file Mrs

To: Melanne Verveer

From: Lois Quam

RE: Mayo clinic announcement of a financial loss in 1993

I am faxing the attached local announcement on a significant financial loss experienced by the Mayo Clinic in 1993. Dr. Robert Waller, the Clinic CEO, feel that declining Medicare reimbursements and the changes due to health care reform are a factor in this loss.

The loss has only been picked up so far by the local paper. They called me for comment. I said that this underscored the problems caused by reform focusing on cost control and not universal security and quality.

I wanted to make sure that the First Lady was aware of this right away because of your ongoing meetings with Mayo and the likely press impact.

Mayo posts 1st operating loss in '93

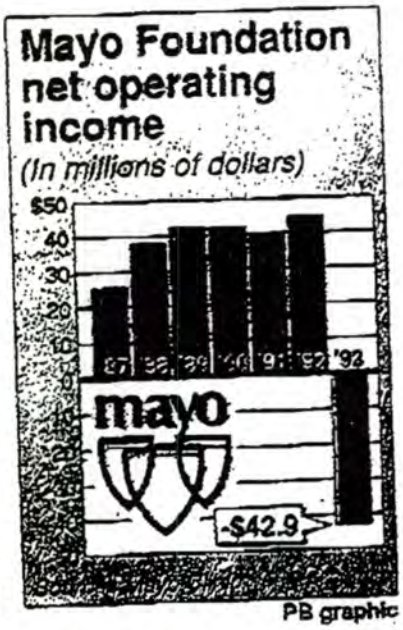
By Jill Burcum
The Post-Bulletin

Declining Medicare reimbursements and decreases in hospital use delivered sharp blows to Mayo Foundation finances in 1993, prompting its first operating loss.

Despite record numbers of patients in 1993, losses totaled $62 million in Mayo's patient care operations. When research and education expenses are added in, as Mayo accounting procedures call for, the medical center posted a net operating loss of $42.9 million for the year. In 1994, accounting procedures will be changed to separate these expenses from patient revenues.

Mayo, however, still cleared $81 million in excess revenues for all operations during the year, thanks to income from investments, contributions and diversification activities. The financial results were released Friday at Mayo's Board of Trustees meeting in Scottsdale, Ariz.

Figures from past years provide a stark contrast to the 1993 financial statement. Total foundation revenues for 1993 increased to $1.58 billion from 1992's $1.5 billion. But in 1992, Mayo cleared $82 million from its patient care operations,



PB graphic

Added Herrell, "We are losing money taking care of Medicare patients. And that's the fastest growth group (at Mayo Rochester)"

Both Herrell and Waller said the impact of government reimbursements on 1993's bottom line may be a harbinger of how further reform could affect Mayo and other health-care institutions.

[illegible] patient use of hospi-

operating income. In 1991, net operating income was $39.7 million.

Top officials at Mayo said the speed with which Mayo's financial outlook changed in key areas was unexpected.

John Herrell, Mayo's chief administrator, said changes in Medicare reimbursements and health care delivery have been noted carefully by officials for the past decade. In 1993, however, numerous trends in health care seemed to come together to affect Mayo financially.

"These trends seemed to accelerate in 1993. That's what really surprised us," Herrell said. "It just all happened so quick."

Patient registrations increased to record levels at all three Mayo campuses, rising to 392,910 in 1993 from 379,338 in 1992. The increase did raise patient care revenues by $80.7 million over the year, from $1.267 billion in 1992 to $1.327 billion in 1993, Mayo officials said. However, patient care expenses rose dramatically during the same period by $148 million, from $1.185 billion in 1992 to this year's total of $1.333 billion.

"We're pleased to report that the number of people who want to come to Mayo continues to increase," said Dr. Robert Waller, Mayo's chief executive officer. "However, factors other than increased registration have reduced the net income Mayo earns from patient care."

Waller and Herrell said Medicare reimbursement restrictions, as well as other government programs, such as MinnesotaCare, combined to reduce Mayo's 1993 income by $55.9 million compared to 1991. In 1994, they said, the reduction in income is expected to reach $82.8 million.

"The demand is there," Waller said. "It's what happens once the patient arrives."

tals, as well as fewer diagnostic procedures performed, had an almost equal impact on Mayo's finances, Waller said.

