CITIZENS LEAGUE
530 Syndicate Building
Minneapolis, MN 55402

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STATEMENT TO THE MINNESOTA STATE LEGISLATURE
REGARDING THE UNIVERSITY OF MINNESOTA HOSPITALS
RECONSTRUCTION PROJECT

Thank you for the opportunity of testifying on this important issue. As you know, the Citizens League has maintained an active interest in this project since its review by the Metropolitan Health Board. We want to make it unmistakably clear from the outset that we support this project, and have all along. There is no doubt that a new hospital is needed, that the present University Hospital quarters are cramped and outmoded. Equally, there can be no doubt of the major contribution that the University of Minnesota has made to the advancement of medicine. But, at the same time, we feel that there are major risks associated with this project for the Hospitals, the University, and the state and its taxpayers. Simply put, we feel that there is an abundant body of evidence which indicates that, if the project is allowed to go ahead at its present size and cost, it might be unable to generage enough revenue to repay the bonds. For that reason, we have been forced to take the position that the project should not be allowed to proceed until it is reduced in size and scope to such a degree that, in the words of Harry Atwood of the University Hospitals Board of Governors, "it is not only financially feasible but also prudent."

Last year, before this issue was ever brought to the Legislature, we voiced our concerns to University of Minnesota Hospitals officials. We indicated that it was not our intent to be obstructive, that we basically were supportive of the project, but that their continued insistence on maintaining an excessively large project would neither serve the University nor the public interest well. At that time we urged them to reduce the size of the project, and were told that they would not consider that option. At the same time, however, we were told that they had, in fact, considered the option and had in effect a contingency plan in the event that political pressure or financial feasibility forced them to scale back the project. To this point that kind of pressure and legislative scrutiny has been lacking.

The recent developments present, then, a new and perhaps final opportunity to thoroughly examine this project and the state's interest in it. Several factors have emerged since last February that are worthy of note and comment:

1. Change in the cost of financing - In February, University Hospitals had figured on interest rates of 7¼% to 8¼%. The rate is now estimated at 10½%.

2. Short-term borrowing needs for the project have doubled - The University already is borrowing $20 million for the project and would be forced to borrow an additional $24 million by 1985. The higher interest rate of these bonds could negatively affect the University's ability to repay the bonds.

3. The estimated annual percentage increase applied to salaries has gone from 8% to 9%.

4. Patient day projections have been modified downward 3% from 197,000 in 1987 to 190,600 in 1987.

5. Raised the projected 1987 average daily patient charge to 13% more than it had proposed in February - That increase, combined with the expected increase from inflation, would boost the charge 118% to $1,163 by that time.

In the fact of these changes, the University of Minnesota has pared $14 million off the project. The modifications were largely, as one member of the Board of Regents put it, "finishing touches," "things the architects might like to have had." But there has been, and there continues to be, little sign that the University of Minnesota Hospitals, its Board of Governors, or the Hospital's Administration is considering major cutbacks in the size of the facility or the number of beds within it. Size and scope are critical, because it is the operating costs of running this hospital, or any hospital, that are especially crucial, far more so than construction costs. (For example, the University of Minnesota Hospitals' operating cost is projected to rise from $120 million this year to $261 million by 1988, an operating cost in a single year that exceeds the entire construction expense.)

Numerous voices have questioned whether the University could attract enough patients to fill all of the beds that it has proposed, generate enough operating revenue to repay the state and avoid having to come back to the Legislature for a supplemental appropriation. Now the danger of that actually occurring has increased dramatically. The University's 1987 debt coverage ratio last February was 1.94 : 1.00. Today, it is 1.52 : 1.00. As John Westerman put it last week, the University felt that it had to have a debt ratio margin of at least 1.5 : 1.00 in order to make the project feasible. As it stands now, the margin is two-tenths of a percent above that. What that means is that . . .

