

Health System Change in Newark, N.J.

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Newark's health system is in the midst of significant structural change as a result of major reforms to the state's health care regulations, which had been in place since 1978. In 1992 the New Jersey hospital rate-setting system was eliminated, and the state hospital charity care program was restructured. These programs were considered important to the financial viability of urban hospitals and to maintaining access to health care services in Newark's urban core, which has among the highest rates of poverty and associated socioeconomic problems in the nation. Five years later, there are signs of growing financial distress among some of Newark's inner city providers, which could indicate a worsening of health care for the poor.

The rollback of state regulation has intensified competition among Newark's health care providers, leading to a rash of hospital consolidations and the emergence of several large hospital-based provider systems. Modest growth in managed care plan enrollment and providers' efforts to position themselves for potential future growth also have accelerated the pace of organizational change. There is an increas-

ing dichotomy between the health care systems in urban and suburban Newark, and it is unclear whether inner city conditions will deteriorate further or whether some combination of state intervention and investment in inner city hospitals by suburban health care networks will stabilize a hemorrhaging system.

While a major goal of New Jersey's hospital rate-setting system was to control costs, it also ensured financial solvency for most of the state's hospitals. As a result, there is substantial hospital overcapacity in New Jersey—and in Newark. Since rate-setting ended, the gap between financially strong and weak hospitals has widened, with nearly 20 percent of the state's hospitals reporting negative total margins in 1996. As of April, only one New Jersey hospital had closed, but Newark's inner city institutions are likely to face growing financial pressure under the new free market hospital payment system.

Many respondents believe that reductions in Newark's excess hospital capacity are imminent, but some fear these changes will be harmful to the area's underserved residents. Most of the region's economic strength and market power is concentrated now in suburban hospitals, and many

respondents expressed concern that services—particularly speciality care, would gradually be moved from inner city to suburban locations. However, shifts in capacity require certificate-of-need (CON) approval from the state Health Department, which has stated its interest in preserving access to care in the inner city. Despite the rollback of New Jersey's rate-setting system, state regulation remains one of the most important determinants of health care system change in Newark.

Organizational change in the health care delivery sector has been dominated by the growth of hospital-based provider systems. Most of the mergers and acquisitions have taken place since 1996. In contrast, most physicians practice independently or in small groups, with few exceptions, such as the 75-physician Summit Medical Group. The major hospital systems are developing mechanisms to align physicians more closely with their institutions, but most of these efforts are in the early phases.

There has been little organized purchaser activity in Newark. Many of Northern New Jersey's large employers have been reluctant to force employees into managed care options. The large commuter population and presence of companies with a regional or national work force reinforce employers' demands for indemnity coverage or multistate managed care products.

The dynamics of purchasing differ in the small-group market, which is regulated by

the Department of Insurance. Since recent reforms created standard benefits packages and limited medical underwriting in this market, enrollment in managed care options has grown.

In general, managed care enrollment in Newark has grown rapidly. Much of the current HMO activity is focused on negotiating discounts with providers rather than implementing innovative financial or care management arrangements. Aside from primary care capitation, providers have not established global at-risk arrangements with HMOs. Many respondents believe that most of Newark's major providers do not currently have an adequate systems infrastructure to manage global capitation contracts effectively. In addition, a large number of New Jersey HMOs have recently merged or reorganized, which has diverted their attention from provider relations.

Perhaps the most important purchaser activity affecting Newark is the state's implementation of mandatory HMO enrollment for Aid to Families with Dependent Children (AFDC) recipients. This is particularly important for inner cities in the Newark area because they have large Medicaid populations and providers that rely heavily on Medicaid revenue.

The long-run outlook for growth of managed health care is uncertain due to provider resistance and the high demand for choice voiced by New Jersey residents. Ultimately, future health system change in New Jersey will depend on the complex interaction between the invisible hand of

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the market and the visible hand of New Jersey State government.

The Newark Community

The Newark Primary Metropolitan Statistical Area (PMSA) has over 1.9 million residents and encompasses five Northern New Jersey counties representing a mix of urban, suburban and rural communities.¹ The 1,570-square-mile region is framed by the Hudson River to the east, the Delaware River and Pennsylvania State border to the west, the New York State border to the north and, to some extent, Interstate 78 to the south. A network of interstate highways and an interstate transit rail system connect New Jersey to New York State and Pennsylvania.

Nearly 40 percent of the region's population is concentrated in Essex County, which includes the city of Newark. Fifty percent of the population is split fairly evenly between Morris County and Union County, which includes Elizabeth. The remaining 10 percent live in Sussex and Warren counties. Approximately 14 percent of the metropolitan area's residents live in the city of Newark and about 6 percent live in Elizabeth. The region's population density ranges from 2,340 persons per kilometer in Essex County to 103 persons per kilometer in Warren County.²

The Newark area has some of the highest concentrations of poverty and affluence in New Jersey. About 6.6 percent of families in the region live below the poverty level compared with the national average of 10 percent, but the poverty rate jumps to 11.3 percent in Essex County, 13.7 percent in Elizabeth and 22.8 percent in the city of Newark. These same disparities exist for median family income, which ranges from \$56,273³ in Morris County to \$25,816⁴ in

the city of Newark. Newark's urban poverty has spread from the inner cities to nearby surrounding areas. A recent analysis of public health in the city of Newark notes that it lags behind most large U.S. cities in many socioeconomic and quality-of-life indicators. For example, Newark's violent crime rate was nearly triple the average of the nation's 100 largest cities.⁵

The Newark metropolitan area's racial and ethnic mix also varies across and within counties. Twenty-two percent of Newark area residents are African American compared with 12.1 percent nationally. Most of the area's African American population is concentrated in the city of Newark and its surrounding areas. African Americans comprise 46 percent of the population in Essex County, 58.5 percent in the city of Newark and 89 percent in East Orange. The remainder of Essex is only 4 percent African American. Union County is 18.8 percent African American while Newark's remaining three counties are primarily white. The region's Hispanic population is slightly above the national average of 9 percent, but 39 percent of Elizabeth's residents are Hispanic.⁶ Large concentrations of undocumented immigrants were reported in the cities of Newark and Elizabeth.

