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CHICAGO HEALTH INSURANCE MARKET

Moderator: DONALD M. PETERSON
Panelists: LOWELL W. JOHNSON*
KENNETH J. MORRISSEY**
FRANK E. E. NICHOLSON***
Recorder: RONALD A. METZLER

- A panel discussion highlighting recent developments in the Chicago health care delivery system.

- The involvement of Chicago area Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and insurers in the financing and delivery of health care services will be explored.

- Issues unique to the Chicago market as well as issues applicable to other geographical areas will be addressed.

MR. DONALD M. PETERSON: I am President of Benefit Trust Life Insurance Company here in Chicago. We have three outstanding non-Society member participants in the health care delivery scene in Chicago, Lowell Johnson, Frank Nicholson and Ken Morrissey, to talk to us about the Chicago health insurance market.

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** Mr. Morrissey, not a member of the Society, is the Employee Benefits Manager of FMC Corporation and a member of the Illinois Cost Containment Council in Chicago, Illinois.

*** Mr. Nicholson, not a member of the Society, is the Vice President of HMO Illinois, Inc. a Blue Cross/Blue Shield plan in Chicago, Illinois.

I will briefly give you an insurance perspective as to what is going on in Chicago. Chicago is a hotbed of activity. While California and Florida have some unique health care activities and Minneapolis and St. Paul have HMO activity, Chicago has a little of everything at this stage of the game. We have virtually every entrepreneurial joint venture that you can possibly think of, either already started, starting next week, or in the process of negotiation.

The way we at Benefit Trust Life look at the Chicago market is that it is, for the most part, divided into three size groups. The larger groups, from 300 lives and over are now self insured or they are administrative services only with a stop-loss. These are administered by Blue Cross or by the extremely large health insurance writers. The second block of groups within the market place, roughly from 30 to 300 lives, has been an extremely competitive brokerage market and there are many insurers from coast to coast operating in there. That is where Benefit Trust Life does most of its business. Lastly, the under 30 lives small group market for the most part is dominated by the METs and certain specific insurers. While some of these insurers may not have a MET, they are operating almost exclusively in the small group market up to possibly 100 lives.

A little bit about Benefit Trust Life will serve for purposes of discussion afterwards. We have about $200,000,000 in premium and ASO equivalence. About a third of this is out of our Chicago office, which includes not just the Chicago metropolitan area but basically the whole state of Illinois. We have ten sales people excluding service representatives and again, they are operating mostly in the under 300 life market selling about 10 to 12 million dollars of new premium each year. I would describe our operating results for the last three years as excellent, preceded by a few years of marginal ups and downs which, for the most part, balanced out during the 1970s and early 1980s. As with most other insurers in the Chicago market, we were working with large rate increases in the late 1970s and especially the early 1980s right up through 1983. The increases started grading down late in 1983 to the situation in 1985 where we were renewing without change and actually renewing with rate reductions. It is my view that the cyclic swing is starting its way back up again. We are seeing that our existing groups are more difficult to retain and

we are going out after rate increases. Our case retention rate in Chicago has generally been in the low 80s. That is pretty good in that relatively small market arena which is getting more competitive right now with so many players.

There are about 35,000 beds in 111 hospitals in the Chicago area. The number of beds is actually down 5% from a year ago. The hospitals themselves claimed 72% occupancy in 1985 and this year they are claiming 68% occupancy. When I was talking with our panelists they all said the hospitals are overestimating the occupancy. We were also discussing the number of HMOs and PPOs in Chicago as of 8:30 yesterday morning, so these figures are now out of date; there are 30 HMOs in the Chicago area and 26 PPOs.

Benefit Trust Life has joined the limited partnership called Private Health Care Systems. It is a preferred provider organization of medium size companies. We hope our PPO product will be on the street by the end of October. We are meeting with HMOs, constantly trying to negotiate various joint venture opportunities. Let's hear what a consultant has to say about the Chicago health care market.