> THERE IS NOW LITERALLY NO MARGIN OF ERROR LEFT IN THE PROJECT AT A TIME WHEN THE ENTIRE HEALTH CARE SYSTEM IS CHANGING DRAMATICALLY, THE REIMBURSEMENT SYSTEM IS CHANGING DRAMATICALLY, AND A COMPETITIVE SYSTEM IS BEGINNING TO EVOLVE.

The Citizens League has spent the last year and a half studying the health care system in our state, the actors involved, and the forces shaping it. There can be no doubt that price competition is on the way. Agreements have been signed between the Minnesota Hospital Association and the Minnesota Department of Health. Hospital Trustees have agreed that prices should be disclosed. The Council of Community Hospitals is already at work developing and refining a price disclosure system that will be flexible enough to adjust for severity of diagnoses. Payors are becoming less willing to tolerate excessive hospital costs.

These trends bode ill for the University of Minnesota Hospitals for several reasons. First, as a teaching hospital they are perceived as partially subsidizing the costs of medical education out of patient revenues. In a competitive environment, payors will avoid any such "extra" charges at all costs. Second, part (and we would emphasize only part) of the University's case load is made up of highly complex procedures and treatments such as heart and kidney transplants, etc. Because these treatments are extremely costly, partial subsidization must come from the hospitals' more ordinary caseload. Again, there is a major question as to whether such arrangements will long be tolerated under a price competitive system.

Both of these factors will put the University at a disadvantage in a more price competitive health care marketplace. But there are several other factors that could

adversely affect University of Minnesota Hospitals' operation under such circumstances and thus jeopardize its ability to repay the state:

1. THERE IS A MAJOR QUESTION AS TO HOW MUCH OF THE UNIVERSITY'S CASE LOAD IS REALLY UNIQUE TO THE UNIVERSITY.

   Much of the University's arguments as to why they will be able to sustain a high enough inpatient demand to repay the bonds rests on the assumption that they have a virtual monopoly on certain kinds of highly specialized care. But estimates differ on exactly how much of the care given at the University fits this highly specialized nature. Bob Dickler, at one point cited fitures as high as 85-90%. Yet a Minneapolis Tribune article by Joe Rigert, found that "Some past and present University physicians say that from 40% to more than half could be handled adequately by specialists in community hospitals." The article continued, "An examination of operating schedules for a Monday and a Friday last March showed that more than half the cases - from a hernia repair to a lymph-node biopsy - could be performed by non-University physicians. Four specialists, including a University surgeon, checked the schedule and agreed on this finding." Given the University's vulnerability to a price competitive system, this finding suggests that over half of the University's patient care business is susceptible to being competed away in an environment that may be increasingly conducive to that occurring.

2. THE GROWING CAPACITY OF OUT-STATE HOSPITALS TO TREAT COMPLEX PATIENTS ON SITE COULD MEAN FEWER REFERRALS TO THE UNIVERSITY.

   In the last six years, regional out-state hospitals raised $192 million in order to improve their facilities. Much of the money went to improve the hospitals' specialized services capacity. Examples of this phenomenon include the Douglas County Hospital in Alexandria, Minnesota, which raised $6 million through a bond issue, and the Rice Memorial Hospital in Willmar, Minnesota, which is completing a $12 mllion rebuilding program. (Minneapolis Tribune, April 12, 1981.)

   The University receives 35% of its patients from outstate Minnesota. It is important to note, however, that the University's percentage of outstate patients has decreased since 1975 and could continue to do so in light of the emerging capabilities of rural hospitals. (Rural hospitals could also be aided by the growing surplus of physicians in this state. If enough of these physicians cannot compete in the metropolitan area, they may decide to go outstate. The number of specialists at the Douglas County Hospital, for example, has grown from 3 to 19 since 1973.)

3. THE GROWING CAPACITY OF LOCAL COMMUNITY HOSPITALS TO TREAT HIGHLY COMPLEX PATIENTS HAS INCREASED AND COULD ALSO MEAN FEWER REFERRALS TO THE UNIVERSITY.

