)	7	(25,099.74)	2	(25,704.86)	9
Net Total	$ 70,678.02	144*	$ 328,596.96	43*	$ 399,274.98	187*
OUTPATIENT						
Bad Debt (701) Write-Offs	185,495.80	1195	30,628.91	7	216,124.71	1202
Bad Debt (702) Charity Care	32,247.83	178	13,950.76	3	46,198.59	181
Total	217,743.63	1373	44,579.67	10	262,323.30	1383
Recoveries	(5,413.60)	36	(000.00)	0	(5,413.60)	36
Net Total	$ 212,330.03	1373*	$ 44,579.67	10*	$ 256,909.70	1383*
INPATIENT AND OUTPATIENT TOTAL	$ 283,008.05	1517*	$ 373,176.63	53*	$ 656,184.68	1570*
TOTAL BAD DEBTS						
Bad Debt (701) Write-offs	$ 236,334.29	1305	$ 286,897.91	36	$ 523,232.20	1341
Bad Debt (702) Charity Care	52,692.48	212	111,378.46	17	164,070.94	229
Total	289,026.77	1517	398,276.37	53	687,303.14	1570
Recoveries	(6,018.72)	43	(25,099.74)	2	(31,118.46)	45
TOTAL NET BAD DEBT	$ 283,008.05	1517*	$ 373,176.63	53*	$ 656,184.68	1570*

NOTE: More than $2,000 amount includes legal settlements totaling $13,553.51

DOLLARS BUDGETED **$ 710,088.00**

*Net total of accounts do not include recoveries.

UNIVERSITY OF MINNESTOA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

OCTOBER 1988 THROUGH DECEMBER 1988

	LESS THAN $100	# OF ACCOUNTS	$100 - $999	# OF ACCOUNTS	$1000 - $1999	# OF ACCOUNTS	$2000 - $9,999	# OF ACCOUNTS	$10,000 +	# OF ACCOUNTS	TOTAL AMOUNT	TOTAL # OF ACCOUNTS
INPATIENT												
Bad Debt (701) Write-Offs	$963.92	29	$24,841.21	65	$25,033.36	16	$80,233.35	23	$176,035.65	6	$307,107.49	139
Bad Debt (702) Charity Care	$343.46	9	$8,753.61	18	$11,347.58	7	$56,952.18	12	$40,475.52	2	$117,872.35	48
Total	$1,307.38	38	$33,594.82	83	$36,380.94	23	$137,185.53	35	$216,511.17	8	$424,979.84	187
Recoveries	($113.12)	6	($492.00)	1	$0.00	0	($25,099.74)	2	$0.00	0	($25,704.86)	9
Net Total	$1,194.26	38 *	$33,102.82	83 *	$36,380.94	23 *	$112,085.79	35 *	$216,511.17	8 *	$399,274.98	187
OUTPATIENT												
Bad Debt (701) Write-Offs	$29,284.76	701	$127,051.85	472	$29,159.19	22	$30,628.91	7	$0.00	0	$216,124.71	1202
Bad Debt (702) Charity Care	$4,853.05	108	$22,707.81	66	$4,686.97	4	$13,950.76	3	$0.00	0	$46,198.59	181
Total	$34,137.81	809	$149,759.66	538	$33,846.16	26	$44,579.67	10	$0.00	0	$262,323.30	1383
Recoveries	($529.85)	24	($2,171.69)	11	($2,712.06)	1	$0.00	0	$0.00	0	($5,413.60)	36
Net Total	$33,607.96	809 *	$147,587.97	538 *	$31,134.10	26 *	$44,579.67	10 *	$0.00	0 *	$256,909.70	1383
TOTAL IP AND OP BAD DEBT												
Bad Debt (701) Write-offs	$30,248.68	730	$151,893.06	537	$54,192.55	38	$110,862.26	30	$176,035.65	6	$523,232.20	1341
Bad Debt (702) Charity Care	$5,196.51	117	$31,461.42	84	$16,034.55	11	$70,902.94	15	$40,475.52	2	$164,070.94	229
Total	$35,445.19	847	$183,354.48	621	$70,227.10	49	$181,765.20	45	$216,511.17	8	$687,303.14	1570
Recoveries	($642.97)	30	($2,663.69)	12	($2,712.06)	1	($25,099.74)	2	$0.00	0	($31,118.46)	45
TOTAL NET BAD DEBT	$34,802.22	847 *	$180,690.79	621 *	$67,515.04	49 *	$156,665.46	45 *	$216,511.17	8 *	$656,184.68	1570

DOLLARS BUDGETED

* Net total of accounts do no include recoveries.

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JULY 1988 THROUGH DECEMBER 1988

	Less Than $2000	# of Accounts	More Than $2000	# of Accounts	TOTAL AMOUNT	TOTAL # of ACCOUNTS
INPATIENT						
Bad Debt (701) Write-Offs	101,653.08	226	328,686.84	46	430,339.92	272
Bad Debt (702) Charity Care	33,956.23	67	182,562.20	26	216,518.43	93
Total	135,609.31	293	511,249.04	72	646,858.35	365
Recoveries	(1,162.12)	12	(29,308.20)	3	(30,470.32)	15
Net Total	$ 134,447.19	293*	$ 481,940.84	72*	$ 616,388.03	365*
OUTPATIENT						
Bad Debt (701) Write-Offs	304,325.76	2226	53,401.13	11	357,726.89	2237
Bad Debt (702) Charity Care	58,191.64	324	19,176.32	4	77,367.96	328
Total	362,517.40	2550	72,577.45	15	435,094.85	2565
Recoveries	(13,313.84)	87	(000.00)	0	(13,313.84)	87
Net Total	$ 349,203.56	2550*	$ 72,577.45	15*	$ 421,781.01	2565*
INPATIENT AND OUTPATIENT TOTAL	$ 483,650.75	2843*	$ 554,518.29	87*	$1,038,169.04	2930*
TOTAL BAD DEBTS						
Bad Debt (701) Write-offs	$ 405,978.84	2452	$ 382,087.97	57	$ 788,066.81	2509
Bad Debt (702) Charity Care	92,147.87	391	201,738.52	30	293,886.39	421
Total	498,126.71	2843	583,826.49	87	1,081,953.20	2930
Recoveries	(14,475.96)	99	(29,308.20)	3	(43,784.16)	102
TOTAL NET BAD DEBT	$ 483,650.75	2843*	$ 554,518.29	87*	$1,038,169.04	2930*

NOTE: More than $2,000 amount includes legal settlements totaling $33,553.91

DOLLARS BUDGETED **$1,459,705.00**

*Net total of accounts do not include recoveries.

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JULY 1988 THROUGH DECEMBER 1988

	LESS THAN $100	# OF ACCOUNTS	$100 - $999	# OF ACCOUNTS	$1000 - $1999	# OF ACCOUNTS	$2000 - $9,999	# OF ACCOUNTS	$10,000 +	# OF ACCOUNTS	TOTAL AMOUNT	TOTAL # OF ACCOUNTS
INPATIENT												
Bad Debt (701) Write-Offs	$2,894.84	74	$47,158.55	118	$51,599.69	34	$131,134.86	39	$197,551.98	7	$430,339.92	272
Bad Debt (702) Charity Care	$695.48	16	$20,757.11	43	$12,503.64	8	$102,696.33	22	$79,865.87	4	$216,518.43	93
Total	$3,590.32	90	$67,915.66	161	$64,103.33	42	$233,831.19	61	$277,417.85	11	$646,858.35	365
Recoveries	($178.12)	10	($984.00)	2	$0.00	0	($29,308.20)	3	$0.00	0	($30,470.32)	15
Net Total	$3,412.20	90 *	$66,931.66	161 *	$64,103.33	42 *	$204,522.99	61 *	$277,417.85	11 *	$616,388.03	365
OUTPATIENT												
Bad Debt (701) Write-Offs	$53,251.42	1362	$212,108.63	835	$38,965.71	29	$53,401.13	11	$0.00	0	$357,726.89	2237
Bad Debt (702) Charity Care	$7,550.63	171	$43,526.57	147	$7,114.44	6	$19,176.32	4	$0.00	0	$77,367.96	328
Total	$60,802.05	1533	$255,635.20	982	$46,080.15	35	$72,577.45	15	$0.00	0	$435,094.85	2565
Recoveries	($1,541.41)	60	($5,884.95)	24	($5,887.48)	3	$0.00	0	$0.00	0	($13,313.84)	87
Net Total	$59,260.64	1533 *	$249,750.25	982 *	$40,192.67	35 *	$72,577.45	15 *	$0.00	0 *	$421,781.01	2565
TOTAL IP AND OP BAD DEBT												
Bad Debt (701) Write-offs	$56,146.26	1436	$259,267.18	953	$90,565.40	63	$184,535.99	50	$197,551.98	7	$788,066.81	2509
Bad Debt (702) Charity Care	$8,246.11	187	$64,283.68	190	$19,618.08	14	$121,872.65	26	$79,865.87	4	$293,886.39	421
Total	$64,392.37	1623	$323,550.86	1143	$110,183.48	77	$306,408.64	76	$277,417.85	11	$1,081,953.20	2930
Recoveries	($1,719.53)	70	($6,868.95)	26	($5,887.48)	3	($29,308.20)	3	$0.00	0	($43,784.16)	102
TOTAL NET BAD DEBT	$62,672.84	1623 *	$316,681.91	1143 *	$104,296.00	77 *	$277,100.44	76 *	$277,417.85	11 *	$1,038,169.04	2930
DOLLARS BUDGETED											$1,459,705.00	

* Net total of accounts do no include recoveries.

SECOND QUARTER FISCAL YEAR - 1989
and YEAR-TO-DATE BAD DEBTS

BY STATE

STATE	SECOND QUARTER NUMBER	SECOND QUARTER AMOUNT	TOTAL FSY 89 NUMBER	TOTAL FSY 89 AMOUNT
Alabama	1	19.00	1	19.00
Alaska	6	2,191.70	9	2,476.10
Arizona	2	1,208.99	3	1,349.79
Arkansas			1	626.25
California	3	287.57	18	2,093.49
Colorado			3	473.06
Connecticut				
Delaware				
Dist. of Colombia			1	706.80
Florida	2	178.94	8	4,638.72
Georgia			2	245.48
Hawaii				
Idaho			2	130.71
Illinois	7	5,795.08	16	7,091.77
Indiana			2	187.18
Iowa	10	10,287.59	16	11,350.33
Kansas	1	28.62	1	28.62
Kentucky				
Louisiana	2	278.27	2	278.27
Maine				
Maryland				
Massachusetts	3	344.30	4	682.95
Michigan	2	521.78	19	11,040.91
Minnesota	1383	495,050.78	2520	793,266.70
Mississippi	2	139.78	2	139.78
Missouri	2	311.90	4	977.20
Montana	9	26,606.04	13	26,749.27
Nebraska	1	75.00	5	254.45
Nevada	1	48.36	1	48.36
New Hampshire				
New Jersey				
New Mexico			1	131.00
New York	15	737.49	19	1,247.62
North Carolina	5	2,813.15	6	2,997.46
North Dakota	19	2,628.77	47	6,276.41
Ohio	2	113.14	7	1,263.76
Oklahoma	8	1,036.48	8	1,036.48
Oregon			4	27,079.55
Pennsylvania	2	41,096.05	5	42,365.65
Puerto Rico				

continued on next page

SECOND QUARTER FISCAL YEAR - 1989
and YEAR-TO-DATE BAD DEBTS

BY STATE/Page Two

STATE	SECOND QUARTER NUMBER	SECOND QUARTER AMOUNT	TOTAL FSY 89 NUMBER	TOTAL FSY 89 AMOUNT
Rhode Island				
South Carolina			1	18.13
South Dakota	44	28,830.12	73	41,797.78
Tennessee				
Texas	9	2,695.17	13	3,190.62
Utah				
Vermont				
Virginia				
Washington			2	218.35
West Virginia			1	52.50
Wisconsin	52	16,467.64	99	20,497.07
Wyoming				
Out-of-Country	6	37,019.18	16	38,168.01
TOTAL	1599	676,810.89	2955	1,051,195.58
Medicare Bad Debt*	-38	-11,000.91	-40	-11,045.91
Legal Settlements	3	15,526.91	6	35,527.31
Bad Debt Agcy Und $50	3	340.96	5	486.06
Bad Debt - Med NC Chgs	3	5,625.29	4	5,790.16
GRAND TOTAL	1570	687,303.14	2930	1,081,953.20
RECOVERIES	45	-31,118.46	102	-43,784.16
NET TOTAL	1570	656,184.68	2930	1,038,169.04

NOTE: Medicare Bad Debts are included in the State Breakdown but are no longer included as a Bad Debt.

SECOND QUARTER FISCAL YEAR - 1989
and YEAR-TO-DATE BAD DEBTS

BY SERVICE

ADMITTING SERVICE	SECOND QUARTER NUMBER	SECOND QUARTER AMOUNT	TOTAL FSY 89 NUMBER	TOTAL FSY 89 AMOUNT
Anesthesiology				
Clinical Research	1	558.80	1	558.80
Dentistry				
Dermatology	2	1,760.57	2	1,760.57
Family Practice				
OB	1	274.28	2	1,265.58
NB	1	185.50	4	1,507.95
GYN	4	3,565.65	8	7,932.01
GYN-Oncology	5	870.93	11	2,388.58
Lab Medicine & Pathology				
Medicine-Blue	6	5,45[illegible].2	11	9,091.45
Green	6	1,675.04	[illegible]	10,291.83
Masonic (Onc)	4	1,490.63	15	12,114.63
Purple			1	34.69
Red A			8	6,120.22
Red B			2	297.24
Rose A	1	1,864.69	2	2,080.07
Rose B				
White A	10	2,024.02	18	6,[illegible]4.77
White B	6	4,360.30	8	4,867.[illegible]
Yellow A	1	1,902.57	2	3,058.63
Yellow B	3	1,053.35	3	1,053.35
Neurology	10	8,104.99	13	11,437.54
Neuro-epilepsy				
Neurosurgery	14	38,673.91	23	48,262.87
New Born-General	3	1,028.06	6	2,615.72
Obstetrics-General	8	5,556.75	17	10,823.10
-Midwife				
Opthamology	4	10,695.40	10	17,120.90
Orthopaedic Surgery	8	7,566.58	19	[illegible],326.23
Otolaryngology	4	4,774.18	7	4,797.17
Pediatrics-General	18	43,488.61	30	54,509.91
Neurology	2	317.25	2	317.25
Neurosurgery	1	40.81	2	3,688.35
Opthalmology	2	3,803.49	2	3,803.49
Orthopaedics			1	130.10
Otolaryngology				
Surgery Green	1	505.42	4	2,633.91
Surgery Orange				
Surg. Transplant				
Urology			1	394.82
Physical Med. & Rehab.	1	449.12	1	449.12
Psychiatry-Child	1	1,924.00	4	2,985.04
-Adult	12	40,926.03	22	51,890.76
Radiology				

continued on next page

SECOND QUARTER FISCAL YEAR - 1989
and YEAR-TO-DATE BAD DEBTS

BY SERVICE/Page Two

ADMITTING SERVICE	SECOND QUARTER NUMBER	SECOND QUARTER AMOUNT	TOTAL FSY 89 NUMBER	TOTAL FSY 89 AMOUNT
Surgery-Blue	12	5,162.19	22	37,170.19
Orange	7	106,921.33	8	107,176.59
Purple	5	4,134.62	10	8,754.77
Red	6	25,720.75	12	31,748.64
White	8	9,950.36	15	38,814.51
Therapeutic Radiology				
Urology	9	18,740.07	19	30,305.19
Unknown	10	65,658.84	17	77,169.79
Outpatient	1402	245,625.48	2580	398,131.66
Total	1599	676,810.89	2955	1,051,195.58
Medicare Bad Debt*	-38	-11,000.91	-40	-11,045.91
Legal Settlements	3	15,526.91	6	35,527.31
Bad Debt Agcy Und $50	3	340.96	5	486.06
Bad Debt - Med NC Chgs	3	5,625.29	4	5,790.16
GRAND TOTAL	1570	687,303.14	2930	1,081,953.20
RECOVERIES	45	-31,118.46	102	-43,784.16
NET TOTAL	1570	656,184.68	2930	1,038,169.04

*NOTE: Medicare Bad Debts are included in Service breakdown but are no longer included as a bad debt.

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JULY 1988 THROUGH SEPTEMBER 1988

	Less Than $2000	# of Accounts	More Than $2000	# of Accounts	TOTAL AMOUNT	TOTAL # of ACCOUNTS
INPATIENT						
Bad Debt (701) Write-Offs	50,814.59	116	72,417.84	17	123,232.43	133
Bad Debt (702) Charity Care	13,511.58	33	85,134.50	12	98,646.08	45
Total	64,326.17	149	157,552.34	29	221,878.51	178
Recoveries	(557.00)	5	(4,208.46)	1	(4,765.46)	6
Net Total	$ 63,769.17	149*	$ 153,343.88	29*	$ 217,113.05	178*
OUTPATIENT						
Bad Debt (701) Write-Offs	118,829.96	1031	22,772.22	4	141,602.18	1035
Bad Debt (702) Charity Care	25,943.81	146	5,225.56	1	31,169.37	147
Total	144,773.77	1177	27,997.78	5	172,771.55	1182
Recoveries	(7,900.24)	51	(000.00)	0	(7,900.24)	51
Net Total	$ 136,873.53	1177*	$ 27,997.78	5*	$ 164,871.31	1182*
INPATIENT AND OUTPATIENT TOTAL	$ 200,642.70	1326*	$ 181,341.66	34*	$ 381,984.36	1360*
TOTAL BAD DEBTS						
Bad Debt (701) Write-offs	$ 169,644.55	1147	$ 95,190.06	21	$ 264,834.61	1168
Bad Debt (702) Charity Care	39,455.39	179	90,360.06	13	129,815.45	192
Total	209,099.24	1326	185,550.12	34	394,650.06	1360
Recoveries	(8,457.24)	56	(4,208.46)	1	(12,665.70)	57
TOTAL NET BAD DEBT	$ 200,642.70	1326*	$ 181,341.66	34*	$ 381,984.36	1360*

NOTE: More than $2,000 amount includes legal settlements totaling $20,000.40

DOLLARS BUDGETED **$ 749,617.00**

*Net total of accounts do not include recoveries.

REVISED

UNIVERSITY OF MINNESTOA HOSPITAL AND CLINIC

BAD DEBT STATISTICS

JULY 1988 THROUGH SEPTEMBER 1988

	LESS THAN $100	# OF ACCOUNTS	$100 - $999	# OF ACCOUNTS	$1000 - $1999	# OF ACCOUNTS	$2000 - $9,999	# OF ACCOUNTS	$10,000 +	# OF ACCOUNTS	TOTAL AMOUNT	TOTAL # OF ACCOUNTS
INPATIENT												
Bad Debt (701) Write-Offs	$1,930.92	45	$22,317.34	53	$26,566.33	18	$50,901.51	16	$21,516.33	1	$123,232.43	133
Bad Debt (702) Charity Care	$352.02	7	$12,003.50	25	$1,156.06	1	$45,744.15	10	$39,390.35	2	$98,646.08	45
Total	$2,282.94	52	$34,320.84	78	$27,722.39	19	$96,645.66	26	$60,906.68	3	$221,878.51	178
Recoveries	($65.00)	4	($492.00)	1	$0.00	0	($4,208.46)	1	$0.00	0	($4,765.46)	6
Net Total	$2,217.94	52 *	$33,828.84	78 *	$27,722.39	19 *	$92,437.20	26 *	$60,906.68	3 *	$217,113.05	178
OUTPATIENT												
Bad Debt (701) Write-Offs	$23,966.66	661	$85,056.78	363	$9,806.52	7	$22,772.22	4	$0.00	0	$141,602.18	1035
Bad Debt (702) Charity Care	$2,697.58	63	$20,818.76	81	$2,427.47	2	$5,225.56	1	$0.00	0	$31,169.37	147
Total	$26,664.24	724	$105,875.54	444	$12,233.99	9	$27,997.78	5	$0.00	0	$172,771.55	1182
Recoveries	($1,011.56)	36	($3,713.26)	13	($3,175.42)	2	$0.00	0	$0.00	0	($7,900.24)	51
Net Total	$25,652.68	724 *	$102,162.28	444 *	$9,058.57	9 *	$27,997.78	5 *	$0.00	0 *	$164,871.31	1182
TOTAL IP AND OP BAD DEBT												
Bad Debt (701) Write-offs	$25,897.58	706	$107,374.12	416	$36,372.85	25	$73,673.73	20	$21,516.33	1	$264,834.61	1168
Bad Debt (702) Charity Care	$3,049.60	70	$32,822.26	106	$3,583.53	3	$50,969.71	11	$39,390.35	2	$129,815.45	192
Total	$28,947.18	776	$140,196.38	522	$39,956.38	28	$124,643.44	31	$60,906.68	3	$394,650.06	1360
Recoveries	($1,076.56)	40	($4,205.26)	14	($3,175.42)	2	($4,208.46)	1	$0.00	0	($12,665.70)	57
TOTAL NET BAD DEBT	$27,870.62	776 *	$135,991.12	522 *	$36,780.96	28 *	$120,434.98	31 *	$60,906.68	3 *	$381,984.36	1360
DOLLARS BUDGETED											$749,617.00	

* Net total of accounts do no include recoveries.

MINUTES
Planning and Development Committee
January 9, 1989

CALL TO ORDER
Ms. B. Kristine Johnson, Chair, called the January 9, 1989 meeting of the Planning and Development Committee to order at 1:40 p.m. in Room 8-106 in the University Hospital.

Attendance:	Present	B. Kristine Johnson, Chair Robert Dickler William Jacott, M.D. Geoff Kaufmann Peter Lynch, M.D. Ted Thompson, M.D.
	Absent	Leonard Bienias Clint Hewitt
	Staff	Shelly Cochran Al Dees Cliff Fearing Greg Hart Nancy Janda Carter McComb Lisa McDonald
	Guest	William Thompson, M.D.

APPROVAL OF MINUTES
The minutes of the December 6, 1988 meeting were approved as distributed.

MAGNETIC RESONANCE IMAGING (MRI)
Mr. Dees, Mr. Hart, and Mr. Dickler reviewed internal discussions that resulted in the recommendation to purchase the MRI with the smaller (1.5T) magnet. The purchase of 1.5T magnet will result in a $150,000 savings, images equal to over the 2.0T magnet, and potentially more secure, ongoing vendor support and maintenance. Administration has determined that it would not be appropriate to rebid the project because the company that was awarded the bid will fulfill the bid. Siemans gave UMHC the option of either going with the 2.0T magnet as bid which is being discontinued or the 1.5T. The 1.5T magnet alternative was given because that is where Siemans is directing their resources and where advances are being made in the imaging and spectroscopy capabilities. Also, the construction contract is in place and the delay could cost up to $185,000. The Planning and Development Committee discussed this change at length, noted the extensive discussion at the last meeting, and endorsed the purchase of the 1.5T magnet.

MAJOR CAPITAL EXPENDITURE
Mr. Hart discussed the capital expenditure policy which does not currently require leased equipment to be brought before the board. However, it was administration's belief that capital expenditures with a value over $100,000

should be reviewed with the board and that those expenditures would be reported on a cash out basis. Mr. Hart then discussed two major capital expenditures.

A LaserTripter is in the process of being leased for $6,000/month for 36 months ($250,000). The laser device is a new mode of therapy for the treatment of renal stones. It will augment the current lithotripter utilized by Urology and would appear to be more beneficial for certain stone desolutions depending upon location. The device has been approved by the FDA and has been in place on a no-cost trial basis for 6 months. Thirty-seven patients have been treated mainly as outpatients. The payback period of the machine is estimated at less than two years. The lease arrangement is being used for both financial and possible technical obsolescence reasons. The acquisition was not budgeted but is being funded because of its revenue generation potential, rapid payback and to remain at the technological edge of renal stone treatment.

Mr. Hart then discussed the leasing of two Kodak chemistry random access analyzers for $4,750/month for 60 months ($285,000). One is to replace an analyzer in Clinical Chemistry which was budgeted and the other is a replacement in Outpatient Laboratories that was not budgeted. Kodak was chosen because their analyzer in the Critical Care Chemistry area has been superior and has allowed for expansion of the menu of tests. Two analyzers are being purchased from Kodak because having three analyzers from the same vendor provides better back-up, more consistent service, improved quality control, time savings in calibration and patient value comparison checks, and decreased staff training time. Also, Kodak has provided a financial incentive to purchase two machines instead of one by reducing the cost of the reagent used with the analyzer. They have also agreed to hold future price increases to 2% per year for five years. (Last year's increases ranged from 6% - 25%.) The more than one million tests per year translate to substantial reagent savings. The lease arrangement was endorsed by the Planning and Development Committee because of the operation efficiencies and that the annual operating savings approximate or exceed the annual lease cost for the unbudgeted machine.

Ms. Janda discussed the purchase of a second hyperthermia system which is estimated at $204,771. The second hyperthermia will be used in conjunction with radiation therapy or chemotherapy to warm up the tumors to enhance the treatment for cancer patients with advanced, locally extensive, metastic or inoperable diseases. The payback period is under two years and some third party payers are reimbursing the hospital. The purchase of the hyperthermia was endorsed by the committee.

Ms. Johnson discussed whether capital expenditures should come before the committee before they are bid out so that they do not have to be presented twice if the estimate is not within prescribed guidelines. After a brief discussion, Mr. Dickler suggested that major capital expenditures be presented after the bids have been received. However, remodeling and construction estimates should be presented as budgeted.

QUARTERLY CAPITAL EXPENDITURE REPORTING

Mr. Hart reviewed a quarterly capital expenditure reporting format for year-to-date expenditures through November. The committee reviewed the format that

includes equipment purchases, bond payments, capital projects, renewal projects and miscellaneous expenses based on the annual budget, roll forward funds, year-to-date expenses and projected annual expenses from year to date projections. Suggestions were made to separate the roll forward funds and look at alternative methods of projecting the annual expenditures based on historical trends as opposed to a straight line projection. Quarterly presentations will be made to the Planning and Development Committee in compliance with the Board of Governor's policy.

INTEGRATED MEDICAL SYSTEMS (IMS)

Dr. LaBree and Mr. Kaufmann discussed IMS which is a computer network which permits physicians in remote locations to communicate through a proprietary software system. In addition, IMS has developed a variety of clinical applications which physicians can acquire for practice management and clinical testing.

UMHC has instituted a pilot program using IMS to determine its acceptability to referring physicians and viability as a communications system. Initial results of the pilot study indicated that the system is viewed favorably by both internal and external physicians. While the primary interest of UMHC is enhanced communication the interest of, and willingness to invest in the network by outside physician practices, is largely dependent on their ability to utilize the hardware for other practice activities.

The general concept is that UMHC will help form a network with IMS and provide communication software to enhance UMHC communications with these practice sites. Practice sites would normally purchase the hardware, especially if they purchase other applications to assist them in their practice.

It was noted during discussion of this proposal that the writeup contained in the agenda did not clearly articulate the purpose of the network for UMHC (communications), and that the other potential uses for the system were solely the prerogative and determination of external practice sites. It was requested that the memo be revised for discussion at other committees and be more reflective of the true nature of the network.

A detailed analysis is currently underway of the financial, legal, and operational issues associated with the proposed network. Dr. Lynch noted potential sensitivity of the faculty to the network and its relationship to other UMHC outreach strategies. Mr. Dickler noted the potential impact of the network and the uniqueness of IMS compared to other vendor systems in its multiple uses which increases the chances of acceptance and use by outside physicians.

UMCA REPORT

Dr. Lynch discussed the UMCA reorganization and current hospital and medical staff discussions. The UMCA Board of directors decided to break up their functions into two groups. One focuses on the contracting, marketing and outreach functions funded by an assessment methodology. The other involves the billing arrangements and includes a reduction in the cost of doing business to the medical departments.

ADJOURNMENT
Ms. Johnson adjourned the Planning and Development Committee at 2:10 p.m.

Respectfully submitted,

Lisa McDonald

Lisa McDonald
Assistant Director of Planning and Marketing

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

January 18, 1989

TO: Members, Board of Governors

FROM: Robert Dickler
General Director

SUBJECT: Magnetic Resonance Imaging Project: Change in Magnet Size

In late 1987 UMHC Radiology and Hospital management staff decided to purchase a magnetic resonance imaging (MRI) machine with a dual range, 1.5 and 2.0 Tesla (T) magnet from Siemens Medical Systems, Inc.. This decision was made because:

A. It was anticipated that further improvements in the quality of diagnostic images would eventually be achieved through use of the 2.0T rather than the 1.5T range.

B. Research completed up to that time indicated that the quality of spectroscopy analysis was directly related to the magnetic field strength utilized. 2.0T was the maximum field strength available.

Research completed during the past year confirms that image homogeneity is better at 2.0T. However, overall image quality is actually poorer at 2.0T due to increased artifacts in images produced by body motion. Current thinking by industry experts is that 1.5T may be the optimum strength for diagnostic imaging.

Because spectroscopy is still a research modality with unproven efficacy, many hospitals making purchase decisions about large MRI machines during the past year have been unwilling to spend the additional money required for the dual range machine and have purchased single range 1.5T machines. Consequently, Siemens and other vendors have concluded that, even if spectroscopy is proven to be efficacious, there will be little market interest unless it can be done on the 1.5T machines already in place.

In light of these developments, Siemens has decided to focus its research and development efforts at the 1.5T level. On October 1, 1988, they introduced a new 1.5T magnet with homogeneity characteristics equal to that of a 2.0T and discontinued further development and marketing of the dual range magnet like the one purchased by UMHC.

Siemens is prepared to deliver the dual range magnet to UMHC as ordered. However, they have indicated that they would accept an amendment to UMHC's purchase agreement changing the magnet to the new high-homogeneity, single range 1.5T. This change would result in a $150,000 price decrease.

After significant deliberation, the administrative staff has concluded that a new high-homogeneity, single range 1.5T rather than the dual range 1.5/2.0T magnet should be purchased from Siemens. In addition to taking advantage of the opportunity to purchase a functionally comparable machine for $150,000 less, we believe it is in the institution's best long term interest to install the vendor's most up-to-date magnet with the field strength at which the vendor is currently targeting its future research and development efforts. This change will not require any change in the facility design or result in a delivery delay.

The magnet size included in the MRI project proposal approved by the Board of Governors was a dual range 1.5/2.0T magnet. **Therefore, the administrative staff seeks concurrence by the Board of Governors to changing the magnet to a high-homogeneity, single range 1.5T through amendment of the purchase agreement with Siemens Medical Systems, Inc..**

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

January 18, 1989

TO: Members of the Board of Governors

FROM: Greg Hart
Senior Associate Director

REGARDING: Capital Expenditures

Attached please find three major capital expenditure reports. These items whose acquisition costs fall in the $100,000 - $600,000 range required for Board reporting, are presented for information consistent with Board of Governors' policy.

The first of the major capital expenditures is a hyperthermia unit for the Therapeutic Radiology Clinic. That unit was budgeted for and is currently out on bid.

We will elaborate on the two other items to a somewhat greater degree than usual at the meeting, because (a) they involve leasing arrangements, and (b) they are (in part) not budgeted, but are financially and programmatically beneficial.

We look forward to discussing these items with you at the Board of Governors meeting on January 25, 1989.

GH/kff

Attachments

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
MAJOR CAPITAL EXPENDITURE REPORT

EQUIPMENT: Hyperthermia System

PURCHASE PRICE: $204,771.00

DESCRIPTION:

Despite remarkable advances in our understanding of cancer in recent years, the disease remains a leading cause of death. Conventional treatment modalities such as surgery, radiation and chemotherapy often fail to help patients with advanced, locally extensive, metastatic or inoperable diseases. For these patients, hyperthermia in conjunction with radiation therapy or chemotherapy may provide an avenue of hope and benefit.

The University of Minnesota Hospital and Clinic Therapeutic Radiology Department began treating patients using hyperthermia in 1985. Although the application of heat alone has a direct cell-killing effect, hyperthermia is used in conjunction with radiation therapy in the clinical setting.

The acquisition of this second hyperthermia machine will allow the Therapeutic Radiologists to deliver treatment in three forms: superficial, interstitial and deep seated. Superficial hyperthermia is used for tumors at or near the body's surface. Interstitial and deep seated treatments as their names imply, are used for tumors located more deeply within the body. The second machine will be used primarily for the treatment of interstitial and superficial tumors.

Planning and Development Committee Review: January 9, 1989

Finance Committee Review: January 25, 1989

Board of Governors Review: January 25, 1989

Senior Associate Director & Director of Operations

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS

MAJOR CAPITAL EXPENDITURE REPORT

EQUIPMENT: 2 Chemistry random access analyzers

LEASE PRICE: $4750/month x 60 months = $285,000

DESCRIPTION:

This is a proposal for lease of two Kodak random access analyzers in the Hospital Laboratories; one to replace an analyzer in Clinical Chemistry, the other to replace a unit in Oupatient Laboratories. The Hospital currently has a random access analyzer from the same vendor (Kodak) in the Critical Care Chemistry area. Its performance has been superior and has allowed for expansion of the menu of tests offered on a 24-hour basis.

The acquisition of a second Kodak analyzer was budgeted for this year. A lease purchase analysis has led to the conclusion that leasing the unit is the preferred method of financing. This second Kodak analyzer is to replace the existing unit in Clinical Chemistry.

The Hospital currently has a third analyzer from another vendor in the Oupatient Lab. It would be beneficial to have all three analyzers from the same vendor. This will provide for better back-up, more consistent service, improved quality control, time savings in calibration and patient value comparison checks, and decreased staff training time.

The replacement of the analyzer in the Outpatient Lab was not budgeted for this year. The bid from the vendor, however, allows for cost savings on the reagents used with the analyzers which more than offset the annual lease costs for the unbudgeted analyzer. If the additional unit is purchased, Kodak has agreed to reduce their current reagent prices by approximately 5%. They have also agreed to hold future price increases to 2% per year for five years. (Last year's price increases for reagents ranged from 6% - 25%). With the large

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Senior Associate Director and Director of Operations

volume of tests run on these analyzers (over 1,000,000 per year), the cost savings from current prices are approximately $20,000 per year. The cost savings by the fifth year are conservatively $40,000 per year.

Given that the annual operating cost savings approximate or exceed the annual lease costs for the third machine, this unbudgeted capital expenditure is justified from a cost-effectiveness perspective.

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS

MAJOR CAPITAL EXPENDITURE REPORT

EQUIPMENT: LaserTripter

Lease Price: $6900/month x 36 months ($250,000)

DESCRIPTION:
The Hospital is in the process of acquiring a LaserTripter. This new laser device incorporating advanced technology is a new mode of and/or adjunct therapy for the desolation of renal stones. It is a device that will augment the current lithotripter utilized by Urology and would appear to be more beneficial for certain stone desolations depending upon location. Further, the device has been approved by Federal Drug Administration (FDA) for use through a percutaneous route in the desolation of biliary and common bile duct stones.

A laser fiber can be guided through a flexible ureteroscope (in the case of renal stones) and through activated laser wavelength turns the stone into a plasma-like substance that is easily eliminated by the patient.

The majority of the patients treated with this device will be outpatients and not require an overnight stay in the Hospital. The payback period on the machine is estimated at less than two years.

The current system has been in place on a no-cost trial basis for six months and 37 patients have been successfully treated. This is the first unit of its type in the Twin Cities, and will be an important part of our lithotripsy program, complementing the existing extracorporeal shock wave lithotripsy units.

A lease arrangement is being used for both financial and possible technical obsolesence reasons. This acquisition was not budgeted. The marketplace advantage this unit will give us, along with the revenue generation potential and rapid payback, make the LaserTripter an appropriate addition to the capital budget.

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Board of Governors Review: January 25, 1989

Senior Associate Director and Director of Operations

American Hospital Association

AHA

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HOSPITAL TAX-EXEMPT STATUS AND THE UNRELATED BUSINESS INCOME TAX: AN OVERVIEW FOR TRUSTEES

An AHA Briefing Paper for Hospital Governing Boards
December 1988

Introduction

The tax-exempt status of the voluntary, not-for-profit sector, including hospitals, is a subject of national debate. The Internal Revenue Service is now conducting an audit of several not-for-profit entities. Congressional hearings also have been held concerning the unrelated business activity of exempt organizations, heightening public awareness of the changing nature and activities of today's hospitals. The Subcommittee on Oversight of the U.S. House of Representatives Ways and Means Committee is examining the unrelated business income tax (UBIT) law and has developed a series of discussion options intended to severely limit the scope of unrelated activities that tax-exempt organizations can engage in without being taxed (See attached appendix for discussion options.) Some sources project that hospitals may lose as much as 50 percent of their net income due to federal and state legislative efforts to strictly limit the activities of today's tax-exempt organizations. Some local governments also are targeting hospitals as potential sources of revenue. They are questioning whether hospitals have moved too far from their traditional community focus in favor of becoming more commercial and business-oriented.

Today, policy makers and the public are increasingly suggesting that not-for-profit hospitals need to demonstrate why they deserve tax-exempt treatment. Hospital governing boards have a key role to play in helping their institutions assess exempt and unrelated activities and preserve the benefits they rightly receive from both. As key links between the hospital and the community, trustees who understand issues affecting the tax status of their institution can more effectively guide their hospital to properly balance its community orientation with its need to obtain sufficient revenue to operate efficiently and effectively.

History of Hospital Tax Status

Like many non-profit organizations, hospitals have traditionally been viewed as dedicated to community service. Federal and state governments have recognized the value of such organizations by granting them special benefits, including tax exemption.

Historically, not-for-profit hospitals have been granted exemption from federal income tax under Section 501 of the Internal Revenue Code if they could prove they were organized and operated exclusively for a charitable or other exempt purpose. Since 1969, the Internal Revenue Service has interpreted the promotion of health to be a charitable purpose and has applied a community benefit test in determining whether a not-for-profit hospital is deemed to be charitable. State and local tax exemptions are governed by state law, however historically, not-for-profit hospitals have been exempt from most state and local taxes, including income, sales/service and property taxes.

Unrelated Business Income Tax

The Internal Revenue Code also recognizes that exempt organizations may engage in business activities unrelated to their exempt functions. However, income from these activities is generally taxed.

The first unrelated business tax was enacted in 1950 by the U.S. Congress in response to charges that not taxing such income led to unfair competition between nonprofits and taxable businesses. The tax initially was applied only to a limited number of exempt organizations; however, the Tax Reform Act of 1969 made all section 501 and 401 organizations subject to the tax. The Tax Reform Acts of 1976 and 1986 further expanded income subject to the application of the UBIT.

Today, Section 512 of the Internal Revenue Code establishes three conditions which must be satisfied for income to be subject to the UBIT. The income must be 1) from a trade or business, 2) that is regularly carried on by the organization and 3) is not substantially related to the performance of the organization's exempt function. The tax also applies to income from debt-financed property. The UBIT is applied at corporate or trust tax rates, depending on the form of the organization.

UBIT and the Growth of the Tax-Exempt Sector

A memorandum from J.J. Pickle (D-Texas), Chairman of the House Ways and Means Oversight Subcommittee, discusses the dramatic growth over the past 20 years of the tax-exempt sector, which now includes about 866,000 exempt organizations with total revenues of more than $300 billion. These revenues comprised about 7 percent of the 1986 gross national product and are being looked at by some as a potential source to help balance budgets and reduce the deficit. The Pickle memo also states that this growth developed since Congress enacted the UBIT.

Hospitals have expanded into nontraditional services and activities for many reasons. These include reduced financial support from government, uncertainty of donations, and opportunities to improve the delivery of care and financial viability of the institution. According to the Pickle memo, today, many exempt organizations derive most of their income from income producing or commercial activities, rather than from more traditional sources of contributions. In June 1987, the U.S. Treasury Department reported that in 1946 organizations that were tax-exempt under Section 501(c)(3) of the Internal Revenue Code (charitable organizations, etc.) derived 59 percent of their revenues from income-producing activities. The memo goes on to say that by 1983, commercial revenues of these organizations had grown to 78 percent.

As nonprofits more actively pursue income producing activities, complaints about unfair competition will continue to arise from taxable businesses. And hospitals appear to be at the center of the controversy. At the subcommittee hearings in June 1987, many industries indicated their concern.

> "The problem of unfair competition encompasses many industries, yet is particularly acute in two areas: health care and universities...the most significant volume of small business complaints are directed at the surge in commercial activities engaged in by hospitals and higher education institutions, which together account for almost 70 percent of the nonprofit sector."

What Trustees Can Do

Trustees can engage in several activities to better understand and address issues surrounding the hospital's tax status. As a first step, the hospital board and executive management should assess the institution's structure and activities to determine how responsive it is to community interests and needs. Has your hospital accurately identified which of its activities are exempt and which are unrelated? Has it examined the extent to which the hospital competes with taxable businesses in the community and how this competition affects relationships with these businesses? Is your hospital aware of the community's perception of the hospital as a charitable organization?

The American Hospital Association has recently distributed to all member hospitals a new publication to help determine how oriented hospitals are to providing benefits to their communities. Community Benefit and Tax-Exempt Status: A Self-Assessment Guide for Hospitals can help trustees and hospital leadership better understand issues related to the hospital's tax status. The guide also can help the board and management better respond to the community and face challenges to the hospital's tax-exempt status. The guide includes three sections that trustees and hospital executives can use to evaluate the hospital's mission and structure; operations, policies, and procedures; and community benefit services and activities. Specific information is included to help assess unrelated business income and how the structure and operation of the governing board can affect the hospital's tax-exempt status. Trustees interested in reviewing the guide should contact their hospital CEO.

Additional copies of the report (catalogue #001800) are available from AHA order processing at a cost of $25 for AHA members and $40 for non-members. Copies can be ordered by calling 1-800-AHA-2626.

Trustees also can help their hospitals keep in touch with external perceptions about the hospital's community orientation. Trustees should become aware of the revenue needs of state and local governments to determine whether their hospital might be looked to as a potential source of revenue. Within the community, trustees also should be aware of small business concerns about the hospital as a competitor and about the extent of the hospital's unrelated business income.

To effectively address the growing governmental and community concern about continuing the tax-exempt status of not-for-profit hospitals, trustees should be prepared to help the hospital aggressively assert its charitable mission. Governing board members should regularly monitor the hospital's progress in fulfilling its charity related goals and objectives. Trustees also should become informed about the extent of their community's medically indigent population and its access to care.

Finally, trustees should be prepared to advocate for continuing their hospital's tax-exempt status with federal, state and local legislators and officials and community groups. Trustees can assist the hospital to communicate the central role not-for-profit hospitals play in the health care delivery system and can help enhance government and community understanding of the continuing value and importance of voluntary hospitals.

Supplemental Readings

American Hospital Association. Community Benefit and Tax-Exempt Status: A Self-Assessment Guide for Hospitals. Chicago, 1988.

American Hospital Association. "Your Best Defense: Protecting a Hospital's Tax-Exempt Status. Live Satellite Teleconference. Chicago. June 16, 1988.

Bureau of National Affairs, Inc. "Proposed Letter to House Ways and Means Committee Chairman Dan Rostenkowski (D-ILL), Along with Memorandum to Ways and Means Oversight Subcommittee Members from Subcommittee Chairman J.J. Pickle (D-TEXAS) and Attached Draft Report Describing Unrelated Business Income Tax Recommendations, for Consideration by Subcommittee." Washington, D.C. June 1988.

Copeland, J. and Rudney G. "Business income of nonprofits and competitive advantage." Tax Analysts Special Report. Tax Notes. November 24, 1986.

Hattis, P. "Tax Challenges prompt not-for-profit hospitals to defend charitable mission." Trustee. Vol. 41, No. 2. February, 1988.

Ryan Advisory, Inc. Health Care Consultants. "The Ryan Advisory." Vol. 17, No. 10. October, 1988.

For More Information

Contact Mary Totten. AHA Division of Hospital Governance, 11E, 840 North Lake Shore Drive, Chicago, Illinois 60611 (312/280-6704).

FOR IMMEDIATE RELEASE
THURSDAY, MARCH 31, 1988

PRESS RELEASE #16
SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1105 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-5522

THE HONORABLE J. J. PICKLE (D., TEXAS), CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES ANNOUNCES SUBCOMMITTEE REQUEST FOR PUBLIC COMMENTS ON DISCUSSION OPTIONS RELATING TO THE UNRELATED BUSINESS INCOME TAX

The Honorable J. J. Pickle (D., Texas), Chairman of the Subcommittee on Oversight, Committee on ways and Means U.S. House of representatives, today announced the released of the Subcommittee's preliminary discussion options regarding the unrelated business income tax (UBIT). The list of discussion options is a follow-up to the Subcommittee's series of earning held in June, 1987.

The Subcommittee is interested in receiving comments from the public on the options set forth below. The Subcommittee requests that such comments be provided in writing, *no later than April 15, 1988.* Written comments received by the Subcommittee will provide a basis for the Subcommittee's development of UBIT recommendations to the full Committee. (Committee rules on page 4 for "Submission of Written Comments" must be followed.) A Subcommittee hearing is expected to be scheduled in late April, following this comment period, to receive testimony from a limited number of invited witnesses. (Details will provided in a subsequent press release.)