MR. LOWELL W. JOHNSON: The perspective that I want to try to bring to you today is from the viewpoint of a person who has been involved in the health delivery system side of this industry for close to twenty years. I will try to give you the viewpoint of the provider community. Our involvement is largely with the providers and what we are hearing from our clients, friends, and contacts throughout the country, not just Chicago, is that this is probably the largest era of fundamental change that health care providers have ever encountered. Many of you recall the old world of Medicare and Medicaid where the Federal Government paid basically whatever costs were incurred. Significant change has occurred. In the Illinois situation, like the rest of the country, Medicare is now on a fixed pricing system using something called DRGs. Basically the provider in Illinois, the average hospital, gets 38% of its revenue from Medicare. For that amount of the revenue the price that will be paid per illness is largely fixed. More importantly, it has not changed since this new prospective payment system started in 1983. There is substantial pressure for the provider community to change its behavior pattern. A second major purchaser is the state's Medicaid program. In the Chicago area, 12% of the

average hospital's revenue comes from Medicaid. Last year Medicaid went to an upfront negotiated price system that resulted again in fixed price with no intent of changing that price at any time in the immediate future. Half of your revenue is coming from patients with fixed prices so we are seeing much more competition. There is excess capacity in this marketplace: too many doctors, too many hospitals, too many of everybody. Our clients indicate that major purchasers are telling the hospital people out there that the only important factor for us in the future is price. As people initiate contractual arrangements, they try to identify low cost producers. It is getting much harder to differentiate the product in this prices driven era. Hospitals used to compete on the basis of meals and on other amenities. A very good example in the Chicago area is Prentice Hospital for Women, a very prestigious hospital affiliated with Northwestern Memorial Hospital. If you choose to have a baby at Prentice Hospital for Women, that price will likely exceed $4,000 before the discharge occurs. If you have that same delivery at Northwest Community Hospital in Arlington Heights, that price will be well under $2,000. Purchasers are starting to say, "We are not willing to pay that subsidy," so the product differentiation is not working as well as it used to. We are also hearing that quality is really two tiers: acceptable and unacceptable. Purchasers want standard care at a standard price. That leads then to the idea that health care providers are transitioning into what we call a commodity business. In a commodity, low cost producers are the people that will survive. Don said occupancy was 68% in the latest statistics. I would argue that if you did an honest bed count, occupancy is closer to 58% in the Chicago market -- and shrinking. Once you get outside of the Chicago Metropolitan Statistical Area, occupancy is approaching 50% in Illinois and shrinking for acute care hospital providers.

The commodity idea, a little product differentiation, and low cost producers result in a highly competitive industry. Don mentioned that there are 111 hospitals in Chicago. There will not be 100 next year at this time. There will probably be significantly less than 100 by 1990, probably in the neighborhood of 70 to 75. The hospital that exists in 1990 is going to be very different from today's hospital. It is going to have more outpatient focus. It will be treating only those who are extremely ill on an inpatient basis. You are going to find shorter lengths of stay, and much less need for hospital

capacity. We are talking about 35,000 beds in Chicago today. I doubt that there will be 20,000 beds in 1995. There is going to be dramatic shrinkage in the need for and in the use of inpatient health care facilities here in Illinois. When that happens, we think the cost structure of those providers is going to be almost identical. If you are going to be a survivor you are going to have to be very cost effective and very cost competitive.

I would like to draw analogies to three other industries that have gone through this wrenching period of change that I think health care is going to resemble. Think about the effect of deregulation on the airline industry. Initially there was fractionalization with all kinds of carriers starting out, everybody frequently changing rates, and changing operations all the time. What is important in the airline industry today is the ability to market and have market share. Think of the transition that airlines went through. Telecommunications is another similar industry. It used to be a very stable industry, with AT&T and mother Bell being your only choices. Consider your own companies today with all the alternate ways of buying telecommunication services. The computer industry is another that I think looks very much like what health care is going to look like for the next five years or so. Who could make the fastest machine? That is still a piece of the competition, but a bigger piece of the competition for computers today is getting shelf space at Sears, and in your local computer stores. Who can get their product in front of the eye of the buyer? It is price competition and it is market share competition.

The current health care market shows a fairly fractionalized industry. A buyer makes a financing decision. He buys his health insurance from Don or from Blue Cross or from someone else, and that financier pays everybody. The patient then accesses the doctor, and the doctor sends him off in many different directions. The doctor could send him to a hospital, lab, nursing home, pharmacy, ambulatory care clinic or others. The financing function basically has been a bill payor. One of the things that is happening very aggressively in Chicago today is that the financial function is changing. It is one of the major change factors that has an impact on the consumer and on the people who deliver this care. The future health care market is going to be a fully integrated system and the driving factor is going to be our financing function.