In Rochester in 1993, for example, hospital use declined by 37,000 patients days during the year, which is the equivalent of closing a 120-bed hospital, according to officials. Waller attributed the hospitalization decline to increasing outpatient procedures.

"This is what society wants and this is what Mayo wants," Waller said. "Patient expectations have changed and medical practice patterns have changed. Many of our patients bring X-rays and blood test results with them from home.

"We're performing fewer tests and procedures per patient and we're hospitalizing a smaller percentage of our patients than ever before."

Mayo's clinics in Scottsdale, Ariz., and Jacksonville, Fla., did not experience similar declines in hospitalization rates, but saw declines in test-orders and surgical procedures, according to officials.

Waller said Mayo's hospital review committee is continuing to study ways to use excess hospital space in Rochester.

Waller and Herrell declined to predict Mayo's bottom line in the coming years. But they noted that steps are being taken to ensure quality and efficiency, with cost-saving measures under way at all three Mayo campuses. For example, plans were announced last month to cut 450 jobs from the Mayo payroll.

The two executives said they see no end to the trends that affected Mayo negatively in 1993.

"People need to be aware of what is happening at Mayo and understand that there continue to be changes in the health-care environment," Waller said.

facsimile
TRANSMITTAL

to: Melanne Verveer
fax #: 202-456-6264
re: See attached
date: February 23, 1994
pages: 12 page(s) total, including this cover sheet

Melanne Verveer

Please see attached from Lois Quam.

Thanks,

Barb Smith

From the desk of...

Barb Smith
Assistant to Lois Quam
United HealthCare
9900 Bren Road East, M.R. 8569
Minnetonka, Minnesota 55343

tel: 612-936-7478
fax: 612-936-1396

To: Melanne Verveer

From: Lois Quam

Date: February 23, 1994

Re: Minnesota Health Care Reform

It was delightful to see you again in Sioux Falls.

The attachments with this fax follow-up on our discussions related to Minnesota.

I am enclosing a brief overview written by me; a letter to me from Steve Miles, M.D., a recent Star Tribune editorial written by Dr. Miles, and finally a newspaper article announcing the delay of the reform package.

Dr. Miles served on the Ethics Working Group for the Task Force. He is a close associate of Senator Wellstone. He has been very involved in Minnesota during this past year when I have been mostly away.

If I can be of more help on this, please don't hesitate to contact me at (612) 936-3630 - work or (612) 647-9624 - home.

State of Health Care Reform in Minnesota

Background

Minnesota passed landmark health care reform legislation in 1991 targeted to expand access to health care towards universal coverage. That legislation was vetoed by Governor Carlson. This legislation was based on the recommendations of the Minnesota Health Care Access Commission chaired by Lois Quam. In 1992, a bipartisan group of legislators with the governor's support led the enactment of legislation to expand access through a subsidized insurance pool called MinnesotaCare and provide a structure for cost control. Specifically, the legislation formed the Minesota Health Care Commission to recommend legislation which would result in a 10 per cent decrease in the health care inflationary trend. The bill provided further budget targets in the out years.

In 1993, the legislation passed with the leadership of the Governor's office which focused on cost control. Expansion of coverage was not an aim of the legislation.

Cost control was achieved primarily through the restructuring of the health care delivery system under a budget target. (The budget mechanism is generally referred to as "trend control" in Minnesota.) Health care providers and health plans/insurers were provided incentives to operate as Integrated Service Networks (ISN, risk-bearing delivery systems operating underneath a budget target. Providers outside of ISN's operated under fee for service price controls under a Regulated All Payor Organization. The legislation provided for the promulgation of regulations related to this structure to be completed and acted upon in the 1994 legislation session and implementation July 1994.

The Governor's Office announced two weeks ago their intent to delay the regulations and implementation for a year. They argued that they were not ready yet to complete regulations and that rural counties and their providers had requested the delay.

The market effects of the legislation however are already widely felt -- and are unaffected by the delay. Metropolitan hospitals and health plans have formed huge consolidations. One of these consolidations, for example, is now the sixth largest employer in Minnesota employing more persons than Northwest Airlines. There is a general consensus in Minnesota that only 3 large entities will survive in urban Minnesota.