In announcing the Subcommittee's request for public comments, Chairman Pickle stated: "The Subcommittee Members met this week and agreed that public comments should be received on a broad series of options on the unrelated business income tax. This should be done before any Subcommittee decisions are made in the area. The discussion options are not specific recommendations, but serve as the generally agreed to starting point for the Subcommittee's discussion. We recognize the very strong and appropriate concerns both of tax-exempt organizations and the business community in this sensitive area of our tax law. We look forward to constructive and detailed comments by all interested parties."

The Subcommittee's discussion options are the following:

I. "Substantially Related" Test:

Repeal "substantially related" test and replace it with a "directly related" test.

Determine whether each income-producing activity standing alone is tax-exempt.

Retain "substantially related" test; however, impose UBIT on specified activities (as listed in A-L below) whose nature and scope are inherently commercial, rather than charitable.

A. Apply UBIT to gift shop, bookstore income (with exceptions for (1) on-premise sales of low-cost mementos, (2) on-premise sales of an educational nature which relate to the organization visited. (3) in the case of a hospital, articles generally used by or for patients, (4) in he case of a university, articles in furtherance of educational programs, or low-cost items (dollar cap), and computer sales not in excess of one sale per student/faculty per year. In addition, applying UBIT to income from all catalog and mail/phone order or other "off-premise" sales (with exception for de minimis sales, in relation to amount of "on-premise" sales).

B. Applying UBIT to all sales or rental income of medical equipment and devices (including hearing aids, portable x-ray units, oxygen tanks), laboratory testing, and pharmaceutical drugs and goods (with exceptions for (1) inpatients, continuous-care outpatients, or emergency treatment outpatients or (2) items not available in immediate geographic area.)

C. Apply UBIT to income from certain health, fitness, exercise and similar activities unless program is available to a reasonable cross-section of the general public such as by scholarship or fees based on community affordability.

D. Apply UBIT to travel and tour services (with exception for services provided by colleges/universities to students/faculty as part of a degree program curriculum, and de minimis sales to non-students/faculty.)

E. Apply UBIT to adjunct food sales (with ex-

ception for on-premise services and/or sales provided primarily for students, faculty, employees, members, or organization visitors).

F. Apply UBIT to income from certain veterinary services such as grooming, boarding, and elective surgery (with exceptions for spaying and neutering, measures to protect the public health, and measures recommended by a veterinarian for the health of the animal).

G. Apply UBIT to hotel facility income which is patronized by the public (with exception for facilities operated, but only to the extent necessary, in furtherance of the organization's exempt purpose). In addition, apply UBIT to certain sales of condominiums and time-sharing units.

H. Apply UBIT to routine testing income (with exceptions for Federal or State mandated activity, pre-surgical medial testing, and laboratory testing which is part of a student educational training program).

I. Apply UBIT to income from affinity credit card/catalog endorsements.

J. Apply UBIT to advertising income and allow deductions from UBIT only for direct advertising costs.

K. Apply UBIT to theme/amusement parks.

L. Apply UBIT to additional specified activities determined to be inherently commercial.

II. Convenience Exception:

Repeal "convenience" exception (income from activities carried on primarily for the convenience of a Section 501(c) (3) organization's members, students patients, officers, or employees). Income from activities that are substantially related to the organization's exempt purpose would remain tax free, subject to the specific rules listed in Section I. above.

III. "Regularly Carried on" Test:

Repeal "regularly carried on" test. Income from an activity that is not a trade or business would remain tax-free.

IV. Tax Treatment of Royalty Income.

Apply UBIT to royalties measured by net or taxable income derived from the property; or royalties received by an organization for use of property if such organization, or closely related organization, either: (1) created such property, or (2) performed substantial services or incurred substantial costs with respect to the development or marketing of such property. Retain present law for certain law for certain non-working property interests, and exception for products that are part of the organization's exempt function.

V. Deduction from Taxable UBIT:

Increase $1,000 UBIT deduction for certain Section 501(c) organizations to $5,000 or $10,000, with phase-out beyond $50,000 income level. Limit the increased deduction to activities directly carried on by the exempt organization.

VI. Unrelated Debt-Financed Income:

Limit the current law UBIT exception for unrelated debt-financed property to only those pension funds, educational institutions and title holding companies that make at least a 20 percent equity investment of their interest in the property. Retain character of debt-financed income received from all pass-through entities.

VII. Subsidiaries and Joint Ventures:

Modify the definition of "control" in the case of exempt organizations having taxable subsidiaries. Define "control" as ownership directly, indirectly, or by attribution of at least 50 percent of stock, by vote or value (rather than 80 percent of combined voting stock, under present law).

Extend "control" rules where exempt organizations in the aggregate own more than 50 percent of the subsidiary's stock.

Provide that a controlled taxable subsidiary's income can be no less than its UBIT would have been if the income-producing activity had been carried on directly by the exempt parent organization.

Aggregate income and activities of controlled subsidiaries for purposes of determining if primary purpose of parent is a tax-exempt purpose.

VIII. Allocation Rules:

With respect to facilities used for exempt purposes as well as unrelated business purposes, allow a deduction against UBIT for a proportionate share of the direct operating cost of the facility (e.g., maintenance, insurance, and utilities), but not allow a deduction for a share of the general overhead of the organization or for depreciation.

IX. Tax Information Reporting/Internal Revenue Service (IRS) Administration:

Expand Form 990-T reporting requirement to include more reporting on: (1) activities and income which the organization claims to be exempt or excluded from UBIT, and (2) revenue sources such as contributions, grants or other funding sources.

Provide more detailed reporting of revenue-producing activities and income on Form 990.

Consider "short form" reporting for small organizations, based on revenues.

Require affiliated group that includes exempt organization to file a consolidated information return.

Recommend that IRS have an integrated examination program fro exempt organizations and subsidiaries (taxable and exempt).

Recommended that IRS conduct the following studies and report on: (1) nonprofit exempt hospital reorganizations subsidiaries); (2) exempt organizations that file Form 990s but do not file Form 990-T's (examining activities of a sample group to determine compliance with UBIT); (3) the feasibility of requiring State and Federal land-grant universities to file an information return; (4) the use, purpose and effect of joint ventures; and, (5) study, after five years, on effect of UBIT changes.

X. Miscellaneous:

Codify IRS position (upheld by some courts) that a social club (or other organization whose investment income is subject to UBIT) may not, in determining UBIT, reduce its net investment income by losses on sales to non-members.

Exempt for UBIT an organization's contingent rental income received through a prime tenant, where the prime tenant leases real estate from a tax-exempt organization, the prime tenant's net profits are based on fixed rents derived from subtenants, and the prime tenant does not provide services to subtenants except through an independent contractor.

Exempt from UBIT investment income earned from non-refundable loan commitment fees.

Modify rules applicable to organizations "testing for the public safety."

Consider modification of various piecemeal UBIT exclusion enacted since 1969.

Details for Submission of Written Comments:

Any interested person or organization may submit comments on the discussion options. Persons submitting statements should submit at least six (6) copies by the close of business, Friday, April 15, 1988, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515.

Formatting Requirement:

Each statement presented for printing to the Committee by a witne any written statement or exhibit for the printed rec or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper any may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or for written comments, the name and capacity of the person submitting the statement as well as any client or person, or any organization for whom the witn appears or for whom the statement is submi
4. A supplemental sheet must accompany statement using the name, full address, a te phone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the members, the press and public during the course of a public hearing may be submitted in other forms.

Star Tribune/Friday/December 16/1988

Minnesota hospitals come out well in death rates of Medicare patients

By Gordon Slovut
Staff Writer

Minnesota's hospitals fared well in the second annual federal rating of hospital death rates for Medicare patients.

Major hospitals such as University of Minnesota Hospital, Abbott Northwestern, Metropolitan-Mount Sinai, Methodist, the Fairview hospitals, United of St. Paul, Hennepin County Medical Center and St. Paul-Ramsey Medical Center had low death rates.

Only one of 165 hospitals in the state had more deaths than the federal government considered to be within the normal range and its death rate was only slightly above the norm.

But the Medicare Hospital Mortality Information study received sharp criticism from the hospital industry, which called it flawed, inaccurate and potentially misleading.

In an introduction to the report, Dr. William L. Roper, administrator of the Health Care Financing Administration, which pays Medicare hospital bills and prepared the report, said that it shouldn't be used to directly compare one hospital's mortality rate with that of another.

He said that the figures in the current study have been adjusted for the age, sex and diagnosis of patients, but that other factors can be involved.

One hospital may get more stroke patients already in comas and thus more likely to die, he said. Another hospital may have a higher death rate because it provides services that attract large numbers of gravely ill patients.

Roper said the continuing study is the beginning of an effort to develop ways to monitor the quality of care in

Hospitals continued on page 18A

HOSPITALS	Over all		
Name / Location	Number of patients	Actual '97 mortality rate in percent (*99 rate in parentheses)	Range of predicted mortality rate / percent
Evaleth Comm. Evaleth, MN	16	25(21)	4-49
Fairmont Comm. Fairmont, MN	559	14(14)	10-16
Fairview Hosp. Princeton, MN	165	10(9)	5-21
Falls Memorial Int'l Falls, MN	169	17(16)	9-19
Fosston Mun. Fosston, MN	212	16(16)	13-22
Gaylord Comm. Gaylord, MN	91	13(11)	3-31
Glacial Ridge Glenwood, MN	139	16(15)	9-21
Glencoe Health Glencoe, MN	215	16(14)	11-16
Granite Falls Granite Falls, MN	216	7(13)	5-16
Grant Co. Hosp. Elbow Lake, MN	146	16(14)	5-39
Greenbush Comm. Greenbush, MN	42	29(26)	5-55
Harmony Comm. Harmony, MN	76	29(14)	10-39
Hendricks Comm. Hendricks, MN	145	16(16)	10-22
Heron Lake Mun. Heron Lake, MN	65	17(4)	13-31
Holy Trinity Grasceville, MN	165	14(12)	13-22
Hutchinson Comm. Hutchinson, MN	359	14(13)	9-16
Immanuel Hosp. Mankato, MN	1012	11(11)	9-13
Itasca Mem. Grand Rapids, MN	695	11(13)	10-16
Jackson Mun. Jackson, MN	169	9(16)	9-16
Johnson Mem. Dawson, MN	143	16(13)	10-22
Kanabec County Mora, MN	165	16(13)	5-39
Karlstad Mem. Karlstad, MN	171	11(16)	10-39
Kittson Mem. Hallock, MN	65	16(16)	9-55
Lake City Hosp. Lake City, MN	334	11(14)	9-16
Lake Region Hosp. Fergus Falls, MN	791	11(12)	11-16
Lake View Mem. Two Harbors, MN	169	13(15)	9-19
Lakefield Mun. Lakefield, MN	99	11(19)	9-22
Long Prairie Long Prairie, MN	79	16(16)	11-22
Madelia Comm. Madelia, MN	164	21(13)	10-22

hat the information isn't adequate to make judgments about the quality of are in a specific hospital or to compare hospitals

However, what other potential use f the data could there be, other than ter-institutional comparison?" Brand wrote.

Richard H. Peterson, executive vice resident of North Memorial Medical Center, Robbinsdale, said that alf the 30 cancer deaths and a third f the 28 pulmonary disease deaths at North were among patients in the ospital's hospice program for the ung. He said that North's mortali within the norms even with those eaths would have been at the low d of the acceptable range if the ospice deaths hadn't been counted

HOSPITALS	Over all		
Name / Location	Number of patients	Actual '97 mortality rate in percent (*99 rate in parentheses)	Range of predicted mortality rate / percent
Madison Hosp. Madison, MN	149	16(13)	5-13
Mahnomen County Mahnomen, MN	65	13(12)	5-23
Meeker County Litchfield, MN	359	16(12)	11-21
Melrose Hosp. Melrose, MN	99	13(9)	10-34
Memorial Hosp. Perham, MN	165	14(22)	11-22
Mercy Hosp. Moose Lake, MN	131	16(16)	9-22
Mesabi Regional Hibbing, MN	761	11(13)	10-16
Milaca Area Hosp. Milaca, MN	139	14(23)	9-21
Mille Lacs Hosp. Onamia, MN	217	13(11)	11-39
Miller-Dwan Hosp. Duluth, MN	314	10(7)	9-17
Minn. Valley Mem. Le Sueur, MN	65	16(17)	9-27
Minnewaska Hosp. Starbuck, MN	359	16(12)	9-19
Monticello-Big Lake Hosp. Monticello, MN	65	16(17)	6-55
Mountain Lake Mountain Lake, MN	139	21(19)	10-39
Murray County Slayton, MN	219	14(16)	10-39
Naeve Hosp. Albert Lea, MN	559	14(12)	9-16
North Country Bemidji, MN	594	11(16)	10-16
Northern Itasca Bigfork, MN	65	6(17)	11-27
Northfield City Northfield, MN	359	11(12)	7-17
Northwestern Thief River Falls, MN	494	9(16)	10-16
Olmsted Comm. Rochester, MN	354	6(12)	9-16
Ortonville Mun. Ortonville, MN	167	16(13)	5-39
Owatonna Health Cent. Owatonna, MN	639	16(16)	9-16
Parkers Prairie Hosp. Parkers Prairie, MN	67	16(6)	5-55
Paynesville Comm. Paynesville, MN	139	13(14)	10-22
Pelican Valley Pelican Rapids, MN	67	6(12)	7-23
Pipestone City. Pipestone, MN	270	14(20)	9-16
Queen of Peace New Prague, MN	216	13(13)	9-19
Red Lake Hosp. Redlake, MN	41	0(6)	5-16
Redwood Falls Mun. Redwood Falls, MN	359	13(20)	11-16
Renville City. Olivia, MN	365	17(16)	10-39
Rice City. Hosp. Faribault, MN	695	13(11)	10-16
Rice Mem. Hosp. Willmar, MN	1466	11(11)	9-14
Riverview Hosp. Crookston, MN	483	14(14)	11-16
Rochester Methodist Rochester, MN	5529	6(6)	9-12
Roseau Area Hosp. Roseau, MN	179	16(14)	13-22
Rush City Hosp. Rush City, MN	69	19(13)	5-27
Sandstone Hosp. Sandstone, MN	69	16(17)	7-21
Sioux Valley Hosp. New Ulm, MN	695	14(14)	9-16
Sleepy Eye Mun. Sleepy Eye, MN	226	14(12)	11-21
Springfield Comm. Springfield, MN	179	11(18)	11-22

HOSPITALS	Over all		
Name / Location	Number of patients	Actual '97 mortality rate in percent (*99 rate in parentheses)	Range of predicted mortality rate / percent
St. Ansgar Hosp. Moorhead, MN	699	6(9)	10-16
St. Cloud Hosp. St. Cloud, MN	2891	9(11)	10-16
St. Elizabeth Wabasha, MN	365	13(16)	9-16
St. Francis Hosp Shakopee, MN	349	14(19)	9-19
St. Francis Hosp Breckenridge, MN	570	13(12)	10-17
St. Gabriel's Little Falls, MN	499	23(16)	11-16
St. John's Hosp. Brownsville, MN	47	16(16)	7-59
St. John's Hosp. Red Wing, MN	699	13(11)	9-16
St. Joseph's Hosp. Brainerd, MN	1619	16(13)	10-14
St. Joseph's Hosp. Park Rapids, MN	497	13(14)	13-19
St. Luke's Hosp. Duluth, MN	1691	10(13)	9-13
St. Mary's Hosp. Duluth, MN	3402	11(13)	10-14
St. Mary's Hosp. Detroit Lakes, MN	493	14(13)	9-16
St. Mary's Hosp. Rochester, MN	7894	6(6)	7-11
St. Mary's Hosp. Winsted, MN	69	16(23)	5-55
St. Michael's Sauk Centre, MN	69	16(13)	4-16
St. Olaf's Hosp. Austin, MN	695	6(13)	9-14
St. Peter Comm. St. Peter, MN	332	[illegible]	[illegible]
Stevens County Mem Morris, MN	219	14(11)	[illegible]
Swift County Benson Benson, MN	354	13(13)	10-19
Tracy Mun. Hosp. Tracy, MN	219	16(16)	11-22
Tri County Hosp. Wadena, MN	697	16(14)	11-17
Trimont Comm. Trimont, MN	139	17(17)	13-39
Trinity Hosp. Baudette, MN	139	11(13)	11-22
Tweeton/Lutheran Spring Grove, MN	7	0(17)	1-59
United District Hosp. Staples, MN	194	17(11)	10-22
United Hosp. Blue Earth, MN	595	16(11)	9-16
Vadheim Memorial Tyler, MN	119	13(11)	10-22
Virginia Reg. Virginia, MN	654	11(14)	9-14
Waconia Ridgeview Waconia, MN	699	13(16)	10-16
Warren Comm. Warren, MN	119	16(16)	9-23
Waseca Mem. Waseca, MN	163	16(16)	10-39
Watonwan Mem. St. James, MN	175	16(14)	11-22
Werner Mem. Marshall, MN	359	16(12)	9-16
Wells Mun. Wells, MN	169	16(11)	10-34
Wheaton Comm. Wheaton, MN	219	16(12)	10-21
White Comm. Aurora, MN	33	16(13)	5-55
Windom Area Windom, MN	139	16(14)	10-22
Worthington Reg Worthington, MN	646	9(16)	10-16
Zumbrota Comm. Zumbrota, MN	91	19(**)	5-35

* Now part of Riverside Medical Center, Minneapolis
** Now part of Metropolitan-Mount Sinai Medical Center

How to read these charts

An overall listing is shown for all Minnesota hospitals covered by the report, along with more detailed information on Twin Cities hospitals. The overall listing contains three groups of numbers:

Column 1/ Total Medicare patients treated by the hospital in 1987.

Column 2/ The percentage of those patients who died within 30 days of being admitted to that hospital, even if they died after leaving the hospital.

Column 3/ A "predicted" mortality rate, based on a computer analysis of various factors such as ages of the patients and other illnesses they may have had. The figures, expressed as a range, are the percentage of patients that the Medicare computer would have expected to die at this hospital. For example, 8-14 means that between 8 percent and 14 percent of the patients would have been expected to die.

Metro chart/ In the additional columns above, the same type of information is broken down into 16 diagnostic groups, from cancer to urology. A caution: At some hospitals the number of patients in a particular category may be small. For example, a couple of hospitals on this chart show 100 percent mortality rates for a particular type of diagnosis — but based on the death of a single patient.

Source: Health Care Financing Administration

HOSPITALS Name / Location	Over all: Number of patients	Over all: Actual '87 mortality rate in percentage (TIE rate in parentheses)	Over all: Range of predicted mortality rate / predicted
Ada Municipal Ada, MN	111	20(18)	8-23
Aitkin Community Aitkin, MN	269	10(10)	11-22
Albany Community Albany, MN	82	10(8)	7-21
Appleton Hosp. Appleton, MN	138	17(17)	8-26
Arlington Hosp. Arlington, MN	72	10(10)	8-26
Arnold Memorial Adrian, MN	81	8(10)	10-23
Buffalo Health Cent. Buffalo, MN	239	13(14)	8-18
Caledonia Center Caledonia, MN	82	10(10)	8-26
Cambridge Hosp. Cambridge, MN	269	10(11)	12-26
Canby Community Canby, MN	163	10(21)	7-18
Cass Lake PHS Cass Lake, MN	35	14(8)	8-30
Chippewa Hosp. Montevideo, MN	269	10(10)	10-19
Chisago Lakes Hospital Chisago, MN	235	11(10)	8-18
Clearwater Mem. Bagley, MN	169	13(20)	13-22
Comfrey Hospital Comfrey, MN	43	2(14)	8-19
Community Hosp. Cannon Falls, MN	163	13(10)	8-26
Community Hosp. Luverne, MN	262	13(13)	13-26
Community Mem. Deer River, MN	117	8(11)	8-17
Community Mem. Spring Valley, MN	164	13(13)	10-21
Community Mem. Winona, MN	1016	13(13)	10-18
Community Mem. Cloquet, MN	248	13(17)	8-18
Cook Community Cook, MN	45	11(10)	8-26
Cook County Grand Marais, MN	66	10(20)	8-23
Cuyuna Range Crosby, MN	269	13(12)	10-18
District Mem. Forest Lake, MN	169	10(13)	8-19
Divine Prov. Ivanhoe, MN	164	14(10)	11-23
Dr. Henry Schmidt Westbrook, MN	83	14(13)	8-27
Douglas County Alexandria, MN	848	13(9)	10-18
Ely Community Ely, MN	134	10(20)	8-22

Hospitals Continued from page 1A

U.S. hospitals. He said he expects the study to improve as it goes along.

But Patti Anderson, spokeswoman for the Minnesota Hospital Association, said she knows of no good public use for the figures. She said the association is planning to do a survey next year of patient satisfaction six months after discharge to try to produce useful information.

William Kreykes, chairman-elect of the association, a vice president of Health One and head of Metropolitan-Mount Sinai Medical Center, criticized the government for including deaths that occur outside the hospital 30 days after the patient's last admission.

"Someone can die in an accident, something that has absolutely nothing to do with the hospital, and be counted in the mortality data," Kreykes said.

"I don't know what this study proves," he said. "All of our hospitals (Health One affiliates) came out well, as far as I know."

Malcolm Mitchell, director of health planning for the Metropolitan Council, said the federal government should be applauded for compiling and releasing the data.

"The more information we get, the better," Mitchell said. "They (Medicare) are perfecting what they are doing and they are getting better at this."

The death rates in most Twin Cities area hospitals were well within what the report describes as the "range for predicted mortality," the norms set for each hospital by Medicare. Deaths are counted if they occur in the hospital or within 30 days after the last admission.

Besides an overall death rate, each hospital was assigned a death rate for 16 types of illness ranging from several kinds of heart disease to cancer, septic infections and urologic disease.

The only hospital in Minnesota to have a death rate above the norm was St. Gabriel's Hospital of Little Falls. Its rate was just 1 percentage point out of the acceptable range. Twenty percent of its 439 Medicare patients in 1987 died. The acceptable range was 11 to 19 percent.

Pat Rioux, public relations director for the hospital, said the average age of the 15 stroke-death patients at St. Gabriel's last year was 84, and that 13 were listed as unresponsive when they were admitted, increasing their risk of dying.

"I wish HFCA would spend some more time being a little more useful," Rioux said. "It's not a big deal for us."

No Minnesota hospital was among 75 around the nation whose death rates were too high for the second year in a row.

The death rate at University of Minnesota Hospital for Medicare patients last year was 8 percent, the bottom of the 8 to 12 percent range, up slightly from its 6 percent mortality rate the previous year.

Abbott Northwestern's mortality rate was 10 percent, the low end of a 10 to 14 percent norm, up slightly from 1986 when its 8 percent was a bit under the norm of 9 to 13 percent.

The death rate at Metropolitan Medical Center, now the north campus of Metropolitan-Mount Sinai Medical Center, was at the bottom of its 9 to 13 percent range. At its south campus, the old Mount Sinai Hospital, the death rate last year was 9 percent, just under its norm of 10 to 14 percent. The two hospitals are now part of Health One.

Another Health One hospital, United in St. Paul, had a 10 percent mortality rate. Its predicted norm was 9 to 13 percent.

Methodist Hospital in St. Louis Park had a mortality rate 11 percent just under its norm of 11 to 15 percent.

Hennepin County Medical Center was at the low end of its norm range for the second year in a row: 12 percent in 1986 and 11 percent in 1987. St. Paul-Ramsey Medical Center's mortality rate stayed at 12 percent, also on the low side of its norm.

Administrators of hospitals were given a chance to include statements with the report. The Minnesotans who took the opportunity generally criticized counting deaths that occur after the patient leaves the hospital and the inclusion of deaths of patients who were admitted in terminal condition.

Jon Braband, associate administrator of Northwest Medical Center in Thief River Falls, commented on the agency's promise that it would stress

Medicare hospital [illegible]rtality information

HOSPITALS Name Location	Over all: Number of patients	Over all: Actual '87 mortality rate in percent ('86 rate in parentheses)	Over all: Range of predicted mortality rate/percent	Canc…: Number of patients	Canc…: Actual mortality rate/percent	Canc…: Range of predicted mortality rate/percent	…ke: Number of patients	…ke: Actual mortality rate/percent	…ke: Range of predicted mortality rate/percent	Gastro-intestinal catastrophe: Number of patients	Gastro-intestinal catastrophe: Actual mortality rate/percent	Gastro-intestinal catastrophe: Range of predicted mortality rate/percent	Infectious disease: Number of patients	Infectious disease: Actual mortality rate/percent	Infectious disease: Range of predicted mortality rate/percent	…disturbances: Number of patients	…disturbances: Actual mortality rate/percent	…disturbances: Range of predicted mortality rate/percent	Lung disease: Number of patients	Lung disease: Actual mortality rate/percent	Lung disease: Range of predicted mortality rate/percent	Kidney disease: Number of patients	Kidney disease: Actual mortality rate/percent	Kidney disease: Range of predicted mortality rate/percent
				Hi[illegible] …stic categories																				
Abbott Northwestern, Minneapolis	4179	10(9)	10-14	140	41	31-52	135	28	20-37	28	46	17-57	24	38	22-61	76	28	10-44	153	26	22-40	14	14	14-67
Bethesda Lutheran Medical Ctr., St. Paul	804	13(12)	10-16	40	43	26-56	63	28	15-40	5	40	5-78	12	50	15-68	17	29	5-62	52	31	15-42	4	50	4-84
Divine Redeemer Memorial, S. St. Paul	426	13(14)	9-16	14	36	19-67	16	38	8-55	3	67	4-88	2	0	4-80	12	8	14-55	20	20	11-40	1	100	2-97
Fairview Riverside*, Minneapolis	868	13(13)	9-14	29	21	21-53	37	30	16-46	12	17	11-58	7	29	8-71	16	38	7-58	52	37	12-40	2	100	10-84
Fairview Ridges, Burnsville	344	10(13)	6-14	4	50	4-82	16	31	9-54	2	0	1-88	1	0	1-97	4	0	2-73	29	14	7-36	1	0	0-97
Fairview Southdale, Edina	2168	11(12)	9-14	74	32	16-51	89	35	19-40	16	75	11-56	22	36	20-61	40	22	12-43	80	26	16-37	11	64	14-75
Hennepin County Med. Center, Minneapolis	1758	11(12)	11-16	40	45	12-62	43	28	13-41	28	19	16-50	29	24	14-49	54	11	9-35	138	21	20-39	31	6	5-52
Lakeview Memorial, Stillwater	408	13(12)	7-13	9	67	1-70	18	44	9-54	2	0	1-91	3	0	0-82	16	31	7-56	28	8	11-37	5	20	12-63
Mercy Medical Center, Coon Rapids	891	12(11)	9-14	23	43	[illegible]	31	19	12-41	8	25	6-66	8	13	7-61	19	32	4-51	44	30	14-43	6	0	7-87
Methodist, St. Louis Park	2487	10(11)	11-15	112	34	[illegible]	94	17	21-38	12	8	18-60	38	24	21-52	52	12	15-40	108	22	16-35	14	7	14-64
Metropolitan Medical Center, Minneapolis**	2186	9(10)	9-13	84	36	[illegible]	56	36	15-41	13	46	18-70	24	17	20-54	56	18	9-38	102	25	18-38	35	6	7-52
Midway, St. Paul	[illegible]	10(9)	9-13	59	29	[illegible]	72	28	18-40	13	38	12-63	8	50	8-78	29	31	13-50	70	16	15-36	2	50	1-83
Mount Sinai**, Minneapolis	1244	9(9)	10-14	44	20	27-56	38	24	15-43	7	57	9-74	19	37	16-60	18	22	6-50	74	16	18-38	7	14	[illegible]
North Memorial Med. Center, Robbinsdale	1997	13(13)	9-14	62	40	27-56	58	21	17-39	22	32	16-57	24	25	16-54	35	14	9-39	86	33	14-36	3	67	[illegible]
Regina Memorial, Hastings	239	13(12)	6-17	6	67	15-81	7	57	7-71	4	50	7-83	3	67	2-86	1	0	0-100	17	18	9-48	2	100	7-91
Sanford Memorial, Farmington	78	10(9)	7-26	3	33	8-89	3	0	6-79	2	50	3-92	1	0	1-97	0	—	—	8	50	3-74	1	0	2-97
St. Johns Northeast, Maplewood	836	12(10)	10-16	31	42	23-59	39	23	15-43	7	43	7-72	15	20	14-58	6	0	2-61	53	26	13-39	4	75	11-87
St. Joseph's, St. Paul	1197	14(16)	10-15	73	62	[illegible]	25	40	12-50	8	63	12-73	10	0	19-55	29	21	8-43	43	26	13-41	5	40	8-82
St. Mary's*, Minneapolis	978	10(12)	9-14	39	26	[illegible]	37	24	15-43	17	41	15-62	6	67	8-75	21	24	11-51	53	17	16-30	4	0	9-77
St. Paul Ramsey Med. Center, St. Paul	2107	12(12)	9-13	50	40	[illegible]	71	31	15-38	21	33	15-57	24	25	17-54	50	22	13-42	129	29	18-37	5	20	8-79
United, St. Paul	2530	10(11)	9-13	97	33	[illegible]	76	25	20-41	19	16	17-56	16	38	14-61	59	15	10-37	106	23	20-39	15	60	15-72
Unity Medical Center, Fridley	936	10(12)	9-14	33	24	[illegible]	38	16	16-41	10	20	8-61	10	20	11-62	18	28	6-51	58	26	15-40	11	18	16-73
Univ. of Minnesota, Minneapolis	2301	8(6)	8-12	145	26	[illegible]	17	24	14-54	21	38	18-61	14	29	10-58	20	10	12-46	45	38	19-49	42	10	3-52

HOSPITALS Name Location	Severe acute heart disease: Number of patients	Severe acute heart disease: Actual mortality rate/percent	Severe acute heart disease: Range of predicted mortality rate/percent	Severe chronic heart disease: Number of patients	Severe chronic heart disease: Actual mortality rate/percent	Severe chronic heart disease: Range of predicted mortality rate/percent	Severe…: Number of patients	Severe…: Actual mortality rate/percent	Severe…: Range of predicted mortality rate/percent	Gastro-intestinal disease: Number of patients	Gastro-intestinal disease: Actual mortality rate/percent	Gastro-intestinal disease: Range of predicted mortality rate/percent	Gynecology: Number of patients	Gynecology: Actual mortality rate/percent	Gynecology: Range of predicted mortality rate/percent	Low risk heart disease: Number of patients	Low risk heart disease: Actual mortality rate/percent	Low risk heart disease: Range of predicted mortality rate/percent	Orthopedics: Number of patients	Orthopedics: Actual mortality rate/percent	Orthopedics: Range of predicted mortality rate/percent	Neurologic disease: Number of patients	Neurologic disease: Actual mortality rate/percent	Neurologic disease: Range of predicted mortality rate/percent	Urology: Number of patients	Urology: Actual mortality rate/percent	Urology: Range of predicted mortality rate/percent
										Low risk diagnostic categories																	
Abbott Northwestern, Minneapolis	100	29	31-47	140	10	16-33	4	50	3-82	212	4	1-8	44	0	0-88	700	4	3-6	482	2	1-5	190	2	0-6	111	0	1-6
Bethesda Lutheran Medical Ctr., St. Paul	35	26	22-53	42	10	13-39	2	0	0-65	54	4	0-20	10	0	0-100	84	4	1-12	79	3	0-16	25	8	0-60	53	0	0-13
Divine Redeemer Memorial, S. St. Paul	28	43	22-58	24	29	7-45	1	100	0-98	27	7	0-78	2	0	0-100	51	4	1-18	45	0	0-19	16	6	0-60	28	4	0-89
Fairview Riverside*, Minneapolis	40	30	22-62	44	25	10-37	1	0	0-98	58	3	1-16	9	0	0-100	70	7	0-22	98	1	0-11	31	10	0-71	25	0	0-65
Fairview Ridges, Burnsville	19	53	15-69	13	15	6-60	1	0	2-97	33	6	0-52	2	0	0-100	40	2	0-27	33	0	0-75	8	0	0-100	9	0	0-80
Fairview Southdale, Edina	86	30	26-47	88	17	15-33	4	25	5-80	130	1	1-7	25	0	0-83	281	3	1-7	228	3	0-7	56	0	0-14	88	1	0-17
Hennepin County Med. Center, Minneapolis	88	39	30-56	72	16	18-36	9	22	5-63	74	5	1-17	9	0	0-100	157	1	3-7	154	2	1-7	88	[illegible]	[illegible]	31	0	0-44
Lakeview Memorial, Stillwater	16	50	16-64	29	52	9-45	0	—	—	28	7	0-62	5	20	0-100	47	2	0-19	113	0	0-6	14	7	0-85	23	0	0-70
Mercy Medical Center, Coon Rapids	43	35	25-64	67	30	12-35	0	—	—	42	5	0-38	6	0	0-100	88	5	1-14	65	3	0-31	80	0	0-9	56	2	0-47
Methodist, St. Louis Park	92	40	27-50	120	17	17-32	6	0	9-61	122	8	1-12	19	0	0-100	319	3	2-7	252	4	1-7	71	3	0-10	124	2	0-15
Metropolitan Medical Center, Minneapolis**	54	37	29-56	85	23	16-34	5	20	10-78	119	3	2-9	21	5	0-100	301	3	2-7	319	2	1-6	113	3	1-10	127	1	0-8
Midway, St. Paul	64	38	28-53	76	16	15-33	3	33	3-86	135	1	1-7	18	6	0-100	165	4	1-8	245	2	1-6	51	2	0-22	80	0	0-10
Mount Sinai**, Minneapolis	[illegible]	44	28-68	54	19	17-39	1	0	1-87	84	2	1-12	6	0	0-100	91	4	1-13	101	2	1-9	182	1	0-6	48	2	0-34
North Memorial Med. Center, Robbinsdale	125	38	29-48	98	27	13-32	8	38	8-71	119	8	1-16	24	0	0-100	309	5	1-7	184	2	0-8	107	3	0-17	88	6	0-40
Regina Memorial, Hastings	13	15	22-84	13	23	8-54	0	—	—	13	8	0-81	3	0	0-100	[illegible]	0	0-24	18	6	0-80	18	0	0-87	7	0	0-100
Sanford Memorial, Farmington	2	50	8-94	3	33	3-86	0	—	—	4	0	0-100	2	0	0-100	8	13	0-98	2	0	0-100	1	0	[illegible]	3	0	0-100
St. Johns Northeast, Maplewood	33	52	22-56	80	25	[illegible]	0	—	—	44	0	0-14	17	0	0-100	88	5	1-13	90	3	0-16	15	0	0-10	46	0	0-20
St. Joseph's, St. Paul	42	48	24-55	47	17	14-37	2	[illegible]	[illegible]	79	1	1-10	9	0	0-100	133	2	1-8	174	3	1-8	35	0	1-6	45	2	0-60
St. Mary's*, Minneapolis	28	46	20-57	47	30	12-30	3	0	[illegible]	86	0	1-8	11	0	0-100	101	5	1-14	131	2	1-8	50	0	0-20	38	0	0-23
St. Paul Ramsey Med. Center, St. Paul	93	43	27-49	99	20	17-34	11	55	7-64	67	6	1-17	11	0	0-100	206	2	2-7	149	1	1-7	388	1	0-7	38	0	0-23
United, St. Paul	[illegible]	18	27-50	99	31	14-34	2	0	1-90	164	1	1-7	31	0	0-100	343	4	2-7	254	4	1-8	109	1	0-7	110	2	0-10
Unity Medical Center, Fridley	41	34	24-54	40	15	10-34	0	—	—	79	3	1-12	18	0	0-100	91	0	1-6	107	1	0-9	30	7	0-71	51	2	0-29
Univ. of Minnesota, Minneapolis	16	44	17-63	59	17	15-36	2	50	1-94	63	3	1-15	12	0	0-100	294	5	2-8	177	1	0-6	281	1	0-5	108	3	0-14

'U' told it hasn't answered all questions about reserves

By Howard Sinker
Staff Writer

State officials said Thursday that the University of Minnesota still hasn't answered all of the questions about reserve funds that are bound to surface during the 1989 Legislative session.

Their opinions were voiced during a meeting of interim President Richard Sauer's financial review committee, which was established this past summer to review university budget procedures.

The group declined to adopt a draft report prepared by Sauer's office, instead passing several motions to be included in a report of committee activities that will be written in the next couple of weeks. Findings will be passed on to President-elect Nils Hasselmo, who will replace Sauer next month.

"It seems the university has a rather immediate problem to deal with," said Legislative Auditor James Nobles. "It's going to be difficult to negotiate through the upcoming session if a lot of questions about the reserves are still unsettled. They really need to get them nailed down with great precision."

Sauer said the current policy, established in the aftermath of financial controversies that led to the resignation of former President Kenneth Keller in March, didn't address some long-term concerns because it was put together quickly.

A motion by Thomas Triplett, state finance commissioner, called for the university to adopt a policy on reserves that includes all of the categories of reserve funds, the funds' sizes, permitted uses and reporting mechanisms for reserve income and expenditures.

Regents adopted guidelines earlier this year calling for central reserves not to fall below $40 million, and established guidelines for how they can be spent. Carol Campbell, interim vice president for finance, said those reserves are about $36 million and should increase to $40.7 million by June 30, the end of the fiscal year.

Other motions adopted by the committee included:

■ Support for the financial recommendations adopted last month by Gov. Rudy Perpich's committee on university financial management, which was headed by Edson Spencer, chairman of Honeywell Inc. They include improved budgeting systems and an overhaul of a computer system that is acknowledged to be inadequate. The Spencer commission also urged that new policies and procedures be distributed by April 1989.

■ Urging the university to disclose more complete financial information than in the past. A longer-range goal is to provide the Legislature with that information in a form similar to what's provided by other state agencies. Campbell said current systems prohibit the university from "complying with that wholly, completely and accurately right now."

■ Asking regents to reconsider their use of private accounting firms in their audit reports. Triplett suggested more reliance on compliance audits by Nobles. Full-blown annual state audits would be unrealistic without more resources, said Nobles, who acknowledged that his office will be paying closer attention to the university. Regent Elton Kuderer said the board's system of switching firms every few years ensures that work gets reviewed.

"Many of the concerns they expressed have been implemented," Campbell said, "but we received a message that there's still further refinement or clarifications of purpose that they'd like to see."

Members of the committee included State Auditor Arne Carlson; Campbell; Kuderer; Nobles; Sauer; Triplett; Rep. Lyndon Carlson, DFL-Crystal; Prof. Warren Ibele; Rep. Phillip Riveness, DFL-Bloomington; Rep. Gloria Segal, DFL-St. Louis Park; Sen. Glen Taylor, IR-Mankato, and Sen. Gene Waldorf, DFL-St. Paul.

"I don't think we got a lot of answers, but we all got a better understanding of what some of the questions are," Nobles said. "The university clearly knows there's more work to be done."

Drugs, treatment to help epileptics tested at U of M research center

by Gordon Slovut/Staff Writer

When Mary Ann Bartlett was 8 years old she began having dizzy spells.

"It was like I was drunk," Bartlett, who is now 37, recalled recently. "It felt like the floor was spinning."

Her doctor said Mary Ann would grow out of it.

One year later, in her fourth grade class, she had a convulsion. Her mother took her to a second doctor.

"She has epilepsy," the doctor said.

Thus began a 28-year quest for a magic drug or drug combination to suppress the seizure-inciting electrical storms in her brain without dulling her senses, causing intestinal difficulties or damaging the kidneys, liver or bone marrow.

Bartlett is one of an estimated 3 or 4 million Americans with epilepsy. Experts say that drugs can adequately control — and in many cases prevent — seizures in 80 percent of them.

Scientists keep coming up with new drugs, a half dozen of which are being tested where Bartlett is a patient — at the Epilepsy Research Center at the University of Minnesota.

Many of the drugs she took over the years were effective, at least for a while.

She never again had a major convulsion. But she continued to have two types of seizures: one in which her right arm became stiff and she lost awareness for 30 to 60 seconds and smacked her lips, and another in which she remained completely awake and able to talk but felt "like I was in a vacuum" for 10 or 20 seconds.

The seizures made her uncomfortable when they occurred in public. "I would get an aura — a warning — that one was coming on," she said. "If I was around people who didn't know me, I would go into the ladies' room until it was over."

Her problem originated in her left temporal lobe, an egg-sized section of brain (it has a twin on the right side) behind the eye that is involved in memory.

Temporal lobe epilepsy (TLE) is the most common form of epilepsy in adults. An estimated 600,000 to 1 million Americans have it. TLE seizures normally leave the person conscious. They involve only part of the brain and body. Sometimes people with TLE simply stare for a minute or so, chew or smack their lips, or seem to be picking at something on an arm, or just mumble.

Drugs almost always bring at least partial control of TLE. But Bartlett was not satisfied with partial control of the seizures and she was

EPILEPSY Continued on page 11E

Continued from page 1E

understandably disappointed whenever the drugs she was taking began to lose their beneficial effect. Over the years she and her mother searched for new doctors and new drugs, a common practice among people with an incurable disease.

In 1975, when drug-therapy seemed to be failing and her seizures were growing more frequent, neurologists at Mount Sinai Hospital in Minneapolis started her on a drug combination that reduced the frequency of her seizures from weekly to one or two a month.

Within three or four years, that combination became less effective. When neurologists changed her prescription again, the frequency diminished, as it had in the past when she was put on a new drug regimen.

But by 1983 she was having eight to 12 seizures a month and enrolled in an experimental drug study at the university's Epilepsy Research Center.

"They got me down to one to five seizures a month (with an experimental drug combination) but I still couldn't get complete control," she said.

Dr. Ilo Leppik, director of the epilepsy research center, suggested that she might be a good candidate for surgery — specifically temporal lobectomy, removal of the part of the brain where her seizures seemed to be originating.

He referred her for testing to Abbott Northwestern Hospital, which, along with St. Paul-Ramsey Medical Center and Gillette Children's Hospital, is an affiliate of the epilepsy research center.

The tests confirmed that the electrical abnormalities in her brain were originating from the left temporal lobe as the university doctors suspected, probably from scar tissue.

Bartlett said she thinks the scar tissue may have been produced by an infection that caused her hospitalization at the age of 5.

"I had a febrile (fever) convulsion when I was 5, so that might be it," she said. Or it might have been caused by a fall from an upper bunk bed when she was 7.

When a cause for epilepsy can be determined, it usually turns out to have been a head injury, an infection such as encephalitis or meningitis, a birth defect, stroke, tumor or other brain disease.

Head injuries in motor vehicle accidents, especially those involving motorcycles, and wars are two of the major causes of epilepsy in adults.

The scar tissue interferes with proper firing of electrical impulses and the aberrant impulses can touch off abnormal firing of brain cells elsewhere in the brain.

Most of the drugs work by slowing down electrical activity in the brain enough so the effects of the scarring are dampened.

The verdict at Abbott Northwestern was that Bartlett was a suitable candidate for brain surgery. It would be done at University of Minnesota Hospital. Its neurosurgeons perform more than 100 epilepsy operations a year. Eighty percent of them are temporal lobectomies, the surgery recommended for Bartlett.

"You can do the temporal lobe surgery because there is a lot of duplication, there are a lot of things one lobe does that is repeated in the other," Leppik said. "We have a built-in double circuit, so most people can do with just one temporal lobe."

Mary Ann Bartlett said she wanted the surgery. "I want complete control, if I can get it," she said.

On Dec. 7, Dr. Robert Maxwell, a University of Minnesota neurosurgeon, cut a horseshoe-shaped flap on the left side of Bartlett's head and, as a last check, placed electrodes on her left temporal lobe.

"We recorded electrical activity for 10 or 15 minutes, looking for the between-seizure spikes (on a graph) which indicate that the temporal lobe really is where the damage is," Maxwell said.

The spikes confirmed the diagnosis.

Maxwell cut away the dura mater, the tough tissue that covers the brain. To prevent a series of tiny hemorrhages from occurring, he coagulated the tiny blood vessels that serve the front section of the temporal lobe. Then he used a miniature vacuum to suction out about 2 inches — the front half — of the lobe.

He put electrodes on the surface of her brain again, checking for inter-seizure spikes to make sure he had taken out the diseased tissue. There were no spikes so he quickly closed the side of her head and sent her to a recovery room.

Hours later Bartlett was able to talk. Her memory seemed to be unimpaired. A week later she was sent home to Vadnais Heights, where she shares an apartment with her fiance.

She will remain on anticonvulsant drugs for about a year, possibly the rest of her life, Maxwell said.

"If they (patients) are seizure-controlled at the end of a year we will begin tapering off their medication," he said.

He said doctors have to be cautious in weaning patients from the drugs because there may be additional spots in the brain with scar tissue. Sometimes the infection or trauma that caused the initial scarring also caused lesser scarring elsewhere, he said.

"Seventy percent of our patients who have temporal lobectomy can have complete seizure control, but only a fourth of that 70 percent can eventually get completely off medications," he said.