Disparities in the health status of Newark residents are striking by race and across counties. The region's infant mortality rate of 6.9 per 1,000 live births for whites is lower than the national rate of 7.8, but the 15.5 rate for non-whites is 25 percent greater than the national average for non-whites.⁷ Other health status indicators are poor, particularly in the city of Newark and nearby communities such as the Oranges, where there are high rates of tuberculosis and substance abuse, high rates of hospitalization for ambulatory

care-sensitive conditions such as asthma and one of the most severe HIV/AIDS epidemics in the nation.⁸

THE HEALTH CARE MARKET

The Newark metropolitan area is not a self-contained health care market. Rather, it is an intersection of several larger multistate markets for health care. For example, even though the PMSA is composed of five counties, Newark is sometimes referred to as part of the 11-county Northern New Jersey region. It also includes several distinct sub-markets. Health care organizations in Newark have competitive and collaborative relationships with providers in counties outside the metropolitan area such as Bergen and Passaic.

Most of the health plans operating in the Newark metropolitan area have a regional, statewide or national focus. The lack of orientation toward a local market is related to the ambiguity of market boundaries in the region. Blue Cross and Blue Shield of New Jersey (BCBS-NJ), Aetna Health Plans and Prudential Healthcare historically have been major indemnity carriers in the Newark region. Many national and regional health plans also do business in Newark.

In contrast, most of Newark's acute care hospitals have had a local market focus and have only recently begun to develop or align with broader regional networks. The Newark region has substantial excess capacity. The number of staffed hospital beds per 1,000 residents is about 47 percent higher than the national average, and hospital days per 1,000 are more than 50 percent above the national average.⁹ Pressures on the hospital industry to reduce excess capacity have escalated as the state's hospital rate-setting system has been deregulated and the market for hospital services has become more competitive.

Newark has 34 percent more physicians per 1,000 residents than the U.S. average for large metropolitan areas and 29 percent more primary care physicians per 1,000.¹⁰ Some respondents, however, particularly in the inner city, perceive an undersupply of primary care physicians. They also report that some solo physicians are moving from Newark to the suburbs. An increase in physician organization initiated by suburban hospital systems and physician groups may support this trend.

The Newark metropolitan area has a labor force of more than 800,000 people. About 40 percent work in Essex County, 28 percent in Morris County and 25 percent in Union County. The regional unemployment rate was 6.4 percent in 1996, ranging from 4.2 percent in Morris County to 7.8 percent in Essex and 13.7 percent in the city of Newark.¹¹ Nearly 20 percent of the region's employment is in manufacturing and more than 34 percent in services. Health care accounts for nearly 11 percent of the region's jobs.¹²

Employment in the Newark region rose by 0.4 percent between 1995 and 1996. Most of the gains occurred in services, trade and finance. Health care has been a major component of the region's employment growth, but this growth is expected to slow due to increasing competition, downsizing associated with hospital consolidations and reductions in public funding. Overall, the 1997 economic outlook for Northern New Jersey is for modest growth consistent with state and national averages.¹³

LEADERSHIP AND DECISION MAKING

Many of the major players in the Newark region have a statewide or national perspective rather than a local focus. The lack of a regional identity has resulted in a lack

of regional leadership, even though there is distinct leadership in many of Newark's sub-markets. Furthermore, Newark's geographic breadth, cultural diversity and socioeconomic heterogeneity create barriers to coordinated regional health care decision making.

Similarly, many of the forces affecting health care, such as state regulation and corporate health benefit decisions, are not local in nature. New Jersey's Department of Health and Senior Services has been the leading force behind the state's regulatory efforts, placing the commissioner in an important leadership position. Because the state plays such a large role in public health and health policy, many local governments have not made major investments in public health infrastructure. The state also plays a major role in Newark's health care system and economy through its investments in the University of Medicine and Dentistry of New Jersey (UMDNJ) and University Hospital, both of which are in downtown Newark.

During the rate-setting era, there was substantial interaction between hospitals and the State Health Department through the annual rate review process, creating a somewhat adversarial culture of give-and-take between hospitals and regulators. Not surprisingly, the regulatory environment gave rise to a strong state hospital association. However, a schism developed in the New Jersey Hospital Association (NJHA) when the 1992 Health Care Reform Act (HCRA) was being negotiated. The state's suburban hospitals lobbied heavily for deregulation of the state rate-setting system and urban providers opposed it. NJHA supported the HCRA, which caused a splintering of the association's membership. A number of inner city hospitals subsequently left the association and formed a group called the Hospital Alliance of New

Jersey to lobby for charity care funding. Some of the state's major teaching hospitals also left NJHA and formed the University Health System (UHS) to advocate for state and federal support for graduate medical education. Although there is some overlap in the membership of the three groups, a number of major institutions remain outside the NJHA.

The emergence of several powerful Newark-based hospital systems has resulted in the increased visibility and influence of the systems' leaders. In particular, the chief executive officer of the St. Barnabas system and the president of UMDNJ have played long-standing roles in New Jersey health care and are thought to be influential in industry and political circles. In contrast, it was more difficult to identify additional key, locally focused health care leaders or influential community-based organizations. The state's take-over of some local government responsibilities, such as Newark's school system, and reports of corruption in the city of Newark's political establishment have created perceptions of a lack of local leadership in that jurisdiction.

The Catholic Church plays an important and complex role in the area. The Archdiocese of Newark has been active in inner city economic development as well as controlling the inner city Cathedral Healthcare System. The Archdiocese reportedly has had a strong influence on the on-going merger discussions between St. Elizabeth Hospital and Elizabeth General Hospital and is involved in continuing efforts to develop Catholic health care networks in New Jersey.

