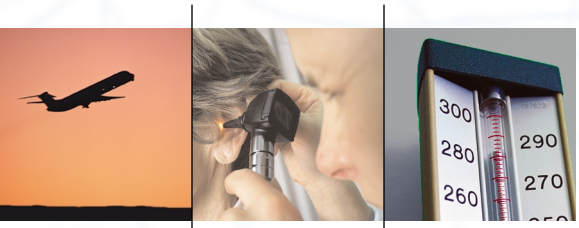
Community Report

THIRD VISIT
2000-2001

NORTHERN NEW JERSEY

Summer 2001



In March 2001, a team of researchers visited northern New Jersey to study that community's health system, how it is changing and the effects of those changes on consumers. The Center for Studying Health System Change (HSC), as part of the Community Tracking Study, interviewed more than 60 leaders in the health care market. Northern New Jersey is one of 12 communities tracked by HSC every two years through site visits and surveys. Individual community reports are published for each round of site visits. The first two site visits to northern New Jersey, in 1997 and 1999, provided baseline and initial trend information against which changes are tracked. The northern New Jersey market encompasses Essex, Morris, Sussex, Union and Warren counties.

Financial Pressures Continue to Plague Hospitals

Since 1999, when hospitals and health plans in northern New Jersey were struggling with poor financial performance, many hospitals' financial problems have worsened. The state hospital association reports that 60 percent of New Jersey's hospitals currently operate in the red. Small and urban safety net hospitals appear to be the most severely affected, raising concerns about low-income and uninsured residents' continued access to care. In contrast, most health plans are now financially stable and reporting profits. Meanwhile, many employers have experienced double-digit premium increases, and some enrollees face reduced options as plans become choosier about their customers and turn down some employers.

Other important developments since 1999 include:

- Health plans shed unprofitable lines of business and experimented with utilization management strategies to improve profitability.
- The New Jersey Legislature debated new managed care laws and added to extensive laws governing health plans already on the books.
- Public insurance coverage expanded, but key safety net providers remain on shaky ground.

Northern New Jersey Demographics

Northern New Jersey	*Metropolitan areas above 200,000 population*
Population, July 1, 1999 [1]	
1,954,671	
Population Change, 1990-1999 [2]	
2.0%	*8.6%*
Median Income [3]	
$32,890	*$27,843*
Persons Living in Poverty [3]	
10%	*14%*
Persons Age 65 or Older [3]	
14%	*11%*

Sources:
1. U.S. Bureau of Census, 1999 Community Population Estimates
2. U.S. Bureau of Census, 1990 & 1999 Community Population Estimates
3. Community Tracking Study Household Survey, 1998-1999

Hospitals in the market have continued to be plagued by financial pressures that stem from continued low payment rates and rising operating costs.

Urban Hospitals' Fiscal Health Remains Critical

Northern New Jersey has long been noted for its excess hospital bed capacity and high utilization of services—both of which have contributed to higher than average health care costs. The market's inpatient capacity is 36 percent higher than that of the average metropolitan market, and its Medicare patients' hospital length of stay exceeds the national average by 50 percent. In the early 1990s, state policy makers sought to address these problems by deregulation, replacing the hospital rate-setting system with a competitive model to drive down costs. Since then, hospitals in northern New Jersey have struggled financially, and significant efficiencies have not materialized.

In the past two years, hospitals in the market have continued to be plagued by financial pressures that stem from continued low payment rates and rising operating costs, due in part to a nursing shortage. In addition, hospitals have seen their revenues diminish because health plans have become more aggressive in their inpatient utilization management efforts—for example, by significantly increasing the number of denied days (days of a hospital stay for which health plans refuse to pay) and downgraded days (days reimbursed at a lower rate than usual).

Northern New Jersey's urban hospitals are in far worse financial condition than its suburban-based hospitals, and the financial gap continues to widen. Urban hospitals—which constitute the core safety net for low-income, uninsured individuals—have been particularly hard hit by declining patient volume and fewer privately insured patients. Although many urban facilities have been financially distressed for some time, the cumulative effect of these pressures has heightened concerns about their viability and implications for low-income, uninsured patients' access to care.