This is what we are calling the idea of managed care. I as the consumer, or I as the business person buy a comprehensive package of services from Blue Cross or the commercial carrier. That financing function drives all of the decisions that are made by the consumer. For example, if you are a member of Frank's PPO at Blue Cross/Blue Shield you can go to any hospital of the 111 in the city. If you do not use one of the 62 hospitals that they have contracted with, you have to pay 20% out of your own pocket. Guess which hospital you are going to use if you are doing business with the Blue Cross PPO? Similarly on HMOs there are contracts, and there is utilization review. Again, that is the whole idea of managed care.

There will still be some specialty "Mayo" clinics. I, for example, think there will certainly be one Rush Presbyterian St. Lukes or Northwestern Medical Center in Chicago into the 1990s and beyond. There will be a need for one very high quality and higher cost facility. There will be people who will be willing to pay the added charge for that facility. Will there be six or seven like there are in Chicago today? I really don't think so. I think the majority are going to have to change drastically within the next five years. I think the health care industry is going to be dominated by integrated companies which incorporate financing, doctors, hospitals, ambulatory surgical -- the whole idea of vertical integration.

The final point is that low cost hospitals survive as independent organizations if they want to be the lowest cost provider around. That is not likely. They are all going to integrate into large systems in the Chicago metropolitan area.

MR. FRANK E. E. NICHOLSON: It is very hard to talk generically about a subject like alternate delivery systems or specifically HMOs. One of the things that I see very graphically here is that this is not a country, it is a continent, and there are huge differences, even within the same state. What I think pertinent is that there are also a lot of similarities. When you compare this community with other parts of Illinois or other parts of the United States, and both Don and Lowell touched on some of them, yes, we are in a health care revolution. Yes, we are undergoing rapid change here. We are definitely in a buyer's market, a purchaser's market. When I think of purchaser's, I think of employers, their employees, the federal and state

government, unions, and some others as well. We are in a marketplace where the supply exceeds the demand, as Lowell put it, right across the board in every category and every dimension. Let me just touch on some of the Chicago area's unique factors. We are a major teaching center; we have seven major teaching hospitals. We have a very interesting situation whereby we have a stagnant city other than in downtown Chicago and along the Gold Coast. Contrast that with the suburbs, which are booming. There have been some very major changes in population patterns. As Lowell mentioned, you have got a very high Medicaid and Medicare population. He said 38% and 12% which is 50% in total. When you compare the Medicare and Medicaid population, however, in the city compared to the suburbs, there are some significant differences. These differences have resulted in differential charges as in Lowell's illustration of Prentice and Northwest Community hospitals.

Being in the HMO business and also being a financial man, I am responsible for making sure that financially we are moving in the right direction in contracting with providers, particularly hospitals. I know what the numbers look like. The average charge for a hospital in the city that we do business with at HMO Illinois is $700 a day. The cost for the same basic services in the suburbs is $500 a day. You begin to see the impact of Medicare and Medicaid and some other factors. There are huge differences within the same service area.

In 1982 there were 400,000 people enrolled in HMOs in Illinois. At the end of 1984 there were 800,000. We are now in excess of 1.3 million. Of that 1.3 million approximately 1 million are in the Chicago metropolitan area. To give you some idea about population, the population of Illinois is approximately 11 million. The population of what we call the Chicago metropolitan area is about 7.5 million. So 1 million out of 7.5 million is about 14% of the total population that is enrolled in HMOs. Not every segment of the population is being offered HMOs at this point in time.

As far as I know, Don was right; there are still 30 HMOs in Chicago. That compares with nine at the beginning of 1984. Everybody seemed to look at the market at the same time and say, "This is a great opportunity to come into the Chicago market," so we have gone from 9 to 30. Based on the information I have from the Department of Insurance that regulates and grants licenses to

HMOs in Illinois, there will be 35 by the end of this year. My own personal prediction -- and it is shared by a lot of my colleagues in the industry -- is that by the end of 1989, that 35 will have shrunk to somewhere between 10 and 15.