Operations on other lobes are rarer for two reasons: fewer seizures originate elsewhere, and there is a greater hazard elsewhere in the brain of damaging tissues needed for normal function such as the senses and control of the arms and legs.

When it is possible to extract scar tissue successfully from other areas, he does it, Maxwell said.

Sometimes it takes two operations — one to map the brain and another to get the tissue.

In the first operation, Maxwell opens the skull and places anywhere from 64 to 72 electrodes on the surface of the brain so a large section of the brain can be mapped for essential function — speech, movement, thinking, for example — in relation to diseased tissue. With that information, he may be able to go deep into the brain safely to remove whatever is causing the seizures.

There is a drastic operation that is sometimes performed on people with widespread damage on one side of the brain who have frequent, uncontrollable grand mal seizures.

The surgeon simply cuts off the ability of the damaged half of the brain to communicate with — and confuse — the healthy half.

The surgeon severs the corpus collosum, the connector between the left and the right sides of the brain.

"It stops the kind of seizures that cause falling and injury," Maxwell said.

Leppik added that he has seen patients whose intellectual function actually improves after the corpus collosum operation. "It reduces interference in the brain, allowing them to think better," Leppik said.

Fairly typical of the patients seen at the research center is James Cran, a contract computer worker with 3M in his 30s whose epilepsy was caused by a severe childhood head injury he suffered when he fell into a manure spreader on his family's Washington County farm in 1959.

Cran is not a candidate for surgery because the damage appears to be hazardously close to essential brain cells.

In 1981 the drugs he had been taking since childhood seemed to lose their effect.

"It was like someone turned off a switch and I would collapse to the floor and, boom! I was out for a second or so," Cran said. "I would find myself on the floor, aware something had occurred."

He started going to the university's epilepsy clinic that December and became one of Leppik's test subjects for new anticonvulsant drugs.

His epilepsy has been fairly well controlled ever since, but there have been times when things went wrong.

"I was taking a new drug in February of 1986 and suddenly I thought I was dead," Cran said. "I ended in the psych ward at St. Paul-Ramsey on a Sunday."

For several days he thought he was in a holding area, awaiting a decision on where he would spend eternity, he said.

"On Thursday I realized I was alive and well, and they released me after eight days," he said.

Cran continues to get experimental anticonvulsant drugs free, and he is now on another experimental drug, Gaba pentin. He said he has had only one or two extremely mild seizure episodes since Nov. 1.

"That's not bad," he said.

"The seizures? Sometimes they are a tingling sensation on my right arm and right leg, but that's it. We'll see how it goes."

$105,000 settlement reported in lawsuit against 'U' Hospital

By Randy Furst
Staff Writer

A settlement has been reached in a medical-malpractice case at University of Minnesota Hospital in connection with a Caesarean section done in 1986, the attorney representing the woman said Saturday.

The settlement was for $105,000, said Paul Benshoof, Bemidji, attorney for Joan Gillespie of Lexington, a suburb north of Paul.

Jack Fribley, an attorney for the university, confirmed there was a settlement but said no papers had been signed yet.

Mark Stageberg, attorney for Dr. Preston Williams, the doctor in charge of the surgery, confirmed the $105,000 settlement figure. Stageberg said the amount to be paid will be shared by the University of Minnesota and Williams.

"It was an emergency 'C' section (with) five hours of surgery with complications in which the doctors saved her life," said Fribley.

Benshoof said Gillespie bled heavily during the operation and as many as 100 sponges were used. One was left inside Gillespie's body.

He said the sponge became affixed to body organs and that Gillespie had three operations to deal with complications from that.

Benshoof said that she may now be infertile, though Fribley said tests indicate she should be able to conceive. She has three children.

Benshoof said Gillespie still has abdominal pain but is doing better as the result of the latest surgery.

Gillespie's baby was delivered by Caesarian section on June 24, 1986.

"About 16 months later, she was told (by a doctor) that she had a huge mass in the stomach," Benshoof said.

Surgery was done to determine what the mass was, and doctors found the sponge from the Caesarian section, he said.

Several people were named in the lawsuit filed by Gillespie, but most were dropped from the case, and the only remaining defendants were Williams and the university, according to the attorneys.

Williams could not be reached for comment.

THE MINNESOTA DAILY

Tuesday, January 3, 1989

Corrections

A headline in the Dec. 2 Daily ("Demands of Jamieson, hospital conflicted/Doctor's aggressiveness may have led to board vote to reduce powers") was incorrect. The University Hospital Board of Governors never voted on Dr. Stuart Jamieson's administrative appointments.

Minnesota Daily
January 4, 1989

Third woman gains elite rank of U acting VP

By Delores Lutz
Staff Reporter

A third woman has joined the elite ranks of the University's top administrators.

Cherie Perlmutter was named acting vice president for health sciences Tuesday, replacing Dr. Neal Vanselow.

Vanselow resigned Nov. 16 to become chancellor of the Tulane University Medical Center in New Orleans.

The appointment of three women as acting vice presidents may be somewhat unusual among public universities. But the implication for permanently filling the vacancies in six of the seven vice-presidential posts is not known.

Cherie Perlmutter

Perlmutter, who came to the University in 1973, has been associate vice president for health sciences since 1984. She will assume the new post Feb. 1 if approved by the Board of Regents.

She receives high marks from health sciences deans, who praise her sensitivity, administrative skills and understanding of the University's complexities.

"Her knowledge of the University is vast and very thorough," said Ellen Fahy, dean of the School of Nursing.

"Of course, I like to see women in leadership positions, even if it's only 'acting.' "

Dr. David Brown, dean of the Medical School, was pleased and enthusiastic about Perlmutter's appointment.

"She is very well qualified, on the basis of experience, to serve admirably in this position," Brown said.

Perlmutter, a career administrator, has a bachelor's degree from Pennsylvania State University. Before coming to the University as assistant to the vice president for health sciences, she served two years as assistant to the director of administration at the Albert Einstein College of Medicine.

She also served several years as the chief operating officer of a Pennsylvania nursing home.

Both of the University's vice presidents for health sciences — Vanselow and Dr. Lyle French — have been white male physicians.

Some women on campus say they are delighted to see a woman in the job, even if the appointment is only temporary.

"It helps the decision process when there are more women, more people of color in these positions," said Patricia Mullen, director of the University's Office of Equal Opportunity and Affirmative Action.

It also aids recruitment of women and minorities in future searches, according to Mullen.

Vanselow said Perlmutter and the two other female acting vice presidents — Shirley Clark in academic affairs and Carol Campbell in finance and physical planning — were selected for their skills, not because of their sex.

"They're all capable people," said Vanselow, who assumes his post at Tulane on Feb. 1. "It doesn't make any difference what your gender is if you're capable."

Perlmutter said she appreciates the support of campus feminists who have lobbied for increased opportunities for women, but she thinks that her gender had little to do with her appointment.

"The women of the University have been very helpful ... pushing for change and the kind of recognition women deserve, but I do think that my appointment has less to do with being a woman than the fact that I have been here for some time and know the role," Perlmutter said.

Vanselow said Perlmutter faces a challenge, especially because of the legislative session.

"It's the busiest time of the year. There will be a lot of work involved, but she's up to it," he said.

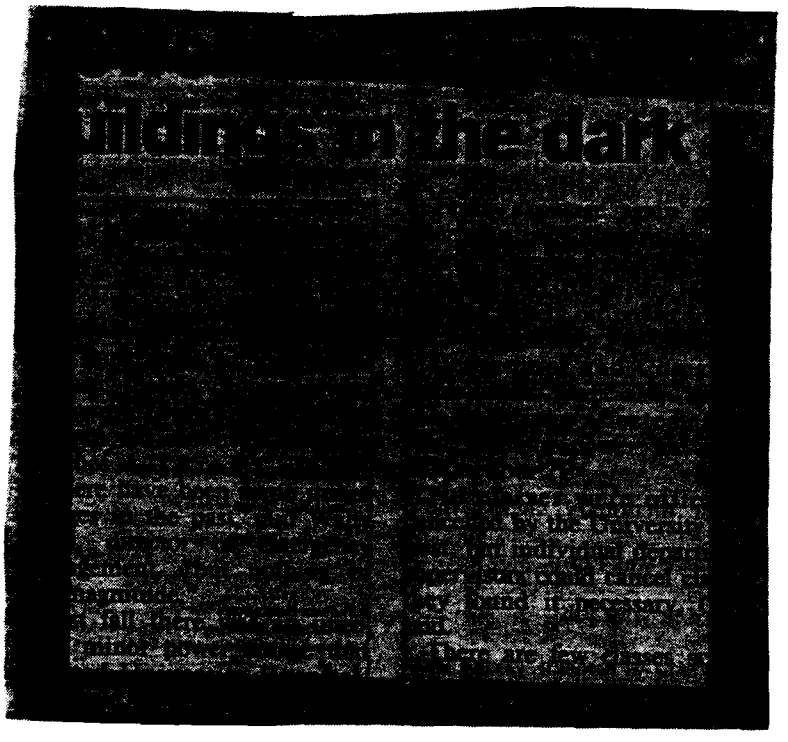
Perlmutter acknowledged it will be a difficult time.

"The new president will have a lot of work to do in gaining credibility with the public. And putting together a (vice presidential) team the president can have confidence in is going to be an enormous task over the next six months," Perlmutter said.

Fahy, dean of the School of Nursing, sees the chance to pick six vice presidents as an opportunity to place women permanently near the top.

"We have to have women in the top leadership positions at the University," Fahy said. "It's a wonderful chance for the new president."

Minnesota Daily
January 9, 1989



Power *from 1*

uled on Friday afternoons, he said, adding that he did not hear of any canceled classes.

But Spanish and Portugese Professor Joana O'Connell said she canceled her 12:15 p.m. Culture and Civilization of Latin America class.

O'Connell said there was no way class could be held in 155 Ford Hall because the room does not have windows.

The lack of windows also caused many 11:15 a.m. lecture hall classes to end early. Other students said their professors simply put up the window shades and continued with class.

The two switches that failed were in Appleby Hall and the Physics Building.

The switch in Appleby failed due to aging. The problem was discovered quickly and those buildings affected regained power by approximately 1:00 p.m., said Tim Coyle, principle plant engineer.

The second switch, in the Physics building, was not found until 3 p.m. and was fixed by 3:30 p.m. The cause of its failure has not been determined, said Coyle.

Coyle said it took until 6 p.m. to regain power in all of the buildings affected by the second switch because crews had to go building to building to restore power.

Minnesota Daily
January 9, 1989

Regent Advisory Council begins trimming names from list of candidates

By John Welbes
Staff Reporter

Candidates for positions on the University's Board of Regents have a slightly better idea of where they stand following Friday's meeting of the Regent Candidate Advisory Council.

Council members turned in their first ballots, trimming on a preliminary basis the original list of 156 candidates to the 63 who received votes Friday.

After the ballot was taken, the council wrestled with the problem of who will be interviewed, and decided that those candidates who received a majority vote in the first ballot would definitely be granted interviews.

That list included 14 names (see list below).

But many candidates are still in the running since the council did not determine the minimum number of votes a candidate needed to be considered for an interview.

The council also crawled to the conclusion that candidates who did not receive votes Friday will have a chance to be 'resuscitated' at the next meeting. A motion to schedule no more than 48 interviews was also passed.

Council members voted for regent candidates representing the 5th District, the student-regent position, and two at-large regent positions. All four seats will be vacated this spring.

Current at-large regents Charles McGuiggan and Wenda Moore, student regent Wally Hilke, and board chairman David Lebedoff (the 5th District's board representative), all have announced they will not seek reappointment.

The council hit an impasse when discussing "Board of Regents responsibilities," a 12-item list that the council drafted. Item 12 originally read: "Assure that all people of Minnesota are afforded equal opportunities to

See **Regents** *page 3*

Regents *from 1*

participate in and benefit from the University."

Before voting to accept the list, council members expressed concern that the item could be interpreted as opposing Commitment to Focus, an unintended connotation. "It is not our function at all to get into that," said council member and former Minnesota Gov. Elmer Anderson.

Council member and President of St. John's University, the Rev. Hilary Thimmesh, said the statement was originally intended to encourage equal opportunity at the University, and the council finally decided on a revised version that read, "assure that the University remain an Equal Opportunity institution."

This is the first time an advisory council has recommended regent candidates to the Legislature. The council will recommend three to four names for each regent slot to the Legislature at the end of January.

Candidates who will definitely be interviewed for each of the open positions on the board are:

Student Regent: Timothy James Allison, Duluth; Miriam Elaine Campbell, Golden Valley; David Gerald Minkkinen, Duluth; Geoffrey Andrew Pollak, New Brighton; Darrin Michael Rosha, St. Paul.

At-large Regent: Gordon Melburn Donhowe, St. Paul; Luella Gross Goldberg, Edina; Dale Roger Olseth, Hopkins; James Patrick Shannon, Wayzata; Sung Won Sohn, Golden Valley.

5th District Regent: Karen O'Link Bachman, Minneapolis; Roxanne Marie Givens, Minneapolis; Thomas E. Holloran, Minneapolis; Jean Burhardt Keffeler, Minneapolis.

University employee announces she'll run for city council

By **Julie Inglebret**
Staff Reporter

After working 30 years at the University Hospital, Joan Campbell hopes to represent the University's Minneapolis campus and the surrounding neighborhoods as a Minneapolis City Council member.

Campbell became the first person to announce her candidacy for the 2nd Ward seat Monday, just hours after Kathy O'Brien said she would not seek re-election.

Campbell will seek the DFL endorsement later this year.

A University Hospital nurse manager and 14-year board member of the Metropolitan Council, Campbell said she is running for the seat because she wants a new career.

"I like being a nurse, but I want a change. At my age, I have to do it now or never," the 52-year-old Campbell said.

Campbell, a 20-year political veteran, said her job at the University Hospital and her Met Council experience will help her better understand issues at City Hall.

"I think having a professional job at the University or anywhere gives me the experience of the real world," she said.

According to Campbell, the main issues Minneapolis will need to address in the 1990s include health and welfare, children, and teenage pregnancy — issues she has worked with as a single parent and as a nurse.

Campbell also said she would continue O'Brien's efforts to keep the neighborhoods — especially Cedar-Riverside — safe, while adding some of her own ideas, such as stopping the deterioration of older neighborhoods.

If elected, Campbell would see new faces around the council table, but she would sit in the chair of an old friend.

About 15 years ago, O'Brien and Campbell met while both

See Campbell page 4

Photo/John Haselmann

University Hospital nurse manager Joan Campbell was the first to announce her candidacy for the 2nd Ward seat of the Minneapolis City Council Monday. She will seek the DFL endorsement later this year.

Campbell *from 1*

worked for the Minnesota DFL.

Despite their friendship, O'Brien said she hasn't officially endorsed any candidates yet.

"I think Joan is a highly qualified candidate. She could do a strong job as a City Council member," O'Brien said.

Campbell said although she and her predecessor agree philo-

[illegible] position," Campbell said.

Later this year, Minneapolis DFL and IR parties will announce their candidate endorsements for the council election, to be held in November.

Two other prospects have expressed interest in representing the 2nd Ward, but have not formally announced candidacies.

Campbell joins a growing list of City Council candidates. Other [illegible]

- 5th Ward — Incumbent Van White is being challenged by Jackie Cherryhomes for the DFL endorsement;
- 7th Ward — Incumbent Sara Carlson may face Pat Baker and/or Dan Cohen for the IR endorsement. Pat Scott and John Wodele may run for DFL endorsement;
- 8th Ward — Incumbent Jon Sayles Belton will face [illegible]

[illegible]

Minnesota Daily
January 12, 1989

U doctors remove rare tumor from Marshall Islands baby

Child travels thousands of miles for surgery at Children's Hospital

By **Delores Lutz**
Staff Reporter

Robbie Term developed a rare tumor when he was three months old.

Doctors removed it, but it grew back. Last week, at six months of age, Robbie had a second operation when University surgeons removed the golf ball-size growth from his upper jaw.

Like many other patients who come to the University's Variety Club Children's Hospital, Robbie was referred by a physician near his home. But for Robbie, the referral sent him on quite a trip.

Robbie lives in the Marshall Islands in the South Pacific, 2,500 miles west of Hawaii.

He left the hospital Saturday with a denture-like device that replaces the upper left jaw and roof of his mouth, allowing him to eat. In a few weeks, Robbie will return to the Marshall Islands, where doctors will watch him closely and dentists will recast his prosthesis as he grows.

The baby's tumor, called melanotic neuroectodermalitis, is so rare that specialists at the University have seen only three cases in the last 10 years, according to Dr. George Adams, associate professor of otolaryngology, who headed the surgical team. Only 140 cases have been reported in the medical literature, he said.

Surgery was Robbie's only hope because the tumor does not respond to radiation or chemotherapy, Adams told reporters at a news conference Saturday, three days after the operation.

Elmina Jabnio, Robbie's grandmother, said through an interpreter that she was "overjoyed" that he came to the University, and she has faith that he will grow up and have a normal life.

But growing up will provide some challenges for Robbie's dentists, said Dr. James Schreiner, who fitted the device Robbie now wears in his mouth.

"The false palate has to be changed and modified, and as the teeth come in, that will be a special problem," said Schreiner, an assistant professor of removable prosthodontics.

Adams said doctors are concerned about the baby because no one can tell whether the tumor is cancerous. "The benign and malignant varieties look exactly the same to pathologists," Adams said.

The cause of the tumor also is unknown, but it could result from the mother's exposure to something in the environment, said Dr. Craig Anderson, an otolaryngologist who was a member of the surgical team. Robbie has a twin who shows no sign of the tumor, his grandmother said.

The Marshall Islands, a United States trust, includes Bikini Atoll, the site of atomic bomb tests in the years after World War II.

Robbie was referred to University specialists because a physician in the Marshall Islands, Dr. Jan Reimers, knew Adams when she trained as a nurse anesthetist at University Hospital, Adams said.

At first, Adams hoped to fly to the Marshall Islands to treat Robbie.

"But the facilities are not there," Adams said. The area lacks large hospitals suitable for lengthy surgery, he said, and it also lacks the high-tech medical equipment, such as a CT scanner, that is essential in treating such cases.

Robbie's hospital bill will be paid by the Variety Club of the Northwest, said hospital spokeswoman Mary Stanik.

Photo for The Daily/Daniel J. Kiefer

Elmina Jabnio, Robbie Term, who traveled from the Marshall Islands to have surgery at the University.

Handed Out at the 1/25/89 Mtg.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1988 TO DECEMBER 31, 1988

	1988-89 Budgeted	1988-89 Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$138,426,644	$155,105,513	$16,678,869	12.0%
Deductions from Charges	23,940,913	33,123,300	$9,182,387	38.4%
Other Operating Revenue	4,290,610	4,743,687	$453,077	10.6%
Total Operating Revenue	118,776,341	126,725,900	7,949,559	6.7%
Total Expenditures	129,386,636	135,718,839	6,332,203	4.9%
Net Operating Revenue	(10,610,294)	(8,992,939)	1,617,355	15.2%
Non-Operating Revenue and Expenses	10,907,103	11,823,227	916,124	8.4%
Revenue Over/Under Expense	$296,809	$2,830,288	$2,533,479	

	1988-89 Budgeted	1988-89 Actual	Variance Over/-Under Budget	Variance %
Admissions	9,159	9,552	393	4.3%
Patient Days	71,217	79,968	8,751	12.3%
Average Daily Census	387.0	434.6	47.6	12.3%
Average Length of Stay	7.8	8.3	0.5	6.4%
Percentage Occupancy	67.1	74.5	7.4	11.0%
Outpatient Clinic Visits	131,092	134,391	3,299	2.5%

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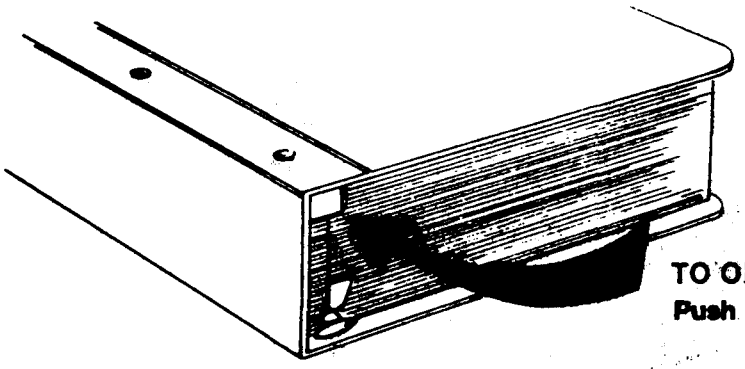

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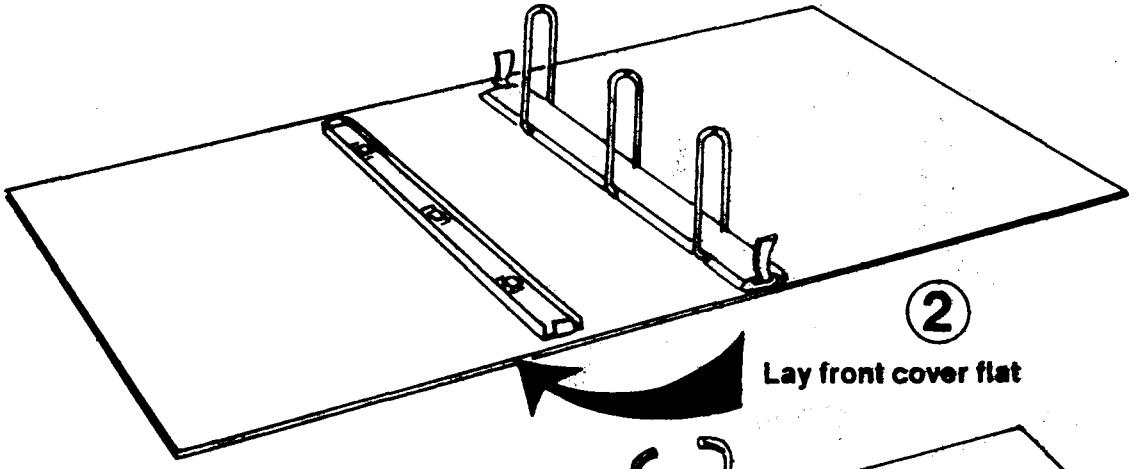

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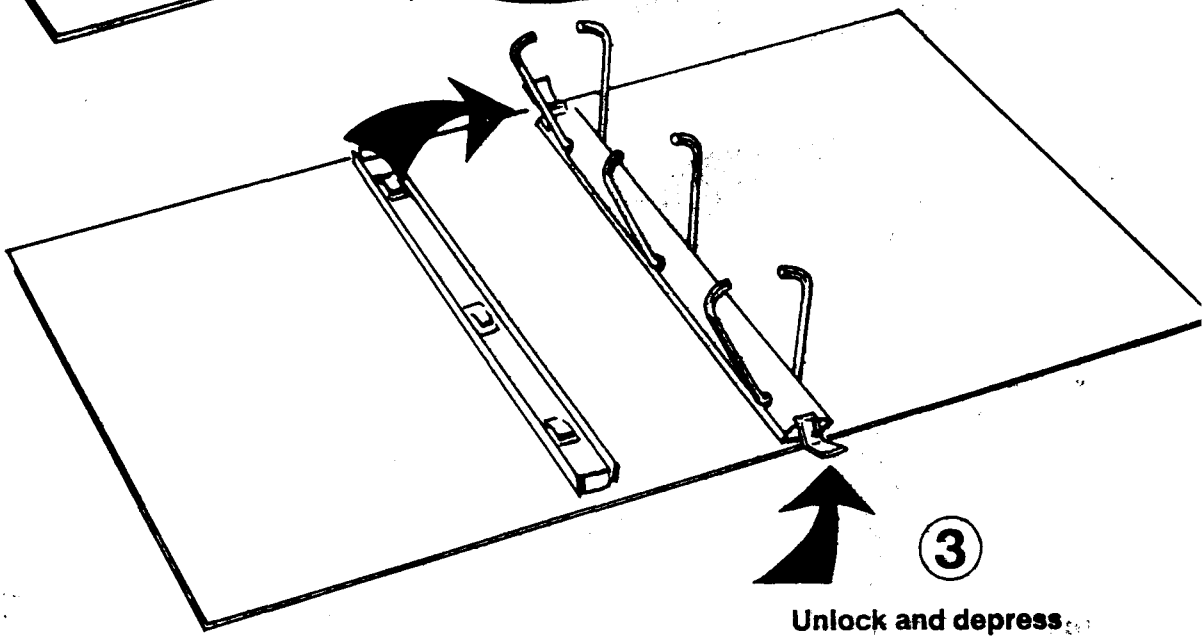

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THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

FEBRUARY 22, 1989

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***** OTHER ATTACHMENTS *****

"A Consumer-Choice Health Plan for the 1990s (Second of Two Parts)", The New England Journal of Medicine, January 12, 1989, pp. 94-101
"A National Health Program for the United States, A Physicians' Proposal", The New England Journal of Medicine, January 12, 1989, pp. 102-108
"Legal Immunity for Medical Peer-Review Programs", The New England Journal of Medicine, January 26, 1989, pp. 233-235
"Can You Afford to Get Sick?", Newsweek, January 30, 1989
"Amendment Removes Doctors' Liability Protection", Minnesota Daily, January 23, 1989
"Judge Clears Way for Jamieson Suite", Minnesota Daily, February 2, 1989
"Hasselmo Names New Finance VP', Minnesota Daily, February 2, 1989
"Donhowe Appointment Praised, But Challenges Loom", Minnesota Daily, February 10, 1989
President of HealthEast Hospitals May Quit", St. Paul Pioneer Press Dispatch, February 10, 1989

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
February 22, 1989
2:30 P.M.
555 Diehl Hall

AGENDA

I. Approval of the January 25, 1989 Meeting Minutes — Approval

II. Chairman's Report — Information
- Mr. Robert Nickoloff

III. Hospital Director's Report — Information
- Mr. Robert Dickler

IV. Special Presentation: "What is an Academic Department of Medicine?" — Information
- Dr. Thomas F. Ferris

V. Committee Reports

A. Planning and Development Committee Report
- Ms. Kris Johnson

1. Quarterly Purchasing Report — Approval
2. Capital Expenditure Policy — Approval

B. Joint Conference Committee
- Mr. George Heenan

The Joint Conference Committee did not meet in February

C. Finance Committee
- Mr. Jerry Meilahn

1. January 31, 1989 Financials — Information
2. Six Month Capital Expenditure Report — Approval
3. Internal Audit — Information

4. Peat Marwick Management Letter — Information

VI. Self-Evaluation Survey Results — Information
- Ms. Nancy Janda

VII. Other

VIII. Adjournment

MINUTES

BOARD OF GOVERNORS

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

JANUARY 25, 1989

CALL TO ORDER:

Chairman Robert Latz called the January 25, 1989 meeting of the Board of Governors to order at 2:34 P.M. in 555 Diehl Hall.

ATTENDANCE:

Present:	Leonard Bienias Robert Dickler Phyllis Ellis Erwin Goldfine Robert Latz David Link Jerry Meilahn James Moller, M.D. Robert Nickoloff Barbara O'Grady Cherie Perlmutter William Thompson, M.D.
Not Present:	David Brown, M.D. Carol Campbell George Heenan Kris Johnson

APPROVAL OF THE MINUTES:

The Board of Governors seconded and passed a motion to approve the minutes of the December 21, 1988 meeting as written.

CHAIRMAN'S REPORT:

Chairman Robert Latz introduced three new Board members, Mr. Erwin Goldfine, Mr. David Link, and Interim Vice President Cherie Perlmutter.

Mr. Latz asked that Board members who have not returned their self-evaluation surveys do so as soon as possible. The results will be reported at the February Board meeting.

Lastly, Mr. Latz reported that the affiliations reporting forms will be forwarded to all Board members shortly.

HOSPITAL DIRECTOR'S REPORT:

Mr. Robert Dickler reported that census continues to be high. Current census is 481.

The Minnesota Daily, Mr. Dickler reported, did run a correction in the January 3, 1989 issue. A copy of that correction is on page 95 of the Board packet.

Mr. Dickler reported that the Joint Commission on Accreditation of Healthcare Organizations had conducted a focused site visit at UMHC on January 10, 1989 to review the contingencies in ambulatory care. The surveyor is expected to recommend that both contingencies be removed.

Lastly, Mr. Dickler reported that he had attended the University Hospital Consortium (UHC) annual meeting. A UHC is examining a plan to implement a computer system to link the member institutions. Mr. Dickler noted that UMHC is one of the most active institutional participants and as such will be honored at a luncheon here hosted by UHC. Mr. Dickler has been elected a member of the Executive Committee.

NOMINATING COMMITTEE REPORT:

Ms. Phyllis Ellis, Chairman, reported that the Committee, which included Ms. Barbara O'Grady and Dr. James Moller, met via telephone conference. The committee nominated Mr. Robert Nickoloff as Chairman and Ms. Kris Johnson as Vice Chairman of the Board of Governors for 1989. Additional nominations were called for; none were made.

The Board of Governors unanimously seconded and passed a motion to elect Robert Nickoloff Chairman and Kris Johnson Vice Chairman of the Board of Governors for 1989.

SPECIAL PRESENTATION:

Dr. John Najarian is the Regents Professor and Chairman of the Department of Surgery and Jay Phillips Distinguished Chair in Surgery. Dr. Najarian provided the Board of Governors with an overview of current clinical practice, research, and future directions of the organ transplantation program at UMHC. The kidney program, Dr. Najarian reported, is the most active, doing 160-180 per year, and a total of 3,000 dating back to 1963. Three products developed here are now being used internationally: kidney preservation unit (Moxs 100), the anti-coagulant lymphocytes globulin (ALG), and the drug cycosporin. Dr. Najarian emphasized that UMHC is recognized as specializing in pediatric transplants, transplants in high risk patients such as diabetics and older patients (over 50).

Dr. Najarian reported that UMHC was the first to do a pancreas transplant in 1967. UMHC is the home of the International Register for Pancreases. The first liver transplant was done in 1968; over 200 have been done. Heart transplantation was started in 1978. Over 200 have been done, with a survival rate of 95% after 1 year, 93% after 2 years and 90% after 3 years. The Heart-Lung Transplantation program is newer. Of the 8 heart-lung transplant patients, 7 are still alive and well.

Current research and future directions in organ transplantation surgery include: hand transplant, brain transplants using the adrenal glands, tolerance to low drug use, and zeno transplants (cross transplants between humans and animals).

FINANCE COMMITTEE REPORT:

Mr. Cliff Fearing reported that admissions for December were 103 above budgeted level of 1,419. The average length of stay was 8 days and patient days were 1,618 days over budget. Outpatient visits were 2.3% under budget. UMHC's overall favorable balance for the fiscal year is $2.8 million, which is $2.5 million ahead of expected levels). Mr. Fearing also noted a marked change in payor mix. There has been a decrease in commercial patients from approximately 30% to 26%.

Mr. Fearing reviewed the recommendations for formulation of the University Audit Committee. The Board of Regents are reviewing the proposed audit process. It has been suggested that all UMHC reports come to the Board of Governors. The Finance Committee has discussed acting as the Audit Committee, reporting to the Board of Governors on a regular basis.

Mr. Greg Hart reviewed a format for the reporting of the quarterly capital expenditures to the Board of Governors. The proposed format utilized the November year-to-date expenditures. The Board of Governors reacted favorably to the format. This information will be reported to the Board on a quarterly basis, beginning with the December, 1988 information.

Mr. Greg Hart reviewed the proposed 1989-90 Compensation Plan. Mr. Hart emphasized the three areas of concern and attention: 1) Pay Equity - recommend another 2 years to achieve parity at a cost of $750,000; 2) Progression Increases - the Hospital is not currently competitive in some areas; and 3) Merit Pay - has had mixed results; the plan recommends no merit pay for 1989-90. Final approval for the compensation plan will be sought in conjunction with the 1989-90 operating budget at a later date.

Mr. Cliff Fearing reviewed the Second Quarter Bad Debts. Bad debts for the second quarter totaled $687,303.14, representing 1,570 accounts. Recoveries amounted to $31,118.46, leaving a net charge-off of $656,184.68. This amount represents 0.86% of gross charges and compares to a budgeted level of bad debts of 1.42%.

The Board of Governors seconded and passed a motion to approve the Second Quarter 1988-89 Bad Debt report as submitted.

PLANNING AND DEVELOPMENT COMMITTEE REPORT:

Mr. Al Dees reviewed the discussion and recommendations to purchase the MRI with the smaller (1.5T) magnet, resulting in a $150,000 savings. The Planning and Development Committee had recommended and endorsed the purchase of the 1.5T magnet.

The Board of Governors seconded and passed a motion to approve the purchase of the MRI with the 1.5T magnet as proposed.

Mr. Greg Hart reviewed, for informational purposes, three major capital expenditures in the $100,000 - $600,0000 range: 1) Laser-Tripter to be leased for $6,000/month for 36 months. This is an advanced mode of therapy for the treatment of renal stones; 2) Two Kodak Chemistry Random Access Analyzers for $4,750/month for 60 months ($285,000). One is to replace an analyzer in Clinical Chemistry which was budgeted and the other is a replacement for one in Outpatient Laboratories that was not budgeted. The operational savings will exceed the annual lease cost for the machine that was not budgeted. 3) Hyperthermia System - at a price of $204,771 to be used in conjunction with radiation therapy to enhance treatment for oncology patients.

Lastly, Mr. Geoff Kaufmann reviewed the Integrated Medical Systems expenditure. This proposal is a computer network to permit physicians in remote locations to communicate through a propietary software system with UMHC physicians. UMHC instituted a pilot program using IMS with 22 external sites and 11 internal sites. Evaluations of the program were extremely favorable. The price, $230,000, would be for the purchase of the software with the individual physician sites purchasing the hardware along with other practice applications directly from the vendor. This was a discussion item and did not require the approval of the Board of Governors.

OTHER BUSINESS:

Mr. Robert Dickler presented gifts of appreciation to out-going Chairman Robert Latz and previous out-going Chairman Barbara O'Grady for their support and untiring work as Chairmen of the Board of Governors.

ADJOURNMENT:

There being no further business, the January 25, 1989 meeting of the Board of Governors was adjourned at 4:25 P.M.

Respectfully submitted,

Kay F. Fuecker
Board of Governors Office

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

February 14, 1989

TO: Members of the Board of Governors

FROM: Nancy C. Janda
Associate Director and
Secretary to the Board of Governors

We are honored to have Dr. Thomas Ferris as our enrichment speaker this month. Dr. Ferris is Professor and Head of the Department of Medicine. He will be speaking to the Board of Governors about an academic Department of Medicine.

This presentation is another in a series of presentations designed to broaden or enhance the Board of Governors familiarity with current issues at The University of Minnesota Hospital and Clinic.

NCJ/kff

Attachment

CURRICULUM VITAE

Thomas F. Ferris, M.D.

Professional Address:

Nesbitt Professor and Chairman
Department of Medicine
University of Minnesota Hospital
Minneapolis, MN 55455

Home Address:

1535 Hunter Drive
Wayzata, MN 55391

Birthplace and Date:

Boston, Massachusetts, 12/27/30
Social Security

Education:

Georgetown University A.B., 1952
Yale University, M.D., 1956

Hospital Training:

1956-57	Internship, Osler Service, Johns Hopkins Hospital
1960-62	Assistant Resident, Yale-New Haven Hospital
1963-64	Chief Resident, Yale-New Haven Hospital
1959-60	USPHS Fellow (Metabolism & Renal Diseases) Research, Yale University
1962-63	USPHS Fellow (Metabolism & Renal Diseases) Clinical, Yale University

Military Status:

1957-59 Captain USAR, (M.C.) 98th General Hospital, Neubrucke, Germany

Positions and Appointments:

1963-65	Instructor, Yale University School of Medicine
1965-67	Assistant Professor, Yale University, School Medicine
1966-67	Visiting Investigator, Regius Department of Medicine, Oxford, England
1966-67	Fellow, Landacre College, Oxford, England
1967-71	Associate Professor, Ohio State University College of Medicine
1967-78	Director, Division of Renal Diseases, Ohio State University College of Medicine
1971-78	Professor, Ohio State University College of Medicine
1978-	Professor and Chairman, Department of Medicine University of Minnesota School of Medicine

Specialty:

1964 Certified, American Board of Internal Medicine

Fields of Interest:

Renal physiology, hypertension and diseases of the kidney

Societies:

American Society for Clinical Investigation
Council on High Blood Pressure, American Heart Association

Societies:

Central Society for Clinical Research
American Society of Nephrology
American Federation of Clinical Research
Sigma Xi
Association of American Physicians
American College of Physicians (Fellow)
American Clinical and Climatological Association

Awards and Honors:

Alpha Omega Alpha, Yale University, 1955
Mosby Book Award, Yale University, 1956
Merck Award, Yale University, 1961
John and Mary R. Markle Scholar in Academic Medicine, 1964-69
Outstanding Teaching Award (presented by Housestaff, Ohio State University School of Medicine), 1969
Outstanding Teaching Award (presented by the Senior Class, Ohio State University School of Medicine), 1976
Commencement Speaker, University of Oklahoma Medical School, 1978
Society of Scholars, Johns Hopkins University, 1987

Editorial Positions:

Associate Editor, Clinical Research, 1971-75
Editorial Board, Kidney International, 1974-
Editorial Board, Archives of Internal Medicine, 1980-
Editorial Board, American Journal of Nephrology, 1981-
Editorial Board, Hypertension, 1983-
Editor, The Kidney, 1985-
Associate Editor, American Journal of Medicine, 1989-

National Committees:

American Board of Nephrology, 1976-1984
Chairman, American Board of Nephrology, 1982-1984

American Board of Internal Medicine, 1982-84
Board of Governors, American Board of Internal Medicine, 1982-1984

Medicine Test Committee, National Board of Medical Examiners, 1975-1978
Chairman, Medicine Test Committee, National Board of Medical Examiners, 1979-1981

Council, Central Society for Clinical Research, 1977-1980
President, Central Society for Clinical Research, 1985

Council, American Society of Nephrology, 1982-1988
President, American Society of Nephrology, 1988

Council, Association of Professors of Medicine, 1984-
President-Elect, Association of Professors of Medicine, 1988

Thomas F. Ferris, M.D.

Committees:

Program Committee, American Heart Association Hypertension Council, 1975-78
Council on the Kidney in Cardiovascular Disease, American Heart Association, 1977-81
Joint National Committee on High Blood Pressure, 1983

Advisory Board and Research Committee, National Kidney Foundation, 1983-1988

Council of Subspecialty Societies of The American College of Physicians, 1984-1988

Veterans Administration Career Development Committee, 1984-1988

NIH Hypertension SCOR Committee, 1984

Visiting Professorships:

Mt. Sinai Hospital, Cleveland, OH., 1974
University of Kentucky, Lexington, KY., 1974
Tulane University, New Orleans, LA., 1974
Wayne State University, Detroit, MI., 1975
Cleveland Clinic, Cleveland, OH., 1975
Medical College of Ohio at Toledo, Toledo, OH., 1975
University of Buffalo, Buffalo, NY., February, 1976
William Beaumont Army Medical Center, El Paso, TX., March, 1976
Kansas University Medical Center, Kansas City, KS., May, 1976
Cleveland Clinic, Cleveland, OH., June, 1976
University of Texas Health Science Center, San Antonio, TX., September, 1976
University of Arkansas, Little Rock, AK., September, 1976
Beth Israel Hospital, Boston, MA., November, 1976
Tufts-New England Medical Center, Boston, MA., November, 1976
Washington University, St. Louis, MO., March, 1977
University of Cincinnati, Cincinnati, OH., March, 1977
Boston, University, Boston, MA., April, 1977
Case-Western Reserve, Cleveland, OH., September, 1977
Thomas Jefferson School of Medicine, Philadelphia, PA., January, 1978
University of Wisconsin School of Medicine, Madison, WI., March, 1978
University of Minnesota Medical School, Minneapolis, MN., April, 1978
Southern Illinois College of Medicine, Carbondale, IL., May, 1979
Baylor College of Medicine, Houston, TX., February, 1980
Peter Bent Brigham Hospital, Boston, MA., March, 1980
University of Hannover, Hannover, Germany, Invited Lecturer, International Symposium on Renal Diseases in Pregnancy, June, 1980
University of Indiana, Indianapolis, IN., October, 1980

Visiting Professor:

University of Alabama, Birmingham, AL., February, 1981
Scripps Clinic and Research Foundation, LaJolla, CA., February, 1981
Paul B. Beeson Professorship Lecturer, Yale University, New Haven, CT., April, 1981
Ohio State University, Columbus, OH., May, 1981
Lucy Cline Visiting Professor, Northwestern University, Evanston, IL., September, 1981
University of Iowa, Iowa City, IA., October, 1981
University of Toronto, Toronto, Ontario, December, 1981
Michael Reese Hospital, Chicago, IL., November, 1982
University of Illinois, Gunnar Lecturer, Urbana, IL., January, 1983
Ohio State University, AOA Visiting Lecturer, Columbus, OH., April, 1983
Temple University, Philadelphia, PA., July, 1983
University of Pennsylvania, Philadelphia, PA., February, 1984
University of Texas, Houston, TX., October, 1983
Temple University, Philadelphia, PA., July, 1983
University of Puerto Rico, San Juan, Puerto Rico, March, 1984
University of Colorado, Denver, CO., February, 1986
Goldsmith-del Greco Lecturer, Northwestern University, Evanston, IL., July, 1986
John Watson Memorial Lecturer, SUNY, Buffalo, NY., May, 1986
University of Michigan, Ann Arbor, MI., November, 1986
Medical College of Wisconsin, Milwaukee, WI., November, 1986
University of Florida, Gainesville, FL., November, 1986
Cleveland Clinic, Cleveland, OH., July, 1987
University of Galveston, Galveston, TX., March, 1988
University of San Antonio, San Antonio, TX., May, 1988
University of Southern California, Los Angeles, CA., October, 1988

Publications:

1. Beck, K., Freedman, L.R., Levitin, H., Ferris, T.F., and F.H. Epstein. Effect of experimental pyelonephritis on the renal concentrating ability of the rat. Yale H. Biol. Med. 34:52, 1961.

2. Ferris, T.F., Morgan, W.S., and H. Levitin. Nephrotic syndrome caused by probenecid. New Eng. J. Med. 265:381, 1961.

3. Ferris, T.F., Kashgarian, M., Levitin, H., Brandt, I., and F.H. Epstein. Renal tubular acidosis and renal potassium wasting acquired as a result of hypercalcemic nephropathy. New Eng. J. Med. 265:924, 1961.

4. Ferris, T.F., Levitin, H., and F.H. Epstein. Renal potassium wasting induced by Vitamin D. J. Clin. Invest. 41:1222, 1962.

MINUTES
Planning and Development Committee
February 3, 1989

CALL TO ORDER
Ms. B. Kristine Johnson, Chair, called the February 3, 1989 meeting of the Planning and Development Committee to order at 2:14 p.m. in Room 8-106 in the University Hospital.

Attendance:	Present	B. Kristine Johnson, Chair Robert Dickler Clint Hewitt William Jacott, M.D. Geoff Kaufmann Ted Thompson, M.D.
	Absent	Leonard Bienias Peter Lynch, M.D.
	Staff	Cliff Fearing Greg Hart Nancy Janda John LaBree, M.D. Lisa McDonald

APPROVAL OF MINUTES
The minutes of the January 9, 1989 meeting were approved with the addition of John LaBree, M.D. for staff attendance.

QUARTERLY PURCHASING REPORT
Mr. Koenig reviewed 2nd quarter purchasing activity of $17,357,959 which includes $1,981,921 for the Medicare settlement. Charges were slightly higher due to the higher hospital census and inclusion of service contracts for the first time. Purchase awards to other than low bidder were summarized. Sole source awards totaled $352,511.

Mr. Dickler asked where were consultants listed. Mr. Koenig responded that they could be listed as a Sole Source or other than low bidder but that there was no definite policy. Mr. Dickler said that the policy would be reviewed and discussed at the next meeting. Set asides totaled $63,314.

Vendor appeals for syringes, central dictation system and pharmaceutical distribution were discussed. The patient care equipment bid has been rebid to accept line item bids and there is the potential that the award will be appealed.

Estimated pharmaceutical savings realized through the Consortium were $537,397 in 1988 with savings of $299,955 in second quarter. The purchasing report was endorsed unanimously.

CAPITAL EXPENDITURE POLICY
Mr. Hart reviewed the proposed capital expenditure policy changes that outline the handling of capital equipment acquired through lease arrangements. Definitions were clarified. Other changes were that "the annual capital budget should include lease payments in the amount anticipated for payment in the budget year". . . "Expenditures associated with lease arrangements shall be reported over the term of the lease, as payments are made." The revised capital expenditure policy was endorsed by the Committee.

CAPITAL EXPENDITURE REPORT
Mr. Hart presented the modified capital expenditure report which has been changed to reflect seasonal patterns. In the first six months $2,585,946 has been spent which is lower than what was budgeted ($3,130,271) for recurring equipment and remodeling. Principal payments of $3,167,947 were lower than the $3,712,272 that was budgeted. A bond payment of $2,815,000 is due 2/1/89. Capital projects expended to date are $482,937.