Such concerns contributed to a recent decision to allocate state funds totaling $9.5 million in 2001 and $5 million in 2002 to Cathedral Healthcare System, a Catholic hospital system with two key safety net facilities in downtown Newark that were in declining financial health and threatening to scale back services. The state also increased its $320 million charity care pool by $36 million this year—and expects to add $25 million more in 2002—to assist hospitals serving the uninsured. Nonetheless, hospital leaders lament that current state funding for charity care remains well below the $700 million available before deregulation.

Meanwhile, the finances of northern New Jersey's two largest, predominantly suburban-based hospital systems—St. Barnabas Health Care System and Atlantic Health System—are improving. Both systems were formed in the mid-1990s and, by 2000, both reported profits, recovering from previous years' losses. Their strong suburban base gives them a more diverse payer mix, with a higher proportion of privately insured patients who supply a steady source of revenue, than their urban counterparts. Although the suburban hospital systems have not escaped labor costs and problems with denied and downgraded days, they have benefited from various cost-cutting measures.

In addition, the nine-hospital St. Barnabas system and four-hospital Atlantic system have been aggressively leveraging their size and reputation in contract negotiations with plans in the past two years and succeeded in winning higher payments. Both systems have established themselves as "must-have" providers that purchasers insist are included in plan networks. They also have gained significant negotiating leverage with plans by moving to system-wide contracts instead of individually negotiated contracts for each affiliated hospital.

Last year, conflict over payment rates and issues such as utilization management led to a highly publicized contract dispute between Atlantic and Aetna U.S. Healthcare. Both parties made concessions, and new contract terms were eventually negotiated.

Aetna is reportedly paying significantly higher rates to Atlantic; Atlantic, in turn, reportedly signed a multiyear contract, which helped ensure the stability of Aetna's network.

Plans Move to Protect Profit, Exiting Public Programs

Since 1999, health plans in northern New Jersey have taken several measures to improve their profitability—including increasing premiums, shedding unprofitable lines of business and implementing aggressive utilization management strategies. While such measures have brought greater financial stability to the plan market, they also have brought rising premiums and fewer options for Medicare and Medicaid enrollees.

Many health plans have instituted double-digit premium increases. Employers in New Jersey's still-tight labor market have generally absorbed the premium hikes, making only modest increases in deductibles and copayments for employees. Many plans and employers also have adopted three-tier pharmacy benefit structures to combat rapidly rising pharmaceutical costs.

Instead of trying to expand market share, health plans have been taking a close look at their portfolios and shedding unprofitable accounts and lines of business. As a result, several plans have decided to abandon the Medicare and Medicaid markets. Three plans stopped participating in Medicare+Choice, and others reduced service areas, citing low payment rates and onerous program requirements. Currently, 90 percent of northern New Jersey's 25,000 Medicare+Choice members are enrolled in either Aetna or Horizon Blue Cross Blue Shield of New Jersey, but some observers believe that both plans may be considering ending their participation in Medicare+Choice.

Furthermore, Aetna recently announced it is selling its Medicaid line of business to AmeriChoice, the second largest Medicaid plan in northern New Jersey. As a result, Aetna's 118,000 Medicaid enrollees in New Jersey are expected to move to AmeriChoice. These changes may be blocked, however, because Aetna is bound by a consent decree to participate in Medicare and Medicaid until 2003, according to the terms of the state's approval of Aetna's recent acquisition of Prudential.

In the past two years, further growth in health care utilization in northern New Jersey—already a high-utilization market—has been reported by health plans. Although many plans have relaxed preauthorization and referral requirements in response to growing market demand for less restrictive care, they also have implemented other utilization management strategies aggressively in an effort to rein in costs. Many plans have adopted more stringent utilization management criteria and are adhering to these standards more strictly. The result has been a growing number of denied and downgraded days, which has angered providers.

Some plans also have increased the intensity of inpatient utilization management. Last year, Aetna placed nurses on site at several hospitals to assist with utilization management, including discharge planning, and plans to triple the number of nurses involved in such utilization management activities by the end of this year. Other health plans similarly report stepped-up activities focusing on discharge planning. Some hospitals view these activities as intrusive, but others reportedly are receptive to having additional personnel provide assistance, particularly as hospitals struggle with a nursing shortage.