Some respondents believe that the larger businesses located in the Newark metropolitan area could be a source of political and financial capital for local infrastructure

development. However, they are perceived by local residents as uninterested in the needs of the community, and some respondents complained that virtually none of the white-collar workers in Newark's downtown actually live in the city.

A final issue affecting perceptions about the Newark landscape is the presence of organized crime and corruption. New Jersey's Attorney General recently uncovered organized crime involvement in health insurance fraud in the state, which has fueled concerns that the large amount of money flowing through the health care system may be increasingly attractive to organized crime.¹⁴

External Forces Affecting the Health System

State policy is a major force affecting the Newark metropolitan area's health care system. The elimination of New Jersey's long-standing hospital rate-setting program catalyzed a wide range of consolidations and other organizational changes in Newark's hospitals in anticipation of a more competitive market environment. At the same time, reductions in state charity care and graduate medical education payments have created new financial pressures for many of Newark's inner city hospitals, which are the major providers of service to the region's poor and uninsured residents. In contrast, the state's CON regulations have protected many of Newark's inner city hospitals from new competition for specialized tertiary services, helping them to maintain a base of insured patients. Local health care policy has had relatively little influence on health system change, and private purchasing activities have also had a limited effect, in part because of the regional or national focus of many of Newark's large employers.

PUBLIC POLICY

State policy is a major influence on the structure and operation of New Jersey's health care system. In 1971 the state began its far-reaching regulation of health care with passage of the New Jersey Health Care Facilities Planning Act, which established mandatory CON, health planning and hospital rate controls for Medicaid and Blue Cross. In 1978 the state legislature extended the rate-setting system to cover all payers and hospitals. The new rate system explicitly recognized the cost of uncompensated care as an allowable cost incurred by hospitals, providing fiscal protection to many of New Jersey's urban providers serving low-income and uninsured patients.

New Jersey implemented a diagnosis-related group (DRG) prospective hospital payment that was fully implemented in 1982. After the federal Medicare DRG system was enacted, the state continued to set Medicare payment rates for New Jersey hospitals under a federal waiver. The waiver was terminated in 1989 and payments to New Jersey hospitals for Medicare patients declined. Under New Jersey's system, other payers were forced to make up the resulting Medicare shortfall, which was estimated at various times to be between \$400 and \$700 million.¹⁵

In 1987 the state established an uncompensated care trust fund financed by a uniform addition to all hospital bills; by 1991 this charge had risen to 19 percent.¹⁶ In addition, the state rate-setting system recognized more than \$700 million in bad debt and charity costs and about \$400 million in direct and indirect graduate medical education expenses.¹⁷

The growing level of subsidies for charity care, medical education and Medicare shortfalls increasingly was opposed by

employers forced to cover the bill and by conservative legislators. The final element in the demise of New Jersey's hospital rate system was the May 1992 ruling of a U.S. District Court that the surcharge used to finance the system was preempted by the Employee Retirement Income Security Act (ERISA) for self-insured employee benefit plans.

The nature of the state's health care regulation and the dynamics of competition among New Jersey hospitals and insurance plans changed substantially with the passage of the 1992 health reform legislation. Major components of the legislation included:

- elimination of state hospital rate-setting;
- restructuring of the state's hospital charity care program;
- reform of individual and small-group insurance regulations; and
- establishment of a state-subsidized insurance program for low-income residents.

In 1993 a new governor was elected on a platform that emphasized reduction of state taxes, which created further impetus for the state to control health expenditures. Nevertheless the state has continued to play an active role in New Jersey health care. Respondents from the state government described a philosophy of reducing government barriers to efficient health care market operation, while at the same time playing a strong role to ensure that gaps in quality and access created by market failures are addressed. In addition to overseeing implementation of the HCRA, the current state administration has streamlined the CON program, implemented a mandatory Medicaid managed care program, developed an integrated services demonstration for seniors,

designed new HMO standards and invested in new sources of health care information for consumers and policy makers.

Elimination of hospital rate-setting has had a profound effect on Newark's market because it has exposed the differing ability of the region's hospitals to compete in a free market system. These differences have been exacerbated by charity care funding reductions. In contrast, the CON program has provided a partial buffer for Newark's inner city hospitals from competition for highly specialized care. Furthermore, the recent state insurance market reforms effectively bailed out BCBS-NJ, Newark's largest insurance plan, from huge annual losses in the individual market. It is more difficult to assess the specific effects of these laws on Newark-based employers and residents.

● **Responses to the End of Rate-Setting**

Passage of the HCRA was followed by predictions of imminent financial demise for New Jersey's inner city hospitals. The initial HCRA agreement created a gradual phasing-down of charity care and Medicare shortfall subsidies, but no such transition was put in place for medical education. Hospitals also were concerned about the financial impact of allowing health plans to negotiate rates. However, hospitals responded more quickly than insurance carriers, and four months after the new law was signed the *New Jersey Star Ledger* reported a large increase in hospital charges.¹⁸ With the exception of Newark's United Hospital, there have been no significant hospital closings since enactment of the HCRA, but a number of distressed hospitals in the Newark region have been acquired by other institutions. According to 1996 data, about 20 percent of NJHA members reported negative total margins and another 19 percent reported

margins below 1 percent; many of these are located in inner city Newark and Elizabeth.¹⁹ A number of respondents speculated that perhaps a dozen institutions were on the brink of fiscal collapse.