INTEGRATED MEDICAL SYSTEMS (IMS) COMPUTER NETWORK
Mr. Kaufmann discussed the status of IMS, a computer network which permits physicians in remote locations to communicate through its proprietary software system. Mr. Fearing stated that UMHC has only committed to purchasing the hardware and software used in the pilot project. The estimated cost is $230,000 and a final agreement should be reached next week. A detailed analysis is currently underway of the financial, legal and operational issues associated with the program before a long term commitment is made.

Dr. LaBree talked about the IMS marketing and operations plan. He said that the key to site acceptance are the clinical applications which, along with the basic hardware at each site, would be purchased by each participant.

UMCA REPORT
Mr. Fearing reported that UMCA will continue their billing function through 6/30/89 at which time the departments have the option to change. Recruitment is underway for an executive director and a medical director. Administration, UMCA representatives and Deloit, Haskins and Sells have been meeting regularly to determine UMCA's future course.

ADJOURNMENT
Ms. Johnson adjourned the Planning and Development Committee at 3:55 p.m.

Respectfully submitted,

Lisa McDonald

Lisa McDonald
Assistant Director of Planning and Marketing

UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospital and Clinic
420 Delaware Street S.E.
Minneapolis, Minnesota 55455

February 13, 1989

TO: Members of the Board of Governors

FROM: Greg Hart
Senior Associate Director

REGARDING: Quarterly Purchasing Report

Attached is a copy of the Hospital's Purchasing Activity report for the period of October through December, 1988.

This report is being submitted for your approval at the February 22, 1989 Board of Governors meeting. Please note that there are some significant issues contained in the "Vendor Appeal" section of the report this quarter. These issues will be reviewed in detail at the meeting.

If you have any questions regarding the report before the meeting, please feel free to call me.

GH/kff

Attachment

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

ADMINISTRATIVE REPORT ON PURCHASING ACTIVITY

PERIOD OF OCTOBER - DECEMBER 1988

I. PURCHASE ORDER ANALYSIS

RANGE	NUMBER OF P.O.'s	DOLLAR VALUE
$ 0 - $ 499	5891	$971,360.40
$ 500 - $1,999	2052	$2,055,193.56
$ 2,000 - $4,999	588	$1,829,229.29
$ 5,000 - $9,999	294	$2,085,155.77
$10,000 - OVER	306	$9,382,139.92
SUBTOTAL	9131	$16,323,078.94

II. CONFIRMING ORDERS

$ 0 - $ 99	140	$7,000.21
$ 100 - $ 499	188	$45,524.10
$ 500 - $ 999	66	$47,366.50
$1,000 - $1,999	48	$65,220.26
$2,000 - OVER	39	$869,768.77
SUBTOTAL	481	$1,034,879.84
TOTAL	9612	$17,357,958.78 **

III. PURCHASE AWARDS TO OTHER THAN APPARENT LOW BIDDER

(Attached)

IV. SOLE SOURCE

(Attached)

V. SET ASIDE AWARDS

(Attached)

VI. VENDOR APPEALS

(Attached)

VII. UNIVERSITY HOSPITAL CONSORTIUM ACTIVITY

(Attached)

**An additional purchase order for $1,981,921.00 was issued for Medicare settlements this quarter.

III. Purchase Award to Other Than Low Bidder, $5,000.00 or More

	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
1.	Aminosyn Solution	Baxter $ 13 555.25	Abbott $ 20,007.50	Pharmacy
		Calcium concentration of solution is unacceptable.		
2.	Bronchoscope	Pentax $ 7.650.00	Olympus $ 9,200.00	OR
		Training expenses would outweigh cost savings; department feels it is in their best interests to purchase equipment consistent with present Olympus equipment.		
3.	Sigmoidoscope	Fujinon $ 6,115.00	Olympus $ 7,300.00	Endoscopy
		Alternate offered is less superior in clarity, resolution, field of vision, and depth of focus, thereby offering less accuracy.		
		Reichert $ 3,580.00	Olympus $ 7,300.00	Endoscopy
		Alternate offered is less superior in clarity, resolution, field of vision, and depth of focus, thereby offering less accuracy.		
4.	Gastroscope	Fujinon $ 7,700.00	Olympus $ 10,864.00	Endoscopy
		Alternate offered is less superior in clarity, resolution, field of vision, and depth of focus, thereby offering less accuracy.		

	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
5.	Colonoscopes & Gastroscopes	Pentax $ 30 240.00	Olympus $ 33,950.00	Endoscopy
		Alternate offered is less superior in clarity, resolution, field of vision, and depth of focus, thereby offering less accuracy.		
6.	Blood Gas/ICa/Na/K Analyzer	Nova Biomedical $ 28.900.00 $ 32.900.00	Radiometer $ 37,853.60	Cardio-Resp.
		Correlations with existing equipment are unacceptable. Standard error is twice that of other instruments. Error codes appear that are not easily resolved.		
		Radiometer $ 36,762.50 $ 34,536.70 $ 32,491.50 $ 37,666.50 $ 37,656.25	Radiometer $ 37,853.60	Cardio-Resp.
		Alternates considered unacceptable for a variety of reasons: two of the machines are not self-calibrating, one did not have a video display unit.		
		Fisher $ 27,875.00	Radiometer $ 37,853.60	Cardio-Resp.
		Unacceptable correlations with current laboratory instrumentation.		

	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
6.	Cont'd	Ciba Corning $ 31,500.00 (2 alternates)	Radiometer $ 37,853.60	Cardio-Resp.
		One machine gave ionized calcium results that did not correlate with current lab instrumentation. Calibrations on the second machine are performed sequentially rather than simultaneously increasing turn-around time for results. Also, multiple error s displayed requiring additional calibrations.		
7.	Ultrasound Imaging System	ATL $ 187,545.00	Acuson $ 236,840.00	Radiology
		N equipment was available for timely clinical trial was available as required by this bid. Additionally, delivery delivery lead time is far too long, and state-of-the-art cine imaging is not avail le.		
		Corometrics/Quantum $ 201,960.00	Acuson $ 23 40.00	Radiology
		No equipment was available for timely linical trail was available as required by this bid. Additionally, many system deficiencies were noted.		
8.	Video Camera System	Stryker $ 15,570.00	ACMI $ 17,052.00	OR
		Alternate system is too heavy and cumbersome for the delicate work done in a limited working area, and the system is more costly to repair.		
		Karl Storz $ 14,544.50	ACMI $ 17,052.00	OR
		Alternate system is too heavy and cumbersome for the delicate work done in a limited working area, and the system is more costly to repair.		

	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
9.	Syringes and Needles	Becton-Dickenson $ 406.099.43	Monoject $ 412,066.02	MS
		Conversion costs plus extra yearly costs associated with use of B-D are estimated at more than $ 22,000.00 greatly outweighing the $ 6,000.00 cost savings offered.		
		Terumo $ 388.719.42	Monoject $ 412,066.02	MS
		Alternate brand cannot be used with autosyringe pumps, packaging is much larger in cubic volume, syringes melt in the sterilization process, and the markings come off when tape is used and then removed.		
10.	Line, Injection, Low Contrast	Spectramed $ 8,400.00	Namic $ 11,000.00	MS
		Product is too rigid which puts undue stress on the angiocath and may result in the catheter disengaging.		
11.	Digital Central Dictation System	Wahl & Wahl $ 190,369.00 $ 196,654.00 $ 171,289.00	Dictaphone $ 271,955.00	Word Process.
		System proposed did not meet minimum specification for total record time (voice storage); numerous specifications and requirements of the proposed were not addressed.		
12.	Spectrum Analyzer	IFR Systems $ 7,787.10	Tektronics $ 10,250.00	ISD
		Error tolerance is too high; dot marker capability is not supported; utilizes a narrower resolution bandwidth than specified; and an IFR unit will not hold a drifting signal at the center of the display.		

	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
13.	Bandaids	Redline Medical $ 4,344.00	C.F. Anderson $ 5,060.00	MS
		Product does not adhere to the skin for an extended period.		
14.	Hemovac Kit	Davol $ 6,930.00	Zimmer $ 7,260.00	MS
		Difficult to compress and plug empty port; plug is stiff and difficult to manipulate; easily contaminated due to absence of plug holder.		
15.	PRN Adapter	Medex $ 7,300.00	James Phillips $ 9,140.00	MS
		Previously evaluated (1987) and found to lack secure fit to I.V. catheters and extension sets.		
16.	Urine Drain Bag	Seamless $ 9,116.25	Bard $ 11,400.00	MS
		Water soaks through the paper drape, contaminating the sterile field, and the bulk of the syringe is bulky and difficult to operate.		
17.	Catheter, Foley 30cc 8, 10 Fr.	Medix $ 5,615.21	Bard $ 6,012.00	MS
		Balloon catheter deflated during preliminary evaluation, the connecting end of the catheter was loose and floppy, and the eyes of the catheter were rough.		
18.	Catheter, Foley 5cc 12 - 30 Fr.	Medix $ 10,353.60	Bard $ 10,764.00	MS
		Catheter balloons are not reinforced, are weak, and are a asymmetrical when inflated with water; the eyes are rough and too small for good drainage and silicone material is rough and rigid.		

	ITEM	UNSUCCESSFUL VENDOR/AMOUNT	SUCCESSFUL VENDOR/AMOUNT	DEPARTMENT
18.	Cont'd	Kendall $ 10,500.00	Bard $ 10,764.00	MS
		Catheter balloons are not reinforced, are weak, and are a asymmetrical when inflated with water: the eyes are rough and too small for good drainage and silicone material is rough and rigid. Additionally, packaging is poor and print indicating catheter size wipes off the catheter.		
19.	Tray, Foley 5cc 16 Fr.	Medline $ 23,049.00	Bard $ 24,609.00	MS
		Hole at the end of the catheter is too small to accommodate pulverized stones during lithotripsy.		
20.	Urine Meter 2000cc	Seamless $ 19,345.20	Bard $ 22,368.00	MS
		Clamp requires two hands for opening which compromises technique and staff person's face is adjacent to opening so splashing on the face is a potential risk.		
		Medix $ 22,006.91	Bard $ 22,386.00	MS
		1800cc capacity and the hanger are inadequate.		
21.	Steri-Strips, 1/2"	Kendall $ 12,000.00 Baxter (2 alternates) $ 11,400.00 $ 15,600.00 Biersdorf $ 11,920.00	3M $ 17,200.00	MS
		Preliminary evaluations found these products to be less adherent. Clinical evaluations would be difficult to conduct because of the difficulty of tracking patients from the O.R. to Patient Care Units. More critically, poor adhesion could potentially cause permanent physical disfigurement. Therefore, a decision was made to treat steri-strips similar to other suture material and provide additional brands upon surgeon's request.		

IV. SOLE SOURCE

VENDOR	CONTRACT/ P.O. NO.	VALUE	DEPARTMENT	PRODUCT
Philip Seward	H090103	$35,000.00	Admin.	Assets of Health Etc.
Hemotec	H089266	$4,000.00	Cardio	Hemotec ACT
American ACMI	H090120	$5,945.00	Cardio	Laryngoscope Kits
C.R. Bard	H090104	$10,400.00	Cardio	Oxygenators
GCX Corp.	H088557	$9,350.00	Cardio	PC Mount
*Narco	H088279	$64,951.00	Cardio	Spacelabs Equip.
Mattson Scientific	H089817	$2,760.00	CHUCC	Software Programming
Gisela's Interiors	H090111	$2,540.00	Facilities	Labor for Upholstering
Design Tex	H090112	$3,819.26	Facilities	Upholstery Fabric
MSA/Mosier Scott	H090102	$2,295.00	ISD	Printer
Hewlett Packard	H091606	$4,080.00	ISD	Disk Packs
Sterling Software	H089907	$22,500.00	ISD	DMS/OS Software
Integrity Solutions	H088819	$17,000.00	ISD	Software License
North Central	H088812	$3,972.00	Labs	Microscope Upgrade
Therakos/J & J	H090182	$47,325.00	Labs	Photopheresis System
Curtin Matheson	H089939	$5,482.50	Labs	Pregnancy Control Sets
Ohmeda	H091427	$3,500.00	Labs-Neuro	Blood Pressure Monitors
Amer. Air Filter	H089322	$4,215.75	M & O	Replacement [illegible] Filters
ZMI Corp.	H087513	$7,200.00	Nursing	Pacemaker
Karl Storz	H088805	$3,800.00	O.R.	Arthroscopes & Cystoscopes
Concept	H088556	$20,745.00	O.R.	Intra Arc Drive & Video Camera
Baxter	H088554	$5,074.65	O.R.	Thermia Unit
Baxter/V. Mueller	H371319	$3,780.00	O.R.	Burs
Zimmer Page	H372646	$2,995.00	O.R.	Bone Screw Set
Impra	88-730	OPEN	O.R.	Graft Implants
Medsurg	H088319	$5,600.00	O.R.	Argon Laser Probe
SIA	H373954	$13,465.00	O.R.	Biopsy Needles
Codman	H088309	$2,135.00	O.R.	Lightsource
Synthes	H088820	$4,886.00	O.R.	Fragment Inst. & Implant Set
Zimmer Page	H088278	$7,920.00	O.R.	Sternal Saw
Acufex	H088808	$2,630.00	O.R.	Shoulder Holder & Mit
Valley Lab	H088299	$7,300.00	O.R.	Electrocautery Unit
Synthes	88-730	OPEN	O.R.	Implants
National Computer	H087789	$3,565.00	Psychiatry	Optical Scanning Device
DVI	H371953	$3,450.00	Radiology	Atherocath
Computer Care	H370755	$2,800.00	Radiology	Software Upgrade
DVI	H373289	$6,030.00	Radiology	Atherocath
TOTAL		$352,511.16		

V. SET ASIDE AWARDS

A. AWARDED BIDS

CATEGORY	VENDOR	AWARDED AMOUNT
Office Supplies	Stationery Sales, Inc.	$1,586.00
Tape (contract)	Halcon	$49,000.00
	TOTAL	$50,586.00

B. DEPARTMENTAL PURCHASES

OCTOBER

	P.O. NUMBER	VENDOR	DOLLAR VALUE
1.	H368511	Medic	$164.60
2.	H368487	Medical & Legal Visuals	$108.35
3.	H368477	Chrom Tech	$111.36
4.	H085534	Trophy Craft	$95.60
5.	H059544	Audio Visual Wholesalers	$32.34
6.	H368640	Chrom Tech	$550.80
7.	H085535	Trophy Craft	$62.25
8.	H368952	Audio Visual Wholesalers	$417.00
9.	H088061	Quality Medical	$173.55
10.	H369395	Medic	$122.40
11.	H085536	Trophy Craft	$235.30
12.	H370127	Medic	$391.40
13.	H087734	Quality Medical Products	$333.45
14.	H370333	Budget Paper	$49.90
15.	H085538	Trophy Craft	$149.40
16.	H087792	Stationery Sales	$1,586.00
17.	H369972	Northern Balance	$68.00
18.	H085537	Trophy Craft	$78.00
19.	H368661	Halcon	$38.10
20.	H369019	Halcon	$3,292.00
21.	H369143	Halcon	$114.30
22.	H369335	Halcon	$685.80
23.	H369261	Halcon	$271.20
24.	H369791	Halcon	$42.60
25.	H369893	Halcon	$114.30
26.	H370020	Halcon	$2,880.50
27.	H370297	Halcon	$127.80
28.	H370653	Halcon	$723.90
29.	H370424	Falcon Heights Medical	$760.60
30.	H368673	Art Materials	$27.00
31.	H369267	Art Materials	$45.00
32.	H369574	Art Materials	$330.60
33.	H370426	Art Materials	$426.60
34.	H369010	Quality Medical	$85.56
35.	H369249	Quality Medical	$225.00
36.	H369556	Quality Medical	$79.00
37.	H369691	Quality Medical	$21.15
38.	H369738	Medic	$160.00

SET ASIDE (cont'd)

39.	H369913	Office Machine Sales	$193.12
40.	H369876	Northern Balance	$68.00
41.	H368553	Halcon	$123.30
42.	H368666	Halcon	$38.10
43.	H368789	Art Materials	$426.60
44.	H369144	Falcon Heights Medical	$387.36
		OCTOBER TOTAL	$16,417.19

NOVEMBER

1.	H085541	Trophy Craft	$42.15
2.	H372461	Chrom Tech	$582.00
3.	H085542	Trophy Craft	$102.30
4.	H088866	Quality Medical	$168.95
5.	H085539	Trophy Craft	$114.90
6.	H370968	Medic	$98.00
7.	H371157	Medic	$287.56
8.	H371303	Halcon	$4,115.00
9.	H371438	Chrom Tech	$492.00
10.	H085540	Trophy Craft	$199.75
11.	H371652	Medic	$392.00
12.	H371790	Budget Paper	$52.20
13.	H088 38	Quality Medical	$224.05
14.	H088 34	Quality Medical	$337.70
15.	H3719 1	Chrom Tech	$48
16.	H3720	Quality Medical	$8
17.	H372280	Audio Visual Wholesalers	$1 0
18.	H372188	Medic	$26 5
19.	H372531	Chrom Tech	$180.00
20.	H371679	H.A. Roberts	$1,178.00
21.	H370904	Falcon Heights Medical	$44.64
22.	H371592	Falcon Heights Medical	$469.44
23.	H371905	Quality Medical	$85.56
24.	H372107	Quality Medical	$225.00
25.	H370909	Art Materials	$357.60
26.	H371011	Art Materials	$27.00
27.	H372568	Art Materials	$90.00
28.	H370722	Halcon	$2,674.75
29.	H370728	Halcon	$80.70
30.	H370902	Halcon	$685.80
31.	H371110	Halcon	$271.20
32.	H371008	Halcon	$127.80
33.	H371303	Halcon	$4,115.00
34.	H371911	Halcon	$3,086.25
35.	H371915	Halcon	$685.80
36.	H372116	Halcon	$60 .60
37.	H372349	Halcon	$38 .00
38.	H372484	Halcon	$114.30
39.	H372102	Quality Medical	$79.00
		NOVEMBER TOTAL	$23,191.85

SET ASIDE (cont'd)

DECEMBER

1.	H373468	Halcon	$952.50
2.	H372965	Halcon	$437.10
3.	H372883	Halcon	$1,490.40
4.	H372684	Halcon	$2,732.40
5.	H373150	Halcon	$85.20
6.	H373074	Halcon	$2,674.75
7.	H373218	Halcon	$114.30
8.	H373224	Halcon	$1,269.84
9.	H373870	Halcon	$3,086.25
10.	H373880	Halcon	$165.90
11.	H374197	Halcon	$124.20
12.	H374190	Halcon	$723.90
13.	H374397	Halcon	$228.60
14.	H374417	Halcon	$124.20
15.	H373165	Quality Medical	$85.56
16.	H364384	Quality Medical	$225.00
17.	H372765	Art Materials	$321.90
18.	H374192	Art Materials	$81.00
19.	H372772	Falcon Heights Medical	$44.64
20.	H373152	Falcon Heights Medical	$58.60
21.	H373055	Falcon Heights Medical	$66.96
22.	H373882	Falcon Heights Medical	$44.64
23.	H372748	Chrom Tech	$239.76
24.	H373903	Chrom Tech	$694.75
25.	H374339	Office Machine Sales	$161.60
26.	H085546	Trophy Craft	$56.85
27.	H374372	Chrom Tech	$140.80
28.	H091211	Quality Medical	$991.15
29.	H085543	Trophy Craft	$94.95
30.	H373034	Quality Medical	$68.00
31.	H089634	Quality Medical	$32.40
32.	H373099	Medic	$45.00
33.	H373449	Chrom Tech	$407.70
34.	H373442	Chrom Tech	$325.00
35.	H085544	Trophy Craft	$97.65
36.	H088875	Quality Medical	$1,031.55
37.	H091202	Quality Medical	$105.00
38.	H373604	Medic	$242.90
39.	H085545	Trophy Craft	$101.85
40.	H091008	Quality Medical	$311.86
41.	H091208	Quality Medical	$1,034.77
42.	H374145	Ability Plus	$1,720.00
43.	H374150	Northern Balance	$68.00
44.	H374149	Medic	$156.95
45.	H374777	Quality Medical	$51.00
46.	H373971	Falcon Heights Medical	$387.36
		DECEMBER TOTAL	$23,704.69

SET ASIDE (cont'd)

C. QUARTERLY GRAND TOTAL

October Purchases		$16,417.19
November Purchases		$23,191.85
December Purchases		$23,704.69
	GRAND TOTAL	$63,313.73

VI. VENDOR APPEAL

1. **VENDOR NAME/$ AMT:** Walter H. Mayer/$60,000
   NATURE OF PURCHASE: Scrub Pants and Shirts
   INTENDED VENDOR/$ AMT: Fashion Seal/$65,600
   REASON FOR APPEAL:

   Vendor contended UMHC might award the contract to another vendor for a scrub with the identical (inferior) thread count that they were offering. Purchasing reassured the vendor that all products with a T152 thread count would be deemed unacceptable.

   STATUS: Contract awarded to Fashion Seal.

2. **VENDOR NAME/$ AMT:** Sherwood/Argyle/$44,590.68
   NATURE OF PURCHASE: Urological Catheters
   INTENDED VENDOR/$ AMT: C.R. Bard/$46,300.80
   REASON FOR APPEAL:

   Sherwood/Argyle contends that UMHC did not give their product a fair evaluation. This claim was unsubstantiated. Products are of inferior quality to specified products and not suitable for use on UMHC patients. Vendor was so notified.

   STATUS: No further communication has been received from the vendor. Contract awarded to C.R. Bard.

3. **VENDOR NAME/$ AMT:** Nova/$28,900.00, $32,900.00
   NATURE OF PURCHASE: Blood Gas/ICa/K/Na Analyzer
   INTENDED VENDOR/$ AMT: Radiometer/$37,853.60
   REASON FOR APPEAL:

   Nova disagreed with testing results obtained by UMHC during evaluation. After correspondence explaining methods and results, and continued disagreement by Nova, the matter was reviewed by the Director of Materials Services who supported UMHC's findings and so notified the vendor. UMHC considers the matter closed.

   STATUS: No further communication has been received from the vendor. Contract awarded to Radiometer.

4. **VENDOR NAME/$ AMT:** BD/$406,099.43
   NATURE OF PURCHASE: Syringes and Needles
   INTENDED VENDOR/$ AMT: Monoject/$412,066.02
   REASON FOR APPEAL:

   BD disagreed with findings of Materials Services. We maintain that conversion costs, as well as extra yearly costs that would be incurred, outweigh any cost savings. The matter was reviewed by the Director of Materials Services who supported the original analysis and findings, and so notified the vendor.

   STATUS: Contract awarded to Monoject.

5. **VENDOR NAME/$ AMT:** Precision Business/$311,184.00
NATURE OF PURCHASE: Digital Central Dictation System
INTENDED VENDOR/$ AMT: Dictaphone/$271,955.00
REASON FOR APPEAL:

Proposal was not considered as it exceeded budget, the vendor failed to provide significant information that was requested on the Proposal, and several pricing errors were noted. Vendor indicated a willingness to lower their price and provide additional or new information. Materials maintained that allowing such substantial changes to the original proposal would be in violation of normal purchasing procedure. After notification of this, vendor requested a meeting with the Director of Materials. The Director supported the original decision, and so notified the vendor.

STATUS: No further communication has been received from the vendor. Award was made to Dictaphone.

6. **VENDOR NAME/$ AMT:** Wahl & Wahl/$190,369.00
/$196,654.00
/$171,289.00
NATURE OF PURCHASE: Digital Central Dictation System
INTENDED VENDOR/$ AMT: Dictaphone/$271,955.00
REASON FOR APPEAL:

Vendor's original proposal did not meet minimum specifications for total record time. After vendor was notified, they proposed that they now offer a brand new system that had just become available. Materials disallowed this as it would be an alteration to the original proposal and in violation of normal purchasing procedure. Vendor was again notified that they were not under consideration. Vendor has now made allegations of an improper award to the competition. Materials is preparing a response at this time.

STATUS: Award was made to Dictaphone.

7. **VENDOR NAME/$ AMT:** North Central Instruments/$76,000
NATURE OF PURCHASE: Operating Microscope
INTENDED VENDOR/$ AMT: Midwest Surgical/$76,990.00
REASON FOR APPEAL:

Vendor contended that UMHC had not evaluated newer, "state of the art" equipment that was offered on the bid. UMHC maintained that the newer equipment still did not address the points that UMHC found inadequate, including fans which blow over the sterile field, bulbs which are physically impossible for some staff to reach during a procedure, a non-waterproof footpedal, and inferior horizontal reach capabilities.

STATUS: No further communication has been received from the vendor. Award was made to Midwest Surgical.

POTENTIAL VENDOR APPEAL

1. **NATURE OF PURCHASE:** Pharmaceuticals
   ESTIMATED VALUE: $ 12,000,000.00

   Original bid was cancelled. A re-bid resulted in an award to the lowest bidder. Twin City Drug, who was low on the original bid, but not the subsequent bid, objected to the re-bid.

2. **NATURE OF PURCHASE:** Patient Care Equipment
   ESTIMATED VALUE: $ 800,000.00

   Original bid was cancelled. Re-bid is being prepared with new specifications. Original low bidder may protest.

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VII. UNIVERSITY HOSPITAL CONSORTIUM ACTIVITY

A. CONSORTIUM PURCHASES

1. **NATURE OF PURCHASE:**	Pulse Oximeter
CONSORTIUM VENDOR NAME:	Nellcor
PURCHASE ORDER #:	H091410
VALUE OF PURCHASE:	$2,400.00
VALUE OF NEXT LOWEST COST:	Not Bid
SAVINGS	$850.00
2. **NATURE OF PURCHASE:**	Ultrasound
CONSORTIUM VENDOR NAME:	Acuson
PURCHASE ORDER #:	H089166
VALUE OF PURCHASE:	$236,845.00
VALUE OF NEXT LOWEST COST:	
SAVINGS:	$36,205.00
3. **NATURE OF PURCHASE:**	Charting Shelf
CONSORTIUM VENDOR NAME:	Hausted
PURCHASE ORDER #:	H369518
VALUE OF PURCHASE:	$2,271.36
VALUE OF NEXT LOWEST COST:	n/a
SAVINGS:	$640.64
4. **NATURE OF PURCHASE:**	Cardiac Monitoring Equip.
CONSORTIUM VENDOR NAME:	Spacelabs
PURCHASE ORDER #:	H088279
VALUE OF PURCHASE:	$64,951.00
VALUE OF NEXT LOWEST COST:	Not Bid
SAVINGS:	$4,624.00
5. **NATURE OF PURCHASE:**	Surgical Dressings Contract
CONSORTIUM VENDOR NAME:	Johnson & Johnson
PURCHASE ORDER #:	n/a
VALUE OF PURCHASE:	n/a
VALUE OF NEXT LOWEST COST:	n/a
SAVINGS:	$1,543.00 (August) $1,631.00 (September) $1,465.00 (October) $ 548.00 (November)
6. **NATURE OF PURCHASE:**	Forms
CONSORTIUM VENDOR NAME:	Standard Register
PURCHASE ORDER #:	various
VALUE OF PURCHASE:	$45,110.38 (quart. total)
VALUE OF NEXT LOWEST COST:	Not Bid
SAVINGS:	$0.00

7.	**NATURE OF PURCHASE:**	I.V. Solutions/Sets
	CONSORTIUM VENDOR NAME:	Baxter
	PURCHASE ORDER #:	n/a
	VALUE OF PURCHASE:	n/a
	VALUE OF NEXT LOWEST COST:	n/a
	SAVINGS:	$32,087.72 (Third Quarter Rebate)
8.	**NATURE OF PURCHASE:**	Pharmaceuticals
	CONSORTIUM VENDOR NAME:	Various
	PURCHASE ORDER #:	Various
	VALUE OF PURCHASE:	n/a
	VALUE OF NEXT LOWEST COST:	n/a
	SAVINGS:	$225,000.00 (Estimated; Second Quarter 1988-89)
	Total Savings This Quarter	**$299,955.36**
	Total Savings This Fiscal Year	**$537,396.84**

gov19b

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

February 14, 1989

TO: Members of the Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: Capital Expenditure Policy

We indicated last month that we would be recommending changes to the capital expenditure policy to more directly outline the handling of capital equipment acquired through lease arrangements. The proposed policy changes are attached.

These recommended changes are presented for your approval. We will be happy to answer your questions at the meeting on Wednesday.

GH/kj

attachments

THE UNIVERSITY OF MINNESOTA
HOSPITAL AND CLINIC
BOARD OF GOVERNORS

Approved: October 26, 1988
Reviewed: February, 1989
Revised:

BOARD OF GOVERNORS
POLICY ON CAPITAL EXPENDITURES

DEFINITIONS

Recurring Capital Expenditures are those construction or remodeling projects or equipment purchases/leases which involve total expenditures of $500 to $100,000 and have a depreciable life of three years or longer.

Major Capital Expenditures are those construction or remodeling projects or equipment purchases/leases which involve total expenditures of $100,000 to $600,000 and have a depreciable life of three years or longer.

Special Projects are those construction or remodeling projects or equipment purchase/leases which involve total expenditures of over $600,000 and have a depreciable life of three years or longer.

Leased equipment shall be defined as "major capital expenditures" or "special projects" based on total expenditures over the entire term of the lease.

LONG-RANGE CAPITAL PLAN

Between April and June of each year the Hospital Director shall provide a long-range capital expenditure plan to the Board of Governors. This plan shall be reviewed by the Planning and Development Committee and the Finance Committee. The plan should identify total capital expenditures anticipated for each of the next five fiscal years, and should also identify anticipated special projects on an item-by-item basis.

The long-range capital plan is provided to the Board for use in financial and program planning. No specific action on the long range capital plan is required. Authorization to proceed with any element of the plan shall not be considered to have been provided until approval of the annual capital budget has occurred.

ANNUAL CAPITAL BUDGET

Between April and June of each year the Hospital Director shall recommend an annual capital budget. This capital budget shall be presented for endorsement

to the Planning and Development Committee, the Finance Committee and to the full Board of Governors. The annual capital budget is a component of the total operating budget which is submitted annually to the Board of Regents for final approval.

The annual capital budget shall include all capital expenditures, and shall identify major capital expenditures and special projects on an item-by-item basis.

The annual capital budget shall include lease payments in the amount anticipated for payment in the budget year.

APPROVAL OF RECURRING AND MAJOR CAPITAL EXPENDITURES

Board of Governors endorsement of the annual capital budget shall authorize the expenditure of up to 105% of the approved budget limit for recurring and major capital expenditures in aggregate. The Board shall be informed of each major capital expenditure as it occurs during the fiscal year prior to the commitment of funds.

A report of year-to-date aggregate capital expenditures and projected year-end capital expenses shall be provided to the Planning and Development Committee and the full Board of Governors each quarter. Expenditures associated with lease arrangements shall be reported over the term of the lease, as payments are made.

If quarterly trends indicate that the approved capital budget will be exceeded by more than 5%, a revised capital expense projection shall be submitted for Board information.

APPROVAL OF SPECIAL PROJECTS

Board of Governors endorsement of the annual capital budget shall constitute conceptual approval only for all special projects. Each special project shall be presented individually to the Planning and Development Committee, the Finance Committee and the full Board of Governors for final approval. No commitment of funds for special projects, other than planning costs, shall occur without final Board approval.

Any expenditure that is expected to cause a special project budget to be exceeded by the lesser of 10% or $250,000 will be presented to the Board for information. Where possible, that information will be presented prior to the authorization of expenditure. Consultation from the Chair of the Board, the Chair of the Planning and Development Committee, and the Chair of the Finance Committee shall be sought when presentation to the full Board prior to expenditure authorization is not feasible.

GUIDELINES FOR PRESENTING PROJECTS TO THE BOARD OF REGENTS

The Board of Governors shall comply fully with terms and conditions outlined in the "Guidelines for Presenting Projects to the Physical Planning and Operations Committee of the Board Regents." Those guidelines reaffirm the Board of Governors authority to review and approve capital projects for The University of Minnesota Hospital and Clinic with four categorical exceptions requiring approval by the Board of Regents. Categories of capital projects requiring approval by the Board of Regents include:

1. Projects with legislative funding

2. Projects which require an increase in capital indebtedness (i.e., sale of bonds, bank loans, etc.)

3. Projects to construct new facilities with an estimated cost in excess of $100,000

4. Increases in project cost over $100,000 for any projects approved pursuant to the above.

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS FINANCE COMMITTEE
January 25, 1989

MINUTES

ATTENDANCE:

Present:	Edward Ciriacy, M.D. Robert Dickler Clifford Fearing Elwin Fraley, M.D. Jerry Meilahn Roger Paschke
Not Present:	Robert Nickoloff Barbara O'Grady Vic Vasmanis
Staff:	Al De Kay Fuecker Greg Hart Nancy Janda Geoff Kaufmann Dan Rode Barbara Tebbitt

CALL TO ORDER:

On January 25, 1989 the Finance Committee was called to order by Mr. Jerry Meilahn at 12:18 P.M.

APPROVAL OF THE MINUTES:

The Board of Governors Finance Committee seconded and passed a motion to approve the minutes of the December 21, 1988 meeting as written.

JULY 1, 1988 THROUGH DECEMBER 31, 1988 FINANCIALS:

Mr. Cliff Fearing reported that the census is 4.3% above budget with an average daily census of 434. Admissions for December were 103 above budgeted levels of 1,419. The average length of stay was 8 days and patient days were 1,618 days over budget. Outpatient visits were 2.3% under budget. UMHC's

favorable balance for the fiscal year is $2.8 million, which is $2.5 million ahead of expected levels. Patient care charges were 12% over budget and routinne revenue was 15.6% over budget. Operating expenditures through December were 4.9% over budget due to higher personnel costs and patient care supplies.

Mr. Fearing noted a marked change in payor mix. There has been a decrease in commercial patients from approximately 30% to 26%. As a result, future charge increases will be less effective. Lastly, Mr. Fearing reported that accounts receivable represent 105.7 days, an increase due to in-house patients.

AUDIT COMMITTEE REPORT:

Mr. Fearing reviwed the recommendations for formulation of the University Audit Committee. The Board of Regents are reviewing the proposed audit process. It has been suggested that all UMHC reports come to the Board of Governors. Committee members suggested that the Finance Committee act as the Audit Committee, reporting to the Board of Governors on a regular basis.

HOSPITAL RESERVES FOLLOW-UP:

Mr. Fearing reviewed the proposed changes to reporting format of the Hospital reserves. Administration has proposed a BOG capital plan reserve level of $38.3 million, a debt service reserve fund of $13 million and a working capital reserve of $16 million. This would impact the balance sheet format, making it less prone to misinterpretation if it is reported separately. The plan would also require Board approval to spend reserves from the designated capital plan reserve.

The Finance Committee seconded and passed a motion to endorse the Hospital reserves proposal, but reserved the right to change this vote as the result of future discussions.

MAJOR CAPITAL EXPENDITURES:

Mr. Greg Hart reviewed, for informational purposes, three major capital expenditures in the $100,000 - $600,000 range: 1) Laser-Tripter to be leased for $6,000/month for 36 months. This is an advanced mode of therapy for the treatment of renal stones; 2) Two Kodak Chemistry Random Access Analyzers for $4,750/month for 60 months ($285,000). One is to replace an analyzer in Clinical Chemistry which was budgeted and the other is a replacement for one in Outpatient Laboratories that was not budgeted. The operational savings will exceed the annual lease cost for the machine that was not budgeted. 3) Hyperthermia System - at a price of $204,771 to be used in conjunction with radiation therapy to enhance treatment for oncology patients.

MRI PROJECT UPDATE:

Mr. Al Dees reviewed the discussions and recommendations to purchase the MRI with the smaller (1.5T) magnet, resulting in $150,000 savings through a

purchase order change. The Planning and Development Committee had recommended and endorsed the purchase of the 1.5T magnet.

The Finance Committee passed and seconded a motion to endorse the purchase of the MRI with the 1.5T magnet as proposed.

INTEGRATED MEDICAL SYSTEMS:

Mr. Geoff Kaufmann reviewed the Integrated Medical Systems expenditure. This proposal is a computer network to permit UMHC physicians to communicate through a a propietary software system with referring physicians. UMHC instituted a pilot program using IMS with 22 external sites and 11 internal sites. Evaluations of the program were extremely favorable. The price, $230,000, would be for the purchase of the software with the individual physician sites purchasing the hardware along with other practice applications directly from the vendor. Mr. Kaufmann noted that they are aiming to have up to 300-400 external sites and 22 internal sites in the system. Drs. Ted Thompson and John LaBree will be supervising the physicians in the program.

SECOND QUARTER, 1988-89 BAD DEBTS:

Mr. Dan Rode reported the bad debts for the second quarter totaled $687,303.14, representing 1,570 accounts. Recoveries amounted to $31,118.46, leaving a net charge-off of $656,184.68. This amount represents 0.86% of gross charges and compares to a budgeted level of bad debts of 1.42%.

The Finance Committee seconded and passed a motion to endorse the Second Quarter 1988-89 Bad Debt report as submitted.

CAPITAL EXPENDITURE REPORT:

Mr. Greg Hart reviewed a format for the reporting of the quarterly capital expenditures to the Board of Governors. The proposed format utilizes the November year-to-date expenditures. The Planning and Development Committee has reviewed it. The Committee members reacted favorably to the format presented. This information will be reported to the Committee on a quarterly basis, beginning with the December, 1988 information.

1989-90 COMPENSATION PACKAGE:

Mr. Hart reviewed the proposed 1989-90 Compensation Plan. Mr. Hart emphasized the three areas of concern and attention: 1) Pay Equity - recommend another 2 years to achieve parity at a cost of $750,000; 2) Progression Increases - the Hospital is not currently competitive in some areas; and 3) Merit Pay - has had mixed results; the plan recommends no merit pay for 1989-90. Administration would like to communicate these changes to employees in the near future. Final approval for the plan will be sought in conjunction with the 1989-90 operating budget at a later date.

1988 UNIVERSITY INTERNAL AUDIT:

Discussion of the internal audit topic was deferred to the February meeting.

ADJOURNMENT:

There being no further business, the January 25, 1989 meeting of the Board of Governors Finance Committee was adjourned at 2:15 P.M.

Respectfully submitted,

Kay F. Fuecker
Board of Governors Office

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

February 22, 1989

TO: Board of Governors

FROM: Clifford P. Fearing

SUBJECT: Report of Operations for the Period
July 1, 1988 through January 31, 1989

The Hospital's operations through the month of January reflect both inpatient admissions and outpatient visit activity that were above budgeted levels. Ancillary and routine revenue were also above budgeted levels.

INPATIENT CENSUS: For the month of January, inpatient admissions totaled 1,573, which was 20 above budgeted admissions of 1,553. Our overall average length of stay for the month was 9.1 days. Patient days for January totaled 13,759 and were 1,820 days over budget. The increase in admission levels over budget was primarily in the areas of Medicine, Neurosurgery and Orthopedics but was offset with a decrease from budget in the areas of Surgery and Ophthalmology.

To recap our year-to-date inpatient census:

	1987-88 Actual	1988-89 Budget	1988-89 Actual	Variance	% Var
Admissions	11,123	10,712	11,125	413	3.9
Patient Days	88,923	83,156	93,727	10,571	12.7
Avg Length of Stay	8.0	7.8	8.4	0.6	7.7
Avg Daily Census	413.6	386.8	435.9	49.1	12.7
Percent Occupancy	71.3	67.0	74.8	7.8	11.6

OUTPATIENT CENSUS: Clinic visits for the month of January totaled 22,269 which was 1,751, or 8.5%, over budgeted visits of 20,518. Areas in which actual visits were significantly over budget included Orthopedic, Emergency Room, Adult Psych, and Family Practice. Community University Health Care Center (CUHCC) visits for the month of January totaled 3,835, which was 133, or 3.4%, under budgeted visits of 3,968, while Home Health visits of 1,031 for the month were 216, or 26.4%, above budgeted visits of 815.

To recap our year-to-date outpatient census:

	1987-88 Actual	1988-89 Budget	1988-89 Actual	Variance	% Var
Clinic Visits	149,080	151,610	156,660	5,050	3.3
CUHCC Visits	28,013	28,770	26,916	(1,854)	(6.4)
HHA Visits	5,116	5,655	6,973	1,318	23.3

FINANCIAL OPERATIONS: The Hospital's Statement of Operations shows total revenue over expense of $1,466,999, a favorable variance of $1,655,661.

Patient care charges through January totaled $181,247,418, which was 12.3% over budget. Routine revenue was 16.0% over budget and reflects our year-to-date favorable patient day variance.

Ancillary revenue was $13,131,081 above budget (11.0%) and reflected the favorable variance in both admissions and clinic visits. Inpatient ancillary revenue has averaged $8,747 per admission compared to the budgeted average of $7,982 per admission. Outpatient revenue per clinic visit has averaged $227 compared to the budgeted average of $225.

Operating expenditures through January totaled $159,091,620 and were $7,681,620 (5.1%) over budgeted levels of $151,409,841. The overall unfavorable variance relates primarily to the increased demand for patient services, and is reflected in higher personnel costs and patient care supplies (drugs, blood, and medical supplies and services).

ACCOUNTS RECEIVABLE: The balance in patient accounts receivable as of January 31, 1989, totaled $94,893,277 and represented 109.6 days of revenue outstanding. The overall increase in our patient receivables in January of 3.9 days occurred primarily in Minnesota Medical Assistance, Blue Cross, CHAMP, and Commercial Insurance.

CONCLUSION: The Hospital's overall operating position is positive and above budgeted levels. Both inpatient and outpatient census levels are above budget. We continue to monitor our demand for service closely and make those operating changes that are necessary and appropriate.

UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

EXECUTIVE SUMMARY OF FINANCIAL ACTIVITY

FOR THE PERIOD JULY 1, 1988 TO JANUARY 31, 1989

	1988-89 Budgeted	1988-89 Actual	Variance Over/-Under Budget	Variance %
Patient Care Charges	$161,444,008	$181,247,418	$19,803,410	12.3%
Deductions from Charges	27,921,770	39,968,409	$12,046,639	43.1%
Other Operating Revenue	5,008,170	5,557,609	$549,439	11.0%
Total Operating Revenue	138,530,408	146,836,618	8,306,210	6.0%
Total Expenditures	151,409,841	159,091,620	7,681,779	5.1%
Net Operating Revenue	(12,879,432)	(12,255,002)	624,430	4.8%
Non-Operating Revenue and Expenses	12,690,770	13,722,001	1,031,231	8.1%
Revenue Over/Under Expense	($188,662)	$1,466,999	$1,655,661	

	1988-89 Budgeted	1988-89 Actual	Variance Over/-Under Budget	Variance %
Admissions	10,712	11,125	413	3.9%
Patient Days	83,156	93,727	10,571	12.7%
Average Daily Census	386.8	435.9	49.1	12.7%
Average Length of Stay	7.8	8.4	0.6	7.7%
Percentage Occupancy	67	74.8	7.8	11.6%
Outpatient Clinic Visits	151,610	156,660	5,050	3.3%

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

February 14, 1989

TO: Member of the Board of Governors

FROM: Greg Hart
Senior Associate Director

SUBJECT: Capital Expenditure Report

Attached please find the capital expenditure report for July-December, 1988. The report format is modified from that which was presented last month. Most notably a "seasonalized" budget for the interim period is portrayed, based upon our historical capital spending patterns. As you can see, our capital expenditures year-to-date are somewhat less than the "seasonalized" budget.

This report is submitted as required by the Board of Governors' Capital Expenditure Policy. No action is required by the Board of Governors.

GH/kff

Attachment

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
CAPITAL EXPENDITURES
7-1-88 THRU 12-31-88

	ANNUAL BUDGET AND ROLLFORWARD			SEASONILIZED BUDGET			ACTUAL EXPENDITURES		
RECURRING EQUIP & REMODEL:	BUDGET	ROLL FORWARD FROM 6-30-88	TOTAL	6-MONTH BUDGET	6-MONTH ROLLFORWARD	TOTAL	88-89 BUDGET	87-88 ROLL FORWARD	TOTAL
EQUIPMENT PURCHASES									
88-89 Budget	$6,718,513		$6,718,513	$1,600,000		$1,600,000	$1,815,545		$1,815,545
Rollforward		$2,847,693	$2,847,693		$1,000,000	$1,000,000		$590,033	$590,033
	$6,718,513	$2,847,693	$9,566,206	$1,600,000	$1,000,000	$2,600,000	$1,815,545	$590,033	$2,405,578
REMODELING PROJECTS	$1,272,650		$1,272,650	$530,271		$530,271	$112,612	$67,756	$180,368
	$7,991,163	$2,847,693	$10,838,856	$2,130,271	$1,000,000	$3,130,271	$1,928,157	$657,789	$2,585,946
PRINCIPLE PAYMENTS									
CT SCANNER	$179,800					$88,300			$88,300
COMPUTER EQUIP	$665,795					$351,656			$351,656
LITHOTRIPTOR	$288,405					$142,045			$142,045
	$1,134,000					$582,001			$582,001
TOTAL:						$3,712,272			$3,167,947

BOND PAYMENTS: $2,815,000 (DUE FEB. 1,1989)

CAPITAL PROJECTS:

	AUTHORIZED BUDGET	EXPENDITURES 1988-89	TOTAL EXPEND. TO DATE
MRI II	$3,600,000	$68,878	$68,878
DERMATOLOGY	$612,410	$39,970	$100,864
MAYO 4 SURG	$1,029,350	$3,150	$3,150
CUHCC	$1,350,000	$309,335	$309,335
MASONIC HOSP	$600,000	$710	$710
COMPUTER UPGRADE	$850,000	--	--
NEURORADIOLOGY UPGRADE	$909,000	--	--
TOTAL	$8,950,760	$422,043	$482,937
MISC. CAPITAL EXPEND		$62,270	
		$484,313	

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

February 22, 1989

TO: Board of Governors
Finance Committee

FROM: Nels E. Larson
Associate Director, Finance

SUBJECT: University Internal Audit Report
1985 and 1987 Recommendations "Not Implemented"

In December, 1988 the University Internal Audit Department issued a report in which they cited eleven (11) recommendations from their 1985 audit, and eight (8) recommendations from their 1987 audit, that they believed to be "not implemented." Below is the current status of those recommendations.