   There is already a surplus of physicians competing for a declining number of patient days in the metropolitan area. The University trains many top specialists who stay in the region, albeit at other hospitals. Due to their training at the University, these institutions can now better compete with the mother institution. Additionally, the University has lost some other top staff in recent years to community hospitals. Example: Dr. Demetre Nicoloff, on the staff at the University for 22 years, is now at Abbott-Northwestern. "When he and a colleague left the University in 1979, the

number of open heart operations dropped sharply - the surgery unit going from 120% of its allotted operating room time to 90%." (Mpls. Trib., 4-24-81)

-- The University which pioneered open heart surgery ranked third in open heart operations in 1979 among Twin Cities hospitals. Heart operations have declined from a high of about 400 in 1978 to a little above 300 in 1980.

-- Abbott-Northwestern Hospital offers two-thirds of the complicated services available through the University, although it can't treat all the more complicated cases, including bone-marrow transplants.

4. THESE TRENDS INDICATE THAT THE UNIVERSITY FACES INCREASINGLY STIFF COMPETITION ON HIGH SPECIALTY PROCEDURES AT THE SAME TIME THAT IT IS LESS THAN COMPETITIVE ON LESS ACUTE PROCEDURES.

Because out-state hospitals and metropolitan area community hospitals have an increased capacity to deal with higher specialty cases (often at lower prices) it appears that the University will have to compete harder for less acute patients. How well are they positioned to do that?

Approximately 84 of the 700+ beds in the new University Hospitals complex are targeted for psychiatric and obstetric care. Yet neither service has been able to meet Metropolitan Health Board minimum occupancy standards in recent years. According to a Tribune article dated March 29, 1981, "The University expects to lose $3.5 million on these two services alone this year."

A key factor in whether the University will be able to compete for less acute patients is its ability to attract HMOs. HMOs are increasingly important because, in part, they represent local market share. Approximately 25% of the Twin Cities population is now covered by HMOs, and that number is expected to rise to 33% by 1985, according to a recent study by the Minnesota Department of Health. Why is this a problem for the University? According to an internal memo of the University's HMO task force, the answer is that:

> "These prepaid groups are exceptionally cost conscious, especially in terms of hospital costs. Their perception is that University Hospitals is high cost because of its teaching and research support roles. They also recognize that,on the average, our patients have complex problems which require above average amounts of service. Thus, for whatever reasons and regardless of the validity of hospital comparisons, there is reluctance on the part of the prepaid group practices to refer their patients for treatment at University Hospitals."

This is an especially serious problem for the University, because HMOs appear very likely to begin covering Medicare recipients. In fact, there is already a national HMO demonstration project at work in the Twin Cities dealing with Medicare patients. Of the HMOs involved with the project, SHARE has the single largest share of the Medicare group. SHARE does not refer patients to the University.

To see the significance of this point, it must be remembered that Medicare recipients now account for 25% of University Hospitals' revenue.

5. FINALLY, BUSINESSES, CONSUMERS AND PHYSICIANS ARE BECOMING MORE COST CONSCIOUS AT THE SAME TIME THAT THE UNIVERSITY IS PROJECTING MAJOR PRICE INCREASES TO COVER THE COST OF THIS PROJECT.

   Major purchasers of care (business, insurers, government) are becoming more conscious of the differing prices charged by various hospitals in the Twin Cities and are preparing to adjust their behaviour accordingly. The federal government recently changed its reimbursement formula for Medicare patients a factor that has already affected, we understand, the strategic feasibility of this project. Several major local employers have contracted with the Foundation for Health Care Evaluation to provide pre-admission screening and utilization review. Ultimately this will mean fewer patients staying fewer days in hospitals, producing less revenue. Minnesota Blue Cross/Blue Shield has also started a program to reduce by about 10% their subscribers hospital utilization. Blue Cross/Blue Shield provides roughly 16% of University Hospitals' revenue. HMO Minnesota, is the University's major HMO affiliation. Given the financial conditions affecting that institution, (BCBS lost $15 million during the first half of this year alone,) some question whether it can afford to sustain its relationship to the University at its present level.