• Hospital Charity Care Funding

Newark's hospitals are among the largest recipients of state charity care funding. In 1992 the state made about \$700 million in bad debt and charity care payments to hospitals. Subsequently, bad debt was eliminated as a reimbursable expense and charity care payments were reduced to \$300 million in 1997. However, a Hospital Relief Fund was created to supplement the charity care program, making payments of \$135 million to hospitals that treat a disproportionate share of patients with AIDS, tuberculosis, substance abuse, mental illness and complex births. In 1997 University Hospital received \$55 million in charity care and hospital relief payments. Cathedral Healthcare System, East Orange, Newark Beth Israel and United hospitals received between \$15 and \$17 million from the two programs.²⁰

Further changes may be in store for New Jersey's charity care program. In December 1996 the State Health Commissioner announced a proposal requiring hospitals receiving charity care payments to implement a managed care program for charity care patients.²¹ The program is intended to encourage hospi-

tals to develop ambulatory provider networks to treat charity care patients in more appropriate settings and perhaps at lower cost. Every hospital that wants charity care funding would have to submit an annual plan to the Health Department describing its provider network, quality assurance program, utilization management program and data capacity. The Health Department is seeking a federal Medicaid waiver to enact the program.

• Certificate-of-Need Regulations

Many of Newark's inner city institutions, such as University Hospital, Newark Beth Israel Hospital and the Children's Hospital of New Jersey, provide highly specialized tertiary care. The ability to perform services such as specialized pediatric care, organ transplantation and cardiac surgery is regulated by the state's CON program. One objective of the CON program is to control health care spending by preventing new investment in expensive facilities and services when sufficient capacity already exists in the community. Another objective expressed by state policy makers is to ensure that

appropriate specialty care capacity is maintained in New Jersey's inner cities. This is illustrated by the Health Department's decision to allow St. Barnabas to acquire the Children's Hospital license from the bankrupt United Hospital only on the condition that it keep those pediatric services in the city of Newark. As a practical matter, CON regulations often protect hospitals with specialty service capacity from development of new competing services.

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In March 1995 the Health Commissioner proposed revisions to the CON program to streamline the process. The proposal made a variety of services eligible for expedited 90-day review, such as magnetic resonance imaging, basic obstetrics, ambulatory surgical care and changes in hours of operations. Full six-month review remains in place for services such as home health, trauma and perinatal care, and for services with a statewide impact such as transplants. State respondents said that under the new regulations, nearly 400 CONs were approved between April 1996 and April 1997. However, some industry groups complained that the process was still too slow and bureaucratic.

The new regulations include a pilot licensing program for cardiac catheterization that allows hospitals to initiate or expand low-risk cardiac catheterization services with an expedited review.²² This was opposed by some of Newark's urban teaching hospitals, fearing loss of additional volume to suburban hospitals.

● Insurance Market Reform

Insurance market reforms initiated by the HCRA and modified over time have been credited with increasing access to individual and small-group coverage throughout the state. In addition, reforms helped the Newark-based BCBS-NJ, New Jersey's largest insurer, regain financial stability. In 1990 BCBS-NJ was one of 11 Blue Cross plans with negative net worth.²³ Prior to the HCRA, Blue Cross was the state's only insurer that was required to

offer open enrollment for individual health coverage. In 1992 BCBS-NJ covered 165,000 individual policyholders and was considered to be a repository for bad risks. In that year it received a \$65 million state subsidy to cover individual market losses.²⁴

The HCRA created two new programs: the Individual Health Coverage (IHC) Program and Small Employer Health (SEH) Benefits Program under jurisdiction of the state's Insurance Commissioner.

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- A requirement that carriers offering small-group coverage in New Jersey also must offer individual coverage or pay an assessment to cover the losses of carriers in this market.

- Establishment of standard benefits packages. The number and specifics of the benefit packages have changed since 1992, but as of 1996 there were three standard plans plus an HMO plan in the individual market and five standard plans plus an HMO plan in the small-group market.

- A series of rules governing health benefits plans, including guaranteed issue and renewal, strict limitations on pre-existing conditions exclusions, community rating in the individual market and modified community rating in the small-group market. Although the state does not regulate premium rates, it has a mandatory minimum loss ratio of 75 percent (e.g., carriers must pay at least \$.75 in benefits for every \$1 collected in premiums).

In 1996 the state reported that 26 carriers, including 10 HMOs, were participating in the individual market and that 186,000 people—including 100,000 who were previously uninsured—purchased standard plans since August 1993.²⁵ Enrollment in the small-employer program grew by more than 10 percent between the end of 1994 and the beginning of 1996, and more than 50 carriers, including 17 HMOs, now participate in the program. More than 800,000 people are covered under small-employer health benefit plans.

Small-group enrollment in HMO options grew from 14 percent in 1994 to about 27 percent in 1996.²⁶ Because the law's prohibitions on medical underwriting eliminated carriers' most important cost-containment tool, many have moved rapidly into managed care products. Several studies of rates in the IHC and SEH are underway. According to respondents, small-employer HMO rates grew at about 2 percent annually between 1994 and 1996 compared with preferred provider organization (PPO) and point-of-service (POS) rates of around 10 percent annually and traditional indemnity rates of 20 to 40 percent annually.

PURCHASING

Purchasers are not considered a major force behind health system change in the Newark market. There are no large employer purchasing coalitions in Northern New Jersey, and the large employers interviewed generally do not offer strong financial incentives for employees to select managed care options.

However, they do consider health plans' National Committee on Quality Assurance (NCQA) accreditation status and Health Employer Data Information System (HEDIS) performance measures in their purchasing decisions. Small employers with fewer than 50 covered enrollees purchase standard benefit plans regulated by the state Insurance Department.

Large national employers with operations in Northern New Jersey, such as Bell Atlantic, Continental Airlines, Prudential Insurance, Federated Department Stores, Hoffman-LaRoche, American Home Products and Schering-Plough Pharmaceuticals, generally offer self-insured benefits programs and a range of managed care products. They also continue to offer indemnity-type options and favor HMOs with broad provider networks to serve their regional work force.