1985 RECOMMENDATIONS

ACCOUNTS PAYABLE

Recommendation 9:

"Hospital Accounts Payable should keep track of the number of times that there are differences between invoices and purchase orders and periodically review their present policy of paying differences less than $50 per line item."

Status: Implementation of this recommendation, to date, had been deferred until the Hospital enhances its purchasing system in such a way that it interfaces with the Accounts Payable system to provide the line item matching process via computer. A proposal to acquire a new purchasing system is currently awaiting management review and approval. In the interim, to implement this recommendation, this review process could be done manually and would require approximately 0.5 F.T.E. additional hours of an account specialist at an annual cost of about $12,000.

Using a very limited sample in testing the differences between invoices and purchase orders it appears we would save approximately $20,000 - $30,000 annually.

EMERGENCY ROOM

Recommendation 19:

"Form 17277, the form used by Emergency Department should be redesigned so that it could be used more efficiently, e.g. the use of NCR carbonless paper should be considered so that patients would not need to sign in two different places for the same type of authorization."

Recommendation 21:

"Form 17277 should be redesigned to maximize efficiency and still be able to record all patient information. As mentioned in Recommendation 19, use of NCR carbonless paper should be considered."

Status: Form 17277 consists of two parts:

The first part is a one page form for Patient Accounting to record payor information, to document authorization of release of information, authorization for assignment of insurance benefits and payment guarantee and Medicare certification. Patient Accounting must submit a hard copy release and authorization with the billing to Blue Cross, Medical Assistance, and several other payors to receive payment.

The second part, Emergency Room Record, consists of two pages to record and document medical treatment and medical patient history. A small portion of information from page one (date patient name, time, physicians, etc.) carbon copies to page two from page one. Additional signatures for consent for treatment and authorization for release of information (duplicate) are required on page three. Additional insurance information from page one must be re-entered on page three.

We concur with the recommendations to redesign form 17277, the Emergency Room Record. During the Fall of 1988 outside consultants reviewed some of the data collection procedures in the Emergency Room, specifically data necessary for the admission/registration and billing functions. Additional review is still required to incorporate or consolidate the clinical information requirements into a more efficient format. Also, as part of this review, will be an analysis of staffing requirements necessary to assure obtaining appropriate signatures. Due to the significant number of other system changes that are of greater importance, we are targeting the Spring of 1990 from implementation of a new form.

Note: Our current inventory level of the existing form is approximately 14,000, or almost a year's supply.

Recommendation 24:

"The Patient Accounting system should be modified to accept all service codes." (Billing statements do not reflect "no charge" professional fees.)

Status: The recommendation cited was specific to a single service code within the Emergency Room. There are, however, wider implications to this recommendation in that thousands of "no charge" transactions are generated on a daily basis throughout the Hospital. These "no charge" transactions come about as departments wish to efficiently generate statistical data but do not wish to generate a patient charge. Presently, if we were to implement the auditors' recommendation, the passing of "no charge" transactions to the Patient Accounting system would result in all of those transactions being posted to patient accounts. This would further expand the size of our billings and unnecessarily complicate them.

We do, however, concur with the recommendation. It require approximately $2,000 in programming time to allow the "no-charge" service codes to pass to the Patient Accounting system but not print on patient billings. This request is currently awaiting computer programming resource assignment in Information Services.

LABORATORIES

Recommendation 29:

"Labs should institute some form of batch control to provide assurance that the number of documents sent to Account Auditing are the number that are entered. This number should also equal the number of test requests logged in for the day."

Status: Effective March 1, 1989 the Laboratory departments will batch their manual charge slips and send them to the Labs Administration office. Each batch will be logged in. The batch of charges will be picked up twice per day by Patient Accounting messenger. The charges will then be entered by Patient Accounting. The batch header will be returned to Labs Administration office with the indication of the number of charges keyed within each batch.

By Fall, 1989 all laboratories, except for Cytogenetics and Heart Catherization, will be installed on the new point of service Clindata laboratory billing system. While Cytogenetics and Heart Catherization labs will not be part of the new Laboratories system, they will receive the capabilities for on-line data entry of their charges. (See Recommendation 30 next page)

Recommendation 30:

"Once adequate batch controls are established, consideration should be given to the manual labs entering the data on-line directly to the Patient Accounting system."

Status: Laboratory personnel will be trained to input billing data from the Cytogenetics and Heart Catherization laboratories into the on-line Patient Accounting system on the Unisys computer. Implementation is anticipated no later than the Fall, 1989 after which it will no longer be necessary to process manual charges.

Recommendation 35:

"The Labs transaction register should be modified to show revenue by service codes and revenue centers so that it could be used effectively by management."

Status: The Hospital has developed a daily transaction report from the Laboratories system (Tape Billing Audit Report and Clinical Laboratories Billing Report) identifying the total number of transactions passed to the Patient Accounting and Billing system. The PA system produces Laboratory Error and Attention reports (B0180D1 and B0184D1) which report the total number of transactions processed and also identify the total number of transactions rejected. The reports are reviewed by a supervisor in Patient Accounting for data integrity and follow-up.

We have taken alternative action with regard to management reporting in that the PA System currently produces on a monthly basis a Department Statistical Report which provides detailed information. The report includes the number and dollar amount of charges for the current month and year to date by service code within each revenue center. The managers in the Laboratories use this report to monitor activity and performance within their areas.

PHARMACY

Recommendation 37:

"All data input should be batched, logged and validated to improve the reliability of documents being input."

Recommendation 42:

"All data input should be batched, logged, and validated, especially data released to the Non-Pharmakon System."

Recommendation 48:

"All charge slips should be batched and sent down to Pharmacy with a batch header on a daily basis. The batch header should include: station, number, date of service, and number of documents."

Status: All three Pharmacy recommendations cited above concern the control and monitoring of Pharmacy charge activity. In responding to these recommendations Pharmacy management had developed alternative methods of testing and documenting Pharmacy charges. These include: (1) comparisons of the Pharmacy Fill List to the Medication Administration Record, (2) comparisons of the Physician orders with system entries, (3) Unit Dose Fee Summary Report, and (4) comparisons of Pharmakon system vs. Patient Accounting revenue reports.

The alternative actions taken by Pharmacy to comply with these recommendations were in place prior to the 1988 Internal Audit review.

It is the practice of the University Internal Audit Department to leave the status of their recommendations "Recommendation Not Implemented" until they complete a second, or subsequent, review. During the 1988 audit the University Internal Audit staff did not review the Pharmacy procedures and hence left these as "Recommendation Not Implemented."

Recommendation 46:

"Purges from the Pharmakon system should be made onto another tape and kept in storage. In this way, reports can be produced as needed."

Status: Implementation of this recommendation is currently scheduled to be a part of the new Pharmakon 2000 system. Installation and implementation of the new system is scheduled for the Fall, 1989 on the IBM mainframe computer.

If we were to implement this recommendation with the current Pharmakon system, which is based on a Texas Instruments mini-computer, we would have to acquire additional tape drives and software for a system that we intend to stop using within the year. Since this recommendation provides no increase in revenue we believe it should be implemented with the new Pharmakon 2000 system.

1987 RECOMMENDATIONS

NUTRITION

Recommendation 8:

"The cashier's reconciliations should be redesigned to include line items for voids."

Status: This recommendation has been implemented. The Daily Cashier Report has been modified to include a line item for voided transactions. A Senior Cashier performs a review of voids by cashiers and investigates any unusual incidents of voided transactions. The detail of the daily voided transactions is recorded on the cash register tapes, which are retained for a period of one year.

Recommendation 9:

"All (Cafeteria) refunds should be adequately documented by describing the reason for refund and requiring the customer to sign for the refund received."

Status: This recommendation has been implemented. Effective December, 1988 all Hospital cafeteria refunds are documented on the Daily Cashier Report and reconciliation. Compliance is monitored by supervisors. Effective December, 1988 refunds are documented by customer signatures. (This recommendation was implemented after the completion of the audit.)

Recommendation 11:

"Voids and refunds should be periodically reviewed by the supervisors, depending on the circumstances."

Status: This recommendation has been implemented. Cafeteria voids and refunds are documented on the Daily Cashier Report and are reviewed by the Cafeteria supervisor who then initials the report. (This recommendation was implemented after the completion of the audit.)

Recommendation 13:

"Coupons should be canceled upon receipt, using a method convenient for the Cafeteria so as to prevent reusing the coupons, and should be kept in the register drawer."

Status: We do not concur that it would be operationally convenient to cancel the coupon immediately upon receipt as this would slow our service through the cafeteria line. In addition, coupons are given as "change," rather than cash, when the value of the coupon presented exceeds the value of the food purchased.

We have, however, taken alternative action to secure the coupons. After the coupons are accounted for in the daily receipt reconciliation process they are kept under lock by the Nutrition Services Associate Director until destroyed by the Hospital's bonded document shredder on a quarterly basis.

Recommendation 19:

"Bridges management should consider establishing an early deposit system where excess accumulated funds are turned into the cash office during a shift to be safe-kept. The amount turned in should be signed off by the cashier and the supervisor. A copy of the document for the cash turned in should be retained by the cashier. This copy would then be used when the cashier balances for the shift."

Status: This recommendation will be implemented by the end of March, 1989. In order to implement this recommendation, the cashier must close the register, count out some cash, document the amount on a form, turn the cash over to the cafeteria supervisor, receive the countersigned document, then reopen the register for business. The supervisor will store the cash in the cafeteria safe until the register is closed out at the end of the shift. A form is being designed to document the early cash deposit. The form will accompany the Daily Cashier Report to reconcile the daily cash receipts.

Recommendation 20:

"Transfer of cash between registers should be documented on a cash exchange slip. The amount should be documented on a two-part form and signed off by both cashiers after the money is counted. The document should then be retained and attached to the reconcilement at the end of the shift."

Status: At the time of their review in 1988 the auditors found that we had implemented the cash exchange slip but that it was not being used consistently. The Cafeteria supervisors have since increased their monitoring of cash transfers to ensure compliance. We therefore consider this recommendation to be implemented.

Recommendation 27:

"Charges from the cash register for through-the-line items should be reconciled to the billings. Any ring-up errors should be documented."

Status: Subsequent to the auditor's 1988 review, procedures were implemented to reconcile on a daily basis the through-the-line catering orders with the Daily Cashiers Report and the catering slips. The catering charges are then billed to departments on a monthly basis. We therefore consider this recommendation to be implemented.

PARKING SERVICES

Recommendation 37:

"The ring-up errors should be recorded on the daily cash reconcilements and reviewed by a supervisor."

Status: In their 1988 review, the auditors found inconsistent compliance with this recommendation. Subsequently, the supervisor of Parking Services has implemented procedures to review ring-up errors on a daily basis. We consider this recommendation to be implemented.

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

February 22, 1989

TO: Board of Governors

FROM: Clifford P. Fearing
Senior Associate Director

SUBJECT: Peat Marwick Main & Co. Letter of Comments and Recommendations

The enclosed letter of comments and recommendations regarding internal control was provided by Peat Mawrwick Main & Co. in conjunction with their audit of the June 30, 1988 financial statements. The letter provides comments and recommendations that would be categorized as "significant" under the Board of Regents Audit Committee Proposal for Implementation of Audit Recommendations. Significant, in this context, means that the recommendation is "unique to a particular unit, involves a difficult issue, and may take more than six (6) months to implement."

Our response to the Peat Marwick Main & Co. recommendations follows their letter.

KPMG Peat Marwick

Certified Public Accountants

Peat Marwick Main & Co.
4200 Norwest Center
90 South Seventh Street
Minneapolis, MN 55402-3900

Telephone 612 341 2222

Telecopier 612 341 0202

January 25, 1989

The Board of Governors
University of Minnesota Hospital and Clinic

Dear Board Members:

We are presenting, for your consideration, our comments and recommendations regarding internal accounting control. These came to our attention during the course of our examination of the financial statements of University of Minnesota Hospital and Clinic (the Hospital) for the year ended June 30, 1988 which we reported upon as of October 26, 1988.

As a result of our examination, we did not identify any condition that we believed to be a material weakness in internal accounting control. This information, however, should be considered in light of Exhibit II which describes the purpose of our study and evaluation of internal accounting controls as part of our examination, and is intended solely for the use of your management in assessing the control environment.

The comments and recommendations presented in Exhibit I are intended to improve the system of internal accounting control. Comments and recommendations which are somewhat less significant and relate to procedural matters have been included in a letter to Mr. Clifford P. Fearing dated January 25, 1989. It should be noted that this letter, by its nature, primarily contains our comments and recommendations for improving such systems and does not include our observations on the many strong features of the Hospital's financial systems. The factual accuracy of our comments has been discussed with the management personnel responsible for the areas impacted by our comments and recommendations.

We would like to take this opportunity to express our appreciation for the courtesy and assistance extended to us by your personnel during the course of our examination. In addition, we would be most pleased to provide assistance in implementing any of our recommendations.

Very truly yours,

Peat Marwick Main & Co.

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Comments and Recommendations

THIRD PARTY LOGS

In our review of third party reimbursement (Medicare, Medicaid and HMOs), we observed that the Hospital's data processing system and manual procedures do not consistently log program activity, including:

- Detail accounts receivable by payor;
- Detail of claims paid;
- Gross charges by payor;
- Patient days by payor; and
- Inpatient and outpatient revenue.

We also noted that detail accounts receivable listings do not contain the information needed to efficiently calculate contractual allowances.

We recommend that the Hospital develop and implement effective third party logs in order to improve the Hospital's ability to generate accurate financial information.

THIRD PARTY CONTRACTUAL AND SETTLEMENT ACCOUNTS

In our review of the third party contractual allowances we observed the following:

- At June 30, 1988 the estimated contractual allowances for Medicare, Medicaid and HMO accounts receivable were not determined on a patient account basis.

- Contractual allowances recorded in the statement of revenues and expenses are not periodically reviewed in comparison to third party vouchers processed, adjustments to third party settlement accounts, or the estimated contractual allowances for third party accounts receivable.

We recommend that the Hospital refine its procedures for estimating and reviewing the contractual allowances for third party reimbursements by incorporating the matters discussed above.

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Scope of Internal Accounting Control Review

As part of an examination of the financial statements, we perform a study and evaluation of the Hospital's system of internal accounting control to the extent we consider necessary to evaluate the system as required by generally accepted auditing standards. The purpose of our study and evaluation, which did not extend beyond October 26, 1988, was to determine the nature, timing and extent of the auditing procedures necessary for expressing an opinion on the financial statements. Our study and evaluation was more limited than would be necessary to express an opinion on the system of internal accounting control taken as a whole.

Management is responsible for establishing and maintaining a system of internal accounting control. In fulfilling this responsibility, estimates and judgments made by management are required to assess the expected benefits and related costs of control procedures. The objectives of a system are to provide management with reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition, and that transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in accordance with generally accepted accounting principles.

Because of inherent limitations in any system of internal accounting control, errors or irregularities may nevertheless occur and not be detected. Also, projection of any evaluation of the system to future periods is subject to the risk that procedures may become inadequate because of changes in conditions or that the degree of compliance with the procedures may deteriorate.

A study and evaluation made for the limited purpose described above would not necessarily disclose all material weaknesses in the system. Accordingly, an expression of an opinion on the system of internal accounting control taken as a whole cannot be made.

UMHC RESPONSE: Peat Marwick Management Letter

THIRD PARTY LOGS

We agree with this recommendation. Our current log system covers only inpatient Medicare and Medicaid. It is an in-house developed system which would require significant resources to revise to meet current requirements for third party contractual allowance calculations. After evaluating the alternative of revising our own Financial Data base and developing a new system versus purchasing a system, we came to the conclusion that we should purchase a system. We are in the process of installing a micro computer based claims management system that has the capability of accumulating all of the necessary data to calculate third party contractual allowances. A final implementation schedule is being developed during the initial implementation phase of the project.

THIRD PARTY CONTRACTUAL AND SETTLEMENT ACCOUNTS

At June 30, 1988, a gross revenue approach was used in some of the calculations for the third party contractual adjustments. During the current year we have redirected our efforts. Currently, resources are being directed toward manual logging of patient specific information from third party vouchers. The installation of the claims management system referenced above will automate much of the process and allow for the expansion of patient account specific calculations of the third party contractual allowance to all governmental and HMO/PPO contractual payors.

SPECIAL ARTICLE

A CONSUMER-CHOICE HEALTH PLAN FOR THE 1990s

Universal Health Insurance in a System Designed to Promote Quality and Economy

(First of Two Parts)

ALAIN ENTHOVEN AND RICHARD KRONICK

Abstract America's health care economy is a paradox of excess and deprivation. We spend more than 11 percent of the gross national product on health care, yet roughly 35 million Americans have no financial protection from medical expenses. To an increasing degree, the present financing system is inflationary, unfair, and wasteful. In its place we need a strategy that addresses the whole system, offers financial protection from health care expenses to all, and promotes the development of economical financing and delivery arrangements. Such a strategy must be designed to be broadly acceptable in our society.

To remedy the deprivation, we propose that everyone not covered by Medicare, Medicaid, or some other public program be enabled to buy affordable coverage, either through their employers or through a "public sponsor." To attack the excess, we propose a strategy of managed competition in which collective agents, called sponsors, such as the Health Care Financing Administration and large employers, contract with competing health plans and manage a process of informed cost-conscious consumer choice that rewards providers who deliver high-quality care economically. (N Engl J Med 1989; 320:29-37.)

WHY UNIVERSAL HEALTH INSURANCE?

The Paradox of Excess and Deprivation

The health care economy of the United States is a paradox of excess and deprivation. We spend about 11.5 percent of the gross national product (GNP) on health care, much more than any other country.[1,2] And whereas other countries have stabilized the share of their GNP that is spent on health, ours has accelerated in recent years. Inflation-adjusted per capita spending for health care grew by 4 percent per year from 1970 to 1980, and by 4.6 percent per year from 1980 to 1986.[1] The Health Care Financing Administration (HCFA) recently projected that according to present trends, health care spending would reach 15 percent of the GNP by 2000.[1] These growing expenditures are adding greatly to deficits in the public sector, threatening the solvency of some industrial companies, and creating heavy burdens for many people.

At the same time, roughly 35 million Americans have no financial protection from the expenses of medical care — no insurance or other coverage, public or private.[3-6] This number is substantially higher than it was 10 years ago, as increasing numbers of employers find ways to avoid supplying coverage for employees and their dependents. Millions more have inadequate coverage that leaves them vulnerable to large financial risks.[7] And uncounted millions have coverage that excludes preexisting medical conditions. Our present system of financing health care systematically denies coverage to many who need it most. Health insurers want to insure those who are the least likely to need medical care and to protect themselves and their policy holders from the costs associated with the care of the very sick.

The U.S. health care economy is inflationary. It is still dominated by fee-for-service payment of doctors and hospitals by third-party intermediaries with open-ended sources of finance. There is no total budget set in advance within which providers must manage the care of their patients. For the most part, there is no incentive to find and use medical practices that produce the same health outcome at less cost. And this method of payment leaves insured consumers largely unaware of the costs of the services they receive.

Health maintenance organizations (HMOs) and preferred-provider insurance (PPI), called "managed care plans," now cover more than 60 million Americans.[8,9] Such plans have the potential to create serious cost consciousness among consumers and providers. But they will not achieve it as long as potential subscribers do not have to pay the full extra cost themselves when they choose a more costly plan. (PPI contracts selectively with providers about price and use controls, and it reimburses patients at a higher rate when they see contracting providers, as a way of motivating patients to use such providers. In turn, access to patients is the incentive for providers to accept negotiated fees and controls.)

The employers of most insured people offer their employees a traditional insurance scheme by which all or most of their medical expenses are reimbursed after the payment of a deductible. If employers offer a less costly managed care plan, they often offer to pay its premium in full, as long as it does not exceed that of the traditional plan. Thus, the managed care plan has little or no incentive to reduce its price or improve its efficiency, because the employee making the choice sees little or no financial reward for choosing it. Some employers offer a fixed-dollar contribution and a cost-conscious choice of plan. In such cases, the managed care plan is motivated to

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reduce its price to attract subscribers. But even then, the Internal Revenue Code permits employees to characterize their premium contributions as nontaxable employer contributions and thus make the payment with pretax dollars. The effect is that if an employee chooses a health plan that is more rather than less costly, the government is likely to be paying about one third of the difference in cost in the form of tax relief.[10,11] As a result, the employee's cost consciousness is attenuated, and the health plan has less need to cut its price to attract subscribers. In any case, health plans have little or no incentive to improve their efficiency in order to serve a few cost-conscious customers if most of their customers are not cost conscious; such plans need only shift costs from the former to the latter.

Moreover, most such "managed care" plans are really little more than traditional insurance arrangements that deal with physicians on an arms-length basis. It is unlikely that they will be able to achieve economical organization and delivery of care without obtaining the support of physicians and their commitment to that goal.

This inflationary financial environment reinforces other powerful cost-increasing factors: a growing supply of doctors looking for ways to make themselves useful; a professional culture that esteems the aggressive use of the most advanced technology without recognizing cost effectiveness as a virtue; the explosive growth of costly new forms of technology; the rising expectations of patients and malpractice litigation when expectations are not met; and an aging population. Little in this system promotes the cost-conscious use of resources or the efficient organization of the delivery system.

In addition, the present system of financing health care in the United States is unfair. It provides most people — those who are regularly employed by a medium-sized or large employer — with coverage either at no cost or at prices subsidized by the employer and the tax system. But the system denies the opportunity of coverage to millions of others for no good reason — to seasonal and part-time employees, self-employed persons, widows, divorcees, early retirees, the unemployed, and others whose employers choose not to provide health care coverage. Not all uninsured people are poor or unemployed. In fact, nearly two thirds of them are members of families with incomes above the poverty level; more than two thirds of uninsured adults belong to the labor force.[3] Viewed another way, when the uninsured are seriously ill (and most expenses are for seriously ill patients), taxpayers, insured persons, or both end up paying for most of their care. Voluntarily or involuntarily, some people are taking a free ride. Those who can do so ought to contribute their fair share to their coverage and be insured.

In the past, our open-ended financing system provided a ready source of financing for those who could not pay, even if it did not ensure equitable access to care. Hospitals simply raised their charges to those who could pay in order to cover the costs of those who could not. In recent years, efforts by employers and the government to contain costs have attacked this means of support for "uncompensated care." Hospitals have come under increased financial pressure to develop strategies to avoid caring for those who cannot pay — even to the point of closing their emergency rooms. Many who cannot pay turn to public providers of last resort, such as county hospitals. But these institutions are also under increasing financial pressure as public finances are strained and the numbers of the uninsured increase.

The present system is wasteful in many respects. We have spent little on evaluating medical technology, and there is much uncertainty about its efficacy.[12,13] Much care appears to be of unproved value.[14,15] There is considerable duplication and excess capacity in our medical facilities. The association between jobs and health insurance complicates and interferes with job mobility, because most people must change health plans when they change jobs. The presence of large numbers of uninsured persons imposes large costs on providers when they perform determinations of eligibility and coverage. The uninsured obtain much of their primary care in the outpatient departments and emergency rooms of public hospitals, instead of in the much less costly setting of a primary care physician's office. The deferment of care for conditions such as hypertension and diabetes adds to health risks and can cause much more expensive emergencies later. The lack of prenatal care can lead to very costly premature delivery and the birth of children with handicaps. The unavailability of insurance imposes heavy penalties on the uninsured: the postponement or denial of treatment, causing avoidable sickness and suffering, and the depletion of personal savings.

For all these reasons, our present system of health care does not reflect American values. We cherish efficiency and fairness, but we have a system that is neither efficient nor fair. Very few Americans believe that other Americans should be deprived of needed care or subjected to extreme financial hardship because of an inability to pay. There is widespread public outrage when a hospital turns away a delivering mother or an injured person for this reason. Congress has passed laws to punish hospitals that do this. But we have failed as a society to create institutions that assure all persons of the opportunity to obtain needed care, when they need it and without an excessive financial burden.

The Need for a Comprehensive Strategy to Promote Efficiency and Equity

To improve the health care system, we need a strategy that is comprehensive. Partial interventions can produce negative consequences or be rendered ineffective by developments elsewhere. Attempts to contain costs by the cost-conscious choice of managed care systems will be fruitless if, somewhere else, open-ended demand is bidding up the prices and standards of

care that the managed care systems must meet. Why should doctors and hospitals accept serious cost containment by HMOs if there is plenty of open-ended demand for their services elsewhere? Partial "categorical" approaches leave people out and create enormous complexities as people change categories. And they can treat unequally people who appear similar but who actually fall into different categories.

The problems of achieving equity and efficiency are intimately related. Attempting to promote efficiency by making everyone conscious of costs conflicts with providing cross-subsidies for uncompensated care. On the other hand, we cannot afford to provide coverage for those who lack it without making the system efficient for all. The accelerating spiral of growth in expenditures has necessitated cutbacks in employer-provided coverage and Medicaid eligibility, and it is one of the main arguments used against universal coverage.

Thus, a satisfactory strategy for the health care economy in the United States must simultaneously address both sides of the paradox of excess and deprivation. We have designed our proposal with two main goals in mind. The first goal is to provide financial protection from health care expenses for all, either through enrollment in comprehensive health care financing and delivery plans or, for the irreducible minimum of people, through public providers of last resort. There will always be some — the homeless, undocumented aliens, and others whose life style does not include enrollment in a health plan, carrying a membership card, and making regular payments — whose needs will have to be addressed by public providers of last resort. But we can drastically reduce their numbers and so ease the financial burden on these institutions.

Our second goal is to promote the development of economical financing and delivery arrangements, by requiring consumers to be conscious of costs in choosing among health care organizations. There is ample evidence that efficient prepaid group practices can reduce the cost of care by 10 to 40 percent, as compared with open-ended fee-for-service practices, even without competition from other HMOs to serve cost-conscious purchasers.[16,17] There is good reason to believe that competition to serve cost-conscious purchasers could motivate cost-reducing innovation and slow the growth of health care spending. Our strategy would be to encourage the spread of HMOs and other efficient delivery arrangements by giving all consumers a choice of plans that requires a consideration of costs. Those who prefer to keep traditional "free choice of provider" arrangements and are willing to pay the extra costs associated with them would be free to do so.

The Need for a Broadly Acceptable Plan

Universal health insurance has not attracted overwhelming support in this country. Those who favor it should consider carefully the sources of opposition and seek to avoid designing a plan with features so objectionable to large numbers of American people or key interest groups that the plan would not be considered seriously in the political process. The idea of universal health insurance raises fears of socialized medicine or total dependence on the government for payment, of radical change or the disruption of satisfactory existing arrangements, of large-scale redistribution of income, or of excessive regulatory coercion. The causes of such fears can be avoided. We have designed a proposal for incremental change that is compatible with American cultural preferences and that should find broad acceptance. We will discuss these issues in the second part of this article.

A Universal Health Insurance Plan Based on Managed Competition with Mixed Public and Private Sponsorship

Under this proposal, everyone not covered by an existing public program would be enabled to buy affordable subsidized coverage, either through their employers, in the case of full-time employees, or through "public sponsors," in the case of the self-employed and all others. We illustrate the general concepts with specific examples of tax rates, employer contributions, benefit packages, and other detailed features of the proposal. These should be understood as illustrative and, within limits, as "tunable dials" that can be adjusted in the political process. A supporting document provides more detail.[18]

State-Level Public Sponsors

Under this proposal, the federal government would enact legislation requiring each state powerful incentives to create a "public sponsor" agency to act as sponsor for people otherwise unsponsored. A sponsor is an institution that ensures each member of its sponsored group financial coverage of health care expenses at a moderate price. In the competitive model we recommend, the sponsor serves as the broker, selecting the coverages to be offered, contracting with health plans and beneficiaries about rules of participation, managing the enrollment process, collecting premium contributions from beneficiaries, paying premiums to health plans, and administering both cross-subsidies among beneficiaries and subsidies available to the whole group. The main sponsors in this country are employers, Taft–Hartley trusts, and the HCFA. Public sponsors would aggregate the buying power of small employers and individuals. In a manner similar to that of very large employers such as the federal government, public sponsors would contract for a wide variety of managed care plans to be offered to the participating population in a competitive annual enrollment. (Whether to offer traditional indemnity insurance would be a management decision made by public sponsors.)

Public sponsors would offer to contract with any person or family not covered through employment who wished to abide by the conditions of participation, including enrollment during the annual open-enrollment period and a "lock in" for the full year.

Such purchases of coverage would be subsidized: the public sponsor would pay 80 percent of the cost of the average qualified health plan, and the person or family covered would pay the rest.

Public sponsors would offer to act as brokers for employers who wished to obtain coverage through these agencies. Small employers and even many medium-sized employers are not large enough to manage competition among health plans effectively.[19] Moreover, small employers that buy insurance on their own are forced to pay higher rates, reflecting greater variability in small groups. A public sponsor could combine these risks and achieve economies of scale. States could achieve such economies in administration as well as greater bargaining power with the health plans by assigning this responsibility to the agencies that already buy coverage for public employees.

Obligations of Employers

Under this proposal, employers would be required to cover all full-time employees (and their dependents not otherwise covered) and to pay an 8 percent payroll tax on the first $22,500 (i.e., half the Social Security wage base) of the wages and salaries of all employees not covered. In addition, employers would be required to offer all full-time employees (those working at least 25 hours per week) a choice of qualified plans, possibly including traditional insurance, and to contribute at least 80 percent of the average cost of the basic coverage, which would include the employees' dependents unless they were covered under a spouse's policy. (Some benefit plans would be more elaborate than others. For each health plan offered, the employer would obtain a quotation for the price of basic coverage, as defined below. The employer's required contribution would then be 80 percent of the weighted average of those prices.) The employees would be required to pay the difference between the employer's contribution and the cost of the health plan they chose.

Before the annual enrollment period, employers would designate each worker as full time, and thus covered automatically, or part time. (Part-time workers could also be designated as covered.) Detailed rules would be developed to specify which workers would have to be designated as full time and covered. Employers could choose to pay the 8 percent tax rather than cover seasonal or temporary workers.

Self-employed persons, early retirees, and everyone else not covered through full-time employment would be required to contribute through the income tax system. An 8 percent tax would apply to adjusted gross income up to an income ceiling related to the size of the household. The ceiling would be calculated to ensure that households with sufficient income paid for approximately the total subsidy that was available to them. The proceeds of the 8 percent tax would be used by public sponsors to subsidize the purchase of coverage by people not covered by an employer.

Why require employers to cover full-time employees and pay a tax on the earnings of workers not covered? Most health coverage in our country is based on employment, and there is no realistic prospect of changing that in the short run. We propose to spread the cost more evenly over all employment, and to fill in with publicly sponsored coverage where employment-based coverage cannot reasonably be expected to work. Publicly sponsored coverage for individuals has to be subsidized to create a strong incentive for even the healthy to subscribe. In the absence of a subsidy, consumers in apparently good health would seek to avoid paying for coverage until they got sick, or would rely on charity care or public providers because they know that our society is unwilling to let people suffer and die without care. Premiums would soar. The market would break down in a spiral of adverse risk selection, as the market for individual coverage in this country has in fact done.[20]

If publicly sponsored and subsidized coverage were available without the mandate or tax, employers would have a powerful incentive to stop providing coverage and send their employees to the public sponsor. People without coverage would demand it from the public sponsor, which would have to provide it without a source of revenue. Therefore, we propose to use the mandate to keep most coverage employment based. (An alternative model, publicly financed and sponsored, will be discussed in Part Two.) The tax on the earnings of workers not covered by employers would raise much of the funds needed for the public sponsor from those who would benefit. This approach would help avoid a large-scale redistribution of income. Also, it would minimize the otherwise strong incentives for employers to reduce the hours of workers to a level below 25 hours per week, to avoid providing health benefits. Viewed in another way, the 8 percent tax would be a means of aggregating premium contributions on behalf of the part-time, seasonal, and other workers whose attachment to a single employer is not strong enough to justify requiring the employer to provide full insurance coverage. Taft–Hartley trusts do this for unionized workers in specific industries; the proposed mechanism would generalize the Taft–Hartley trust idea to everyone who was not employed full time by a single employer.

We recognize that there are good arguments against the employer mandate and the tax. Any tax distorts economic decision making. This issue will be discussed in Part Two.

Subsidies to Premiums for the Poor

To encourage nearly universal coverage, individuals and families would be eligible for an additional federal subsidy toward the portion of the health insurance premium that they would have to pay if their adjusted gross income was below 150 percent of the poverty level for their family size. Without a subsidy, a family's share of an average premium would be approximately $500. For many families of four with an income equal to 100 percent of the poverty

level — approximately $11,000 — this would be a substantial expenditure that many would feel they could not afford.

For families with an income below 100 percent of the poverty line, the subsidy would equal the amount of the family's premium contribution (assuming the health plan chosen was no more expensive than the average cost of a basic health plan). For families whose income was between 100 and 150 percent of the poverty level, the subsidy would decrease to zero on a sliding scale as income approached 150 percent. This subsidy would be available both to full-time employees covered by their employers and to those buying coverage through the public sponsor, provided their income was low enough to qualify. The administration of the subsidies would be handled by the agency chosen by each state. We would prefer to see the public sponsors kept out of the process of income testing, because they are not meant to be welfare agencies. One possible approach would be for such testing to be carried out by public welfare agencies that would certify the eligibility of persons and families for subsidies.

Subsidies for Small Businesses

Small businesses are an important source of new jobs. We would suggest easing the burden of providing coverage for them in two ways. First, as noted earlier, they would be able to buy coverage through the public sponsor, thus realizing the benefits of the public sponsor's economies of scale. Second, small businesses (those with fewer than 25 full-time employees) that arranged coverage through the public sponsor would be required to pay no more than 8 percent of their total payroll for basic benefits for their employees. If the employer's 80 percent contribution for health insurance exceeded 8 percent of the payroll, the sponsor would subsidize the excess amount.

Creating an Environment with Cost-Conscious Choice

Employers would be required to make a fixed contribution that would be independent of the health plan chosen. (As discussed below, this contribution would vary with the health-risk categories of the enrollees in each plan.) The amount of an employer's contribution that could be excluded from the employee's taxable income would be limited to 80 percent of the average cost of a qualified health plan in the employer's geographic area. The HCFA would offer employers a variety of approved risk-rating systems to translate this into individual tax-free amounts. Additional tax-free contributions under Section 125 of the Internal Revenue Code, which authorizes tax-favored "cafeteria benefit plans," would not be allowed.

The defined-contribution approach and the limitation on the amount of tax-free employer contributions are intended to promote both efficiency and equity. With these limitations, employees who chose more costly plans would have to pay the extra costs with their own net-after-tax dollars. This requirement should promote the choice of less costly plans. In addition, the limit on tax-free contributions would help make funds available to lower-income people not currently covered.

Qualified Health Plans

Qualified health plans would have to include the basic benefits package specified in the HMO Act, possibly with tighter definitions and restrictions to reduce costs. This package would be updated periodically through legislation and regulation. Deductibles could be no higher than $250 per person in 1988, adjusted for inflation; health plans would pay at least 80 percent of the fees of contracting providers. We would prefer to allow only a small copayment or deductible for inpatient hospital services, because patients have relatively little influence over decisions about the use of such services. However, if more substantial cost sharing among patients were allowed, the premiums could be reduced and, with them, the overall cost of the scheme to taxpayers. Total out-of-pocket expenditures for deductibles and coinsurance for contracting providers' services covered by the health plan could not exceed 100 percent of the annual premium. Qualified plans could not exclude coverage for preexisting conditions for members who enrolled during an annual open-enrollment period. Our intent is to encourage the development of cost-effective managed care plans. Thus, health plans would be free to limit or exclude coverage of the services of nonparticipating providers, except in emergencies when participating providers were not available.

Continuity of Coverage

One goal of the proposal is to have everyone join a health plan during the annual enrollment period and stay in that plan for the subsequent year, unless a "qualifying event" occurred (such as divorce or a move to a new home). This provision would reduce administrative costs and new beginnings on annual deductibles, and would improve the ability of health plans to manage care. Everyone would start the year either covered by his or her employer in a health plan of the employer's arranging or covered by a health plan arranged by the public sponsor. The subsidy of 80 percent of the average cost of qualified health plans contracting with a public sponsor would come either from an employer or from the public sponsor (in the case of part-time employees or other uncovered workers).

People who moved from one part-time job to another would simply keep paying the public sponsor the difference between 80 percent of the average premium and the cost of the coverage they had chosen. Similarly, people who moved between part-time jobs (or unemployment) and full-time jobs with employers that arranged coverage through the public sponsor would feel no discontinuity. When a person was hired, the employer would simply pay 80 percent of the average premium to the public sponsor (as the employer would do for each of its other full-time employees). The sub-

scribers would pay their shares either through the employer or through the sponsor.

When a person took or left a job with an employer that acted as an independent sponsor, there might be some discontinuity. In the detailed design of the program, a choice would have to be made between permitting changes in the health plan when they are caused by a job change and preventing them by complex rules.

Federal–State Cost Sharing and Administration

The federal government would collect revenues from three sources — the payroll tax paid by employers, taxes from self-employed persons and others eligible to buy subsidized insurance from the public sponsor, and additional revenues derived from a limitation on the amount of an employer's contribution that employees could exclude from their taxable income. The federal government would make these monies available to any state that created a public sponsor agency operating in accordance with federal guidelines.

Using the prices charged by health plans contracting with the public sponsors, the HCFA would determine the average cost nationally of a qualified health plan. After adjusting this cost to regional market areas (probably Metropolitan Statistical Areas) to account for regional variation in input prices (primarily wages), the HCFA would agree to pay each public sponsor half of the regionally adjusted cost for each enrollee to whom the sponsor sold a health plan. The public sponsor would be required to subsidize the enrollees to the amount of 80 percent of the average premiums of the health plans with which it had contracted. In states with high bills for medical care, relative to wages and other input prices, the average premiums would be likely to be higher than the regionally adjusted national average cost. These states would be required to contribute more than 30 percent of the cost to fund the state's share of the program. Conversely, states with relatively low medical care costs would pay less than 30 percent for their share.

A scheme of the general type outlined here could be financed and managed by the federal government, by the states, or by the states with federal guidelines and financial support. The federal government is likely to be able to develop and apply superior competence, and its taxing power is needed to make universal health insurance a reality. Otherwise, states competing to attract jobs would be reluctant to place such burdens on their employers. But the federal government could raise the money and turn it over to the states, as it does with Medicaid.

In this model, each state would be the guarantor of coverage for its citizens. There are several reasons to prefer the plan that involves state responsibility with federal support and guidelines. First, there is considerable diversity among states' health care systems and policies. Second, a substantial part of the money required to care for the uninsured now comes from more or less broadly based state and local sources, including employers' payments to private hospitals for bad debts or free care, and direct appropriations from state and local governments to short-term hospitals and medical programs for care for the recipients of general assistance. The states now rely on various mixes of these sources. The requirement for partial state funding is intended to keep this proposal from being regressive in relation to the status quo, by ensuring that this broadly based funding would be retained in the health care system. Third, there is wide variation among market areas in the cost and use of services. The responsibility for costs should be decentralized to the state level in order to motivate states, local governments, and employers to support cost-reducing policies.

Relation to Medicare and Medicaid

We propose no initial change in Medicare and Medicaid. The public sponsors would have enough work to accomplish the objectives set out thus far. However, once this program was operating successfully, there would be opportunities to use the capabilities of the public sponsors to assist the Medicare and Medicaid programs. For example, Medicaid programs should consider contracting with the public sponsors to provide coverage for families on welfare, in order to ease the transition from welfare to work. The existence of the public sponsor would mitigate the work disincentive associated with losing eligibility for Medicaid because of an extra dollar earned, and a Medicaid–public sponsor agreement might mitigate this disincentive further. The existence of nearly universal coverage through the public sponsor should greatly reduce the number of people who "spend down" into Medicaid. As for Medicare, it might find an advantage in using the public sponsors as brokers for HMO enrollment.

Managed Competition, Technology Assessment, and Management of Outcomes

Here we address the institutional framework within which consumers and providers decide about their participation in plans for health care financing and delivery and the incentives and constraints within which physicians and managers make their decisions about care and resource allocation.

The market for health plans is not inherently competitive. Market forces do not automatically lead it to produce an efficient, much less a fair, outcome.[19-22] In a free market, health plans could pursue profits or survival by using numerous competitive strategies that would destroy efficiency and fairness and that individual consumers would be powerless to counteract: risk selection, market segmentation, product differentiation, discontinuities in coverage, refusals of insurance for some people, biased information, and anticompetitive behavior. Consumers avoid buying coverage until they get sick, and health plans protect themselves with elaborate strategies, including medical review (e.g., testing for the human immunodeficiency virus) and the exclusion of coverage for preex-

isting conditions. For 35 million Americans to lack coverage is the sort of thing that happens when people are left to a free market.

The type of market structure that we believe can produce reasonable efficiency and fairness is one of managed competition in which intelligent collective agents, called sponsors, contract with competing health plans and continuously monitor and adjust the market to overcome its tendencies to failure. Managed competition has been discussed extensively elsewhere.[19-22] The key idea is that sponsors would manage a process of informed, cost-conscious consumer choice that would offer the reward of more subscribers to health plans whose providers delivered high-quality care economically.

The sponsors could employ various tools and strategies to counteract the causes of market failure. For example, when consumers had a choice of plan, the medical costs expected per person might be distributed unevenly among the different plans in what is called biased risk selection. If all patients had to be insured for the same price, achieving a favorable selection might be very advantageous to a health plan. The techniques of attracting good risks and repelling bad ones are many and subtle. If the incentives were not structured properly, a health plan might be led to underserve sick patients in order to encourage them to switch to another plan at the next enrollment period.[23] Or if the health plans were free to vary the premiums or decide whether to renew an enrollment, they would find it advantageous to charge high premiums to high-risk enrollees, or to offer them poor coverage or none at all.

The sponsor could attenuate these incentives by "risk rating" — the process of identifying and grouping persons according to the characteristics that help predict medical expense, with a different price quoted to cover the people in each group. Then the incentive to discriminate against the sick could be reduced by allowing the health plans to charge higher prices for the care of people in high-cost groups. Unfairness to these people could be avoided by tying the sponsor's contributions to the costs in each category, thus protecting the sick from higher costs. For example, the sponsor should pay each health plan an amount equal to the expected cost of efficient care for each of its enrolled patients with the acquired immunodeficiency syndrome, in order to avoid a disincentive to the enrollment and care of such patients. Medicare uses a rudimentary risk-rating system in contracting with HMOs.[24] In addition, the sponsor might contract for standardized coverage in order to prevent the manipulation of the terms of coverage to select patients in particular risk groups. And the sponsor could manage the enrollment process, including contacts between beneficiaries and health plans that might be designed to select for risks. Finally, the sponsor could monitor performance with regard to risk selection and take corrective action as needed. In this way, sponsors could control economic incentives so that the health plans would produce efficient and fair service.

For managed competition to yield efficient, high-quality care, providers, sponsors, and consumers must all be well informed about the constituents of such care. Thus, it is essential that the institutional framework include effective, broad-based programs in technology assessment, the risk-adjusted monitoring of outcomes, and outcomes management. Bunker et al. have proposed the creation of an "institute for health care evaluation" that would establish a uniform data base, identify technologies for assessment, and carry out and disseminate the results of evaluations.[25,26] Blumberg has defined "risk-adjusted monitors of outcomes" as statistical systems that measure outcomes continuously and enable comparisons to be made that take into account appropriately the differences in patient mix of the populations being compared.[27] This approach can be used, among other things, to identify specific providers whose outcomes are better or worse than expected. Ellwood has recently proposed "outcomes management . . . a common patient-understood language of health outcomes; a national data base containing information and analysis on clinical, financial, and health outcomes that estimates . . . the relation between medical interventions and health outcomes . . . and an opportunity for each decision-maker to have access to the analyses that are relevant to the choices they must make."[28]

Such information strategies are complementary to the process of managed competition; neither can have its intended effect without the other. The information enables sponsors and consumers to choose health plans wisely and to be informed about cost–quality tradeoffs. It enables physicians to avoid using their resources on treatments that do not improve outcomes and to save them for treatments that do. Managed competition rewards them for acting on such information.