Concerns about the Current State of Health Care Reform in Minnesota

The general optimism and pride in Minnesota reform has recently given way to skepticism and conflict for several reasons.

First, the focus on cost control has diverted attention from the fundamental goals of universal coverage. Many people, including Wellstone, feel that the reform movement has been hijacked. What started as an effort to secure coverage and reform insurance became focused on cost control and the building of big corporate medical entities. The Governor and his staff are blamed for this.

The delay of the regulations means that there are no effective regulations to govern these new bodies. There is significant concern from consumer groups, Senator Wellstone and others that these large entities will not consistently act in the public interest without countervailing public regulation. The delay strengthens these entities.

Second, the achievements in expanding coverage through the MinnesotaCare program appear to be less significant than hoped. The Governor slowed enrollment in the program initially by not staffing adequately. In excess of 50,000 Minnesotans applied for or enquired about the program in the early months -- and received no reply from the State. These problems were corrected later. However, the program's management has been inconsistent. It is widely believed that funds and enrollment have been manipulated relative to Medicaid as reviewed in the attached memo. The data in the attached memo is not yet public in Minnesota.

Third, the heavy emphasis on cost control in the absence of commitment to universal coverage and quality measures has skewed the program to perverse incentives. Achieving cost reductions can still be most easily achieved in Minnesota in ways that harm security and may diminish quality. Insurance reform has consistently been blocked by the Governor and some portions of the industry.

Lessons for National Health Care Reform

Minnesota illustrates the limitations of a state acting alone. The barriers of ERISA, Medicaid and other federal statutes inhibit state's ability to protect the consumer and pool purchasing. The result in Minnesota has been the development of strong, large health plans without a consumer bargainer on the other end (e.g. health alliance). Despite significant effort, Minnesota has not successfully address health care reform on its own. Moreover, there is constant concern about the effects of Minnesota of being too far ahead of bordering states.

Minnesota experience is also beginning to demonstrate the problems of not having a health alliance. Minnesota risks being dominated by a powerful health plan industry with no consumer recourse except the legislature. The legislature and Department cannot effectively protect consumers' interest. The issues are too complex and too constant. A negotiating body, like the health alliance, is needed.

Finally, Minnesota demonstrates now the dangers of moving ahead on cost control without universal coverage. Putting pressure for cost control without universal coverage and quality protection encourage perverse outcomes simply because it is easiest to control costs by reducing coverage and cutting corners on quality. A focus on cost control also without addressing the uncompensated care problems of providers gives them incentives to disinvest.

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February 22, 1994

Lois Quam

Dear Lois,

Thank you for your inquiry into my editorial of February 17. I will briefly outline why the promising Minnesota health care reform project appears to have stalled. My analysis is limited by not being based on a comprehensive review of all data pertaining to this new reform. Such data has not been compiled. I have been a participant-observer in this reform process. I worked with the Health Care Access Commission (the Commission which created the first proposal which antedated Minnesota's current law), Minnesotans for Affordable Health Care (a public interest group lobby influential in passage) and with one of the HealthRight Commissions.

There are four major reasons the health care reform process in appears to have stalled.

1. States (or private payers) will not commit to universal access given the continued ability to cost shift or dump to federal (or state) payers.

MinnesotaCare, the subsidized insurance plan, has failed to address the gap between Medicaid and regular insurance. When it began, Minnesota 350,000 persons who were uninsured including about 55,000 uninsured children. MinnesotaCare has insured about 4,000 more children than were covered under the earlier Childrens Health Plan and about 35,000 adults. Enrollment in MinnesotaCare has leveled out. Given that the number of uninsured persons has been rising nationally by about 5% during this period, Minnesota care is probably doing barely better than keeping even with the number of uninsured.

Though complete data is not available, it appears that the state ping-ponged people back and forth to Medicaid to maximize federal revenues. Corrective legislation was required in the last session to plug that gap. The state also terminated several thousand Minnesota Care policies for failure to pay premiums. Given the lack of executive branch commitment to universal access, it is not surprising the state reform Commission barely noted universal access as a priority in its 1992 report to the legislature. New legislation was passed to force them to address the issue. The late

1993 report by the Commission on universal access is a superficially written, poorly documented, and entirely inadequate. There have been no major initiatives by insurers in reaching Minnesota's uninsured. Cost-containment does not make access a priority. Based on Minnesota's experience, I would suggest it represents a decision to not accept access as a priority.