Newark's hospital systems are major employers and purchasers of care. The St. Barnabas system has about 20,000 employees, University Hospital and UMDNJ have 11,500 workers and the Atlantic System employs 10,000. These systems encourage their workers to select health benefits plans that contract with their own institutions. The First Option Health Plan, for example (which was owned by a group of hospitals and physicians until it recently agreed to be acquired by Foundation Health Systems), covers about 72,000 enrollees affiliated with hospital or health care systems throughout the state. Similarly, Prudential, a Newark-based insurance company, only offers Prudential products to its employees.

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The state of New Jersey is becoming a major force in the purchaser market as it moves its entire Medicaid AFDC population into HMOs. This is particularly important for inner city Newark, where more than 20 percent of the population is Medicaid eligible. New Jersey has substantial bargaining clout, insuring more than 700,000 people statewide under its Medicaid program.²⁷ Managed care became mandatory for Essex County AFDC recipients in January 1996. As of August 1996, 340,000 Medicaid beneficiaries were enrolled in 13 commercial HMOs and the Garden State Health Plan.²⁸ All of the state's 450,000 AFDC recipients were slated for enrollment by 1997. The state also plans to expand HMO coverage for its Social Security income (SSI)-related aged blind and disabled populations. Medicaid managed care is reported to have had both positive and negative effects. The state reports that preliminary surveys indicate high patient satisfaction.²⁹ Providers in Newark reported that physicians receive much better reimbursement under Medicaid managed care than under the traditional Medicaid program, but that hospital payments have been reduced.

The state also purchases coverage for public employees through its State Health Benefits Policy and Planning Organization, which represents nearly 800 employers (including many local governments) and approximately 260,000 employees and retirees. It offers a standard indemnity product, a POS plan and 14 HMOs. Respondents did not tout the state program as particularly innovative, but noted that the share of premiums paid by employees who select the traditional plan recently was increased.

Organization of the Health Care System

Newark's health care system has undergone a significant consolidation of hospitals and health plans. Hospitals are joining forces to create economies of scale and bargaining clout with managed care plans. Competition is beginning to intensify among the newly formed systems, although there is still significant competition among individual hospitals. These changes have been accelerated by the elimination of state rate-setting, but continue to be influenced by state charity care and CON policy. At one time, many suburban Newark residents traveled to New York City or Philadelphia for highly specialized care, but that has been changing with establishment of many of these services closer to home.

Much of the health plan consolidation is a byproduct of national HMO merger activity as well as efforts by local plans to expand their regional contracting capabilities. In contrast, the physician community remains relatively dispersed and independent. However, hospital systems and national for-profit physician management companies such as MedPartners are beginning to compete for physician partners and affiliates.

PROVIDER ORGANIZATIONS

Provider consolidation in the Newark area has occurred in response to the perceived need for market power to negotiate effectively with health plans. Over the past 12 months, the St. Barnabas System has added six hospitals; the three principal members of the Atlantic System formally merged; and the Catholic Via Caritas System was formed. The emerging hospital networks have pursued distinct system-building strategies.

- St. Barnabas is a suburban system that has acquired inner city hospitals, Atlantic has focused on suburban locations and Via Caritas represents a mix of urban and suburban providers.
- Both Atlantic and St. Barnabas have begun to centralize administrative functions and develop formal structures for hospital-physician integration, while Via Caritas has decided on a decentralized approach.

All of the major hospital systems are working to develop stronger relationships with physicians for health plan contracting. Their strategies appear to include gradually building physician allegiance through development of more formal physician-hospital organizations, new management services and greater physician participation in systemwide planning efforts. Hospitals generally have not attempted to purchase physician practices or otherwise exert control over doctors.

The St. Barnabas Health System is New Jersey's largest hospital organization with 3,200 beds and 4,000 affiliated physicians. It has a teaching affiliation with New York's Mount Sinai School of Medicine. The two original members of the St. Barnabas system, the 600-bed St. Barnabas Medical Center located in suburban Essex County and Community Medical Center of Toms River in Ocean County, are financially strong and have good reputations for quality and service. St. Barnabas's success is reported to stem from an "obsession with customer satisfaction" and a physician-friendly approach. St. Barnabas has been successful with a strategy

of recruiting "star" physicians. It is beginning to develop physician alignment strategies and plans to implement a more formal organization to integrate hospital and physician care around January 1998.

One criticism of St. Barnabas is that a number of its new acquisitions are weak financial performers located in unattractive locations. Three of its newly acquired facilities—Newark Beth Israel, Irvington General and Union—are located in urban neighborhoods. St. Barnabas's short-term strategy is to increase the market share of these institutions and implement operational changes to improve their financial performance. It also has moved quickly to centralize administrative functions such as purchasing, human resources and information services at the system level.

Another objective is to offer a full range of services within the St. Barnabas system. The recent acquisition of the 550-bed Newark Beth Israel Hospital provides St. Barnabas with the state's sole license to perform heart and lung transplants as well as other specialty services it previously could not provide, including open-heart surgery. Some respondents are concerned that St. Barnabas will gradually attempt to move these services from Newark to Livingston. However, St. Barnabas representatives emphasized the system's commitment to a strong presence in the inner city and recent capital investments and physician recruitment efforts it has made on behalf of its inner city hospitals.