State Increases Health Plan Regulation

Many states have increased regulation of the managed care industry in recent years, but, in comparison with the nationally representative sample of communities that HSC tracks, New Jersey's regulation is among the most aggressive. In the past two years, the New Jersey

Health Insurance Status

Northern New Jersey	*Metropolitan areas above 200,000 population*
Persons under Age 65 with No Health Insurance [1]	
12%	*15%*
Children under Age 18 with No Health Insurance [1]	
8%	*11%*
Employees Working for Private Firms that Offer Coverage [2]	
84%	*84%*
Average Monthly Premium for Self-Only Coverage under Employer-Sponsored Insurance [2]	
$198	*$181*

Sources:
1. Community Tracking Study Household Survey, 1998-1999
2. Robert Wood Johnson Foundation Employer Health Insurance Survey, 1997

Health System Characteristics

Northern New Jersey	*Metropolitan areas above 200,000 population*
Staffed Hospital Beds per 1,000 Population [1]	
3.8	*2.8*
Physicians per 1,000 Population [2]	
2.6	*2.3*
HMO Penetration, 1997 [3]	
17%	*32%*
HMO Penetration, 1999 [4]	
25%	*36%*

Sources:
1. American Hospital Association, 1998
2. Area Resource File, 1998 (includes non-federal, patient care physicians, except radiologists, pathologists and anesthesiologists)
3. InterStudy Competitive Edge 8.1
4. InterStudy Competitive Edge 10.1

Plans report that they have been reeling under the onslaught of New Jersey's managed care legislation.

Legislature has enacted new managed care laws, adding to the already extensive ones on the books.

A broad patients' rights law with various consumer protections was passed in New Jersey in 1997. The law prohibited gag clauses and mandated access to specialists and emergency care. It also expanded state oversight of health plans' financial status. In addition, it established a health plan report card that documents patient satisfaction and plan performance on a variety of clinical measures. Finally, it imposed financial sanctions on plans that fail to meet certain performance standards.

In 1998, New Jersey passed regulations, which became effective in June 2000, instituting a 10 percent annual penalty for late payments by plans to providers and setting a 45-day time limit for providers to contest claims. To ensure plans' financial solvency and avoid problems similar to those that caused two high-profile plan failures in 1998, the state recently established licensure requirements for provider organizations accepting certain risk arrangements. In addition, the state has required that plans contribute $50 million to a provider bailout fund to help compensate providers who were left holding the bag when the two plans folded. Recently, the New Jersey Legislature passed one of the strongest managed care laws in the nation—one that would permit patients to sue their health maintenance organizations (HMOs), and the governor signed the bill into law.

Plans report that they have been reeling under the onslaught of New Jersey's managed care legislation. One plan executive estimates he spends 20 to 25 percent of his time addressing regulatory issues—far more than he spent five years ago. Another plan noted that changes under the state's new prompt-payment requirement alone have required information systems' investments of $1 million. The fact that New Jersey has put health plans on a fast track to implement administrative simplification requirements in the federal Health Insurance Portability and Accountability Act (HIPAA) has created additional cost pressures. One plan expects that changes necessary to become HIPAA compliant will be its single largest expenditure this year.

The pressure on plans to compete in this tough regulatory environment—particularly with a mounting need for capital—may lead to further consolidation. Northern New Jersey experienced some plan consolidation over the past few years due to plan failures, as well as national mergers such as Aetna's with U.S. Healthcare and, more recently, with Prudential. Although 13 plans continue to operate in the area, market share is concentrated among five. Aetna, the leader in the HMO market, accounts for almost 40 percent of all enrollees.

Horizon Blue Cross Blue Shield of New Jersey is the only not-for-profit plan among the top five competitors; the four others are publicly traded firms. Competitive pressures may lead Horizon to renew its efforts, previously blocked by the state, to convert to for-profit status. The recent for-profit conversion of nearby New York City-based Empire Blue Cross Blue Shield may lend support to Horizon, if the plan decides to move in that direction.

Retreat from Managed Care Strategies

The current HMO penetration rate in northern New Jersey, 25 percent, is far lower than the penetration rate in many other markets nationally. Despite concerns about the market's high costs and high utilization, HMOs have been slow to make inroads in northern New Jersey, largely because many large employers with highly skilled and often unionized work forces have favored less restrictive coverage.

Since 1999, plans in the area have sought to attract enrollment by introducing more open-access products that

eliminate gatekeeper requirements. In addition, some plans are considering developing hybrid products that allow direct access to specialists, sometimes within narrower subnetworks. Many are also scaling back other restrictive product features such as preauthorization and referral requirements.