In addition, such information is a public good. The profit incentive does not motivate the production of such information in socially optimal amounts. Substantial support by government is both necessary and a wise investment for taxpayers in the long run. All providers must participate in uniform systems of data reporting, because selective reporting on a voluntary basis will not produce credible data. Thus, action is required on the part of the states, the federal government, or both. Although large employers and government agencies (e.g., the HCFA) can gather, analyze, and publish much of this information, it will not have credibility with physicians until they participate actively in its development.

Coverage, Costs, and Budgets

The Congressional Budget Office, which makes such estimates for the Congress, has estimated the effects of our proposal on coverage, costs, and public-sector budgets.[29] Here we report their estimates, which are similar to our own.[18]

Of the 35 million people who are currently uninsured, according to Congressional Budget Office estimates, approximately 22 million would be covered by their employers under the proposed program, and the remaining 13 million would be eligible to purchase subsidized coverage from a public sponsor (Table 1). In addition to the 13 million currently uninsured people who would be eligible to buy coverage from the public sponsor, 6 million people currently purchasing nongroup insurance would be able to do so. Employers would purchase coverage for 43 million people in addition to those now covered by employer-sponsored insurance (this includes many self-employed people who currently purchase coverage).

Government needs money for five purposes under this proposal: (1) to subsidize 80 percent (50 percent from the federal government) of the cost of an average health plan for households in which no member is a full-time worker; (2) to subsidize small businesses arranging coverage through the public sponsor, whose unsubsidized costs exceed 8 percent of payroll; (3) to subsidize the individual's share of the premiums when family income is less than 150 percent of the poverty level; (4) to cover the increased cost to the federal employee's health benefits program; and (5) to cover the revenue lost from the reduction in taxable wages when employers contribute to the health insurance of previously uninsured employees.

This money would be raised in three ways. First, there would be an 8 percent tax on the first $22,500 of the wages of noncovered workers and a similar tax on self-employed persons and others. Second, there would be a limit on the amount of an employer's contribution to health insurance that could be excluded from an employee's taxable income. Third, the states would be required to fund part of the program, using monies saved because of the large reduction in the costs of hospital care that is publicly sponsored or uncompensated.

Table 1. Health Insurance Status of the American Population at Present and as Projected under the Proposal.*

Projected Types of Coverage	Totals (Projected)	Current Types of Coverage			
		Employment-based group†	Other private	Medicare, Medicaid, or CHAMPUS‡	None
		millions of people§			
Totals (current)	241.2	135.1	19.7	51.1	35.3
Employment-based group†	178.3	135.1	13.6	7.1	22.5
Medicare, Medicaid, or CHAMPUS‡	44.0	—	—	44.0	—
Public sponsor	18.9	—	6.1	—	12.8

*Source: Preliminary Congressional Budget Office simulations based on the March 1988 Current Population Survey.[29]

†Includes all people with employment-based coverage, regardless of other insurance, except those covered by Medicare.

‡CHAMPUS denotes the Civilian Health and Medical Program of the Uniformed Services. Figures include veterans covered by the Department of Veterans' Affairs.

§People are classified according to their own insurance and work status or that of the family member whose plan covers them.

Table 2. Probable Effects of Full Implementation of the Proposal on the Federal Budget.*

	Cost or Savings (Billions of 1988 Dollars)
Outlays	
Matching contributions to public sponsors	8.7
Subsidies to small businesses	3.9
Subsidies to low-income individuals and families	3.9
Cost added to health-benefit plan for federal employees	0.2
Savings to Medicare, Medicaid, and CHAMPUS†	−3.9
Total	12.8
Revenues	
Payroll tax on part-time workers‡	4.4
Income tax on others eligible to buy from public sponsors	2.5
Cap on exclusion of employer contributions from individual income-tax and payroll-tax bases	11.2
Savings from elimination of all health care benefits from Section 125 of Internal Revenue Code	§
Revenue loss from mandated employer contributions — individual income and payroll taxes	−5.7
Total	12.4
Net effect on federal budget deficit	0.3¶

*Source: Preliminary Congressional Budget Office estimates based on 1988 Current Population Survey and August 1988 base line.[29]

†CHAMPUS denotes the Civilian Health and Medical Program of the Uniformed Services.

‡Net of income-tax and payroll-tax offsets due to lower wages.

§Not yet estimated, but expected to be small.

¶Value shown is approximate because of rounding off.

We think that the cost of the benefit package we have described would be approximately $2,400 per family per year.[18] The Congressional Budget Office estimates that with a $2,400 annual family premium our proposal would not have a significant effect on the federal deficit (Table 2). New federal expenditures (after accounting for offsets) would be approximately $12.8 billion; this would be balanced by approximately $12.4 billion in additional tax revenue. There is some uncertainty associated with all such estimates, but we believe that these are accurate enough to demonstrate that a proposal such as ours can be crafted that has no effect on the deficit. As we have shown, the proposal has been designed with a number of "tunable dials." Some marginal adjustments may be necessary to achieve deficit neutrality (or may be desirable for other reasons), but the proposal as currently formulated is close to "budget neutral."

State-government expenditures required to provide the 30 percent subsidy for people who would buy health insurance directly from the public sponsor are estimated at $5.2 billion. Some states would be able to fund these expenditures in large part by redirecting current state and local government expenditures in support of care for the uninsured poor. In 1983, state and local governments spent more than $2 billion for general-assistance medical programs,[30] and in 1986 they spent $1.4 billion in direct appropriations to short-term care hospitals (Fraser I, American Hospital Association: personal communication). The need for such expenditures would diminish greatly

when almost everyone had insurance, and most such funds could be used to support the states' 30 percent subsidy of the regionally adjusted national cost of a health plan.

In some states, care for the uninsured poor is delivered largely by private hospitals and paid for through cost shifting to private payers. In such states new revenues would be required to provide the state's share of the subsidy to be used by the public sponsor. However, raising these new revenues would not harm the productive capacity of the states' economies. They would not be diverting funds from other sectors to the health care sector but simply shifting the source of the subsidy from a private-sector cross-subsidy to a direct public subsidy. Nationally, the private-sector cross-subsidy was approximately $7 billion in 1986 (Fraser I, American Hospital Association: personal communication). We expect the subsidy to increase to $8.3 billion in 1988.

In its first full year of implementation, we expect that our proposal would increase total health care expenditures by approximately $15 billion—3 percent of current health care expenditures and 0.3 percent of the gross national product. This would be a one-time increase. As Medicare and Medicaid have taught us, the important effects of a new health care program are not seen in the static, first-year effects, but rather in the long-term effects. It is ambitious but reasonable to set it as a goal for a program such as the one we propose — given cost-conscious demand and managed competition among health plans — to restrain health care costs to a rate of growth close to that of the GNP. If this favorable result were to occur, we would reduce health care costs by $15 billion per year (that is, $15 billion in the first year, $30 billion in the second year, $45 billion in the third year, and so forth), as compared with the current path of expenditures. These savings, which would be shared by the government and private employers (and ultimately by wage earners), would soon dwarf the one-time cost increase that our proposal would create.

In the second part of this article, we will discuss the general characteristics and expected effects of our proposal and compare it with alternative systems. We pay particular attention to effects on the organization of medical practice and the delivery of medical care.

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SPECIAL ARTICLES

A CONSUMER-CHOICE HEALTH PLAN FOR THE 1990s

Universal Health Insurance in a System Designed to Promote Quality and Economy

(Second of Two Parts)

ALAIN ENTHOVEN AND RICHARD KRONICK

Abstract We describe the characteristics necessary for a plan for universal health insurance to find broad acceptance. Such a plan must represent incremental, not radical, change; must respect the preferences of voters, patients, and providers; must avoid major disruption in satisfactory existing arrangements; must avoid creating major windfall gains or losses; must avoid large-scale income redistribution; and must not be inflationary.

Our proposal would create a framework that would encourage the efficient organization of care. Successful organizations would probably be those that attracted the loyalty and commitment of physicians, integrated insurance and the provision of care, and aligned the interests of doctors and patients toward high-quality, cost-effective care. The proposal's chief potential disadvantage would be its effect on the employment opportunities of low-wage workers, but this effect could be minimized.

In addition, we discuss a proposal to mandate coverage by employers of full-time employees, legislation enacted recently in Massachusetts, high-risk pools, and the system followed in Canada, comparing each of these alternatives with our proposal. (N Engl J Med 1989; 320:94-101.)

GUIDELINES FOR A BROADLY ACCEPTABLE PLAN

Universal health insurance has not attracted overwhelming support in this country. Indeed, its enactment in any form would be a remarkable achievement. To be politically viable, a proposal for universal health insurance must respect American cultural preferences for pluralism, diversity, local solutions, and individual responsibility. It must consider the preferences of providers and consumers for a variety of systems and styles of care. It must not provoke the strong opposition of large or important groups. What are the fears and concerns of the opponents of universal health insurance, and how does our proposal seek to dispel them?

Socialized Medicine

Universal health insurance in the United States would not have to resemble "socialized medicine" as it exists in the United Kingdom or Scandinavia. Many Americans instinctively reject any system they think would be bureaucratic, inconvenient, impersonal, or unresponsive to patients' needs and preferences — traits sometimes associated with the British and Swedish systems.[1-3] Many fear a framework that would be inefficient and by which care would therefore be rationed in queues or in which advanced technology would be unavailable. American physicians fear a system in which their professional judgments about patients' needs would be subordinated to political considerations. Most would resist having their incomes and working conditions circumscribed by political factors that bore no relation to the quality and value of their services. The national experience with Medicare and Medicaid suggests that physicians resist depending totally on government as the source of payment.

As we showed in the first part of this article, coverage that is nearly universal could be achieved in large part through a diversity of health plans (nonprofit and for profit) in the private sector such as now exists in the United States. We call our proposal "A Consumer-Choice Health Plan for the 1990s" because it would present consumers with a choice among such health plans and an opportunity to exercise cost–quality judgments that reflected the consumers' own preferences. The health plans would be responsive to patients because they would need to compete for subscribers. The plans would have to give value for money, because consumers would be conscious of costs in their choices. Health plans would also have to compete for the participation of physicians and thus would have to respect their professional judgments and aspirations. Payment to the physicians would be made through the health plans in which they participated, thus coming ultimately from satisfied enrollees. Such a model would be inherently much more adaptable than a public-sector monopoly.

Radical Change and Large Windfall Gains or Losses

A universal health insurance plan would not necessarily mean radical discontinuity with the present, nor would it necessarily create large windfall gains or losses. Nor would it have to mean major disruption in the current arrangements by which most employed people are satisfactorily covered. Incremental change is one of the most consistent themes of American politics. If we were making a fresh start in health insurance, we would not recommend an employment-based system, because of the many problems associated with

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it. But the present system involves large vested interests and liabilities that cannot simply be ignored. For example, many employers have obtained the services of employees in part by promising them health benefits after retirement. The present value of such liabilities exceeds $200 billion.[4] An acceptable policy could not suddenly transfer such a responsibility from employers to the taxpayers in general. Most Americans obtain good coverage through their employers and consider their arrangements satisfactory.[5] To disrupt these arrangements would provoke opposition needlessly. So we have designed a proposal for nearly universal coverage, one that would neither cause large windfall gains and losses nor disrupt satisfactory arrangements. The only immediate change for most people who are covered through employment would be an end to "cost unconsciousness" in their choice of health plan.

Redistribution of Income

Our society appears to have little taste for income redistribution, and a universal health insurance plan does not have to involve extensive redistribution. Inevitably, in the case of the poorest people, who cannot be expected to pay the cost of their care, others with higher incomes must help them, just as they do today. But our proposal would raise a large part of the needed funds from nonpoor working people who are uninsured today.

Health care financing in the United States today is regressive. Lower-income families that are insured (or their employers) pay premiums similar to those paid by higher-income families, hence spending a higher percentage of their income. Financing a universal insurance scheme could be similarly regressive. Our point is not to advocate regressive financing, but to separate universal health insurance conceptually from income redistribution.

Some may consider it harsh to require low-wage workers to pay the equivalent of an 8 percent tax toward their health insurance. If taxpayers of more ample means were willing to take on the burden of covering the poor, we would consider it to be all to the good. But it is important for low-income people to have health care coverage, even if they must pay a substantial part of the cost themselves.

Inflation

Universal health insurance does not have to be inflationary. On the contrary, reform of the total system is needed to cure the present lack of awareness of costs that contributes so much to inflation. Overinsuring the well-to-do without considering costs is much more inflationary than being conscious of costs and covering the poor. Medicare and Medicaid exacerbated inflation because they locked in the fee-for-service cost-reimbursement modes of provider payment and effectively blocked reform of the system. There is now an adequate supply of doctors and hospital beds, so increasing the numbers of the insured need not bid up prices substantially.

Small Business

We recognize that our proposal is likely to incur strong opposition from small businesses that do not now offer their employees coverage. Such businesses would see it as a tax increase that would damage their competitive position. In Part One we described methods to soften the blow. More could be done if other sources of financing could be identified. The uninsured are no healthier than the rest of us; some of them will be seriously ill, will need care, and will be unable to pay. We view employers and employees who do not participate in health insurance, but who receive care, as taking a "free ride" at the expense of other employers and taxpayers.

Effects on Medical Practice, Coverage, and Employment

Medical Practice

If our proposal were enacted and successful, how would it affect the organization and delivery of medical care? What would be the characteristics of the organizations that would be likely to succeed in the framework we have designed?

First, there would be room for much variety in the systems and styles of care, reflecting the circumstances and preferences of patients and providers. Our proposal need not lead physicians to fear being engulfed by one monolithic salaried practice for all. Second, successful organizations would have to attract the loyalty and commitment of physicians. Successful health plans could not be seen by participating physicians as "just another insurance company" in an adversarial relation. Controls on the use of health services cannot produce economical care in the face of opposition by physicians. Increasingly, physicians would select one health plan and form a loyal and relatively exclusive relation with it, seeing themselves as responsible participants in its management, perhaps with some equity interest, not just as "hired hands." Physicians would take part responsibly in all important decisions, working in partnership with managers skilled in the nonmedical aspects of program operation. Physicians would see their personal success as related to that of their chosen health plan; they would be willing to adapt and sacrifice in order for the plan to succeed. Insurance companies have important roles in marketing, finance, management of facilities, data collection and analysis, and other business functions. In the long run, the most successful such companies would be the partners of physicians, not their employers.

Third, successful organizations would integrate insurance and the provision of care, as health maintenance organizations (HMOs) do today. Provider or-

ganizations would be motivated to organize the delivery of care for maximal efficiency. Because the size of premiums would depend primarily on the efficiency of the provider, the provider's income and the volume of patients would both depend on the provider's ability to restrain costs while providing good care. Thus, physicians would evaluate the benefits and costs of specific practices, curtailing practices that did not produce better outcomes for patients in order to free resources for those that did.

Fourth, in the long run, the most successful organizations would probably be large prepaid group practices and other multispecialty group practices, because they appear to foster economical practice styles.[6-8] One key to economy and quality is the presence of busy, proficient doctors, which requires matching the numbers and types of physicians to the needs of the population served. Prepaid group practices and other systems with a similar organization can also match other resources, such as beds and equipment, to the needs of the population served. And they can organize care in the least costly settings, with an emphasis on outpatient care and home care. Other factors that favor large multispecialty group practices are those of mutual professional support and stimulation, group support for continuing medical education, a group size large enough for resources and risks to be shared, peer-group participation in decisions about clinical policies, and greater opportunities for physicians to choose their life styles.

Fifth, in successful organizations the interests of doctors would be aligned with those of patients in providing economical care of high quality and avoiding incentives to provide care that was not in the patients' best interests, considering both quality and cost. Physicians would avoid the powerful incentives for short-term maximization of profits that are inherent in some forms of public stock ownership.

Through a combination of democratic social choice and market forces, society would signal what it was willing to pay for care. Then physicians would do their best to provide the highest standard of care achievable within those limits.

How would physicians be paid? Neither a straight salary unrelated to individual performance nor an uncontrolled fee-for-service system based on "usual, customary, and reasonable" charges would align doctors' interests with those of patients. The workings of market forces on health plans that were free to adapt and innovate would probably lead to the development of performance-based systems of pay somewhere between fee-for-service, with "resource-based relative-value scales," and salaries, using peer judgment and various indicators of performance.

What about traditional fee-for-service individual and single-specialty group practices? We doubt that they would generally be compatible with economic efficiency. We would expect this type of practice to continue, but to decline gradually in importance. Fee-for-service solo practitioners would continue to be found in individual practice association HMOs and preferred-provider insurance plans, but under contracts with regard to fees, controls on the use of services, and risk sharing. Some physicians would work independently. Some would survive in private solo practice without health plan contracts, serving the well-to-do, much as private practice survives in the United Kingdom. For best results, however, physicians ought to organize themselves in cohesive units that could take responsibility for managing the quality and economy of care.

What we have proposed is a strategy for reforming the delivery of health care by reforming the system of payment. Its effectiveness would be enhanced if there were also a supply-side strategy that assisted in the formation of a greater number of efficiently organized systems of care.

Coverage

There is no precise basis for predicting the rates of participation by people now uninsured. Experience with large-scale programs in which the size of the employees' contribution exceeds that of the one we propose suggests that participation rates would be high. Public sponsors would have to market their services actively. Our proposal would give the states incentives to market coverage effectively, since each person enrolled through the public sponsor would bring into the state a federal contribution equal to half the adjusted average cost of the premium. And each enrollee would represent one less potential burden on the taxpayers for uncompensated care. Providers could make free rides unattractive by instituting relatively tough collection policies with regard to uninsured persons who could pay for care. The availability of subsidized insurance would make such policies more acceptable.

Employers, Employment, and Real Wages

Our proposal would affect wages, employers, and employment. In a perfectly competitive market, the total payments for each worker's services — wages, fringe benefits, and payroll taxes — should equal the value of his or her contribution to the output of the firm. After a period of adjustment, any increase in health insurance costs or payroll taxes would be offset approximately by a decline in real wages. In real labor markets, however, various factors might prevent wages from declining by as much as the employer's increase in costs for health benefits. Thus, increases in such costs might result in higher prices or lower profits.

Even so, in the case of part-time workers who are currently uninsured or those in firms with fewer than 25 employees but with wages above 108 percent of the minimum wage, we would expect the long-term effect to be a reduction in wages of approximately 8 percent. On the other hand, part-time workers and those in small firms who are now insured at a cost in excess of

8 percent of their pay would see an increase in wages, employment opportunities, or both. Currently uninsured full-time workers in firms with more than 25 employees whose wages exceed the minimum wage by the amount of the employer's cost to insure them would also see a reduction in wages roughly equal to the employer's cost for health insurance. But in exchange, such workers would receive access to health care coverage and mainstream care at competitive subsidized rates.

Employers that now provide coverage would be relieved of the expense of coverage for spouses whose employers do not provide coverage, as well as the hidden tax of charges that help cover bad debt and free care, which average about 10 percent of hospital bills. Also, they would face a reduced disadvantage in relation to employers that do not now insure their employees. Small employers that now pay more than 8 percent of payroll for health insurance would find their costs reduced. For employers who do not currently provide insurance, this proposal would close down a free ride by deliberately taking away a competitive advantage vis-à-vis employers that do cover their employees. However, for small employers, it would do so at a cost limited to about 8 percent of payroll. The proposal would also offer them a way of buying coverage at competitive group rates.

Employers that now provide coverage for their employees are burdened by three types of mandate whose valid social purposes would be served more effectively by our proposal and that therefore could and should be repealed or preempted by federal law. These are, first, the many state insurance laws that mandate coverage in specific amounts and for specific types of services; second, the so-called COBRA continuity law, which requires employers to sell coverage to former employees and their dependents for 18 or 36 months after the termination of employment; and third, Section 89 of the Internal Revenue Code, which imposes complex rules against discrimination in favor of highly paid employees. Under our proposal, the federal government would set a minimal benefit package as a national standard, continuity of coverage for employees who left firms would be provided through the public sponsors, and coverage would be universal, with limits on the tax break for the highly paid. These would be important steps in the simplification of employers' obligations. In appraising their total effect, one should bear in mind that a major element of our proposal is the creation of incentives for efficiency as a means of containing the growth of health care costs.

The most important potential negative effect of our proposal, as compared with the status quo, would be a reduction in opportunities for employment among people with few job skills by, in effect, raising the minimum wage. To part-time workers and employees of small firms, our proposal would mean an implicit 8 percent increase in the minimum wage. Requiring employers to cover full-time employees could add a cost of 11 percent of pay in the case of individual coverage for a worker receiving the minimum wage ($3.35 per hour), and 27 percent in the unusual case of such a worker who covered his or her family. In the drafting of legislation to implement this proposal, further provisions should be designed to reduce this burden, especially the extra burden of family coverage.

Any tax or regulatory mandate distorts economic decision making. If this proposal were enacted, there would be negative effects on employment, as there are now in our employment-based system of coverage. But the achievement of widespread health insurance inevitably entails some taxes and regulations. Our present method of providing health insurance through employment groups is subsidized by taxes to a great degree. We must look for a realistic compromise — what economists call a "second best" — because universal health insurance without some regulation and tax support is impossible.

Young people are the group whose employment would be most likely to be affected, because a comparatively high percentage of them work at the minimum wage.[9] Strong evidence suggests that a 10 percent increase in the minimum wage would reduce the employment of 16- to 19-year-olds by about 1 percent, although some studies have found the effect to be as much as 3 percent.[9-11] The effect would be much smaller among older workers because fewer of them work at the minimum wage. Mitigating actions are possible. The minimum wage could be adjusted to allow employers to pass along part or all of the increase in the cost of health benefits. The employment of people under 18 could be exempted from the mandate and tax. Thus, the negative effects on employment need not be large.

Strategic Alternatives Based on Managed Competition

The mixture of public and private financing and administration in the model we have described is not the only way to achieve universal health insurance that is based on managed competition. Indeed, the employment-based model has many important disadvantages, such as gaps in coverage, cost, inequity, and complexity. The presence of a large number of private sponsors creates great complexity as each tries to deal with health plans on the basis of its own preferred system of pricing or of rating risks. We have proposed this approach because we believe it represents politically feasible incremental change and meets our guidelines for a broadly acceptable plan. It does have important advantages, such as keeping the function of sponsorship decentralized and largely in the private sector, and keeping employers together as a focused political group interested in cost. Thus, we consider this proposal the most plausible starting point for incremental reform. There is, however, another serious possibility.

In many respects, the simplest model would be one that is financed and administered publicly. One of us proposed such a model 10 years ago,[12] according to which government would raise all the revenue, except for individual premium contributions, with taxes such as those on payroll, income, and consumption. This approach would spread out the costs of health care and avoid placing an extra burden on those who employ sicker workers. Acting as a sponsor on behalf of all persons covered, a government agency (federal or state) would contract with the participating health plans, design and operate a single risk-rating system, and manage the enrollment process. All health plans would have to play by a single set of rules. The system could be managed either by the Health Care Financing Administration (HCFA), currently the best-qualified sponsor, or even better, by a newly constituted agency somewhat independent of political pressures, whose design would resemble that of the Federal Reserve System. Such a model would be less open to innovation than one with substantial private-sector sponsorship, since the decentralization of the sponsorship role entailed by private-sector involvement would make it easier to test new ideas.

What would happen if the competition to serve cost-conscious buyers were ineffective in constraining the growth of expenditures to a rate considered satisfactory by society in general? Such a scenario could emerge if the public sponsors were ineffective in pursuing policies to encourage competition and if relatively noncompetitive market structures persisted. In response, one action that a publicly financed and administered model could take would be to institute a system of administered prices analogous to that used in hospitals under the Medicare prospective-payment system. The health plans would then receive fixed, periodic prospective payments based on the composition of their memberships according to diagnostic cost groups, and they would have to accept such payments as payment in full.[13] They would compete with regard to quality and service but not with regard to price.

The immediate adoption of a publicly financed and administered model would represent radical change, create large windfalls, and disrupt satisfactory existing arrangements. Providers would probably feel threatened by such a concentration of power on the demand side. However, a system that was publicly administered in large part might evolve from our mixed proposal if the public sponsors could work effectively, causing large numbers of employers to choose to arrange coverage for their employees through them. Thus, those who would prefer to see a model that was financed and administered publicly might view our incremental proposal as one step in an evolutionary process toward public sponsorship on behalf of those who would not be better served by private-sector sponsors. If all but the largest employers chose to contract for coverage through a public sponsor, many disadvantages of the employment-based system would be alleviated. Thus, with the enactment of our proposal, some of the main benefits of public financing and administration would be realized without the threat of a government takeover of the whole system.

Comparisons with Some Prominent Alternatives

Mandated Coverage of Full-Time Employees by Employers

President Richard Nixon in 1974 and Senator Edward Kennedy in 1987 proposed requiring employers to provide coverage for all full-time employees and their dependents.[14,15] Senator Kennedy would require employers to cover all employees working 17.5 hours a week or more, and their dependents, with a health plan that met certain standards. Employers would be required to pay 80 percent of the premium, and in the case of low-wage workers, 100 percent. The secretary of health and human services would be required to select and certify regional insurers in each of six to eight regions, which would offer indemnity plans and managed care plans at low and high options on a community-rated basis. The secretary would encourage the regional insurers to contract with groups of small businesses for administrative services.

As explained earlier, requiring employers to cover their full-time employees is a necessary part of a larger strategy that subsidizes the coverage of those not covered through employment but tries to keep the sponsorship of most health insurance in the private sector. Senator Kennedy has performed a valuable service in helping to place universal health insurance on the national agenda. But his proposal does not pretend to achieve universal health insurance or cost containment by itself. It would leave gaps: the self-employed, part-timers working less than 17.5 hours at any given job, employees during their first 30 days on the job, the unemployed, those outside the labor force, workers in firms not covered by the Fair Labor Standards Act or with fewer than six employees (for the first five years), and dependents of workers in these categories. In the short run, the Kennedy proposal would leave out at least 10 to 12 million people, and eventually more, as employers responded to its incentives. By not taxing all employment that was not covered by health insurance, it would give employers a powerful incentive to find ways to meet their needs with 17-hour-per-week employees. And it would provide no mechanism for aggregating premium contributions from these people. At the same time, it would create a disincentive to hiring part-timers who worked more than 17.5 hours per week. It lacks a built-in strategy for cost containment. The community-rated regional insurers do not appear likely to promote effective competition in organizing local health systems for efficiency. In leaving intact the current tax treatment of employer-provided health insurance, the proposal

would not promote cost-conscious consumer choice and would be unlikely to lead to cost containment.

Massachusetts

Massachusetts recently enacted a law "to make health security available to all citizens of the Commonwealth and to improve hospital financing,"[16] with two main features. First, the act creates a public sponsor, the Department of Medical Security. The department will contract with health plans to make affordable coverage available to small businesses and, subject to the availability of funds, will provide subsidized coverage for individuals who are otherwise unsponsored. Second, starting in 1992, the act will impose a "play-or-pay" tax on all employers of six or more workers, which would be equal to 12 percent of the first $14,000 of each employee's wages. Employers will be able to deduct the costs of their health benefits from this amount. Thus. employers who spend at least this much on health benefits will not pay the tax. Employers of five or fewer employees, temporary or seasonal employees, part-time employees who work less than 20 hours a week, and employees covered elsewhere (e.g., on a spouse's plan) will all be excluded. The Department of Medical Security will use the revenues generated by this tax to provide subsidized coverage. Various small incremental steps over the next four years are intended to prepare for the extensive change in 1992.

Philosophically, this act resembles our proposal in its use of incentives to motivate the private sector to provide coverage and in the use of a public sponsor to fill the gaps left by the private sector. In appraising the concept, one must bear in mind that several powerful factors seriously inhibit an individual state in the design of a universal health insurance program. First, by the enactment of the Employee Retirement Income Security Act of 1974, Congress preempted state regulation of employee benefit plans.[17] States may not require employers to provide health benefits. Second, the federal income-tax treatment of employer-provided health benefits amounts to a key subsidy for private health insurance, the limitation of which would be an important way of creating cost-conscious choice. Third, the states compete for taxpaying residents and businesses. A state government contemplating an increased tax on business has reason to fear that it may cause established businesses to migrate and new businesses to choose to start elsewhere.

In our view, the exemption of many employees from the play-or-pay payroll tax is regrettable. The combination of a public sponsor that will sell subsidized insurance to those not covered through employment, with exemptions for employers from mandates and play-or-pay taxes, invites insolvency for the program. Not only will the public sponsor be required to provide coverage for the employees of small businesses that currently do not provide health benefits, but we would expect many small businesses that currently do provide coverage to stop. The public sponsor would then be required to cover the newly uninsured employees of such small businesses without a source of funds for the subsidy. Better methods of cushioning small business from the costs of employment-based universal health insurance are available, which retain the financial base to support it.

The Massachusetts law is not incompatible with a strategy of managed competition, but it does not require it. Without the authority to limit the extent of employers' contributions that are tax-free under federal income and payroll taxes, Massachusetts cannot create a key feature of managed competition — namely, cost consciousness among consumers in the choice of plan. For most of the 1980s, Massachusetts has relied on a regulatory approach to cost containment. We believe managed competition would be more effective in the long run because of its focus on the reorganization of the delivery system into efficient units. And we believe managed competition would be more acceptable in the great majority of states that have chosen not to regulate hospital revenues. Finally, the Massachusetts legislature has not identified all the sources of funding needed to carry out its intentions. We believe the superior taxing power of the federal government is needed.

High-Risk Pools

Six states have enacted legislation creating health insurance pools to serve people who are not eligible for group insurance and who, because they are at high medical risk, cannot buy individual insurance.[18] Typically, these pools offer to sell insurance to such people at 150 percent of the price of a standard-risk policy. The pools are supported by subsidies from all the health insurance companies in the state. Enrollments are low, even in relation to the target populations.

This strategy has been ineffective, for several reasons. First, most of the uninsured are not "medically uninsurable." Bovbjerg and Koller, who have studied high-risk pools, report a consensus guess that only about 1 percent of the general population is medically uninsurable.[19] Second, the price is too high. Without a subsidy, few people can afford such insurance or will choose to purchase it. There is no good reason why they should not be granted tax subsidies equal to those available to the employed. Third, insurers have objected that the expansion of this program, which they and their policyholders must subsidize, puts them at a competitive disadvantage in relation to employers who have the option to insure themselves and escape the burden of subsidizing the pool. Thus, they lack an incentive to market it effectively. Fourth, this approach includes no incentives for efficiency in the care of high-risk patients.

Canada

What about the Canadian system as a model for the United States? In Canada's federal–provincial system,

the federal government makes a substantial per capita payment to each province's health insurance plan, provided the province publicly administers universal, comprehensive coverage for hospital and physicians' services and meets certain other conditions. The provinces finance hospital care through prospective global budgets, determined on a historical basis, with annual increases for inflation, increases in workload, and approved new programs. Physicians are paid on a fee-for-service basis, according to a fee schedule negotiated between each province and its medical association. About 76 percent of the expenditures for health care are included in the provincial budgets, with the provinces remaining "at risk" for the cost of care and therefore interested in containing its growth.[19]

It is hard to imagine a process of incremental change by which the Canadian model would be recreated in the United States. But any fair appraisal of the Canadian model would have to acknowledge some major strengths and achievements. Canada has universal coverage at a 1985 cost of 8.6 percent of the gross national product, as compared with 10.6 percent in the United States. Its share of the gross national product has apparently stabilized, whereas ours is accelerating. Canadians have much less paperwork because there is a single insurer for everyone — the provincial government — to whom the physicians send their bills. Fee-for-service payment gives the doctors an incentive to deliver services, whereas hospital expenditures are capped by global prospective budgets. Thus, Canadian doctors have a financial interest in hospital productivity, because their receipts for services to inpatients are directly related to the number of patients hospitals can serve within their limited budgets.

Would the Canadian system be a good model for the United States? The answer is very uncertain. The Canadian system is locked into the fee-for-service model, with no built-in forces of the market or other forces to lead its providers to organize the system for optimal quality and efficiency. It does not make considerations of quality assurance and use control in the physicians' interest, as the managed-competition model might do here. Nor does it motivate doctors to avoid providing services of little or no marginal benefit to the patient. We do not know how much of Canada's lower rate of expense is the result of greater efficiency and how much the result of the denial of access to technology that would be beneficial.

Serious questions can be raised about the capability of the American federal and state governments to manage the whole health care system with a tolerable level of competence. The Canadians have a parliamentary system that is less vulnerable than our own to the pressures of special-interest groups. They have a stronger tradition of civil service. And the provinces operate on a smaller scale and with much more cultural homogeneity than many of our larger states.

But the key problem is that an attempt to enact a system like the Canadian one, involving a virtually complete government takeover of health care financing, would represent far too radical a change to be politically feasible in this country. The achievement would be impressive enough if someone could muster a winning coalition to support the incremental changes we have proposed. But any serious attempt to reproduce the Canadian model would provoke the intense and concerted opposition of powerful groups. Providers would resist the notion of government as the sole source of payment. Health insurance companies, HMOs, other intermediaries, and administrators would resist the threat to put them out of business. Millions of relatively well-to-do Americans would fear that "socialized medicine" would deprive them of access to high-quality care and advanced technology. Although some might support it (big business, eager to unload its heavy liabilities, or the millions badly served by the present system), we would expect a firestorm of opposition. We see no evidence that the American people are sufficiently fed up to consider taking such a leap. And as we have shown, it is not necessary to fight such battles to achieve universal health insurance.

Conclusion

Critics will point out that there is no certainty that a strategy of managed competition would in fact restrain the growth of health care expenditures to tolerable levels. They can point to the negative experience of the 1980s, when an apparently competitive system emerged that was accompanied by accelerated growth in expenditures. This experience is not directly relevant, however, because key elements of managed competition were missing: widespread cost-conscious demand, an effective sponsor to manage the competition for a large part of the population, relevant information about cost and quality, and an understanding of the necessary ingredients of managed competition. In short, fragments of "competition" were present, but not a comprehensive and concerted strategy. As with any bold public-policy initiative, there can be no guarantee that this one would succeed. The vision of managed competition as a national strategy represents a complex extrapolation from some successful experiences, using generally accepted economic theory.

What is clear is that continuing on the present path will produce results that are increasingly unsatisfactory: more and more people lacking coverage, expenditures rising to intolerable levels (15 percent of the gross national product and beyond), and little confidence that the money is being well spent. In comparison, the uncertainties of universal coverage under managed competition are surely to be preferred.

The only proved method for bringing the growth in total expenditures into line with the gross national product is for government to take over most of health care financing and place it under firm global budgets. This is what many industrialized democracies have done, at least in the case of hospital care. Even in that

case, however, there is no assurance that stability in the growth of reported financial expenditures would not be achieved at the cost of many delays or denials of care — thus, by a shifting of the costs of illness back to patients and other sectors of the economy. None of the countries that have adopted global budgets in the public sector have solved the problem of creating incentives for the efficient organization and delivery of care.

In view of our historic preferences for limited government and decentralization, our reliance on incentives in the private sector, and our at least partial success with relatively efficiently organized systems of health care, it seems reasonable to give comprehensive reform of incentives a serious try before something more alien and drastic is considered.

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A NATIONAL HEALTH PROGRAM FOR THE UNITED STATES

A Physicians' Proposal

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Abstract Our health care system is failing. Tens of millions of people are uninsured, costs are skyrocketing, and the bureaucracy is expanding. Patchwork reforms succeed only in exchanging old problems for new ones. It is time for basic change in American medicine. We propose a national health program that would (1) fully cover everyone under a single, comprehensive public insurance program; (2) pay hospitals and nursing homes a total (global) annual amount to cover all operating expenses; (3) fund capital costs through separate appropriations; (4) pay for physicians' services and ambulatory services in any of three ways: through fee-for-service payments with a simplified fee schedule and mandatory acceptance of the national health program payment as the total payment for a service or procedure (assignment), through global budgets for hospitals and clinics employing salaried physicians, or on a per capita basis (capitation); (5) be funded, at least initially, from the same sources as at present, but with all payments disbursed from a single pool; and (6) contain costs through savings on billing and bureaucracy, improved health planning, and the ability of the national health program, as the single payer for services, to establish overall spending limits. Through this proposal, we hope to provide a pragmatic framework for public debate of fundamental health-policy reform. (N Engl J Med 1989; 320:102-8.)

OUR health care system is failing. It denies access to many in need and is expensive, inefficient, and increasingly bureaucratic. The pressures of cost control, competition, and profit threaten the traditional tenets of medical practice. For patients, the misfortune of illness is often amplified by the fear of financial ruin. For physicians, the gratifications of healing often give way to anger and alienation. Patchwork reforms succeed only in exchanging old problems for new ones. It is time to change fundamentally the trajectory of American medicine — to develop a comprehensive national health program for the United States.

We are physicians active in the full range of medical endeavors. We are primary care doctors and surgeons, psychiatrists and public health specialists, pathologists and administrators. We work in hospitals, clinics, private practices, health maintenance organizations (HMOs), universities, corporations, and public agencies. Some of us are young, still in training; others are greatly experienced, and some have held senior positions in American medicine.

As physicians, we constantly confront the irrationality of the present health care system. In private practice, we waste countless hours on billing and bureaucracy. For uninsured patients, we avoid procedures, consultations, and costly medications. Diagnosis-related groups (DRGs) have placed us between administrators demanding early discharge and elderly patients with no one to help at home — all the while glancing over our shoulders at the peer-review organization. In HMOs we walk a tightrope between thrift and penuriousness, too often under the pressure of surveillance by bureaucrats more concerned with the bottom line than with other measures of achievement. In public health work we are frustrated in the face of plenty; the world's richest health care system is unable to ensure such basic services as prenatal care and immunizations.

Despite our disparate perspectives, we are united by dismay at the current state of medicine and by the conviction that an alternative must be developed. We hope to spark debate, to transform disaffection with what exists into a vision of what might be. To this end, we submit for public review, comment, and revision a working plan for a rational and humane health care system — a national health program.

We envisage a program that would be federally mandated and ultimately funded by the federal government but administered largely at the state and local level. The proposed system would eliminate financial barriers to care; minimize economic incentives for both excessive and insufficient care, discourage administrative interference and expense, improve the distribution of health facilities, and control costs by curtailing bureaucracy and fostering health planning. Our plan borrows many features from the Canadian national health program and adapts them to the unique circumstances of the United States. We suggest that, as in Canada's provinces, the national

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health program be tested initially in statewide demonstration projects. Thus, our proposal addresses both the structure of the national health program and the transition process necessary to implement the program in a single state. In each section below, we present a key feature of the proposal, followed by the rationale for our approach. Areas such as long-term care; public, occupational, environmental, and mental health; and medical education need much more development and will be addressed in detail in future proposals.

Coverage

Everyone would be included in a single public plan covering all medically necessary services, including acute, rehabilitative, long-term, and home care; mental health services; dental services; occupational health care; prescription drugs and medical supplies; and preventive and public health measures. Boards of experts and community representatives would determine which services were unnecessary or ineffective, and these would be excluded from coverage. As in Canada, alternative insurance coverage for services included under the national health program would be eliminated, as would patient copayments and deductibles.

Universal coverage would solve the gravest problem in health care by eliminating financial barriers to care. A single comprehensive program is necessary both to ensure equal access to care and to minimize the complexity and expense of billing and administration. The public administration of insurance funds would save tens of billions of dollars each year. The more than 1,500 private health insurers in the United States now consume about 8 percent of revenues for overhead, whereas both the Medicare program and the Canadian national health program have overhead costs of only 2 to 3 percent. The complexity of our current insurance system, with its multiplicity of payers, forces U.S. hospitals to spend more than twice as much as Canadian hospitals on billing and administration and requires U.S. physicians to spend about 10 percent of their gross incomes on excess billing costs.[1] Eliminating insurance programs that duplicated the national health program coverage, though politically thorny, would clearly be within the prerogative of the Congress.[2] Failure to do so would require the continuation of the costly bureaucracy necessary to administer and deal with such programs.

Copayments and deductibles endanger the health of poor people who are sick,[3] decrease the use of vital inpatient medical services as much as they discourage the use of unnecessary ones,[4] discourage preventive care,[5] and are unwieldy and expensive to administer. Canada has few such charges, yet health costs are lower than in the United States and have risen slowly.[6,7] In the United States, in contrast, increasing copayments and deductibles have failed to slow the escalation of costs.

Instead of the confused and often unjust dictates of insurance companies, a greatly expanded program of technology assessment and cost-effectiveness evaluation would guide decisions about covered services, as well as about the allocation of funds for capital spending, drug formularies and other issues.

Payment for Hospital Services

Each hospital would receive an annual lump-sum payment to cover all operating expenses — a "global" budget. The amount of this payment would be negotiated with the state national health program payment board and would be based on past expenditures, previous financial and clinical performance, projected changes in levels of services, wages and other costs, and proposed new and innovative programs. Hospitals would not bill for services covered by the national health program. No part of the operating budget could be used for hospital expansion, profit, marketing, or major capital purchases or leases. These expenditures would also come from the national health program fund, but monies for them would be appropriated separately.

Global prospective budgeting would simplify hospital administration and virtually eliminate billing, thus freeing up substantial resources for increased clinical care. Before the nationwide implementation of the national health program, hospitals in the states with demonstration programs could bill out-of-state patients on a simple per diem basis. Prohibiting the use of operating funds for capital purchases or profit would eliminate the main financial incentive for both excessive intervention (under fee-for-service payment) and skimping on care (under DRG-type prospective-payment systems), since neither inflating revenues nor limiting care could result in gain for the institution. The separate appropriation of funds explicitly designated for capital expenditures would facilitate rational health planning. In Canada, this method of hospital payment has been successful in containing costs, minimizing bureaucracy, improving the distribution of health resources, and maintaining the quality of care.[6-9] It shifts the focus of hospital administration away from the bottom line and toward the provision of optimal clinical services.

Payment for Physicians' Services, Ambulatory Care, and Medical Home Care

To minimize the disruption of existing patterns of care, the national health program would include three payment options for physicians and other practitioners: fee-for-service payment, salaried positions in institutions receiving global budgets, and salaried positions within group practices or HMOs receiving per capita (capitation) payments.

Fee-for-Service Payment

The state national health program payment board and a representative of the fee-for-service practition-

ers (perhaps the state medical society) would negotiate a simplified, binding fee schedule. Physicians would submit bills to the national health program on a simple form or by computer and would receive extra payment for any bill not paid within 30 days. Payments to physicians would cover only the services provided by physicians and their support staff and would exclude reimbursement for costly capital purchases of equipment for the office, such as CT scanners. Physicians who accepted payment from the national health program could bill patients directly only for uncovered services (as is done for cosmetic surgery in Canada).

Global Budgets

Institutions such as hospitals, health centers, group practices, clinics serving migrant workers, and medical home care agencies could elect to receive a global budget for the delivery of outpatient, home care, and physicians' services, as well as for preventive health care and patient-education programs. The negotiation process and the regulations covering capital expenditures and profits would be similar to those for inpatient hospital services. Physicians employed in such institutions would be salaried.

Capitation

HMOs, group practices, and other institutions could elect to be paid fees on a per capita basis to cover all outpatient care, physicians' services, and medical home care. The regulations covering the use of such payments for capital expenditures and for profits would be similar to those that would apply to hospitals. The capitation fee would not cover inpatient services (except care provided by a physician), which would be included in hospitals' global budgets. Selective enrollment policies would be prohibited, and patients would be permitted to leave an HMO or other health plan with appropriate notice. Physicians working in HMOs would be salaried, and financial incentives to physicians based on the HMO's financial performance would be prohibited.

The diversity of existing practice arrangements, each with strong proponents, necessitates a pluralistic approach. Under all three proposed options, capital purchases and profits would be uncoupled from payments to physicians and other operating costs — a feature that is essential for minimizing entrepreneurial incentives, containing costs, and facilitating health planning.

Under the fee-for-service option, physicians' office overhead would be reduced by the simplification of billing.[1] The improved coverage would encourage preventive care.[10] In Canada, fee-for-service practice with negotiated fee schedules and mandatory assignment (acceptance of the assigned fee as total payment) has proved to be compatible with cost containment, adequate incomes for physicians, and a high level of access to and satisfaction with care on the part of patients.[6,7] The Canadian provinces have responded to the inflationary potential of fee-for-service payment in various ways: by limiting the number of physicians, by monitoring physicians for outlandish practice patterns, by setting overall limits on a province's spending for physicians' services (thus relying on the profession to police itself), and even by capping the total reimbursement of individual physicians. These regulatory options have been made possible (and have not required an extensive bureaucracy) because all payment comes from a single source. Similar measures might be needed in the United States, although our penchant for bureaucratic hypertrophy might require a concomitant cap on spending for the regulatory apparatus. For example, spending for program administration and reimbursement bureaucracy might be restricted to 3 percent of total costs.