St. Barnabas's most recent acquisition further increased its inner city presence and its

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specialty care capabilities. In 1996 the 429-bed United Hospital declared bankruptcy, hampered by a large debt, increasingly poor payer mix and declining charity care payments. United's major asset was its designation as the Children's Hospital of New Jersey. Three local systems (Cathedral, UMDNJ-UH and St. Barnabas) and Primary Health Systems, a Pennsylvania-based for-profit hospital chain, expressed interest in acquiring United. Ultimately, the United board worked out an arrangement with St. Barnabas, which paid \$13 million to acquire the facility and its existing debt. St. Barnabas has closed the adult hospital, but has agreed to keep the Children's Hospital in the city of Newark at its Newark Beth Israel campus and to maintain three outpatient facilities in United's service area. The lynchpin of the deal was the Health Commissioner's decision to allow St. Barnabas to transfer the Children's Hospital CON to its Newark Beth Israel Hospital campus. This gave St. Barnabas the sole franchise as the Children's Hospital of New Jersey while ensuring that the services remained in the city of Newark. UMDNJ and Cathedral contested the agreement, claiming that the decision should have been made in bankruptcy court rather than in negotiations among St. Barnabas, the United Board and the Health Department. The deal has been completed, however, and pediatric services are now being offered at Newark Beth Israel.

In May 1996 Morristown Memorial Medical Center located in Morris County, Overlook Hospital in Union County and Mountainside Hospital in Essex County merged to form the Atlantic Health Care System. In April 1997 Passaic General Hospital was added to the system, which now has over 1,500 beds. Members of the Atlantic System have teaching affiliations

with UMDNJ. The system's strengths are reported to be good location, geographic focus and a reputation for quality. Atlantic plans to continue growing and may try to acquire up to four new hospitals over the next year. All of Atlantic's purchasing, finance, billing, management information systems (MIS) and human resources are operated at the system level.

The Atlantic system is centralizing its managed care activities through the newly formed New Jersey Health Resources (NJHR) group, which is responsible for contract negotiation, global risk-contracting, infrastructure development (e.g., information and clinical management systems, claims processing) and physician practice management. Atlantic's hospitals also have their own physician-hospital organizations (PHOs) and independent practice associations (IPAs), which hold the system's few risk contracts. It is unclear whether these will ultimately be consolidated into a single systemwide structure. A substantial proportion of Atlantic's volume comes from the Summit Medical Group, which admits most of its patients to Overlook Hospital. The nature of this relationship may change with the recent acquisition of Summit by MedPartners.

In February 1997 several Catholic hospitals in Northern New Jersey announced the formation of the Via Caritas Health System, bringing together two Catholic orders, The Sisters of Charity of St. Elizabeth, which runs St. Mary's Hospital in Passaic and St. Joseph's in Paterson, and the Sisters of the Sorrowful Mother (SSM), which runs Northwest Covenant Medical Center's three facilities in Morris and Sussex counties. The Via Caritas system has 7,000 employees and about \$600 million in annual revenue. St. Joseph's hospital is a highly specialized teaching facility affiliated with New York's

Mount Sinai School of Medicine. It draws some of its cardiac and pediatric patients from the Newark metropolitan area. It is currently talking with a number of other hospitals about joining the system.

A second Catholic entity is the 600-bed Cathedral Healthcare System, affiliated with the Archdiocese of Newark. Cathedral includes St. Michael's, a large tertiary care teaching hospital located in the Central Ward of Newark, and St. James, a small community hospital in the city's Ironbound section. Cathedral has a small base of commercial patients (about 15 percent) and relies heavily on Medicare and Medicaid. It also serves a large proportion of uninsured patients. Cathedral competes primarily with UMDNJ and the St. Barnabas system.

The future relationship between the two Catholic health systems is uncertain. The Newark Archdiocese exercises a great deal of influence over Northern New Jersey's Catholic hospitals and has expressed a desire for the hospitals to join forces rather than being picked off by non-Catholic systems. Despite this, a number of respondents expressed the opinion that Via Caritas and Cathedral are unlikely to unite because of the differences among their respective managements.

University Hospital is a state-owned 518-bed teaching hospital in downtown Newark run by UMDNJ, New Jersey's only medical school. Established in 1969, UMDNJ sponsors approximately 1,100 medical residency positions accounting for just under half of New Jersey's 2,500 residents in 1995.³⁰ UMDNJ officials cite its strengths as good-quality care (disputed by some respondents) and its unique tertiary services (trauma, liver transplant, cardiac and AIDS care). Its major vulner-

abilities are high costs, an inner city location and a patient mix dominated by Medicaid recipients and the uninsured, which are distinct disadvantages for competing in a deregulated environment. UMDNJ-UH has had to cope with recent budget cuts due to reductions in charity care funding and state appropriations.

University Hospital has remained independent in the face of the market's rapid consolidation. UMDNJ officials report difficulty finding willing partners and express concern about being isolated in the market. UMDNJ has historically used its residency programs as leverage for negotiating with other major teaching hospitals, but this is probably not sufficient to attract a strong teaching hospital partner, particularly because several major teaching hospitals have recently shifted their medical school affiliations. Many people expressed the hope that UH will never close because of its role as Newark's public hospital, but some have suggested that UMDNJ should consider moving the bulk of its residents to other institutions and substantially downsizing the physical plant.

INSURERS AND HEALTH PLANS

Newark's commercial health benefits market continues to be dominated by indemnity and PPO products. Managed care's late start is attributed by some to the state's history of rate-setting, which prohibited commercial insurance plans from negotiating hospital discounts and set limits on the discount arrangements established by HMOs. Consumer demand for broad physician choice and lack of support from the state's medical community also are contributing factors. Recent HMO enrollment reportedly is brisk; the region's HMO enrollment is estimated to be 25 percent of the total population.³¹

Most of New Jersey's locally based HMOs that included Newark in their service area, such as Rutgers Community Health Plan, CoMed and, most recently, FirstOption, have been acquired by national or regional companies. HMOs report that employers are increasingly looking to NCQA accreditation as a "Good Housekeeping seal." And the state is playing a more active role in the HMO market through issuance of consumer-focused HMO regulations and mandatory HMO enrollment for Medicaid recipients, which began in January 1996 for Essex County residents.