2. Health care reform that proceeds from cost containment to universal access is easy to coopt.

Cost containment is more of a management problem, than a public issue. The shift to cost containment moves the health care reform debate "inside" away from the public forums where the problem is understood as an inability to feel secure about health care.

This shift from a public concern to an insider's problem is exemplified in the different data that is the focus of a cost-containment debate. The shift from access to cost-containment has enabled industry groups to center the reform process on a bewildering set of cost containment data of obscure origins and obscure significance. This includes brain-numbing data on the cost of claims processing, that Minnesota is "17% cheaper" than the national average according to an industry consultant, or on billions "saved" from future projected health care costs. It is not often noted that the base year for cost containment have been repeatedly set forward by the Commission and by the legislature. Meanwhile, important data pertaining to costs and access has not been generated. Three years into reform, there is no system of monitoring changes in the number of uninsured Minnesotans. The last study was done about four years ago during the previous administration.

Cost containment data excludes public participation in an important way that the more readily understandable access data does not. Cost containment statistics (real and imaginary) become proxy indicators for the success of reform during the early phase of implementation. Access numbers are more readily perceived as "life experiences" enhance the political accountability of reform by educating and mobilizing the public.

3. Health care reform is so complex that public engagement in reform, which abates after passage, can monitor the early trajectory of reform closely enough to assure that the reform is reliably launched.

Media coverage of state based reform lasted only a few weeks after the passage of first legislation. There has been no significant public monitoring of the effects of the legislation. There was limited attention to the content of a successor bill. Health care reform was not even mentioned as a 1994 legislative priority by the major newspaper in the state. Legal content centered media coverage does not convey the real dynamic of reform which should be described in terms of health care that is given or denied, personal bankruptcies, and enhanced life-opportunities. Accordingly, policy-content

centered media coverage also lessens accountability of public officials in the implementation of reform.

Furthermore, the inherent plasticity of a complex reform law and the short public attention span means that the dynamic of reform can not be assured or predicted from the content of the bill. It will be highly shaped by the post-enactment influence of health care industry groups. Ways must be found to assure a high degree of public accountability after the reform law is passed. An access focus seems better for this purpose.

4. After passage of legislation, the necessary engagement of key health care industry groups in implementing the reform, vastly improves their ability to guide the reform according to their inertial priorities, rather than according to a new vision.

The many implementation committees of the HealthRight bill invited the major industry players back into the process. The Health Planning Advisory Committee illustrates the dynamic. This Board was given broad responsibilities to develop a plan to oversee the introduction and dissemination of new technologies. Committee appointees reflected local interests rather than the larger reform priorities. The major players were medical technology companies, major insurers, tertiary care hospitals, and rural players who did not want to be shut out of getting new technologies.

Soon after it was convened, a consortium of medical device manufacturers introduced a report on principles for technology assessment which was readily adopted as the framework for Committee work. Those principles were well stated in themselves but did not address ways in which industry shaped technology assessment through sponsored research, sponsored scientific publications, advertising, and so on. The Committee then went on to recommend that it not make any binding proposals which might evaluate a technology, certify which or how many facilities could use it, or in any way impinge on responsible medical judgement. Instead, it would play an educational role. This limited role is accepted and now, a year and a half later, the Committee is, I believe, soon to release a report grappling with saying something useful about a technology.

It is impossible to say how generalizable our experience in Minnesota is. I believe that universal coverage, not cost containment, must be the focus for reform. Any reform bill must build in firm, people-centered monitoring endpoints by which the implementation of reform is held readily, quickly, and regularly accountable. The design of implementation must remain in the control of a body accountable for the larger reform process so that it is not steered according to local priorities.

I hope this is helpful to you.

Sincerely,

Steve Miles, M.D.
Associate Professor of Medicine

Friday, Feb. 18, 1994
Mpls. Star Tribune

Proposed health care networks may be wolves in sheep's clothing

By Steven Miles

Minnesota's Health Care Commission has unveiled its recommendations for the next steps for health care reform in Minnesota. These steps will affect the health care premiums of every Minnesotan and the state's economic climate.