The recent move by some health plans to more loosely managed products has been accompanied by plans' and providers' waning interest in risk-contracting arrangements, which plans once advocated as an essential strategy for engaging providers in controlling costs. Atlantic invested $20 million in its physician-hospital contracting entity, Health Resource Partners, only to have it close two years later after failing to secure risk contracts from health plans. St. Barnabas' physician-hospital contracting entity, Physician Partnership, also struggled without risk contracts and has recently shifted focus to become the exclusive network of providers for St. Barnabas employees under its newly formed self-funded health insurance plan. Physician Partnership is the sole option for more than 22,000 St. Barnabas employees and their dependents; eventually, the plan may be marketed to local employer groups interested in direct contracting.

Several hospitals that had pursued mergers or affiliations with expectations of growth in risk contracting have abandoned these relationships. Chilton Memorial Hospital and Valley Health System (located just outside the market area) decided to go their separate ways in January 2001 because their more than three-year affiliation failed to yield any risk-bearing managed care contracts. Hudson County's Bayonne Hospital recently terminated its affiliation with Atlantic for similar reasons. Some observers contend that New Jersey's new regulations concerning risk arrangements have contributed to the decline of such arrangements. Others note that providers were slow to develop the infrastructure to accept risk contracts, and few risk arrangements ever materialized in the market.

Public Insurance Expands, but Safety Net Is Shaky

New Jersey recently has made significant strides in expanding public insurance coverage, following a period of slow enrollment in the State Children's Health Insurance Program (SCHIP). With a waiver from the Centers for Medicare and Medicaid Services—formerly the Health Care Financing Administration—New Jersey expanded the program to include adults with incomes up to 200 percent of the poverty level. The new program, known as New Jersey FamilyCare, includes the 70,000 children originally enrolled in SCHIP. It also will offer coverage to 125,000 low-income, uninsured adults.

The initial demand for New Jersey FamilyCare has been overwhelming. In fact, the volume of applications suggests that the program is fast approaching its enrollment cap. State officials are grappling with whether to use waiting lists or appropriate more funds to expand the program to include more people. The state has been financing its share of the $200 million program with tobacco settlement monies, employer contributions and enrollee premiums. A projected state budget deficit, however, may severely constrain the state's ability to find additional funding.

Meanwhile, the state-owned safety net provider in Newark, University Hospital, has become financially stressed over the past two years. Though improving now as intensive efforts take hold, this situation has prompted the state to consider possible mergers with other downtown hospitals—either St. Michael's Medical Center (part of Cathedral) or Newark Beth Israel Medical Center (part of St. Barnabas). Although both potential merger partners also are longstanding safety net providers, there is some concern that a merger would diminish overall

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Although New Jersey has successfully expanded public insurance options through New Jersey FamilyCare, state budget constraints may ultimately limit the reach of this program.

capacity to care for low-income and uninsured people, particularly in downtown Newark.

There also is concern that an imminent plan to establish a new residency program at the University of Medicine and Dentistry of New Jersey (UMDNJ) through the Atlantic Health System will deplete University Hospital of essential financial resources and physicians. UMDNJ is interested in establishing a suburban affiliation to attract a more diverse group of residents and compete more aggressively with academic medical centers located nearby in New York City and Philadelphia. For University Hospital, which has the current local residency program, such a move could prove challenging. It might even prompt the state to move more quickly with its merger plans for the hospital.

Issues to Track

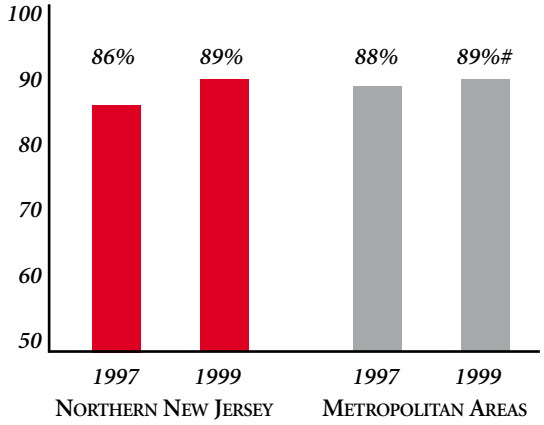
Financial pressures continue to plague many northern New Jersey hospitals, leaving some downtown facilities in a particularly precarious condition and threatening their capacity to care for low-income and uninsured people. Health plans' financial condition has generally stabilized, but competitive pressures in an intense state regulatory environment may promise change in the plan sector as well. As plans attempt to restore profitability and respond to consumer demand for less restrictive products, it is likely that employers will face escalating premiums, making health insurance coverage more costly. And although New Jersey has successfully expanded public insurance options through New Jersey FamilyCare, state budget constraints may ultimately limit the reach of this program.