The Illinois Association of HMOs wants to make sure that the one thing that doesn't happen is that employers and employees are left holding any financial bag when some of the HMOs don't make it. There is no way that 35 HMOs are going to make it in this market. My own personal prediction is that some of them will go out of business having paid their debts, and there will be mergers and consolidations. I would be very surprised and very disappointed if any of them went bankrupt and anyone was left holding any financial bag other than the HMO itself.

The national HMOs that are in this market are MaxiCare, PruCare, United Health Care Systems, Health America, HMO America, CIGNA, Metropolitan, Humana, Whittaker/Travelers and Fireman's Fund. What is interesting is that none of them are among the three largest HMOs in the market. Those are HMO Illinois, Michael Reese and Anchor. HMO Illinois is the organization that I work for that is a wholly owned subsidiary of Blue Cross/Blue Shield of Illinois. The other two are particularly interesting because they were both started by two of those seven major teaching hospitals that we touched on earlier. That is one of the ways those two teaching hospitals are positioning themselves for the future. What they have done in addition to establishing their own HMOs is to expand from the inner city where both are located out into the suburbs, establishing satellites there that have affiliated with local community hospitals. In order to stay competitive they have a relationship with the community hospitals and only refer back to the major centers the tertiary referrals for those services that cannot be provided in the community hospitals.

Let's have a look at how HMO Illinois has positioned itself and how well it has done. Remember, we talked about one million enrollees in the Chicago metropolitan area. We have 195,000 of those. Anchor and Michael Reese have about 120,000 and 130,000, respectively. We are significantly the largest in terms of members. Downstate as part of HMO Illinois we have 40,000 members, and as part of a product line of Blue Cross/Blue Shield as opposed to the separate

corporation another 40,000 members. In total we have 275,000 out of 1.3 million.

Blue Cross actually started experimenting with alternate delivery systems back in 1970 and was way ahead of its time. There were quite a number of different experiments that started in 1970 and continued through the 1970s. Our first product in Chicago was called CoCare, established in 1973. With the advent of the federal HMO Act, we decided that in order to be competitive we had to have a federally qualified HMO, which we called HMO Illinois. We decided to phase CoCare down and out within three years so that we wouldn't have a federally qualified and a non-federally qualified product competing against each other. The reason I mentioned CoCare is that the wheel has now turned full circle. We have now positioned ourselves for what we believe to be some additional changes that are going to happen in the marketplace, and have resurrected CoCare. We now have a federally qualified and a non-federally qualified product available to use if the marketplace decides there is a need for it.

Why and how did we get into the business? I won't go into much detail on this but I am a personal believer that the climate of any organization is set by the people at the top, so the president has to believe in it, and sell the board. That is exactly what happened in our case and that process started about five or six years ago. It is not easy for any Blue Cross/Blue Shield Plan and it is not easy for a commercial insurer, either, to get into ventures that are so totally different from the traditional business. As a number of us saw the change that was taking place in the marketplace, it was imperative that we as an organization position ourselves for that change and for the purchaser's market that we have moved into. One of the things we did was form a totally separate corporation including dedicated actuaries and dedicated underwriters who are basically only responsible for HMO or alternate delivery system activities. They are different products that need to be treated differently, even though I believe they are the products of the future and may well totally replace the traditional products as we know them.

We have also in the last year or so developed and put into the market a PPO product. We already have 150,000 members in it. We have developed another interesting product that we call the Medical Services Advisory Program whereby

either on the PPO or on traditional products we will lay this utilization program on top of it. There is pre-admission certification and concurrent review of all elective admissions and then all admissions in terms of the appropriateness of that admission and the concurrent review. The review is performed by nurses and physicians who are employees of Blue Cross/Blue Shield. We are finding that to be an extremely attractive product in the marketplace. From a managed care standpoint we are very active in all of its facets; HMOs, PPOs and other managed care products. We have 30 competitors and in this market it is hard to hold onto the market share. Blue Cross/Blue Shield has maintained its market share with about 2.5 million of 2.6 million members. You can see we are the big boy/girl on the block and there to be shot at by everybody else. So far we have maintained our market share and our objective is to increase it despite the competitiveness of the market.