The plan's debut was barely noted in the press. It deserves wide debate.

In 1993, the commission focused on controlling health care costs. It set aside the pressing needs of 300,000 Minnesotans without health insurance who are too rich for welfare but can't afford to buy insurance.

The commission told the Legislature that insurers and HMOs should be replaced with new health care "networks" which would provide comprehensive care on a budget to anyone. These networks were to differ from insurance companies that succeed by avoiding responsibility for people who are more likely to be sick.

The Legislature accepted the network idea but told the commission to come up with a three-year plan for universal health care in Minnesota. The commission also promised to say more about how its network idea would work. The commission's latest report is disappointing news.

The commission proposes to postpone many needed reforms until 1997.

■ It allows insurers to refuse to cover a policyholder's preexisting condition for a full year. Insurers get an additional year every time a person changes policies, for example because of moving to an area that does not have the old insurer's doctors. The commission allows insurers to charge such Minnesotans with preexisting conditions a full price with an added extra risk surcharge for this partial coverage.

■ It allows health insurers to burn up to 28 percent of premiums for personal policies for administrative costs at least until the year 2000. This perpetuates the high bureaucratic waste in this essential and too costly public services.

■ It allows insurers to charge people in hazardous industries, like farming, 29 percent more for insurance until 1996 than a worker with a safer job (and 17 percent more until 1997). It encourages people to join insurance purchasing cooperatives. But if people in hazardous occupations join such a cooperative they may pay up to 67 percent more for insurance than people with safe jobs. Not counting the premium surcharge for age.

■ It allows insurers until 1997 to charge more to employees of small companies that hire people who are sick or people who have ill people in their families.

Last year, the commission said the new networks were to be a break with the past. The new networks were needed because the entrenched practices and world view of health insurers could not be rooted out.

This year, the commission has decided to build old abuses into the networks. The new networks will have three years to learn the avoid-the-sick insurance philosophy and to build the same costly bureaucracy for spotting and deflecting risky persons or their costs onto the state.

Making new networks to play by the old rules is a costly bureaucratic make-work project. It will be financed by Minnesotans' health care premiums.

Why is health care reform in Minnesota slowing down? Gov. Carlson is part of the reason. He appointed many commissioners and staffs the commission from within the Health Department. He is urging the feds to slow down on health care reform so that state reforms can prove themselves.

State legislative leaders are not as aggressive as several years ago. Activist groups and some politicians who have led health care reform are frustrated with the pace. What's more, health care providers such as the Minnesota Hospital Association and the Metropolitan Health Care Council are pushing for faster health care reforms.

The commission proposes to pull universal access out of a hat on July 1, 1997. Its report has a table showing steadily falling numbers of uninsured each year. It gives no data to support these numbers. They are a political wish, not a projection. This year, a million Americans will join the 39 million who are uninsured.

On July 1, 1997, the commission says that insurance abuses will legally stop, insurance companies will sell to everybody, all consumers must buy insurance, and uninsurance will come to an end. Watch for a white rabbit and some colored scarves too.

Steven Miles, of Minneapolis, is a physician at Hennepin County Medical Center and an associate professor of medicine at the University of Minnesota.

Health care

State commissioner suggests slowdown for health care plan

O'Brien recommends delay in development of rules

By Glenn Howatt
Staff Writer

The fast pace of Minnesota's health care reform program would be slowed under a recommendation issued Thursday by Health Commissioner Mary Jo O'Brien.

In a report issued to the Legislature, O'Brien recommended delaying by one year full implementation of MinnesotaCare and put off development of rules that would govern the system. Many of those rules were to be finalized by the time the Legislature returns later this month.

Because the commissioner's office had been charged with drawing up the system's rules, her report yesterday was awaited eagerly by legislators, health care industry officials and consumer advocates for the tone it would set for reforms in the coming year.

While many in the industry thought O'Brien's report was a natural outgrowth of where reforms had been headed, some were left wondering whether this was the first signal that they might be losing steam.

But O'Brien maintained that what is at issue is not the reforms as they stand, but the speed at which they can be implemented.

"This recognizes what we can and cannot do in a short period of time," O'Brien said.