These observations suggest several important issues to track:

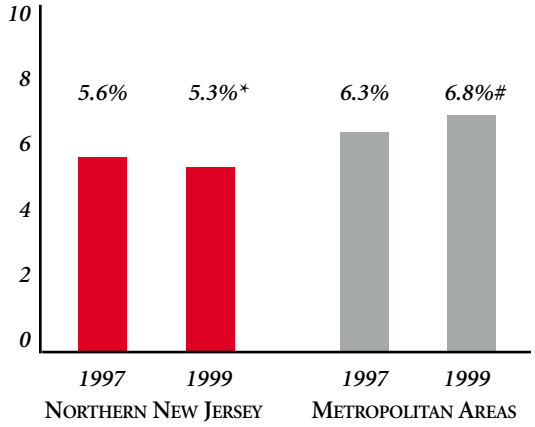
- Will New Jersey's hospitals achieve financial stability, and, if so, at what price for the safety net?
- How will health plans continue to deal with mounting cost pressures? Will plans continue to withdraw from the Medicare and Medicaid markets? Will another wave of plan consolidation materialize?
- How will employers respond to rising premiums? Will employers increase cost sharing for employees? Will greater pressure emerge to control costs and utilization, and, if so, how will plans respond?
- How will the state deal with the overwhelming demand for coverage under New Jersey FamilyCare? Will the state's projected budget deficit limit this program's potential?

Northern New Jersey's Experience with the Local Health System, 1997 and 1999

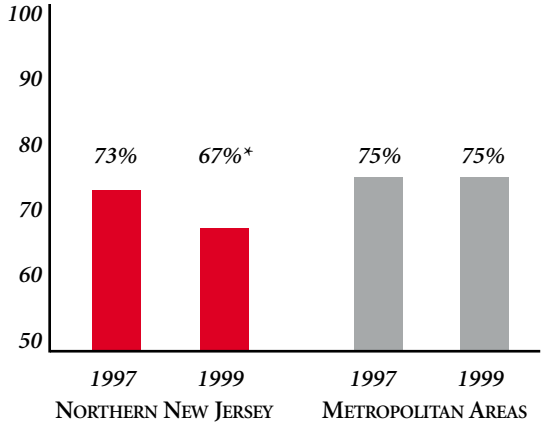
Persons Satisfied with the Health Care They Received in the Last 12 Months



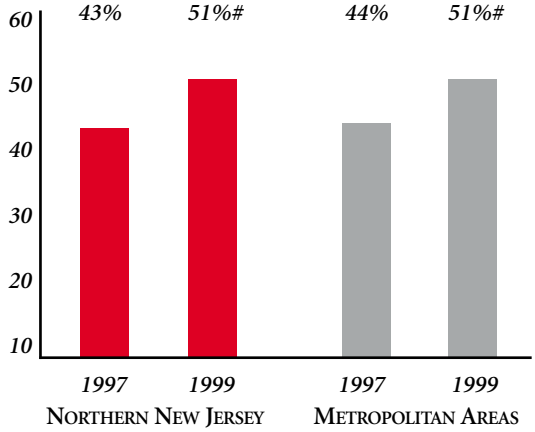
Persons Who Did Not Get Needed Medical Care in the Last 12 Months



Physicians Agreeing that It Is Possible to Provide High-Quality Care to Their Patients



Persons with Insurance that Requires Gatekeeping



** Site value is significantly different from the mean for metropolitan areas over 200,000 population.*
 # Statistically significant difference between 1997 and 1999 at p< .05.

The information in these graphs comes from the Household and Physician Surveys conducted in 1996-1997 and 1998-1999 as part of HSC's Community Tracking Study.

The Community Tracking Study, the major effort of the Center for Studying Health System Change (HSC), tracks changes in the health system in 60 sites that are representative of the nation. Every two years, HSC conducts surveys in all 60 communities and site visits in 12 communities. The Community Report series documents the findings from the third round of site visits. Analyses based on site visit and survey data from the Community Tracking Study are published by HSC in Issue Briefs, Data Bulletins and peer-reviewed journals. These publications are available at www.hschange.org.

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