Global budgets for institutional providers would eliminate billing, while providing a predictable and stable source of income. Such funding could also encourage the development of preventive health programs in the community, such as education programs on the acquired immunodeficiency syndrome (AIDS), whose costs are difficult to attribute and bill to individual patients.

Continuity of care would no longer be disrupted when patients' insurance coverage changed as a result of retirement or a job change. Incentives for providers receiving capitation payments to skimp on care would be minimized, since unused operating funds could not be devoted to expansion or profit.

Payment for Long-Term Care

A separate proposal for long-term care is under development, guided by three principles. First, access to care should be based on need rather than on age or ability to pay. Second, social and community-based services should be expanded and integrated with institutional care. Third, bureaucracy and entrepreneurial incentives should be minimized through global budgeting with separate funding for capital expenses.

Allocation of Capital Funds, Health Planning, and Return on Equity

Funds for the construction or renovation of health facilities and for purchases of major equipment would be appropriated from the national health program budget. The funds would be distributed by state and regional health-planning boards composed of both experts and community representatives. Capital projects funded by private donations would require approval by the health-planning board if they entailed an increase in future operating expenses.

The national health program would pay owners of for-profit hospitals, nursing homes, and clinics a reasonable fixed rate of return on existing equity. Since

virtually all new capital investment would be funded by the national health program, it would not be included in calculating the return on equity.

Current capital spending greatly affects future operating costs, as well as the distribution of resources. Effective health planning requires that funds go to high-quality, efficient programs in the areas of greatest need. Under the existing reimbursement system, which combines operating and capital payments, prosperous hospitals can expand and modernize, whereas impoverished ones cannot, regardless of the health needs of the population they serve or the quality of services they provide. The national health program would replace this implicit mechanism for distributing capital with an explicit one, which would facilitate (though not guarantee) allocation on the basis of need and quality. Insulating these crucial decisions from distortion by narrow interests would require the rigorous evaluation of the technology and assessment of needs, as well as the active involvement of providers and patients.

For-profit providers would be compensated for existing investments. Since new for-profit investment would be barred, the proprietary sector would gradually shrink.

Public, Environmental, and Occupational Health Services

Existing arrangements for public, occupational, and environmental health services would be retained in the short term. Funding for preventive health care would be expanded. Additional proposals dealing with these issues are planned.

Prescription Drugs and Supplies

An expert panel would establish and regularly update a list of all necessary and useful drugs and outpatient equipment. Suppliers would bill the national health program directly for the wholesale cost, plus a reasonable dispensing fee, of any item in the list that was prescribed by a licensed practitioner. The substitution of generic for proprietary drugs would be encouraged.

Funding

The national health program would disburse virtually all payments for health services. The total expenditure would be set at the same proportion of the gross national product as health costs represented in the year preceding the establishment of the national health program. Funds for the national health program could be raised through a variety of mechanisms. In the long run, funding based on an income tax or other progressive tax might be the fairest and most efficient solution, since tax-based funding is the least cumbersome and least expensive mechanism for collecting money. During the transition period in states with demonstration programs, the following structure would mimic existing funding patterns and minimize economic disruption.

Medicare and Medicaid

All current federal funds allocated to Medicare and Medicaid would be paid to the national health program. The contribution of each program would be based on the previous year's expenditures, adjusted for inflation. Using Medicare and Medicaid funds in this manner would require a federal waiver.

State and Local Funds

All current state and local funds for health care expenditures, adjusted for inflation, would be paid to the national health program.

Employer Contributions

A tax earmarked for the national health program would be levied on all employers. The tax rate would be set so that total collections equaled the previous year's statewide total of employers' expenditures for health benefits, adjusted for inflation. Employers obligated by preexisting contracts to provide health benefits could credit the cost of those benefits toward their national health program tax liability.

Private Insurance Revenues

Private health insurance plans duplicating the coverage of the national health program would be phased out over three years. During this transition period, all revenues from such plans would be turned over to the national health program, after the deduction of a reasonable fee to cover the costs of collecting premiums.

General Tax Revenues

Additional taxes, equivalent to the amount now spent by individual citizens for insurance premiums and out-of-pocket health costs, would be levied.

It would be critical for all funds for health care to flow through the national health program. Such single-source payment (monopsony) has been the cornerstone of cost containment and health planning in Canada. The mechanism of raising funds for the national health program would be a matter of tax policy, largely separate from the organization of the health care system itself. As in Canada, federal funding could attenuate inequalities among the states in financial and medical resources.

The transitional proposal for demonstration programs in selected states illustrates how monopsony payment could be established with limited disruption of existing patterns of health care funding. The employers' contribution would represent a decrease in costs for most firms that now provide health insurance and an increase for those that do not currently pay for benefits. Some provision might be needed to cushion the impact of the change on financially strapped small

businesses. Decreased individual spending for health care would offset the additional tax burden on individual citizens. Private health insurance, with its attendant inefficiency and waste, would be largely eliminated. A program of job placement and retraining for insurance and hospital-billing employees would be an important component of the program during the transition period.

Discussion

The Patient's View

The national health program would establish a right to comprehensive health care. As in Canada, each person would receive a national health program card entitling him or her to all necessary medical care without copayments or deductibles. The card could be used with any fee-for-service practitioner and at any institution receiving a global budget. HMO members could receive nonemergency care only through their HMO, although they could readily transfer to the non-HMO option.

Thus, patients would have a free choice of providers, and the financial threat of illness would be eliminated. Taxes would increase by an amount equivalent to the current total of medical expenditures by individuals. Conversely, individuals' aggregate payments for medical care would decrease by the same amount.

The Practitioner's View

Physicians would have a free choice of practice settings. Treatment would no longer be constrained by the patient's insurance status or by bureaucratic dicta. On the basis of the Canadian experience, we anticipate that the average physician's income would change little, although differences among specialties might be attenuated.

Fee-for-service practitioners would be paid for the care of anyone not enrolled in an HMO. The entrepreneurial aspects of medicine — with the attendant problems as well as the possibilities — would be limited. Physicians could concentrate on medicine; every patient would be fully insured, but physicians could increase their incomes only by providing more care. Billing would involve imprinting the patient's national health program card on a charge slip, checking a box to indicate the complexity of the procedure or service, and sending the slip (or a computer record) to the physician-payment board. This simplification of billing would save thousands of dollars per practitioner in annual office expenses.[1]

Bureaucratic interference in clinical decision making would sharply diminish. Costs would be contained by controlling overall spending and by limiting entrepreneurial incentives, thus obviating the need for the kind of detailed administrative oversight that is characteristic of the DRG program and similar schemes. Indeed, there is much less administrative intrusion in day-to-day clinical practice in Canada (and most other countries with national health programs) than in the United States.[11,12]

Salaried practitioners would be insulated from the financial consequences of clinical decisions. Because savings on patient care could no longer be used for institutional expansion or profits, the pressure to skimp on care would be minimized.

The Effect on Other Health Workers

Nurses and other health care personnel would enjoy a more humane and efficient clinical milieu. The burdens of paperwork associated with billing would be lightened. The jobs of many administrative and insurance employees would be eliminated, necessitating a major effort at job placement and retraining. We advocate that many of these displaced workers be deployed in expanded programs of public health, health promotion and education, and home care and as support personnel to free nurses for clinical tasks.

The Effect on Hospitals

Hospitals' revenues would become stable and predictable. More than half the current hospital bureaucracy would be eliminated,[1] and the remaining administrators could focus on facilitating clinical care and planning for future health needs.

The capital budget requests of hospitals would be weighed against other priorities for health care investment. Hospitals would neither grow because they were profitable nor fail because of unpaid bills — although regional health planning would undoubtedly mandate that some expand and others close or be put to other uses. Responsiveness to community needs, the quality of care, efficiency, and innovation would replace financial performance as the bottom line. The elimination of new for-profit investment would lead to a gradual conversion of proprietary hospitals to not-for-profit status.

The Effect on the Insurance Industry

The insurance industry would feel the greatest impact of this proposal. Private insurance firms would have no role in health care financing, since the public administration of insurance is more efficient[1,13] and single-source payment is the key to both equal access and cost control. Indeed, most of the extra funds needed to finance the expansion of care would come from eliminating the overhead and profits of insurance companies and abolishing the billing apparatus necessary to apportion costs among the various plans.

The Effect on Corporate America

Firms that now provide generous employee health benefits would realize savings, because their contribution to the national health program would be less than their current health insurance costs. For example, health care expenditures by Chrysler, currently $5,300 annually per employee,[14] would fall to about

$1,600, a figure calculated by dividing the total current U.S. spending on health by private employers by the total number of full-time-equivalent, nongovernment employees. Since most firms that compete in international markets would save money, the competitiveness of U.S. products would be enhanced. However, costs would increase for companies that do not now provide health benefits. The average health care costs for employers would be unchanged in the short run. In the long run, overall health costs would rise less steeply because of improved health planning and greater efficiency. The funding mechanism ultimately adopted would determine the corporate share of those costs.

Health Benefits and Financial Costs

There is ample evidence that removing financial barriers to health care encourages timely care and improves health. After Canada instituted a national health program, visits to physicians increased among patients with serious symptoms.[15] Mortality rates, which were higher than U.S. rates through the 1950s and early 1960s, fell below those in the United States.[16] In the Rand Health Insurance Experiment, free care reduced the annual risk of dying by 10 percent among the 25 percent of U.S. adults at highest risk.[3] Conversely, cuts in California's Medicaid program led to worsening health.[17] Strong circumstantial evidence links the poor U.S. record on infant mortality with inadequate access to prenatal care.[18]

We expect that the national health program would cause little change in the total costs of ambulatory and hospital care; savings on administration and billing (about 10 percent of current health spending[1]) would approximately offset the costs of expanded services.[19,20] Indeed, current low hospital-occupancy rates suggest that the additional care could be provided at low cost. Similarly, many physicians with empty appointment slots could take on more patients without added office, secretarial, or other overhead costs. However, the expansion of long-term care (under any system) would increase costs. The experience in Canada suggests that the increased demand for acute care would be modest after an initial surge[21,22] and that improvements in health planning[8] and cost containment made possible by single-source payment[9] would slow the escalation of health care costs. Vigilance would be needed to stem the regrowth of costly and intrusive bureaucracy.

Unsolved Problems

Our brief proposal leaves many vexing problems unsolved. Much detailed planning would be needed to ease dislocations during the implementation of the program. Neither the encouragement of preventive health care and healthful life styles nor improvements in occupational and environmental health would automatically follow from the institution of a national health program. Similarly, racial, linguistic, geographic, and other nonfinancial barriers to access would persist. The need for quality assurance and continuing medical education would be no less pressing. High medical school tuitions that skew specialty choices and discourage low-income applicants, the underrepresentation of minorities, the role of foreign medical graduates, and other issues in medical education would remain. Some patients would still seek inappropriate emergency care, and some physicians might still succumb to the temptation to increase their incomes by encouraging unneeded services. The malpractice crisis would be only partially ameliorated. The 25 percent of judgments now awarded for future medical costs would be eliminated, but our society would remain litigious, and legal and insurance fees would still consume about two thirds of all malpractice premiums.[23] Establishing research priorities and directing funds to high-quality investigations would be no easier. Much further work in the area of long-term care would be required. Regional health planning and capital allocation would make possible, but not ensure, the fair and efficient allocation of resources. Finally, although insurance coverage for patients with AIDS would be ensured, the need for expanded prevention and research and for new models of care would continue. Although all these problems would not be solved, a national health program would establish a framework for addressing them.

Political Prospects

Our proposal will undoubtedly encounter powerful opponents in the health insurance industry, firms that do not now provide health benefits to employees, and medical entrepreneurs. However, we also have allies. Most physicians (56 percent) support some form of national health program, although 74 percent are convinced that most other doctors oppose it.[24] Many of the largest corporations would enjoy substantial savings if our proposal were adopted. Most significant, the great majority of Americans support a universal, comprehensive, publicly administered national health program, as shown by virtually every opinion poll in the past 30 years.[25,26] Indeed, a 1986 referendum question in Massachusetts calling for a national health program was approved two to one, carrying all 39 cities and 307 of the 312 towns in the commonwealth.[27] If mobilized, such public conviction could override even the most strenuous private opposition.

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MEDICAL INTELLIGENCE

LAW–MEDICINE NOTES

LEGAL IMMUNITY FOR MEDICAL PEER-REVIEW PROGRAMS

New Policies Explored

WILLIAM J. CURRAN, J.D., LL.M., S.M.HYG.

THE past few years have seen extensive legal activity concerning the provision of immunity from liability, especially in antitrust suits, to physicians who take part in peer-review programs to monitor performance and to discipline fellow physicians in hospitals and other medical care organizations.

In previous decades, physicians were reluctant to participate in peer-review activities because they feared retaliatory lawsuits by disgruntled physicians who sued hospitals to gain reinstatement to medical staffs and, in more aggravated disputes, sued physician members of peer-review committees for libel or slander and sought financial awards for alleged disparagement of their professional reputations. These problems were serious enough. They often resulted in substantially weakening the resolve of medical-staff committees to recommend disciplinary action in any but the most severe situations.[1,2] Critics of physician-operated monitoring programs commonly pointed to the low percentage of cases in which recommendations for disciplinary action were made as evidence that physicians could not be trusted to police their own profession. Yet the same critics often opposed strong statutes at the state level to provide immunity and thus protect peer-review committees from vexatious, unfounded lawsuits.

These substantial fears on the part of physicians and hospitals involved in monitoring the performance of physicians were minor, however, as compared with the new fears created by the federal antitrust laws. Only a few years ago, the courts removed the exemption of the "learned professions," such as medicine, law, architecture, and dentistry, from the antitrust laws.[3] Lawyers for physicians who were the targets of disciplinary actions then called in specialists in antitrust law as consultants. These specialists brought entirely new doctrines to the field of medical-practice litigation. They dealt in concepts with far-reaching consequences that could result in very large damage awards in the courts.[4,5]

The essential problem of applying the antitrust laws to the operation of a medical staff at a medical facility is that these laws have a built-in bias against competitors' having the power and authority to limit or exclude business opportunities for other practitioners in the same field. Yet this is the very purpose of a medical-staff credentials committee. The result of denying permission to a new physician to practice in a hospital or limiting the privileges of doctors already on the hospital staff to perform certain clinical procedures has, by definition, the consequence of reducing business competition for the remaining medical-staff members.

The case that has brought this changing environment into the sharpest focus for physicians and medical organizations across the country is *Patrick* v. *Burget*,[6] which began in the small city of Astoria, Oregon, at a time when the controversy had taken various forms in a series of regulatory and legal forums for some years.[7,8] This case, discussed in another "Law–Medicine Notes" article[9] during the earlier stages of its progress through the courts, had its primary impact when the plaintiff, Dr. Patrick, won a verdict in the federal district court for violation of the Sherman Antitrust Act, sections 1 and 2. The finding was that the defendants had improperly restricted the plaintiff's opportunity to practice in Astoria. The activity found illegal was the conspiracy among the defendant physicians, particularly their refusal to refer patients to the plaintiff and their activities in the peer-review program at Columbia Memorial Hospital, the only hospital in Astoria. The defendants had been involved in a disciplinary action against Dr. Patrick at Columbia Memorial Hospital, in which they alleged that he had engaged in improper clinical practices that could endanger patients. The jury awarded Patrick $650,000 in damages — a figure that was trebled under the statute to $1.95 million; to this amount were added punitive damages of $90,000, another $20,000 in compensatory damages, and another $228,600 in attorneys' fees. The grand total of the award was a staggering $2.3 million.

National medical organizations pressed state legislatures and the U.S. Congress to broaden the often weak immunity laws concerning medical peer review to include more effective protection against antitrust liability. The most important result was the enactment at the federal level of a "medical shield law" called the Health Care and Quality Improvement Act of 1986. This legislation affords considerable protection to members of the medical staffs of hospitals and other medical facilities who act in good faith to monitor and discipline physicians for violations of quality-of-care and ethical standards. However, as pointed out in my earlier review,[9] the law contains a number of detailed requirements; if any of them is not met, immunity does not apply. Well-trained and experienced antitrust lawyers can be expected to test this law for weaknesses on behalf of clients who are disciplined and thus lose opportunities to practice (and compete) in medical facilities.

Because of the potential weaknesses of the new federal law, medical and hospital groups were greatly encouraged when the federal court of appeals reversed the trial court in the *Patrick* case and established a much stronger legal immunity for physicians and hospitals against antitrust suits. The appeals court's opinion provided immunity against claims that the federal antitrust laws had been violated under any circumstances, on the grounds that the actions of the members of the peer-review committee were in pursuit of policy clearly articulated in state law.[6]

The joy of the medical and hospital groups was short-lived, however. Quite rapidly, the U.S. Supreme Court accepted the *Patrick* case for review and, in a unanimous decision, reversed the opinion of the appeals court and reinstated the order of the district court, including the full award of more than $2 million to the plaintiff.[10]

The grounds for reversal were that the court of appeals had erroneously applied the "state-action" exemption to the activities of physicians on the hospital committee. The Supreme Court held that "state action" could not be found, because the committee's activities were not closely regulated and reviewed by any state agency and thus could not be considered an integral part of state regulatory policy.

The Supreme Court pointed to the fact that the Oregon regulations dealt only with the establishment of hospital committees and their mandated duties. The regulations did not set up a process for appealing such committees' actions to any state government agency. Also, appeals to the Oregon courts by physicians who were disciplined by hospital peer-review bodies were said to be quite circumscribed. The Court did, however, refuse to rule on whether a stronger, more substantive court-review system might provide an adequate basis for state supervision.

Justice Thurgood Marshall, after arriving at this conclusion, asserted that the Court was "not unmindful" of the argument that to uphold such liability, an admittedly heavy burden in this case, could strongly discourage physicians from participating in medical peer-review activities. The justice observed, however, that this circumstance was a problem of policy, to be resolved by the legislature, not the courts.

No later legislative effort can, of course, have any effect on the *Patrick* case itself. The verdict of the district court will stand. In congressional testimony, it was indicated that many, if not all, of the physician defendants were without adequate insurance protection. At least one of the defendants had 100 percent of his professional income attached after the verdict was passed down.[11]

The various medical and hospital organizations that submitted amicus curiae briefs in the *Patrick* case have some further thinking to do about how legislative action can help remedy the problems that the *Patrick* case now presents for legitimate, effective programs of quality assurance and malpractice-risk management. The suggestion of Justice Marshall that they seek state legislation establishing stricter, everyday supervision of hospital peer-review programs could be accepted,[12] but state review of each disciplinary action to determine whether the state agency agreed (on the merits of the evidence) with the action taken by the committee would be egregiously expensive and time-consuming. Moreover, it would constitute a substantial increase in governmental involvement in hospital operations. It seems doubtful that medical societies, hospital groups, or quality-assurance organizations will seek these changes at this time.

This complex situation has now been further confused by a new decision in another federal court of appeals, this time for the 11th Circuit, concerning an antitrust suit in Florida.[13] The physician in this case had been admitted to practice in three different hospitals for one-year probationary periods. In one of the hospitals, several problems allegedly occurred, and the credentials committee recommended that reappointment for another year be conditioned on the physician's agreement to seek psychiatric treatment under the state medical society's impaired-physician program. The physician refused to follow the recommendation, and the hospital later revoked the physician's privileges. The other two hospitals, once they were made aware of the action taken at the first hospital, examined the matter, and each took action to revoke the doctor's privileges to practice in that institution. Before the third hospital could complete the process, the physician brought action against all three hospitals and against several physicians on the credentials committee of each of the institutions. Not only did the doctor sue each hospital individually for the committees' actions under the antitrust laws (seeking treble damages), but he sued the hospitals as a group, alleging a "community conspiracy" to deprive him of his opportunity to practice anywhere in the area of Florida covered by the hospitals.

The court of appeals dismissed the antitrust actions against the hospitals individually on the basis of a "state-action" immunity similar to that applied by the intermediate court in the *Patrick* case. It held that the Supreme Court's opinion did not prevent this ruling because the Florida court system's examination of peer-review decisions in hospitals was broad enough and substantive enough to constitute adequate state supervision. As noted earlier, the Supreme Court had specifically left this question open. In the *Bolt* decision, the Court had observed that "a state may choose to regulate private economic activity through a state agency; it may just as readily choose to regulate such activity through its courts. Indeed, regulation through the judiciary may be more likely to ensure accurate implementation of the state's policy, for courts are especially well suited to divine, interpret, and enforce legislative policy."[13]

The court in this latest case left several factual and procedural questions open when it allowed a trial on the allegation of the plaintiff that the three hospitals had acted in concert without independent deliberation

— that is, that there was a "community conspiracy" violating the plaintiff's right to practice. Nevertheless, this decision is likely to please medical and hospital organizations. These groups will generally be more satisfied with court examination and supervision of peer-review committees' monitoring and disciplinary procedures than with much more intrusive state-agency regulatory systems.

We have undoubtedly not seen the end of litigation and remedial legislation in this field. If anything, the confusion at present is worse than it was a year ago. Nevertheless, the confusion presents an opportunity for some imaginative policy solutions. The medical peer-review process must have better legal protection than it now has. Otherwise, the process may lose its significance as a mechanism for monitoring, excluding, and disciplining physicians. Standards of high-quality medical care can be endangered by a weakened system of medical peer review. State legislatures and the Congress agree that effective medical peer-review systems are in the public interest. It is necessary now for the interested parties to develop cooperative plans in order to establish a reasonable, consistent immunity protection for good-faith efforts made in medical peer-review programs.

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Can You Afford to Get Sick?

As costs soar, cutbacks in health benefits create a new corporate battleground

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If you and your employer haven't already had a little talk about medical coverage, you will—soon. The results of the discussion may shape your financial future and could affect your health.

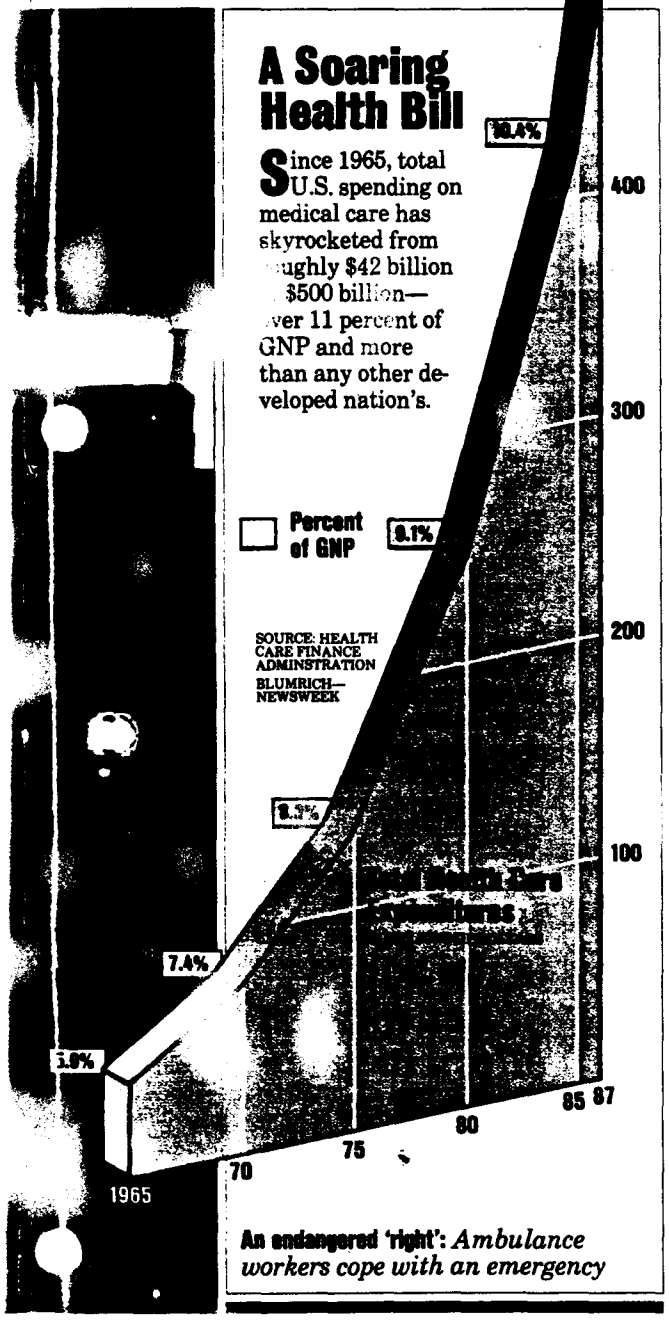
Consider the case of Sammie Harbour. Ever since childhood, the Seattle resident has suffered from sickle-cell anemia, the life-threatening blood disorder. Now 27, Harbour has been in and out of hospitals, survived potentially fatal sickle-cell "crises" and undergone more than 100 costly transfusions. In 1987 he got a new job as a computer operator for Computer Sciences Corp., a California-based computer-services firm. Harbour could afford medical coverage only under the firm's health-maintenance organization (HMO)—a plan that provides comprehensive medical care at a fixed price to the company. The HMO told Harbour it wouldn't pay for him to see the physicians he had consulted since childhood. Forced to choose between a job he liked and doctors he trusted, Harbour quit and joined another company with a better health plan. "In my old job I had to call the insurance company every time I made a move," he says. "[Changing employers] was the only way I could survive."

If Harbour felt bad about his departure, so did his bosses. "We lost a good employee," says Jim Burlong, a spokesman for CSC. But the company says it's had no choice but to introduce cost-saving measures like the HMO and a 20 percent hike in employee contributions to its medical plans. Over the past few years, the firm has seen the price of providing health care to its workers go through the roof. In 1988 alone, the company's health-insurance bill rose by a whopping 30 percent.

Call it the fourth inalienable right. Along with life, liberty and the pursuit of happiness, working Americans have come to expect that an honest job will come with full medical insurance. Now soaring medical costs threaten to change all that. In the past 20 years the overall cost of health care in the United States has skyrocketed from about $50 billion to more than $500 billion (chart). The low inflation of the Reagan era hasn't stopped the spiral: in some states the cost of insuring a family of four has risen by about 400 percent since 1980, says Ellen Kaplan, an insurance consultant in Framingham, Mass. If the trend continues, some experts say, companies will simply no longer be able to provide ordinary Americans with adequate care. "By the year 2000," says former secretary of health, education and welfare Joseph Califano, now a health-care consultant to large corporations, "the only person in the United States who can afford to get sick will be Donald Trump."

The crunch has turned the issue of health-care benefits into a corporate battleground. Struggling to contain costs, companies are hiking employee premiums, hiring "health management" consultants to second-guess doctors and sending workers to "physician networks." Some firms have stopped paying for certain types of workers—and certain kinds of treatment. The threat to the bottom line is so great that a proposed new accounting rule would force companies to report the potential cost of covering current and future retirees on their balance sheets. When the rule is approved, the pressure for savings will only intensify. Before the end of 1990, predicts a report released last month by the Health Insurance Association of America and Johns Hopkins University, corporations will have to absorb another double-digit increase in health-insurance premiums. Employers face a "year of bitter medicine," the report concludes.

Corporations are cutting back just as federally sponsored health-care programs have come under the scalpel. The government has tightened its payments to hospitals under the Medicare programs and boosted premiums for care outside hospitals. It has also slapped a surtax on wealthy senior citizens to help pay for a new cata-



An endangered 'right': *Ambulance workers cope with an emergency*

RICH FRISHMAN

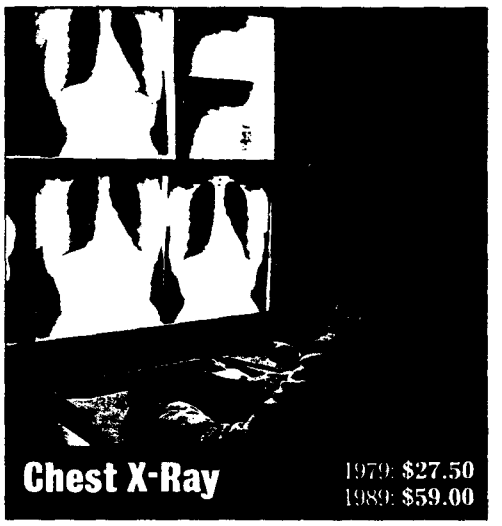
In my old job I had to call the insurance company every time I made a move. [Changing employers] was the only way I could survive.

—Sammie Harbour, Sick Worker

A Sharp Pain in the Wallet

An aging population, malpractice suits and fierce competition for new technology have all added to the rising cost of medical treatment. In a midsize city like Seattle, Wash., prices for chest X-rays, Caesarean sections, coronary-bypass surgery and dentures have all roughly doubled.

ESTIMATES FOR SEATTLE AREA FROM KING COUNTY MEDICAL BLUE SHIELD



Chest X-Ray 1979: $27.50 1989: $59.00

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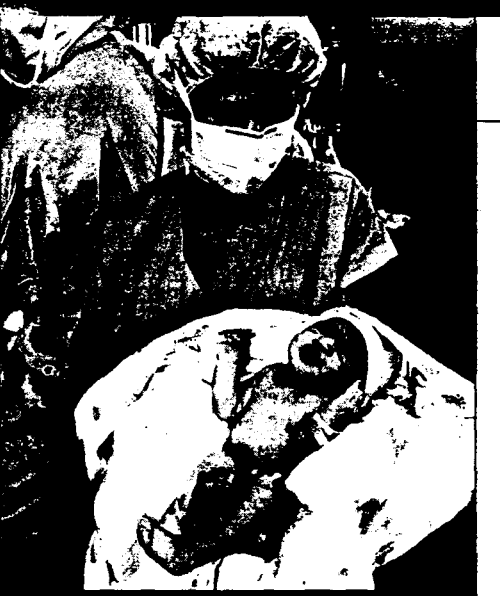


Caesarean Section 1979: $5,010 1989: $10,900

© DAVID YORK—MEDICHROME

strophic-health-insurance plan. Not even the very poor have been spared. In some states, coverage under Medicaid—a joint federal-state program—has eroded to the point where a family of four with an annual income of more than $4,248 is no longer eligible for benefits. With the Bush administration vowing to cut the budget deficit without raising taxes, still more cuts in federal medical spending seem inevitable.

As many as 37 million working Americans—many self-employed or working for small businesses—have been left without any health insurance at all. Mark and Pascale White run a small woodworking company in Boxboro, Mass. Last year the Whites found themselves without coverage after Pascale became pregnant and their insurance company, Golden Rule, canceled their company's group policy. After Mark White wrote to senators, representatives and the local paper, Golden Rule agreed to reinstate the coverage—but at three times what the couple paid for their old policy. (Golden Rule says the cancellation of the Whites' policy resulted from a reshuffling of its Massachusetts operations after the state denied the company's request for a rate increase.) The Whites eventually bought coverage from another insurer, but the only affordable policy they could find didn't cover the $1,400 tab for the baby's hospital care. Still, they consider themselves lucky. "Pregnancy has a beginning and an end," says Mark White. "God forbid anyone has any serious problems."

Cost consciousness hasn't only caused pain. In some cases it has helped improve prevention—by pushing companies to do more health screenings, fund prenatal care and adopt employee "wellness" programs (page 51). But in other cases, a growing number of doctors and health experts worry, the cutbacks may be affecting the quality of medical care (page 48). Dr. Derace Schaffer, chief of radiology at the Genesee Hospital in Rochester, N.Y., says managed-care plans, with their endless stream of permission forms, has doctors "drowning in paperwork." More important, he believes the system pressures them to give less than optimal care. "It doesn't matter what is good for patients," Schaffer says. "Financial dictates are increasingly mandating how patients are cared for, regardless of the clinical situation."

With no end to the cost spiral in sight, respected specialists are beginning to question whether the current, patchwork system of public and privately funded medical coverage can work anymore. Last week the National Academy of Science's Institute of Medicine approved plans to examine the crisis in employer-sponsored health insurance. In two recent issues of the influential New England Journal of Medicine, a Stanford economist and a group of respected physicians argue for a nationwide health-care program that would mesh public and private efforts. Any such move is sure to draw strong opposition from many companies, doctors' groups like the American Medical Association and conservatives who would see it as a step toward socialized medicine. But Journal editor Dr. Arnold Relman strongly endorses the need for more action. "When we try everything and it fails and we're forced to confront reality," he says, "we're going to have to have a systematic plan."

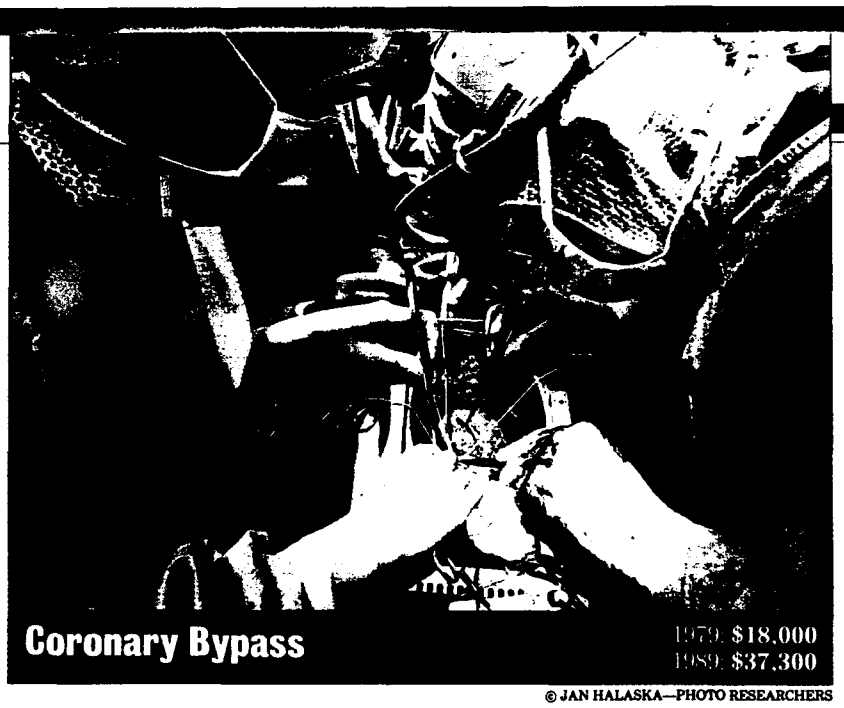
ARTHUR GRACE—NEWSWEEK

The causes of the crisis: What's behind the health-insurance spiral? As Americans live longer, they are consuming more and more medical services. Across all demographic groups, demands have increased for quality health care and state-of-the-art treatment. Says Jack Owen, executive vice president of the American Hospital Association: "People expect a lot more than the system can deliver." The AIDS epidemic has put an added burden on the system. In 1991, medical costs for new AIDS cases alone could approach $6 billion.

Increased legal action has run up the tab. Malpractice suits are now routinely

By the year 2000, the only person in the United States who can afford to get sick will be Donald Trump.

—Joseph Califano
Health Consultant



Coronary Bypass 1979: $18,000 1989: $37,300

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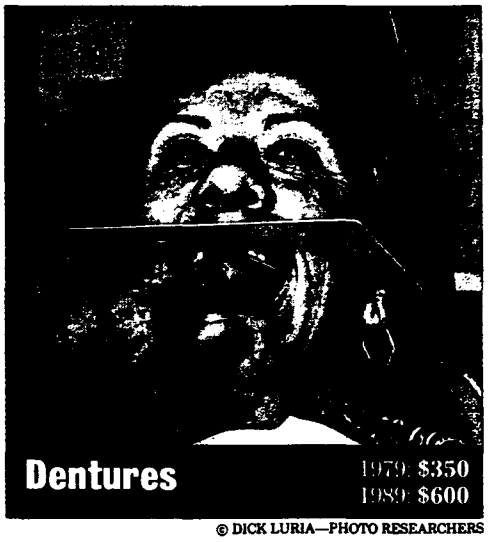


Dentures 1979: $350 1989: $600

© DICK LURIA—PHOTO RESEARCHERS

filed for everything from allegedly faulty diagnoses to mishandled child deliveries. Malpractice premiums have soared to cover the possibility of court battles, and physicians pass along those added costs in higher fees. "Defensive medicine" aimed at reducing vulnerability to lawsuits has brought a sharp increase in procedures that some consumer advocates think are unnecessary. Dr. Sidney Wolfe, head of Ralph Nader's Health Research Group, cites Caesarean sections, coronary bypasses and carotid-artery surgery. "Cutting back [on these procedures] would save money, provide better care and reduce death," Wolfe says.

Technology has contributed to the runaway costs. Lifesaving—but enormously expensive—equipment such as CAT scanners have revolutionized medical care. They have also become objects of intense competition. If a new machine or procedure is likely to attract top doctors and new patients, every hospital in town wants one.

Some experts wonder whether emphasis on state-of-the-art care is always worth it. Take the recent introduction of nonionic contrast material into radiology. The substance, a dye injected into the bloodstream that makes organs show up on an X-ray, is somewhat safer for patients than the dye that has been used for years. It carries a mortality risk of 1 in 250,000, compared with 1 in 30,000 for the old dye. (Patients most at risk are the elderly or people with cardiac problems or specific allergies.) For that small new difference, the nonionic material costs roughly 10 times as much as the ionic kind. If used routinely, it could add as much as $1 billion annually to the nation's health-care budget. Still, doctors say they have no choice but to use the new dye. "What is the attorney going to say to me if I use ionic contrast and the patient dies of a reaction to it?" asks radiologist Schaffer. "He's going to say, 'Doctor, don't you know that you could have used a nonionic contrast material?' Society hasn't addressed the cost-benefit issues of modern medicine, so I continue to do anything I can to benefit the patient."

Prices are driven even higher by what some call "the Pentagon effect" in the medical-supply industry. "You go into the hospital and you wonder why the TV screen labeled a medical TV screen costs $3,000, instead of $250 like the one down at Radio Shack," says Schaffer. Some point a finger at the monopolistic atmosphere and steadily growing profit margins in the drug and medical-equipment business. Bernstein Research, a securities-research firm that covers the industry, says medical-supply companies are expected to grow by an annual rate of 14 to 16 percent.

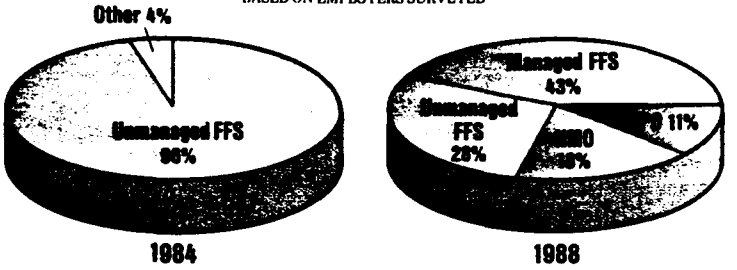
For years a Robin Hood ethic has also prevailed in the American health-care

Say Goodbye to the Age of Free Rides

A 1984 employer survey reported that 96 percent of insured workers were enrolled in traditional health plans. As of 1988, only 28 percent were.

Types of Group Health Plans

BASED ON EMPLOYERS SURVEYED



Unmanaged Fee for Service: Old-fashioned coverage that allows workers to choose their own doctors and get reimbursed for all or part of whatever physicians and hospitals charge

Managed Fee for Service: Like the old plans, but keeps tabs on utilization by, for example, requiring prior approval for some hospital admissions

Health Maintenance Organization (HMO): Companies hired for a fixed overall fee to provide medical care for employees. Workers are covered only for treatment approved by the HMO.

Preferred Provider Organization (PPO): A group of medical personnel who contract to furnish services at discounted prices in return for prompt payment and a certain number of patients. Employees must choose doctors from the list.

SOURCE: HEALTH INSURANCE ASSOCIATION OF AMERICA BLUMRICH—NEWSWEEK

system. Taking from the rich (those covered by private-insurance policies) to give to the poor (the under- and uninsured) has become the accepted norm. To finance care for the nation's 37 million uninsured—who tend to come into the hospital through the emergency room—doctors and hospitals inflate the bills they send to privately insured patients. In recent years tighter insurance-company restrictions have made that process more difficult. But it is still widespread. Hewitt Associates, a benefits-consulting firm in Chicago, estimates that "cost shifting" is responsible for one third of the yearly increase in some companies' medical bills.

The squeeze on benefits: Handed the bill for these new costs, corporate America has flinched. As recently as 1984, 96 percent of insured U.S. workers were covered by company-health plans that let them choose how to spend their medical dollars, then reimbursed them for all or most of those costs. Now only 28 percent of workers enjoy such plans. The rest have had to swallow new programs that restrict coverage, scrutinize medical forms or specify which doctors they can see (page 47). The J.C. Penney company used to offer insurance coverage to both employees and their spouses. Now it will cover the spouse only if the employee is the principal wage earner in the family. First Interstate Bancorp will soon require employees who don't go to doctors on an approved list to pay a greater share of the cost. The Digital Equipment Co. in Maynard, Mass., recently hired a cost-management firm to review employees' hospital reports and recommend ways to limit care. Says benefits manager Ed Brady: "Costs were rising, and there

Costs Vs. Quality of Care: Tracking the Side Effects

A disturbing question with no easy answers

Have the aggressive efforts to cut costs hurt the quality of medical care? The question haunts physicians and corporate penny pinchers alike, and it will dominate the debate over reforming the nation's health-care system for years. But the unsettling answer is that nobody knows for sure—in part because nobody can agree on what "quality" means. "To the patient, it means getting out better than when he went in," says Jack Owen, executive vice president of the American Hospital Association. "To the physician, it means to save a life and no infection. To an administrator, it means no malpractice. To an insurer, it's 'What's the cost?' "

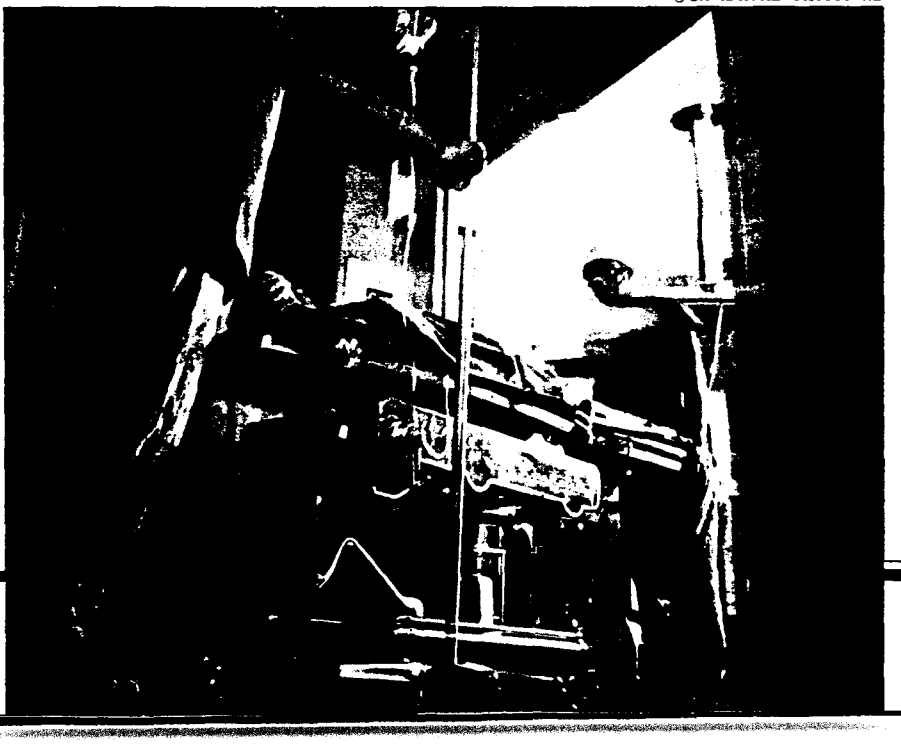
In America, *quality* care has traditionally meant *more* care—"doing everything scientifically possible for everybody, every day, all the time," says the American Medical Association's Dr. James Todd. But even before the explosion in costs, experts were raising doubts about how many of those tests and treatments were actually necessary and effective, and how many only prolonged a patient's agony—or worse, inflicted new ills. After an exhaustive review of the medical literature and consultations with physicians, Dr. Robert Brook, deputy director of the Rand Corp.'s health program, concluded that some 40 percent of coronary bypass operations are questionable, as are 33 percent of carotid-artery surgeries and 25 percent of endoscopies. Based on those findings, Brook says: "A whole chunk of what we do could be safely eliminated."

When they get down to individual cases, physicians invariably differ on which procedures are worthwhile and which are excessive. Patients are even more in the dark, and many have unrealistic expectations. The wide range of cost-containment measures themselves have had bizarre, sometimes contradictory effects on how health care is delivered. Some 300 hospitals closed in the last four years, mostly in rural areas. Yet some of the patients they served may arguably fare better by taking helicopters to larger, urban hospitals with more specialized services. Insurance cutbacks have helped swell the number of Americans with little or no coverage to as many as 37 million. But that does not mean they necessarily go without medical attention. Many are treated at public clinics; others are "absorbed" in health facilities by creative bookkeeping.