"You have to give the marketplace the information so they know what kind of choices they are making," O'Brien said. "Once we have developed the rules, then the marketplace needs at least a year and maybe longer to figure out how it is going to purchase health care."

Two significant pieces of the health care puzzle not addressed by the commissioner's report were how to provide coverage for the uninsured and how to finance the reform program.

Without those components, many in the health care industry viewed the long-anticipated report as continuation of business-as-usual for at least another year.

That has left some, such as chiropractors and allied professionals, upset that they will have to continue to try to coexist in a system that they say is already stacked against them.

But others, such as hospital, clinic and health plan officials, said the commissioner's proposal yesterday was realistic and beneficial for the changes already happening in the health care marketplace.

Some of the changes, especially the pace of mergers and consolidations among players, has others even more worried, and they hope that the Legislature will go beyond the commissioner's recommendations and rethink health care reform altogether.

Report continued on page 7D

Health care

Report/ Some county boards have asked for delays

Continued from page 1D

"There's still so many flaws in the basic concept," said Heather Robbins of the Rice County Board, one of 27 that have passed resolutions asking the Legislature to put reforms on hold.

"This delay is not necessarily the delay desired by the counties who passed the resolution," Robbins said. "What is of real danger is the vertical monopolies that have been created. The rules don't offer any protection against that. That is the real problem."

Concerns from communities outside the metro area have been leveled against MinnesotaCare since its inception, and the commissioner's report attempted to address some of them.

One proposal that was dropped was a requirement that ISNs be required to serve the population within state-drawn districts. Some said this would make it too difficult for smaller ISNs to survive and would only invite metro-area plans, with all of their resources, to dominate rural areas.

In its place, the department offered a new type of health plan called community ISNs, which would be allowed to start under less hefty guidelines.

"We are looking at ways to help communities with incentives and flexible regulations so that they have the ability to form community-based ISNs that are responsible to the community," O'Brien said.

But to Deb Anderson, director of the Community Clinic Consortium, the concept of community ISNs and some other rules that would require ISNs to work with community-based clinics is encouraging, but too many problems remain.

"The reality of it is that it doesn't address the uninsured," Anderson said. "It only takes care of those who are insured. No one wants to talk about the uninsured."

Dave Renner, a lobbyist with the Minnesota Medical Association, also thinks more attention needs to be paid to the question of universal access.

"Political realists will say it can't be done in a short session and in an election year," Renner said. "At a minimum, we have to get it back on the agenda. We are advocating that we have to bite the bullet."

But most in the industry applauded what they saw as some breathing room to find their bearings under reform and lessen the worry about effects of regulation.

"We had hints that the department had gotten the notion that they were very heavy handed and they realized they need to back off," said Ric Davenport, who chairs the legislative committee for the Minnesota Medical Group Management Association.

^PM-MN--Mayo Clinic, Bjt,1200
^Mayo Basks in Clintons' Praise, But Worries About Their Plan
^Eds: Also moved in advance Nov. 11 as b0573
^With AP Photo
^By CHRISTOPHER CONNELL= ^Associated Press Writer=

ROCHESTER, Minn. (AP) Hillary Rodham Clinton calls the Mayo Clinic ''a symbol of excellence'' and a pacesetter in saving medical dollars. The White House extols Mayo as ''a model for reform.''

But Mayo is worried about what the Clinton health reforms hold in store for it.

The clinic is a bastion of medical specialists at a time when Washington says the country needs more primary care physicians.

It fears that President Clinton's plan for restructuring the health insurance marketplace will make it harder and more expensive for patients from far away to come to Mayo.

''We're scared out of our bloody wits about geographic exclusion,'' said Dr. J. Desmond O'Duffy, a rheumatologist at Mayo who remembers when patients from Saskatchewan slowed to a trickle after Canada went to national health insurance in the 1960s.

For decades, patients from across America and the world have journeyed to this remote city amid the corn fields of southeastern Minnesota seeking help from the physicians carrying on the practice started by a 19th century frontier doctor, William Worrall Mayo, and his two surgeon sons.

Mayo has been girding for health reforms for nearly a decade, looking for ways to expand its reach beyond the 315,000 patients who make their way to Rochester each year. Forty-five percent are from out of state.