The future health care market will continue to be a buyer's market. The supply will continue to exceed the demand. Managed care definitely is the wave of the future. I don't know where HMOs and PPOs are going to fit in or what they are going to be called in the future, but they are all going to be programs where you cannot have unlimited choice regardless of price. You are going to have some form of utilization control and reimbursement through arrangements that are other than fee for service whether they be capitation or different types of reimbursement arrangements. There will be some rewards where the physicians are rewarded for judicious use of resources. There will be some protection to those physicians against the catastrophic items. I agree with the comments that were made earlier. I don't believe the hospital occupancy numbers. Hospital occupancy is going to drop dramatically further, in my opinion, and it has to if in fact managed care products are a wave of the future.

One quick comment on the whole issue of price and quality: We have been in a price market. I am convinced that particularly the larger employers are just as concerned about quality as they are about price. The winners are going to be those that can provide a quality product in terms of medical care and service at a price that the buyer is prepared to pay and that may not be the lowest price. Then I believe we are going to start moving from that evolution into the next phase where employers are going to ask the organizations that they are working with:

(1) how they can help improve employees' life style?

(2) how they can help reduce absenteeism?

(3) how they can help encourage more productive employees when they are actually at work?

Who is going to survive and thrive in this business? Those organizations that are the best managed, the most innovative, understand the marketplace, listen to the marketplace, and react and respond to the marketplace will survive and thrive. It really is no different than any other business. We as an organization certainly intend to be a survivor and even more so, we intend to be a thriver.

MR. KENNETH J. MORRISSEY: As Benefits Manager with a major industrial corporation in Chicago, I am going to talk to you about the Illinois health care market. In late 1984 the Governor signed a bill called the "Illinois Health Finance Reform Act." This act provides for the formation of something called the Illinois Health Care Cost Containment Council. If it wasn't for the fact that the chairman of our corporation is a political acquaintance of the Governor I don't think I would have been able to gain all the knowledge that I have received from the council. The other members of the council include people from providers, insurers, labor and other consumer interests. The major focus of the legislation is to promote health care cost containment and access to quality health care services through competition, consumerism and greater provider productivity. The council's primary duty is to study, analyze and make recommendations to the legislature concerning the most appropriate cost containment systems for the state. The second duty is to monitor hospital prices. Part of the original legislation for at least the first year required us to issue reports to the legislators about how hospitals were doing in limiting price increases to the rate of increase in the general economy. The third duty is to promote and counsel the general public on health care costs and utilization of health service. The last duty is to collect and publicize hospital utilization and cost data.

I hope to spend some time discussing that last element with you. I am not the data expert with the council, so I will try to do the best I can when we finish to answer questions in this regard. My goal is to give you an outline of the reports that are produced from the Illinois health finance data collection system and are available to everyone in this room.

We spent a couple million dollars over the past few years putting the system together. The system has data on each patient discharged from an Illinois hospital per year. There are approximately 1.8 million discharges each year. We have information on the financial operations and selected price data of each hospital. We have Medicare cost reports as part of our system. To date we have used the data to analyze hospital prices and to produce quarterly summary reports. We have put out two quarterly summary reports and in each of the successive reports we have gotten greater compliance. I think the compliance right now is close to 90 or 95% of all discharges in the state. In terms of your role as a health care actuary there is no question that this information could be invaluable. We provide a series of six reports and these reports are available to interested parties. The first three reports contain summary information on hospitals and payors. The fourth and fifth reports are an appendix of the first three with more detailed information. The sixth report is an extremely detailed report that is only available on tape. To give you an idea of the amount of information in that sixth report, there are 10,000 lines of information per hospital. If we were to print the sixth report there would be in excess of one hundred pages per hospital.

The first report shows the number of discharges, average length of stay, average total charges per discharge, average daily room and board charges and ancillary charges by hospital. The hospitals are arranged by what we call Health System Agency (HSA) Areas. There are eleven HSA Areas in the state. This report enables you to compare average charges per discharge at the various hospitals and basically to see the variability of the charges depending upon the type of room occupied and the ancillary services used. This information could help me to define what I might want to do in terms of purchasing health care for our employees. Our role as an employer is to purchase health care for employees at the most effective price.