In general, researchers have found strong evidence that the more restrictive a health-insurance plan is, the less medical services its recipients receive. But analysts have been hard pressed to document whether those people end up any sicker as a result. One possible exception is a study published last fall in the New England Journal of Medicine. It found that Medicare patients with hip fractures were discharged from hospitals sooner and were more likely to end up in nursing homes after the introduction of "prospective-payment systems." (Such plans allocate fixed prepaid sums to hospitals for patients' care and allow hospitals to profit if overall care costs less.) Alarmingly, patients were also 200 percent more likely to still be in a nursing home a year later, "exposing the Achilles' heel of PPS," according to Dr. John Fitzgerald of the University of Indiana School of Medicine.

Even while they struggle to define "quality," medical experts are increasing-

Pressures to hold down expensive treatment and hospital stays: *Outside an operating room*



was a feeling there wasn't any control."

The new watchword for benefits officers like Brady is "managed care." The term can refer to prepaid health-care plans like HMO's and preferred provider organizations (PPO's). It also covers the use of "utilization management" companies employed to monitor doctors' decisions (NEWSWEEK, May 23, 1988). So far, the only large employer to wage a nationwide managed-care offensive is New Jersey-based Allied-Signal Corp. Under its system, Allied contracts with Cigna Corp., which promises it fixed medical costs for three years. Employees are automatically enrolled in Cigna's extensive HMO network, where they receive virtually free treatment. Unlike most HMO's, employees may opt out of the network at any time, but their reimbursement is substantially reduced. Besides Allied, corporate giants like Southwestern Bell and Prudential have launched managed-care plans.

Big companies aren't alone in cutting back. Frank Foster, chairman of Diagonal Data Corp. in Lakeland, Fla., has only 90 employees. But, he says, "the rise in what it costs us to provide health care for our employees has been brutal. It just keeps going up." Diagonal, a computerized maintenance-management firm that Foster founded in 1982, used to give its workers "first dollar," or 100 percent coverage for all outpatient services. After the cost of its corporate-insurance policy rose 22 percent, Diagonal cut back to only 80 percent coverage. It also made the first day's room and board in a hospital deductible. While the restrictions are still modest compared with some other firms, Diagonal benefits manager Sally Goshen worries about the effect they could have on corporate recruiting.

ly being asked to weigh the more illusive notion of "value" as well. Inevitably, that leads to further imponderables—including assigning a worth to human life. Duke University medical economist David Eddy touched off a storm last year when he suggested that routine mammograms might not be worthwhile. Annual exams do prevent roughly 20 deaths among every 10,000 women tested over a 10-year period. But they also have a high false-positive rate, and if all women were tested annually, the cost would be about $1 billion a year. "The way we've done it in the past is to say, if there's any benefit at all, let's ignore the costs and do it," says Eddy. "We need to explicitly examine the pros and cons, and give priority to practices that yield the most benefit given the resources they consume."

Massive efforts are under way to try to do just that. Virtually every major health-care organization is establishing better guidelines for what constitutes "appropriate" care. Belatedly, doctors are joining in. In one of the biggest projects, Rand and the AMA are developing "practice protocols," incorporating reams of data on what treatments have proven most effective, for which patients, over long and short periods. Rand's Brook hopes to make that information available to doctors and patients on portable computer systems, allowing both to make more intelligent choices. AMA's Todd thinks that will ultimately help doctors cut costs—"based on scientific, medical knowledge, rather than economic expediency."

Only hope: Such systems are several years away from completion. In the meantime, many physicians insist that the imperative to control costs is shaping too many medical decisions. Consider the case of Lu Anne Washburn, 26, of Milwaukee, who discovered last year that she is dying from a rare disease called primary pulmonary hypertension. Her HMO has refused to pay for the drug therapy that has temporarily extended her life, or the $90,000 heart-lung transplant doctors say she desperately needs, because the Medicare guidelines it follows consider such treatments "experimental." With the transplant, doctors say Washburn has a 50 percent chance of surviving for one year and a 25 percent chance of holding on each year after that. Without it, her chances drop to zero. Her only hope may be to fight her HMO in the courts—provided she lives long enough to hear a verdict.

HANK MORGAN

Financial dictates are increasingly mandating how patients are cared for, regardless of the clinical situation.

—Dr. Derace Schaffer
Radiologist

Doctors also complain that the prospective-payment systems in many HMO's give them a dangerous incentive to undertreat patients. For Dr. G. Scott Stevens, a Seattle family practitioner, the reality hit home the day an HMO patient, a recovering alcoholic fighting temptation to drink, came for permission to see a former counselor again. The additional care would cost Stevens as much as $800. "Wouldn't I rather take that money home to my family?" he asked himself. Ultimately, Stevens made the referral. The patient recovered, went to medical school and is now a practicing physician. "But I actually had to think hard about it," Stevens said. In the end, he dropped out of the HMO.

'Cookbook' treatment: Some experts believe that these dilemmas will be eased by efforts to better quantify what treatments are appropriate. Such studies might also reduce the time doctors now spend arguing with professional second-guessers. But some physicians fear that more quantification will also bring more paperwork, more vexing "national averages" to meet and more arbitrary "cookbook" approaches that ignore the circumstances of individual patients. "Doctors have to make social decisions as well as medical decisions," says radiologist Dr. Derace Schaffer of Rochester, N.Y. "But that's not factored into the data."

By now, cost-control experts are tired of hearing that the "art" of medicine can't be judged, or at least tempered, by scientific principles. With costs spiraling inexorably upward, the health-care profession has reached a critical juncture, says Dr. Philip Caper, a Dartmouth Medical School professor and president of the Codman Research Group. "Either medicine will organize itself and motivate members to deal with these issues," Caper says, "or they will be led by the purchasers." It may be impossible to say whether that will hurt medical care, but it will certainly make it more of a gamble.

MELINDA BECK *with* MARY HAGER *in Washington and* ELIZABETH BRADBURN *and* LISA DREW *in New York*

The rise in what it costs us to provide health care for our employees has been brutal. It just keeps going up.

—Frank Foster
Company Chairman

CHARLES LEDFORD

ment. "We have to have good group-insurance benefits in order to be competitive," Goshen says.

In employee-owned firms, health-insurance problems can pack a double whammy. When Florida Home Builders Health Benefit Trust, the largest self-insurance fund in Florida, notified members that it would no longer cover claims, it left Siegfried Plumbing, a three-employee firm based in Riviera Beach, Fla., without major medical insurance. The company, owned by Kimberly and Tom Siegfried, was faced with a financial nightmare. Because two of the couple's three children were once diagnosed as having a seizure disorder, insurers turned them down flat for coverage. The couple finally got a policy—but their annual premium will soon increase to almost $6,000 per year. That, says Kimberly Siegfried, "could be enough to throw us into the red."

Trimming benefits isn't the only way employers are holding down costs. Increasingly, firms are searching for ways to keep some workers off the benefit wagon entirely. As of last month, Iliff Thorn, a real-estate company in Phoenix, Ariz., will no longer accept salespeople into its group-insurance plan. The company adopted the measure after watching its insurance rates rise 30 percent in 1987 and an additional 50 percent in 1988. Saleswoman Janine Watson's reaction was that of many of today's uninsured. She simply decided to take the chance of going without coverage at all. "I'm betting against the odds that I won't get sick," Watson says. "If something horrible went wrong and I had to go into the hospital, I wouldn't be able to pay the bills."

Some workers have found that even having insurance is no guarantee. Gary Frantz, a San Francisco artist, purchased a policy from Coastal Insurance Co. in 1985 specifically written to cover medical expenses incurred from AIDS. When he died of AIDS in November 1987, the Santa Monica insurance company still hadn't paid him a penny. Frantz, who instructed his attorney to continue fighting the insurer after his death, was vindicated early this month when Coastal agreed to settle the case by paying an undisclosed amount of money to six AIDS organizations. Coastal says the settlement was not an admission of liability.

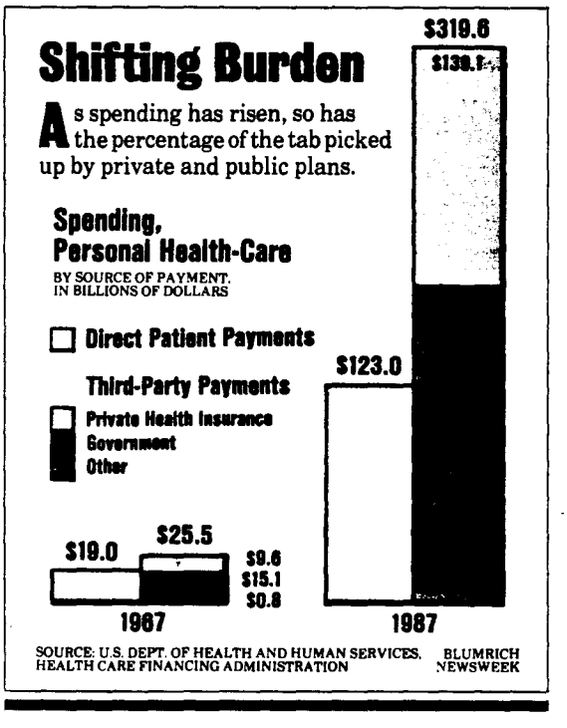
The outlook for the future: With workers and policyholders beginning to prevail in some health-insurance battles, corporate America is already drafting its strategies for the future. By the next century, almost all companies will have switched to managed care. An article in last week's issue of Modern Healthcare magazine estimates that within the next 10 years, up to 80 percent of the insured population will be enrolled in HMO's and PPO's. The shift will demand a fundamental change in the way society thinks about medicine—a change some industry experts believe may be for the better. Says Willis Goldbeck, head of the Washington Business Group on Health and a proponent of managed care: "People have to give up this free-choice nonsense and buy care from people who are willing to be held accountable. High quality and cost efficiency go hand in hand."

Many may consider instituting "cafeteria style" health-benefits plans, where employees are allowed to select from a menu of choices. Workers at Steelcase Inc., in Grand Rapids, Mich., can choose from eight medical plans, three dental options and various forms of disability plans. Employees with money left over can put it in tax-free accounts to cover out-of-pocket health care or off-site day care. The plan stipulates that as health-care costs go up, benefit dollars will increase only 80 percent as quickly. The result: the company has built-in protection from inflation.

The proposed new accounting rules would force companies to show shareholders the long-term costs of providing medical coverage. The measure, which has already been recommended by the influential Financial Accounting Standards Board, would put a big dent in earnings statements, and force a significant number of firms into paper bankruptcy. To balance the books, companies may have to cut health-benefit costs even further, or at least make them more predictable. Many are likely to shift to "defined contribution" plans, where coverage is limited to a fixed amount per employee, or per procedure.

Corporate cost containment has already spawned innovations in health-care delivery. A new genre of facilities is being pioneered in California. Called recovery-care centers, they offer patients an alternative to hospitalization. The centers, which provide medical services for up to three days following surgery, look more like hotels than hospitals. They offer gourmet meals, private rooms and TV sets with VCR's. The philosophy behind the center is simple: contentment hastens healing. With all the amenities, it costs $300 a day—less than at most hospitals.

The environment in which doctors work may prove less appealing. "It used to be that you'd wander into the lunchroom and people would be talking about cases," says Dr. Ted Barnett, a young radiologist in Penn Yan, N.Y. "Now they're talking about what the HMO's are doing to them." Doctors will have to sit still for more administrative tasks such as filling out approval forms and justifying their practice habits to outside cost monitors. Most of this review process will be invisible to patients. Already, "there's a huge conspiracy of silence, if not lying, to keep information from the patient,"



says Dr. William Phillips, a private family practitioner in Seattle. "All these things are going on about them, and they don't know it."

Proposals for change focus on the need to coordinate the scattering of private and public plans. Stanford health economist Alain Enthoven outlines a "Consumer-Choice Health Plan for the 1990s" in the Jan. 5 issue of the New England Journal of Medicine. Under Enthoven's system, qualified managed-care companies would compete for corporate and government contracts at the state level. Employers would be required to cover all full-time employees and pay an 8 percent payroll tax for each uncovered worker. Employers who offer no coverage at all would have to pay extra income taxes.

In the same issue of the NEJM, a group called Physicians for a National Health Program sketches another blueprint for reform. Their program would provide necessary medical care through public insurance administered by state and regional boards. Under the physicians' plan, which is similar to the Canadian national health system, patients would carry cards entitling them to care at any hospital or doctor's office. They would not be billed for approved care, nor would they have to worry about deductibles, copayments or out-of-pocket costs.

As corporate managers and policymakers grope for ways to ease the crisis in medical costs, these plans and others like them will receive increasing attention. In the meantime, the battle over benefits is sure to escalate. In the end, the solution may have less to do with limiting health care than persuading everyone to accept a greater share of the burden. Says Dr. James Sammons, executive vice president of the American Medical Association in Chicago: "People are going to have to come to grips with the fact that everyone is going to have to hurt a little." In a nation that views health care as a right, not a privilege, that medicine may not go down easy.

ANNETTA MILLER *with* ELIZABETH BRADBURN *in New York,* MARY HAGER *in Washington,* KATE ROBINS *in Boston,* BETSY ROBERTS *in Miami and* JUDY HOWARD *in San Francisco*

'Wellness' Plans: An Ounce of Prevention

Quaker Oats Co. has decided that keeping its employees healthy is the right thing to do—for its bottom line. As part of its health plan, the Chicago-based company offers workers the means to keep fit, tips on cutting medical costs and something more: cash bonuses to employees who stay healthy. Kathy Kahn likes that. Kahn is one of 10,000 Quaker Oats employees who received bonuses averaging $150 in 1987—as rewards for helping the company keep its annual rise in health costs to just over 5 percent. "With this plan," she says, "I feel I have a certain amount of control over my health benefits."

With so much of corporate America grumbling about the cost of a pound of cure, a growing number of companies are paying for an ounce of prevention. Two out of three firms with 50 employees or more now offer some health-promotion activity, according to a new study published in the American Journal of Public Health. Many plans still only help workers quit smoking or lose weight. But others have begun to take a more aggressive approach. Worried about the skyrocketing cost of premature births, appliance maker Sunbeam Corp. started a mandatory prenatal course that has slashed the average cost per baby by nearly 90 percent. The course offers advice on proper nutrition and warns of the dangers of smoking, drinking and taking drugs. As the insurance crunch gets worse, predicts Curtis Wilbur, director of employer marketing for Johnson & Johnson Health Management Inc., "wellness" programs "increasingly will be seen as an important part of an overall corporate strategy to contain runaway health-care costs."

DAVID WALBERG

An on-site gym and medical-spending tips: *Quaker Oats employees*

At Quaker, financial necessity was the mother of innovation. In the early 1980s the company's health-care costs jumped between 20 and 30 percent a year. Executives decided the best response was to keep more workers healthy. They installed a fitness center in Quaker's headquarters. They introduced a program to teach employees ways of maximizing return on their health-care dollars. Tips include how to avoid risky or unnecessary surgery and how to reduce hospital stays. Before the program began, the company saw an average of 769 hospital days logged each year for every 1,000 employees. That figure was cut to 325 last year, a 58 percent reduction.

Quaker also began offering "dividend incentives" to employees who stay well. Each year the company budgets a medical "expense account" for each worker. If an employee doesn't use his full allotment, he gets a refund. Says employee-benefits director Robert Penzkover, "It means that if you stay healthy you're still going to get something out of the plan. You're not just tossing money in to take care of fellow employees who smoke and drink too much."

Aerobics classes: Companies that don't want to develop their own wellness programs are contracting out. Johnson & Johnson's Live for Life plan worked so well in-house that it now sells the program to other firms. One client is Saatchi & Saatchi, the advertising giant. Johnson & Johnson's Health Management subsidiary built an on-site health club at Saatchi's New York headquarters. Employees pay between $10 and $20 a month for aerobics classes, exercise machines and health seminars. One study of the Live for Life program by the Leonard Davis Institute of Health Economics at the University of Pennsylvania's Wharton School found that it could save companies more than 40 percent in hospitalization costs. Of course, no amount of Exercycling will keep all employees from getting sick. But wellness is proving one benefit that pays the company back—with fitter employees and a trimmer insurance budget.

JOHN SCHWARTZ *with* TIM PADGETT *in Chicago*

Financing Long-Term Care

The choice: better insurance or more taxes

BY JANE BRYANT QUINN

Of all the medical-spending issues facing Americans, long-term health care most deeply troubles the heart. It's the flip side of the gift of longer life spans. Older people tremble at the thought of drifting into years of helplessness. Their children shop frantically for home-care services and nursing homes. The bill is huge, often taking all of a senior's savings.

Polls of public opinion say "there oughtta be a law." And indeed, our elected representatives have proposed nearly 100 of them. The sticking point is who should pay.

Contrary to a lot of the rhetoric you hear, America *does* have taxpayer-financed nursing-home insurance. It's called Medicaid. Seniors pay their own way in the nursing home until their income and assets almost run out. After that, Medicaid covers their bills. So the problem isn't that the aged lack a safety net. It's that they don't want to spend their own savings first.

That's reasonable for married couples, where a wife can be impoverished by the cost of her husband's care. The new 1988 catastrophic health-insurance law provides more money for the spouse at home.

But many seniors have a further desire, which—in my judgment—should *not* be a trigger for public action. They want to leave more of their money to their children. To this end, they're pushing for a taxpayer-funded nursing-home program that will let them keep much of their personal savings intact.

As it is, many seniors preserve their assets by playing games with the Medicaid rules. They give away their property to their kids, to make themselves artificially "poor." Then, claiming indigence, they turn to the taxpayers for help.

In many states, these "new poor" aren't supposed to get aid right away. But almost anyone with a smart adviser can duck through a loophole and collect.

Even accounting for these ploys, private savings still covered 51 percent of the nursing-home bill in 1986, to the tune of $19.4 billion. If seniors are relieved of a substantial part of that obligation, taxpayers will have to fill the gap. Here's what's being discussed:

■ *A comprehensive federal program.* A plan devised by InterStudy, a health-care think tank in Excelsior, Minn., would sweep Medicaid's nursing-home benefits into Medicare. Seniors could also get health care and other help at home, with all services depending on special doctor approval. To finance this $50 billion wish list, InterStudy would take an extra $30 a month from high-income Medicare beneficiaries and add a 4.6 percent surcharge to your income tax. It would also charge nursing-home residents a portion of their incomes (but not assets) and raise estate taxes. That's just for starters—because no one knows what long-term health care will really cost. Are Americans willing to pay?

■ *A federal home-health program.* While Medicaid finances nursing-home care, not much money is spent helping seniors stay at home. But demand for "free" home care could be enormous. Rep. Claude Pepper's home-health bill, killed last year by Congress, carried a five-year price tag of $30 billion—all financed by higher social-security taxes.

■ *Expanded private insurance.* As a business, nursing-home insurance is in its infancy. Insurers don't know how to price the product because they haven't a clue as to what the claims will be. Most of the policies sold last year had so many restrictions that anyone entering a nursing home had only four chances in 10 of collecting on their coverage, according to a study by the United Seniors Health Cooperative in Washington, D.C. If you need care just because you're frail and confused, your policy might not pay. Often, coverage is triggered only by a hospital stay. Newer policies are more generous, but they don't come cheap.

■ *A government/private mix.* Some promising experiments are being funded by the Robert Wood Johnson Foundation, which supports research on health-care issues. For example, California and Massachusetts are looking at ways to provide private insurance at prices low-income seniors can afford.

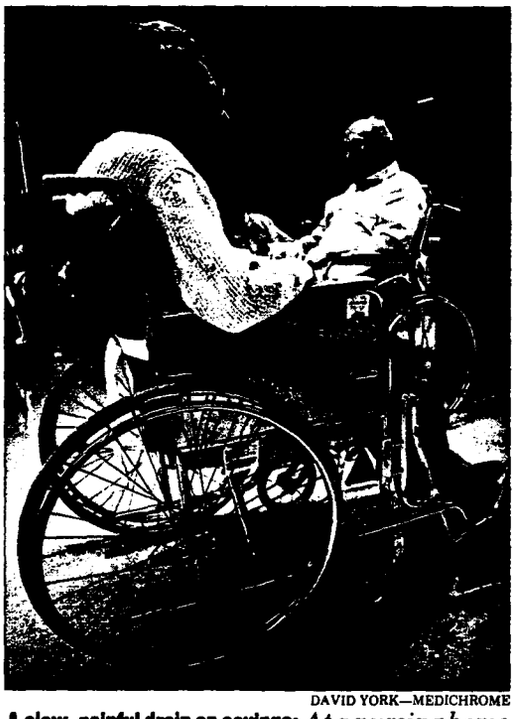
Whether to buy nursing-home insurance depends on your age. If you're under 60, don't. You'll find better coverage in the future. Consider it only if it's offered by your employer, where group premiums might be 30 percent less.

But by the age of 65, insurance is a good buy for people with assets to protect. You'll pay around $675 a year for a typical policy, compared with $2,100 at 79.

If you do buy, don't sign on the strength of the sales literature (which might waffle) and the agent's pitch. Read the policy itself. You want (1) all coverage to apply without your having to be in a hospital or skilled-nursing facility first; (2) to buy inflation protection. Today's policies might pay $60 a day, but what will that buy 20 years from now? A bottle of Geritol? (3) A clear, written statement that you will be covered for Alzheimer's disease; (4) home-health care; (5) guaranteed renewability, at the same price, regardless of your health (although high claims could force up the premiums for all the policies in your category).

Seniors most likely will have to keep spending their own savings. But there are ways of making it less painful. Better private insurance is one. Another, says USHC president James Firman, is to quicken the market for reverse mortgages, to help you finance home-health care by drawing money out of your home. If you'd rather pay taxes, by all means tell the White House. But in my view, old-age costs are the thing that we're all supposed to be saving money *for*.

Associate: VIRGINIA WILSON



DAVID YORK—MEDICHROME

A slow, painful drain on savings: *At a nursing home*

Amendment removes doctors' liability protection

A physicians' dilemma: the patient's living will vs. family wishes

By Mike Casey
Staff Reporter

Physicians could be found liable for following treatment plans outlined in their patients' "living wills," according to an amendment passed Friday in the Senate Judiciary Committee.

The amendment strikes from the living will bill, known officially as the Adult Health Care Act, a section that protects physicians from malpractice suits. The bill is designed to give patients the legal right to choose their own treatment if they become unable to communicate.

Opponents of the amendment fear that physicians might be sued when they abide by living wills in opposition to family members' wishes.

Proponents said the standards of reasonable medical practice offer physicians enough protection in acting upon instructions like those of a living will. Critics also said that establishing legal protection for physicians might allow for violations of patients' rights.

Opponents of the amendment said it would give physicians added immunity when going into court, said Sen. Gene Merriam (DFL-Coon Rapids), who proposed the amendment. "I don't buy that."

The liability clause clouded the living will issue and the bill will be more saleable in its basic form, he added.

The Minnesota Citizens Concerned For Life and other proponents of the amendment argued that the liability section would give physicians unlimited power when deciding whether or not to withhold treatment of a patient.

Sen. Ember Reichgott (DFL-New Hope), the bill's author, said the lack of liability will not hurt the bill's chances of passing out of committee today. But she said the amendment removed the confidence needed by seniors in making out their living will and doctors in abiding by the document.

"There may be three or four different treatment options a doctor can choose within the bounds of reasonable medical practice," Reichgott said.

In some cases, patients may want to die rather than undergo further medical treatment, opponents said. Without protection from liability, physicians may ignore the patients' wishes and keep the patient alive, rather than risk a malpractice suit.

Lawrence Poston, representing the Minnesota Medical Association, said the lack of a liability clause weakens the bill.

"There are many ways of approaching the same medical problem," he said. If the doctor chooses the treatment within the living will against the wishes of the family, then he or she can face a lawsuit, he added.

The bill is expected to move quickly through the Senate but not before its opponents propose at least two more amendments.

One anticipated amendment would narrow the bill to include only terminally ill patients, and the other would add some language protecting those people who do not sign a living will.

Reichgott said she and the Living Will Coalition would be willing to accept irreversible condition instead of terminally ill. Thus, people with Alzheimer's disease and those in a coma could be included in the bill.

No action is planned on the House version of the bill until the Senate version is passed.

Minnesota Daily
January 23, 1989

Minnesota Daily
February 2, 1989

Judge clears way for Jamieson suit

By Delores Lutz
Staff Reporter

Five University employees must answer questions to help Dr. Stuart Jamieson find "John Doe" and "Mary Roe," a Hennepin County judge ruled Wednesday.

But their depositions must be limited to attempts to learn who told a newspaper reporter Jamieson was under investigation last summer, District Court Judge Henry McCarr decided.

The ruling clears the way for Jamieson's three-month-old defamation suit to proceed. He named Doe and Roe as defendants so the legal discovery process could be used to identify the newspaper's sources, according to Jamieson's lawyer, Terence Fruth.

The University employees asked McCarr in November to quash the subpoenas. In rejecting their motion, the judge gave lawyers two weeks to agree on a schedule for the depositions or appear at a hearing Feb. 17.

The suit is no "fishing expedition," McCarr wrote, because each of the officials is "a conceivable suspect" as the source of the Aug. 2 news story that ran in the Star Tribune.

The story carried various allegations of professional misconduct by Jamieson, who then was the University's chief of cardiovascular surgery and head of the Minnesota Heart and Lung Insti-

Stuart Jamieson

See **Jamieson** *page 5*

Jamieson *from 1*

tute.

After another surgeon refuted allegations that Jamieson had ordered surgery on a woman who already was dead, the newspaper apologized for its story based on information from unnamed sources who lacked "first-hand knowledge" of the events.

In September, Jamieson was stripped of his two administrative posts.

Jamieson was wronged by the published allegations, McCarr wrote in an eight-page memorandum; therefore he has the right to find Doe and Roe.

"The Plaintiff's professional reputation was undeservedly tarnished by some as yet unidentified person or persons," McCarr wrote. "Plaintiff should be permitted to depose likely perpetrators of the falsehood."

But attorney Dayle Nolan said evidence of falsehood has not been established.

Nolan is representing Nancy Gruber, a University Hospital nursing supervisor who is among the five people Fruth hopes will help identify Doe and Roe.

The other University officials subpoenaed are Robert Dickler, general director of University Hospital; James Coggins, administrative director of the surgery department; Dr. Henry Buchwald, a surgery professor; and Dr. John Foker, an associate professor of surgery.

Their attorneys could not be reached for comment Wednesday.

McCarr wrote that shielding the newspaper's sources behind the media's traditional legal right to use anonymous informants would encourage others to commit slander.

Professor Donald Gillmor, co-director of the Silha Center for Media Law and Ethics, disagreed.

"Embedded in that statement is the assumption that all those who direct the press are naive, insensitive and unethical, and I don't accept that assumption," Gillmor said.

Affidavits filed in the case have provided a glimpse of power struggles and turf battles within University Hospital and the Medical School. Jamieson has accused Foker of professional jealousy, and Gruber has accused Jamieson of sexual harassment. Jamieson has countered that she was fighting back because he tried to have her fired for incompetence.

The judge noted a "lack of affection" between Jamieson and the other five University officials.

"Those personality clashes at the University of Minnesota Hospital would make prime copy for the afternoon TV soaps," the judge wrote. "No question about it, the University of Minnesota personnel (who the) plaintiff wishes to depose could themselves be, or could know who are, the 'sources' in the erroneous newspaper article."

Minnesota Daily
February 2, 1989

Hasselmo names new finance VP

By John Welbes
Staff Reporter

In a surprise move Wednesday, University President Nils Hasselmo appointed Gordon "Gus" Donhowe as the University's senior vice president for finance and ations.

owe, former Minnesota f commissioner and current executive officer of Fairview pitals, will serve a one-year appointment in the administrative position that Hasselmo changed to a "senior" vice president position. Hasselmo will appoint another search committee in a year.

The senior vice president for finance and operations will be responsible for a cluster of University vice presidents. Donhowe will apply for the position when his year-long term is up.

He was not among the two finalists recommended for the position by a University search committee in January. Hasselmo said he left his options open because "the University's current situation places special requirements on the finance and operations position.

"It has also become clear to me that this assignment requires a person who comes down sprinting — not just running," Hasselmo said, adding that Donhowe's name was one he started to consider even before finalists were recommended by the committee.

"There was no political influence involved in the decision," Hasselmo said.

He met with Pat Mullen, director of affirmative action and equal opportunity employment, before making the decision. To comply with University hiring guidelines, Hasselmo was advised by Mullen to begin another national search for the position within a year.

Donhowe served as vice chairman of the Spencer Commission,

Donhowe *from 1*

the group appointed by Gov. Rudy Perpich to examine University financial management.

Donhowe said implementing the commission's recommendations will be a top priority.

Hasselmo first contacted Donhowe about the job Friday morning, Donhowe said.

That same afternoon, Donhowe was selected as an at-large finalist for a University regent position by the Regent Candidate Advisory Council. Donhowe's name was among the 16 sent to the Legislature by the council, but he said he will now withdraw his candidacy.

That leaves the Legislature with seven candidates to consider for the at-large position. Bruce Hamnes, a council member from Stephan, Minn., said the council will have to decide at its Feb. 13 meeting whether to recommend another candidate in place of Donhowe or leave the slot empty.

On his application for a regent position, Donhowe listed Gov. Perpich as a reference. Perpich has criticized University financial management, saying he will withhold increased funding of the University's biennial budget request until he is convinced the University is addressing financial management problems.

Donhowe stressed that his hiring was not an attempt to influence the governor concerning the legislative request.

"I think the University will be approaching with a full court press at the Legislature," he said. "It's as much in the Legislature's hands as it is the governor's."

Board of Regents Chairman David Lebedoff called Donhowe "the right person at the right time." He said that although the search committee "produced some very good people, I think the point of any search is to get the best person."

Regent Charles Casey of West Concord, Minn., said Donhowe is well-known in the public and private sector, and added that if Donhowe does have influence with the governor, "it doesn't hurt anything."

Ettore Infante, dean of the Institute of Technology and a member of the search committee

Gordon Donhowe

for the finance position, said he was delighted with the appointment. "The search committee is an aid to the president," he said. "I have the highest respect for Gordon Donhowe. The University's in good hands."

The two finalists had been Frederick Rogers of Carnegie-Mellon University in Pittsburgh and Steven Manos of Tufts University in Medford, Mass. Rogers said he was surprised by Hasselmo's decision. "But after talking to him, I understand it," Rogers said.

Hasselmo had told Rogers previously he was undecided, but had not explicitly mentioned the possibility of bringing in an outsider.

Rogers said the need to appoint someone "who's very strong in the Legislature" was a key reason for Hasselmo's decision.

Manos, who withdrew from consideration Tuesday afternoon, declined to comment on Hasselmo's decision. Both Rogers and Manos said they were uncertain if they'd apply for the position when it opens up again in a year.

Donhowe works at Fairview-Riverside Medical Center in Minneapolis, and said he will shuttle between the two jobs during February. He will start full-time at the University March 1.

In addition to his positions with Fairview Hospitals and the state, Donhowe held numerous positions at The Pillsbury Co. between 1955 and 1982.

U regents expected to approve VP today

By John Welbes
Staff Reporter

When Gordon "Gus" Donhowe as selected by University Presi-nt Nils Hasselmo to be the new nior vice president for finance d operations last week, the cision was lauded by many ate leaders.

But due to the challenges of his tion, even his admirers n praise could be elusive the future.

State Auditor Arne Carlson id reaction to Donhowe's selec-on at the Capitol has been credibly favorable. "It's like hen Lou Holtz came to Minne-ta," Carlson said.

Donhowe's appointment is ex-cted to be approved by the oard of Regents today.

Mark Brenner, chair of the culty consultative committee, id he was "startled that (Has-lmo) could talk (Donhowe) into king the position."

Donhowe is "going to be under e microscope from all direc-ons."

See Donhowe page 3

Donhowe appointment praised, but challenges loom

Donhowe *from 1*

The finance position came into the spotlight last spring when questions surfaced about expenditures at the presidential residence, Eastcliff, and news of a reserve fund that had gone unnoticed by the regents. Then-vice president David Lilly resigned in the wake of the fiscal controversy.

Donhowe, who will soon be leaving his current job as chief executive officer of Fairview Hospitals, works in an office next to the University's West Bank, with a riverside view of the institution.

He has worked in the public eye before as state commissioner of finance from 1983-85. He said that highly visible public positions present "something of a handicap because if you screw up — it's a beaut."

"You can't sweep your mistakes under the rug as easily in a public situation."

He and his wife both have degrees from the University, as does one of their three children.

While growing up in Northfield, Minn., he got the nickname "Gus", but he would only say the name's evolution is "a long story. It's one of those happenstances of childhood in a small town."

He regularly sports a bow tie, and appreciates its practicality. "It's difficult to spill gravy or soup on them," he said.

Gordon Donhowe

A cabin in Wisconsin on the shore of Lake Superior is his spot for sailing and relaxing. "That's my get-away," he said.

Donhowe, now 59, spent 26 years at The Pillsbury Co. before beginning a series of career changes that began when he accepted the state commissioner of finance position in 1983.

Donhowe is "disarmingly quiet," but will be someone students can relate to, said Carl Platou, the former CEO of Fairview Hospitals. Platou recruited Donhowe to join the hospital administration after Donhowe's stint as commissioner for finance.

"I wouldn't be surprised if he rides his bike to campus every day," Platou said.

A resident of nearby St. Anthony, Donhowe said the ride would be easy. His commuting time by car right now is about five minutes, and he said, "I've been accused that my career pattern has been dictated by regularly trying to shorten my commute time."

As for his motives for taking the job, Platou figures that Donhowe "feels a service to the University and state is the most important thing he can do."

Irwin Rubenstein, the University's faculty lobbyist, said that Donhowe brings a lot of personal integrity to the position. "He already has a reputation of integrity and experience. I hope he'll be able to make a strong case for the University."

Donhowe also served on the search committee for finance vice president with with Mike Rice, a College of Liberal Arts senior. Rice said Donhowe was the person committee members turned to for answers to finance-related questions. "He has a very relaxed attitude," Rice said, "but is very competent."

Carlson, who served on Interim President Richard Sauer's financial review committee, said the Legislature will be expecting Donhowe to overhaul the University's accounting system.

Such a plan was included in the recommendations of the Spencer Commission, Carlson said. The Spencer Commission, on which Donhowe served, was set up by Gov. Rudy Perpich to study the University's financial management.

"Those changes will be bringing them into the 21st century," Carlson said.

"A wall of isolation in Morrill Hall" contributed to the University's recent problems, Carlson said. "It's almost as if the phone didn't exist." He said that Donhowe will have to make sure the University continues to open up and explain University finances to the Legislature.

Donhowe commented that "there's really no substitute for candor. Nils said the same thing when he said the administration would be an open one."

Carlson said Donhowe "has to bring some common sense to the administration." Legislators think Donhowe is capable of doing that, he added.

There had been two finalists recommended for the finance position by a University search committee, but Brenner said that "people weren't overly excited by the two. They just did not garner enthusiasm."

That left Hasselmo worried, Brenner said, because the finance vice president position is a key one.

The day Hasselmo selected Donhowe, Perpich recommended that an additional $17 million be designated for the University.

University officials and Donhowe were quick to deny any political motivations that Perpich might have had, but not all legislators believe it.

"You don't play hostage games," Carlson said of Perpich's action. "To throw a little bribe money, that doesn't sit very well."

Regardless of how Perpich's actions were perceived, Rep. Lyndon Carlson (DFL-Crystal) said Donhowe is "highly respected by legislators on both sides of the aisle."

Carlson, chair of the education division of the appropriations committee, said legislators will look for improvements in the management of the University's physical plant, along with implementation of the Spencer Commission's recommendations.

The University's legislative request for funds is at the Capitol, and Brenner said if Donhowe is to influence the request, he would have to do so before the end of March, when the University will "have its report card from the Legislature."

Donhowe will start full-time at his new position on March 1.

"It's amazing," Platou joked. "The University is now in the hands of a Swede and a Norwegian."

Minnesota Daily
February 10, 1989

President of HealthEast hospitals may quit

By Walter Parker
Staff Writer

John Reiling, the president, chief executive officer and driving force behind the financially troubled HealthEast hospital system, is reportedly ready to step down.

Reiling, 39, Thursday refused to confirm or deny widespread rumors that he is leaving the St. Paul-based system, which lost $12 million in its fiscal year ended Aug. 31, 1988, and continued to lose money in its first quarter of fiscal 1989. But Reiling has told associates of his plans to quit, on or before the next meeting of the HealthEast board of directors, which is scheduled for Feb. 16.

"Nothing has been given to the board of directors yet," he said Thursday, then corrected himself to withdraw the word "yet." He said he has refused in the past to respond to rumors about his plans and will continue that stance.

He also said that despite continuing losses — which he said are no more than budgeted — HealthEast has stabilized after a rocky period dating back to its formation in September 1986.

HealthEast, which includes five

Please see HealthEast/9A

John Reiling

HealthEast/ System's chief may quit

Continued from Page 1A

hospitals, among other enterprises, in the east metropolitan area, employs about 5,000 people. The company was organized when the boards that operated Midway, Mounds Park, Bethesda and St. John's two hospitals combined their operations.

In mid-1987, St. Joseph's Hospital joined the group and expensive efforts were begun to make it the system's main hospital, including developing a cardiac surgery program to challenge United Hospital's St. Paul dominance in that area.

Along the way, Mounds Park and St. John's Eastside hospitals, both St. Paul fixtures for decades but running less than half full, were closed. HealthEast also took over operation of Divine Redeemer Memorial Hospital of South St. Paul and made Bethesda into a specialty care center for the elderly and patients with long-term lung disease.

Combining and reorganizing longtime competitors has been a costly, controversial process. Observers praised the company's efforts to bring efficiency and cost-effectiveness to a hospital market glutted with too many beds. Reiling, perhaps more than any other individual, was identified with that process.

It also was a politically and economically difficult process. Among the challenges:

- Merging all physicians' staffs into a single medical staff for hospitals stretching from South St. Paul to Maplewood.
- Standardizing procedures and philosophies for hospitals representing three religious faiths and even more traditions.
- Redistributing authority from each hospital's community-based board to an overall superboard.

Reiling, who came from the St. John's-affiliated Health Resources Inc., has been at the helm by himself for the past year. Before that, he and Nick Hilger, who had been president of the Baptist Hospital Fund, were designated "co-presidents" of HealthEast. Hilger moved to Colorado after resigning in December 1987.

Last summer, HealthEast, which had issued $138.9 million in tax-exempt revenue bonds through the St. Paul Housing and Redevelopment Authority the previous December, announced that the bonds were in technical default because of continuing operating losses.

Reiling stressed at the time that payments on the bonds were not in jeopardy, and that the default related to required debt service coverage ratios — or financial "cushion." The bonds had been issued to consolidate old debt and pay for expansion of various centers.

Reiling, who reached the top of a $220 million company at a relatively young age, said Thursday that HealthEast's losses continued in the first quarter of fiscal 1989, which started Sept. 1. But he said the losses were budgeted and reflected "dramatic" improvement over the same period last year, when losses were running at more than $1 million a month.

He said he could not detail the first-quarter results because of financial reporting requirements that call for all interested parties to receive the information at the same time.

He also acknowledged that the recently received final audited results for fiscal 1988 show a loss larger than the $12 million previously reported, but said he could not reveal how much the loss was because of financial reporting requirements.

Reiling and others at HealthEast have said the system's difficulties are not related to a shortage of patients. In fact, there have been several times lately when acute care beds were hard to find.

The company is carrying a significant debt load, with added interest expenses. In addition, last summer officials said the company was being hurt by contracts with health maintenance organizations that gave the HMOs steep discounts from the hospitals' billed charges.

Two months ago, negotiations with Physicians Health Plan broke off when HealthEast said it could not afford to renew a contract to participate in PHP's popular Medicare Select Plan at the reimbursement rates PHP was offering.

It was one of the first times a hospital system has "walked away" from an HMO contract. Industry observers noted at the time that the event reflected the enormous economic strains in the Twin Cities health care market. Both sides were coming off years of major losses and apparently had little room to maneuver.

Reiling noted on Thursday that HealthEast announced two pieces of good news this week. One was the accreditation of its hospitals by the Joint Commission on Accreditation of Health Care Organizations; another was the approval for Bethesda to receive special exemption from Medicare's payment system that encourages prompt dismissal from the hospital.

The exemption was a key step toward achieving plans to make Bethesda a regional center for patients needing longer-term rehabilitation and care, he said.

St. Paul Pioneer Press Dispatch
February 10, 1989

Response Rate: 100%

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS

SELF-EVALUATION SURVEY

DECEMBER, 1988

RESULTS

ASSESSMENT OF STRUCTURE AND COMPOSITION

1.	Does the Board of Governors consist of a workable number of members to function efficiently and effectively?	14 Yes	1 No
2.	Is there an appropriate mix of professional talents and skills among Board members?	9 Yes	6 No
3.	Is the Committee structure appropriate for the management of issues?	14 Yes	1 No

Please describe any changes that you would like to see made to the structure or composition of the Board of Governors or to the committees.

- Forty percent of respondents desire greater representation by public members on the Board of Governors.

ASSESSMENT OF PROCESS

4.	Was your orientation to the Board of Governors thorough and useful?	14 Yes	0 No	1 Abstain
5.	Are Board meetings scheduled at appropriate intervals?	14 Yes	1 No	
6.	Are monthly agendas organized in a way that allow priority issues to be discussed at appropriate times?	15 Yes	0 No	
7.	Are the Board of Governors business meetings conducted efficiently?	14 Yes	1 No	
8.	Is the background material included in the agenda packets clear, concise and relevant?	15 Yes	0 No	
9.	Is an appropriate level of information being transmitted from the Committees to the Board?	14 Yes	1 No	
10.	Is the level of information about current issues provided at the Board meetings adequate?	13 Yes	2 No	
11.	Are "enrichment" presentations made at Board meetings useful? (i.e., Advancements in Dermatology, Seizure Surgery)	14 Yes	1 No	
12.	Is the annual Board of Governors Retreat a useful opportunity for reviewing issues in depth?	14 Yes	0 No	1 Abstain
13.	Are staff members responsive in answering questions and providing necessary information outside of scheduled business meetings?	14 Yes	0 No	1 Abstain
14.	Do you receive an adequate amount of information on continuing education opportunities offered by external groups?	14 Yes	1 No	

15. Are your requests made of the Board Office being met?

15	0
Yes	No

Please describe any changes that you would like to see made in the way that the Board of Governors functions.

- Two respondents felt monthly agendas should be less structured, leaving more time for in depth discussion of current issues.

ASSESSMENT OF PERFORMANCE

					Weighted Average
16.	Are the members of the Board generally familiar with the marketplace and the environmental factors affecting the Hospital and Clinic?				
	1 Almost Always	11 Often	3 Sometimes	0 Rarely	2.9
17.	Does the Board and Hospital employ an adequate strategic process in charting the direction of the Hospital and Clinic that anticipates or responds to environmental factors?				
	6 Almost Always	7 Often	1 Sometimes	1 Rarely	3.2
18.	Does the Board effectively monitor the Hospital's [illegible]l position?				
	9 Almost Always	3 Often	1 Sometimes	2 Rarely	3.3
19.	Does the Board make informed decisions on medical staff appointments, reappointments and clinical privileges that result in fulfillment of its responsibility for ensuring a properly functioning medical staff?				
	6 Almost Always	5 Often	2 Sometimes	2 Rarely	3.0
20.	Are quality assurance mechanisms used by the Board in a way that allows it to evaluate the quality of care provided at the Hospital and Clinic?				
	5 Almost Always	5 Often	3 Sometimes	Rarely	2.9
21.	Does the Board effectively monitor Hospital personnel policies and compensation plans?				
	5 Almost Always	5 Often	4 Sometimes	1 Rarely	2.9

22. Does the Board Effectively monitor Hospital purchasing policies and practices?

Almost Always	Often	Sometimes	Rarely		
8	5	0	2		3.3

23. Does the Board strike an appropriate balance in dealing with governance decisions verses management decisions?

Almost Always	Often	Sometimes	Rarely		
7	6	1	1		3.3

24. Does the Board play an effective role in evaluating the Hospital Director?

Almost Always	Often	Sometimes	Rarely	Abstain	
2	1	5	2	5	2.3

25. Do Board members handle matters of apparent or potential conflict of interest appropriately?

Almost Always	Often	Sometimes	Rarely	Abstain	
5	5	1	2	2	3.0

26. Do Board members generally initiate formal and informal opportunities for communicating with constituencies and members of the community?

Almost Always	Often	Sometimes	Rarely	Abstain	
0	1	11	1	2	2.2

Specific suggestions as to how the Board of Governors can improve its performance would be helpful:

- One fifth of all respondents would like to discuss the hospital's "strategic direction" more frequently and clearly.
- One third of respondents noted that the Board of Governors relies heavily on staff for guidance on matters of quality assurance. This reliance was not viewed as being inappropriate. The importance of Board familiarity with the process employed in monitoring quality was emphasized.

- Respondents generally felt slightly more knowledgeable about purchasing policies than personnel policies.
- Almost half of all respondents were unfamiliar with how and by whom the Hospital Director is evaluated.
- Almost all respondents expressed a desire to become more active in representing The University of Minnesota Hospital and Clinic within the community.