Today Mayo is a $1.5 billion medical empire with 1,015 staff physicians and medical scientists here and hundreds more in satellite clinics in sunny Scottsdale, Ariz., and Jacksonville, Fla.

In the past two years Mayo has merged with the 107-physician Midelfort Clinic and bought Luther Hospital in Eau Claire, Wis., and purchased smaller clinics in Decorah, Iowa, and Wabasha, Minn. It is developing a major family health center with John Deere & Co. in Waterloo, Iowa.

It is part of a network providing care for 14 major employers with 600,000 people in the Minneapolis-St. Paul area, and it has contracts with a score of other corporate clients. Its laboratories handle complex tests for doctors and hospitals worldwide.

''We're reaching out,'' said Dr. Michael B. O'Sullivan, a pathologist and chairman of Mayo's regional practices board who grapples with how to maintain high standards while delivering care on wider fronts.

John H. Herrell, chief administrative officer, said, ''It will be difficult for Mayo to compete in some ways in a managed care environment.''

''We've got to somehow strike a deal with every accountable health plan in the country to facilitate their patients coming to Mayo if they want to come,'' he said.

Walter Zelman, a senior White House health adviser, says Mayo has nothing to fear from the Clinton reforms.

''Individuals could still choose to go to the Mayo Clinic or any other doctor that was outside the health plan that they were in,'' he said. ''If Mayo is outside your network, you might pay a little bit more.''

But Zelman predicted health plans will be eager to sign contracts with Mayo so they can advertise that ''if you enroll in our plan, you go to the Mayo Clinic.''

Mayo says most patients arrive now without being referred by their hometown doctor. The Clinton plan would encourage most Americans to sign up for plans where primary care ''gatekeepers'' would discourage unnecessary use of specialists.

Rochester residents pay 15 percent to 22 percent less for their medical care than people elsewhere, largely thanks to the clinic.

While health costs nationally escalated almost 10 percent a year from 1988 to 1992, Mayo's revenues per patient grew at less than 5 percent.

How does Mayo do it?

Dr. Robert R. Waller, the soft-spoken Mayo president, offered a tongue-in-cheek explanation.

''We're fee for service. We're predominantly specialists. We take care of very sick patients. And we invest heavily in research and education. That's why we're less costly,'' he said.

Those are all attributes often cited for the high cost of U.S. medicine.

Mayo is all of those things, but with a difference.

Mayo charges for each procedure its doctors perform, but all the doctors are on salary.

''You don't have an incentive to do more or less than the service called for,'' said Waller, an ophthalmologist who still sees patients in the clinic.

''You don't have that one-week wait for the neurologist. You don't have to do all this chasing around with beepers, letters and phone calls,'' added internist Juan Bowen, who left an academic practice in Columbus, Ohio, last year to join Mayo. ''Things get done more quickly here.''

Patients rave about the attention they get.

''With other doctors, it's 'I'm in a hurry, Mr. Barbeau' or 'I'm in a hurry, Napoleon,''' said Napoleon Barbeau, 79, of Taylors Falls, Minn., a retired salesman undergoing radiation treatment for prostate cancer.

''These commercial guys, they've got to make money,'' he said. ''With these (Mayo) individuals you can be in their office without interruption for hours.''

Dr. Douglas L. Wood, a cardiovascular specialist, said that when he is stumped by a patient's problem, ''I can call any of my colleagues and simply ask. I don't worry about exposing myself for not knowing something.''

After a five-year apprenticeship, every doctor in a specialty is paid the same. Mayo does not reveal the salaries, apart from its top officers (Waller made $426,769 in 1991, not high among people in his league.) But many of Mayo's surgeons and specialists could probably command more in private practice.

Mayo rewards its staff in other ways.

''They never deny us new technology if we say it's essential to our clinical practice,'' said Dr. Fletcher A. Miller, who diagnoses heart valve problems with non-invasive echocardiograms.

Some patients come for heart bypass surgery or cancer treatment; others just want a second opinion or thorough physical.

Martha Hennes, 50, a nurse from Lemonte, Ill., came on crutches because the leg she broke last March hadn't healed properly and was causing hip problems.

''My doctor thought this place would get to the bottom of it,'' said Hennes, who paid extra for the Mayo treatment. Her insurance would cover 90 percent of the bill at certain hospitals in Chicago, but only 80 percent