The two largest Newark-based insurance plans are BCBS-NJ and Prudential Healthcare. Both offer HMO, PPO, POS and indemnity coverage. Other major HMOs operating in Newark are Aetna/U.S. Healthcare, Oxford HealthPlan, Cigna/CoMed, HIP Health of New Jersey and FirstOption, a New Jersey-based provider-sponsored HMO that recently agreed to be acquired by California-based Foundation Health Systems. There also are a number of HMOs that focus predominantly or exclusively on Medicaid. Two of the largest in Newark are the UMDNJ-sponsored University Health Plan and the Garden State Health Plan.

The regional nature of Newark's large employers and resistance of white-collar employees to restricted choice plans have led purchasers to favor HMOs with broad provider panels. According to several respondents, Aetna/U.S. Healthcare initially offered a very limited New Jersey panel, but has developed one of the broadest HMO networks in the state in

response to employer demand. Similarly, Oxford recently introduced an open access model, which allows patients to go directly to specialists and is available to Newark employers.

Many of the managed care companies have focused primarily on negotiating hospital rate discounts. Aside from primary care capitation, respondents gave little evidence of provider risk-sharing arrangements. Many plans and providers characterized hospitals and PHOs in Newark specifically and New Jersey generally as not yet ready to manage global capitation contracts effectively. In addition, the plans were described as being distracted by merger activity and unable to focus on developing provider risk arrangements.

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Recent health plan merger and reorganization activities affecting the Newark market include:

- Foundation Health System's pending acquisition of a 70 percent share in First Option;
- the merger of U.S. Healthcare and Aetna;
- the reorganization of Prudential's managed care division and appointment of a new CEO; and
- the planned acquisition of BCBS-NJ by Indiana-based Anthem Inc., which was canceled following an opinion by New Jersey's Attorney General that BCBS-NJ assets were, in effect, a public trust and would have to be donated to a charitable foundation when the sale closed.³²

The FirstOption merger reflects the need of a growing health plan to establish a region-

al presence and access new financing. Company officials described their pending decision to merge with Foundation Health Systems as influenced by the need for a seamless multistate network to serve regional employers and for new capital to update its administrative and information systems.

The growth of large hospital systems may be followed by direct contracting arrangements that compete for health plan market share. Although no examples of directing contracting were identified, interest has been expressed by some of the region's providers.

Care of the Poor

Newark's poor and disadvantaged residents are concentrated primarily in the inner city neighborhoods of Newark, Elizabeth and Orange, which represent some of the highest incidences of poverty, crime, poor health status and declining urban infrastructure in the nation. Some people assert that the city of Newark has never recovered from the 1967 riots. Slightly more than 13 percent of Newark-area residents are uninsured compared with the U.S. average of 15.2 percent, but this regional average masks much more severe conditions in Newark's inner city.³³ Although data on insurance coverage are not available on a sub-county level, the city of Newark's median family income is only 52 percent of the metropolitan area average, indicating a much greater likelihood of residents who are uninsured, underinsured or on medical assistance.³⁴

Despite a fairly well-defined area where its poor residents are concentrated, neither the specific jurisdictions nor the Newark PSMA have established an organized system of care for the poor. Much of the health care provided to Newark's low-income and uninsured populations is delivered in hospital inpatient departments, clinics and emergency rooms.

Despite a fairly well-defined area where its poor residents are concentrated, neither the specific jurisdictions nor the Newark PSMA have established an organized system of care for the poor. Much of the health care provided to Newark's low-income and uninsured populations is delivered in hospital inpatient departments, clinics and emergency rooms. Newark and Elizabeth have limited ambulatory services networks available to the poor outside of hospital settings.

Newark's sole public institution is University Hospital. Other major safety net hospital providers in Newark are East Orange General Hospital, the Cathedral Healthcare System, the Hospital Center at Orange and Newark Beth Israel Hospital. Many of these institutions are known for serving defined neighborhoods and ethnic groups. For example, St. James Hospital serves a large Portuguese patient base, Columbus Hospital is a major provider to the Italian community and United Hospital, until its closure in spring 1997, was a key provider of services to the mostly African American community of Orange.

The Newark region has only one federally qualified community health center (FQCHC), which operates six sites in the city of Newark. It delivered about 75,000 outpatient visits in 1995, but is considered to be financially vulnerable. It recently closed several sites and reduced the availability of certain services. Local health departments provide only limited direct medical services. Newark's Department of Health and Human Services, for exam-

ple, delivered about 5,000 medical visits in 1994.

The state has supported uninsured patients' access to general acute hospital care through its charity care program. New Jersey residents qualify for the program if their incomes are below 200 percent of the federal poverty level. The state makes partial payments for residents with incomes between 200 and 300 percent of poverty. However, total hospital charity care payments have been reduced from more than \$700 million in 1992 to about \$440 million currently (including the Hospital Relief Fund). The state recently developed a proposal to require hospitals to set up a managed care network as a condition of receiving charity care funds. If enacted, this proposal may have a favorable long-term impact on the availability of ambulatory services for Newark's inner city residents. But in the short run, some providers may have difficulty implementing the operational changes needed to remain eligible for charity care funding.

Another state effort to improve access to health care is the newly established Health Access New Jersey Program. Administered by the Health Department, the program provides subsidies for the purchase of individual health coverage to individuals and families with incomes below 250 percent of poverty according to a sliding income scale. The program's funding of \$50 million in 1995 was thought to be sufficient to subsidize

approximately 30,000 people.³⁵ Future funding is subject to approval of the state legislature.

New Jersey's inner city hospitals rely heavily on medical residents to provide service to poor and uninsured patients. It was reported that more than 50 percent of the residency slots in New Jersey hospitals are for primary care practitioners, and the proportion of medical residents who are international medical graduates (IMGs) is more than twice the U.S. average.³⁶ Some New Jersey hospitals have been criticized for relying on medical residents for patient care services, but not providing high-quality educational programs. Future state and federal policy changes may affect the availability of medical residents to provide care in New Jersey hospitals. For the past several years, federal policy makers have debated limiting Medicare graduate medical education payments to hospitals that train IMGs. New Jersey's medical education establishment also has been discussing residency reductions of about 25 percent. While these policies are sensible from an education

and physician supply perspective, they may have an adverse impact on indigent care service delivery in inner city teaching hospitals.