The second report is a little bit more sophisticated than the first. It shows the number of discharges, average length of stay and average total charges by service category. The service categories are medical/surgical, oncology, obstetrics, pediatrics, psychiatry and other by hospital within HSA area. The third report allows us to compare average length of stay and average charges per discharge by payor category for the state. The payor categories are insurance companies, Medicare, HMOs, self-administration and self-pay. The data for the quarter ending September 20, 1985 showed statewide totals of 6.5 days per average length of stay and $4,300 average cost per discharge. Medicare average length of stay was nine days compared to 4.2 for self-pay. A comparison of costs by payor shows that self-pay is lowest, with HMOs and self-administration a close second. Medicare is almost double the self-pay costs. The fourth report is similar to the third report except that the payor data is reported by hospital by HSA Area.

Report number five is a lot more sophisticated. It is similar to earlier reports; however, all the discharges are reported by DRG, by age, and by hospital. All 471 DRGs are picked up on our state reports because we are picking it up from the UB-82 records. This report has the added advantage of picking up information by DRG and by age grouping.

We have spent several million dollars in putting together a massive data collection system and we plan to maximize its usage. The next stage is for the council to appropriately determine how we will use this information. We need your participation in terms of that particular discussion. I really urge you to attend the council meetings and to provide input into the council in terms of what type of information you need as a health care actuary. I represent the business side; from the insurance side there are insurance representatives. Whatever you want within reason we will give you and that is the purpose of the system.

We have a newsletter with a form to fill out if you want further information. If you want this information you can either contact the council directly here in Chicago or in Springfield or fill out the form that is contained in that newsletter and we will give you our mailings. Most of the information will be provided at no cost. There is a nominal charge for the tape.

On a final note, we are coming out with a fourth quarter report within the next month. We had the opportunity to look at some preliminary numbers. There was a 5% increase in health care costs between the second and third quarter of 1985. I expect that we are going to see similar types of numbers on the fourth quarter report. These numbers are running at least twice of what the national numbers are running. Last time I looked, national numbers were running about 9.6%. I would not be surprised if Illinois numbers are running in the area of 15 to 20% over the past 12 months. It looks like we are back to double-digit increases in health care costs.

In ending, I really enjoyed discussing the Illinois Health Care Cost Containment Council activities with you. Again, I want to emphasize that I am not the data expert on the council; we do have a number of people that I consider experts in this particular area. I just tried to whet your appetite in terms of the information which is available to you just by asking.

MR. PETERSON: I think we have heard three very knowledgeable people who are outside of our actuarial profession. In particular, the reference to the data that is available has shed a light on a problem we have been living with. Actuaries in the health section have been searching for help to price the new and different products in our marketplace. Perhaps this will be a start. I sincerely hope that those of you from other states might make your legislatures aware of what Illinois is doing. I imagine it is readily transferable. I would hope that we could get some data that we might be able to compare what we see in Illinois with other states. What questions or comments might you have for these gentlemen?.

MR. DOE: Does the data collected in your system reflect the charge the hospitals are making, or does it reflect the amount of money they are being reimbursed?

MR. MORRISSEY: It is charge information. In terms of the other aspects of some of the other data we are collecting, we do have substantial information on the Medicare price report side. We have that all computerized on our system and available, but it is essentially charged data.

MR. DOE: I am concerned about the cost shifting that is taking place, because hospitals are cutting deals with HMOs and PPOs on those insurers that do not have discounts with hospitals. It would be interesting to see the true increase in terms of what the hospitals are actually collecting in the way of revenues.

MR. THEODORE W. GARRISON: Ken, I would like to ask what you as a large employer are able to do from a cost containment or managed care area and how you keep your employees out of high cost hospitals? With 40,000 lives perhaps you have influence that the smaller employers would not. If you were a smaller employer what would you be able to do in those areas?

MR. MORRISSEY: I think that is a difficult question to answer. We have done a lot of things over the past five to six years. I don't know if any one of those was the one right thing to do. For example, in 1976 we implemented our first federally mandated HMO out in Philadelphia. Now we are probably up to offering close to 55 or 60 HMOs throughout the corporation. At that particular period of time we thought HMOs, as an alternative form of health care delivery, were providing substantial cost savings to FMC. Based upon some special studies that we have done relative to adverse enrollment over the past year, it is probably costing us money in several markets. Our strategy at this particular period of time is tighter management of our existing HMO contracts, substantial penetration of PPO contracts where we have major operations, and last but not least, we are working at some substantial shift in managed care for our employees. Currently we have mandatory second opinion programs. We don't have any first dollar coverage throughout the corporation. It is getting to the point right now where every little thing that we do has a significant input on total dollars. FMC spends about 50 million dollars a year in health care. I think every company is different. There aren't enough hours in a day for us to go through and numerate the things that probably should or should not be done. I have a person working full time in the area of health care cost management. She is involved in literally 100 projects relative to health care.