   At the same time then that these changes in reimbursement, referral patterns and hospital utilization are occurring, the University, already one of the highest priced providers, is proposing a net rate increase 13% higher than it suggested last February. By 1987 then, when combined with inflation, the University's prices will have increased 118% to cover the costs of the project. Inpatient charges per 1987 patient day would be $1,163, approximately $131 greater than what was projected last February.

FOR THESE REASONS IT NOW APPEARS INCREASINGLY CERTAIN THAT UNLESS THE PROJECT IS SUBSTANTIALLY REDUCED IN SIZE, THE UNIVERSITY'S ABILITY TO REPAY THE STATE AND ITS TAXPAYERS WILL BE IN SERIOUS JEOPARDY.

We do not know and cannot know exactly how large this institution needs to be. Last spring, we suggested that a total bed size of 500 beds or so would be enough. Many others including the Minnesota Medical Society have also suggested that the project needs to be reduced in order to be a more viable option.

We hope that the University and the Board of Regents are seriously considering substantially reducing the project during this important period of "reassessment".

But we think that the Legislature should also be doing some "reassessing" itself. In the context of emerging developments within the health care system and the competitive trends that are impacting this project, we would strongly urge the Legislature to insist on getting answers to the critical questions which remain on this project before any construction is initiated.

* WHAT CAPACITY, IN TERMS OF SIZE AND COMPLEXITY, IS THE MINIMUM NEEDED IN ORDER TO CARRY OUT THE MISSION OF UNIVERSITY OF MINNESOTA HOSPITALS?

  Of the top 10 research facilities in the country, the University of Minnesota is tied with California (Los Angeles) for the second largest. Both have 715 beds. Of the rest, three top research universities do not own hospitals and three others have institutions with fewer than 550 beds. At least 40% of the nations 64 university-owned hospitals have 500 or fewer

beds. How much smaller could this institution be and still maintain the preeminent position to which it aspires?

* WHAT IF OTHER, ALREADY BUILT PUBLIC HOSPITAL FACILITIES WERE AVAILABLE FOR FULLER UTILIZATION BY THE UNIVERSITY OF MINNESOTA HOSPITALS?

  Would this change the requirements for new construction? We have heard from the chairmen of Commissioners of the state's two largest counties that the public hospitals for which they are financially and administratively responsible should be evaluated for the contribution they might make to the University's facilities needs. And, it is increasingly clear that the growing financial burden of these hospitals will accelerate interest in some sort of consolidation.

  At one point there seemed to be a great deal of interest on the part of the University's then two public teaching hospitals and the VA to join forces and increase coordination. Why is that not a good idea in lieu of present economic circumstances?

* WHAT WILL UMHs' BOARD OF GOVERNORS DO IF, IN FACT, PATIENT REVENUES DO NOT PROVE SUFFICIENT TO PAY OPERATING COSTS AND DEBT SERVICE?

  Will there be more agressive "marketing"...spending money to attract a larger market share of the patient pool?..at whose expense?..would this be a proper strategy for a public institution already somewhat better insulated from market risk than private competitors?

  Would they turn to general university resources, in accordance with the agreement with the State Department of Finance, preempting general funds?

  Would they turn to philanthropy...joining the growing crowd at the door of a surprisingly small room?

  Would they return here to the Legislature and make a case for a special appreciation, needed to cope with unforeseen developments? What is the contingency plan?

We do not know and cannot know the answers to these questions. But they should be answered to the Legislature's satisfaction before the bonds are sold and before any construction is allowed to proceed. There would appear to be three options in terms of getting these questions answered.

1. Leave it up to the University.

2. Leave it up to the Legislature either a special legislative commission or perhaps the legislative auditor.

3. Try to find a credible, objective outside group such as the Minnesota Cost Coalition to examine these questions and report back to the Legislature.

At the moment we would favor either the second or the third option, believing that at the same time the University is reassessing its options, it would be helpful to have some additional study done as well.

If the Citizens League can be of further help to you in this matter we would be happy to comply.