The overall impact of recent health system change on care for the poor in Newark is difficult to quantify, but the most obvious effect is the recent deterioration in the finan-

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cial status of inner city hospitals that provide the bulk of the care to Newark's poor and uninsured residents. United Hospital had a community-friendly reputation and was one of the few New Jersey hospitals with an African American CEO. Its closure raises key concerns about the loss of inner city jobs and the need for community members to use other institutions that are not considered equally culturally sensitive. Surrounding hospitals also are worried about the impact of United's closure on their respective indigent care burdens.

Mandatory Medicaid managed care is another major change affecting care for the poor in Newark's inner cities. It is too early to understand its impact on the health status of Medicaid recipients, but there are early indications of winners and losers among Newark's health care providers. For example, Newark's community health center reported that some of its financial problems stem from newly implemented HMO contracts.

Some respondents noted an outflow of health care professionals in response to Newark's poor socioeconomic conditions. Doctors practicing in inner city hospitals increasingly are reported to have suburban offices. However, since the region has a relatively comprehensive public transportation system, it is possible that people living in the inner city could visit these physicians via trains or bus lines.

At present, health care for the poor in Newark seems precariously balanced on the backs of inner city hospitals struggling to remain solvent. Few special programs for

the uninsured have been developed locally, and the system is hampered by a lack of outpatient capacity. The state must balance continued budgetary pressure with its commitment to New Jersey's inner cities. Ultimately, development of systems to adequately and appropriately care for Newark's low-income and uninsured residents will probably require commitment of new financial resources and development of innovative health care financing and delivery strategies at the hospital and state level.

Issues to Track

While many hospitals and health insurance plans responded cautiously in the initial years of deregulation, caution has been replaced by a rapid pace of organizational change and consolidation.

Major recent changes to New Jersey's health care regulatory structure have had a far-reaching impact on health care in Newark. While many hospitals and health insurance plans responded cautiously in the initial years of deregulation, caution has been replaced by a rapid pace of organizational change and consolidation. However, beneath the surface of recent mergers are fundamental questions about how these organizational changes will

affect the services available to inner city residents, whether new organizations will be successful at integrating and improving clinical services and what shape state policy interventions will take if serious quality or access problems arise.

Recent health system change is perceived to have had both positive and negative effects on the Newark metropolitan area. The most common concern is that the combined impact of hospital deregulation, increasing competition among plans and providers and reductions in state charity

care funding will hurt inner city hospitals and reduce access to care for New Jersey's poor, disenfranchised and uninsured residents, particularly minorities and the working poor. Some respondents believe that the introduction of mandatory Medicaid managed care may improve recipients' access to primary care services, but others are concerned about the future availability of specialty care. In contrast, suburban residents now have more convenient access to high-technology tertiary care as suburban hospitals have gradually added new services.

New Jersey's health care costs are still perceived as high, although some respondents believe that recent changes have put downward pressure on annual rates of growth in health benefits premiums. Many respondents are concerned that quality of care improvements in New Jersey have not benefited inner city and suburban residents uniformly. Some also believe that relaxation of CON regulations could diminish quality as specialized services such as cardiac catheterization are diffused across a broader range of providers.

There is much speculation about whether the growth of the large hospital systems that include urban and suburban providers will ultimately be a stabilizing factor for Newark's health care system. To the extent that provider systems such as St. Barnabas make substantial investments in hospitals like Newark Beth Israel and develop models that encourage their medical staff to rotate through urban and suburban locations, both the quality of health care and the economic opportunities in Newark's inner city neighborhoods could improve substantially. In contrast, if St. Barnabas substantially downsizes these institutions and transfers specialty

services to suburban locations, the inner city will suffer.

The fate of the region's growing number of financially distressed hospitals is also uncertain. Newark has excess beds, but a disproportionate number of its distressed hospitals are located in inner cities. The region's hospital capacity may be reduced by "planned" private sector consolidations and by "unplanned" closure of distressed institutions. Based on recent experience with United Hospital, the Health Department is likely to play an active role if other important inner city institutions appear likely to close.

While the financial status of Newark's provider organizations can be monitored closely, determining the impact of system change on access to care for the poor is more complex. Future tracking efforts in Newark should attempt to assess whether current disparities between Newark's inner cities and suburban areas increase or are diminished. The state's charity care policy is one important determinant of access to care for the poor in Newark. In particular, the state's proposal to create a managed care charity care system could create strong incentives for hospitals to develop and expand outpatient service networks in areas with insufficient primary care capacity. Improved outpatient services for the poor should also be reinforced by the state's move to mandatory Medicaid managed care.

Another question is whether HMO-style managed care will catch on among the Newark area's commercial and Medicare populations. The region's low HMO penetration rates and recent HMO regulations issued by the state reflect caution on the part of purchasers, consumers and regulators. However, health plans are responding

to consumer preferences by providing broader networks and more flexible products for the commercial market. These changes could boost HMO enrollment if combined with sufficient price savings. In contrast, the decision to implement mandatory managed care for the AFDC population places a greater responsibility on the state to ensure that HMOs provide appropriate quality and access to care.

Finally, it is important to monitor the extent to which physicians align more closely with hospitals and health plans, and

the mechanisms that are used to achieve this goal. Entry of national physician management companies into the Newark market could accelerate the pace of change beyond what is occurring at the hospital system level. In contrast, the pace of physician-hospital integration and alignment may be slowed if the use of global capitation remains low in the Newark market.

Regardless of the nature and pace of future health system change, the Newark market will continue to be shaped by a mix of market forces and public policy that is unique to New Jersey.

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