MR. JOHNSON: Many of the new products are designed for smaller employers and METs.

MR. SANFORD B. HERMAN: Given the fact that you have these statistics, have you gone to some of the centers and shown them the numbers and asked them for explanations? Have you found that some of these hospitals that show up as being efficient are using that data in their own marketing efforts?

MR. MORRISSEY: You have to remember that the data system has only been in place for the third successive quarter. The Illinois Hospital Association is doing some analysis of our data tape. We have seen some hospitals in the state use the information that we have put out on the price report in their marketing. I would imagine as more and more hospitals become aware of the available data, their marketing people will use it to best advantage. The hospitals have been sensitive to the release of this data.

I think the council is just learning how to best use the data and we will be spending our efforts, at least over the next year, in terms of analyzing the data, and the proper framework to release the data to the public. That is where we are at this point relative to the council's development. For the initial year and a half of the council's existence we have been concerned with getting and processing the massive amounts of data. Now the question is, how do we best use it? We need your input. Right now we have no one from the business side serving on the data technical advisory group. Again, we have a massive amount of data on the state computer system and the question is how do we best use it? How do we furnish it to you? You have a right to that data.

MR. DOE: Have there been any discussions or specific plans to do analysis of the cost of length of stays based on demographics in order to normalize the data to some more interpretable fashion which would include some level of severity of treatment?

MR. MORRISSEY: I have a proposal here by the Commission on Professional Hospital Activities out of Ann Arbor which we will probably accept. It is a business plan to develop case mix index and severity of illness measures. We are redoing this now and we may be granting a contract to this group to do that particular analysis. We have so much information that it is a question of how we effectively utilize that data. I think with some management changes, which

we plan to make in the counsel over the next year, we are going to produce some very responsive reports for your needs and use.

MR. PETERSON: Before the session started I overheard one gentlemen saying that they were starting an alternative care division. Benefit Trust Life and Lincoln National are doing the same thing. How has the impact of Blue Cross/ Blue Shield starting the HMO and other alternative care approaches affected the stereotype Blue Cross operation that we have grown to know and love the last few years in Illinois?

MR. NICHOLSON: Well I think the marketplace has to be the best judge of that. Blue Cross is not one organization, it is 74 different plans that happen to have an association based in Chicago. It is a loose-knit association, each of the plans operates very autonomously. As I look at our own organization, I think and I hope it came across in my comments this morning, we have been one of the leaders in anticipating and seeing the change that was going to take place in the marketplace. We have stayed on the cutting edge of that change. As I look at the organization, there is no doubt that it is a more lean, mean and hungry organization than it used to be. I think it is a combination of the increased competitiveness in the marketplace. It is brutal out there, not just in Chicago, but all over the state of Illinois. We are better managed and have better people on board. We are going to be very formidable in the marketplace and we are going to be more formidable than we have been and are today. Our objective is to significantly increase our market share, which is one way of increasing your dominance or improving your position in the market. Secondly, we also have to be financially viable at the same time. There are a number of organizations that have moved into this marketplace, that have built up membership, but have lost a lot of money doing it. It is very easy to do that; it is much more difficult to build up market share and also be financially viable. Those are our twin objectives.

MR. PETERSON: Lowell, you are dealing with some of the insurers, some of the industrial firms as well as the hospitals, the hospital corporations, and the HMOs. Any closing comments from you as to some of the reactions to the clients that you are involved with in this scene in Chicago? What can we expect next year?

MR. JOHNSON: We can expect more of the same and more intensity in terms of the competition, particularly if the numbers turning up at the Cost Containment Council prove to be true. If the average price per illness is going up in double digit rates, look for an intensely strong reaction on the part of the purchasers. I think if your companies are faced with having to try to put double digit rate increases on hospital insurance premiums in 1987, you are going to see basically a revolt against the health care provider community here in Illinois or anywhere in the country. The tolerance of that kind of price change on the part of the purchaser, in our judgment, is just not there, so I would look for just an increase in competition in the future.