CENTER for STUDYING HEALTH SYSTEM CHANGE

Community Report

NORTHERN NEW JERSEY

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In March 2005, 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 75 leaders in the health care market. Northern New Jersey is one of 12 communities tracked by HSC every two years through site visits. Individual community reports are published for each round of site visits. The first four site visits to northern New Jersey, in 1996, 1998, 2000 and 2002, provide trend information against which changes are tracked. The northern New Jersey market encompasses Essex, Morris, Sussex, Union and Warren counties.

URBAN-SUBURBAN HOSPITAL DISPARITIES GROW IN NORTHERN NEW JERSEY

Hospitals and physicians are aggressively expanding capacity to deliver profitable specialty services in suburban areas of northern New Jersey, fueling concerns about the cost of care. While expansions are occurring in the suburbs, smaller urban hospitals surrounding Newark continue to have financial difficulties, leading to the closure of several facilities. Meanwhile, health plans and employers have identified few promising strategies to contain costs but continue to experiment with new benefit and network designs. Other important developments in the market include:

- Growing numbers of specialist physicians are terminating contracts with health plans—or threatening to do so—in an effort to obtain higher payments.
- Employers are increasing employee cost sharing, but most are holding off on adopting consumer-driven health plan designs.
- Recent increases in the state's charity care funding pool have helped hospitals, but access to ambulatory care remains limited for uninsured people.

Suburban Hospitals Expand, While Urban Facilities Struggle

Hospital systems are expanding and upgrading facilities in suburban areas of northern New Jersey, while smaller hospitals serving urban areas are struggling. The area's two largest hospital systems—St. Barnabas Health Care System and Atlantic Health System—are competing aggressively for market share in the wealthy, suburban areas of the market where most of the area's population growth is occurring. Meanwhile, smaller community hospitals that serve the aging urban communities surrounding the city of Newark confront declining admissions, growing charity care burdens and deteriorating financial performance, resulting in several hospital closures in recent years. A third group of facilities, comprised of safety net hospitals that serve inner-city Newark, remain viable sources of care for underserved populations, but financial constraints limit their ability to upgrade facilities. These developments raise the prospect of widening disparities in care among the three groups of hospitals and the patients they serve.

Suburban Hospitals

Suburban hospitals are expanding profitable specialty services, such as cardiac care, cancer care and orthopedics, and marketing these services as distinct niche products within their institutions. St. Barnabas, the state's largest hospital system with five hospitals in northern New Jersey, reportedly has several hundred million dollars in planned expansion projects for its suburban facilities, including two large emergency department expansions, new diagnostic radiology facilities, additional neonatal intensive care unit and obstetrical beds,

Northern New Jersey Demographics

Northern New Jersey	*Metropolitan Areas 200,000+ Population*
Population[1]	
2,069,188	
Persons Age 65 or Older[2]	
13%	*10%*
Median Family Income[2]	
$34,923	*$31,301*
Unemployment Rate[3]	
6.1%	*6.0%*
Persons Living in Poverty[2]	
13%	*13%*
Persons Without Health Insurance[2]	
13%	*14%*

Sources:
[1] U.S. Census Bureau, County Population Estimates, 2003
[2] HSC Community Tracking Study Household Survey, 2003
[3] Bureau of Labor Statistics, average annual unemployment rate, 2003

and a major cancer center expansion. Similarly, Atlantic Health System is developing a new cardiovascular institute at one of its suburban hospitals and has completed a neurology center and cancer center at other facilities. Several other suburban hospitals are expanding emergency department capacity to help compete for market share, since most inpatients are admitted through emergency departments.

Improving financial performance among suburban hospitals has sped expansion efforts. Hospital systems have used their considerable negotiating leverage to secure sizable payment rate increases from private insurers. However, hospitals complain that the actual revenues they receive from insurers are limited by retrospective denials of coverage and other methods used to reduce spending on hospital care. Other factors that have boosted suburban hospital finances include increased admissions because of the closure of some urban facilities and modest increases in funding from the state's charity care pool (see box on page 3).

On the other hand, several local hospitals have experienced significant reductions in Medicare revenue because of a 2003 revision to outlier payments that compensate hospitals for exceptionally high-cost Medicare patients. Given the area's long lengths of stay, this national policy change may have had more impact in northern New Jersey than in other parts of the country and tempered some hospital expansion activities. But the hospitals reportedly have been able to partly recoup the lost revenue by increasing rates paid by private insurers.

Urban Hospitals

In contrast to their suburban counterparts, hospitals serving the lower-income, urban communities surrounding Newark and Elizabeth have experienced considerable financial hardship, although the mergers and acquisitions that occurred during the 1990s have provided a buffer for some facilities. Two of these hospitals closed over the past two years. St. Barnabas—a large suburban hospital system—closed West Hudson Hospital just east of the northern New Jersey market in 2003. Another urban facility, the Hospital Center of Orange, was closed in 2004 by Cathedral Healthcare System. The latter closure was notable because the hospital had planned to construct a new facility just before the new Medicare outlier payment policy radically changed the hospital's financial position.

Most observers viewed these closures as necessary to reduce excess hospital capacity in aging urban communities with stagnant or declining populations. Additional hospital closures are expected in the near future, including three facilities near the cities of Newark and Elizabeth that may be closed or converted to post-acute care facilities.

Inner-City Safety Net Hospitals

The safety net hospitals serving inner-city Newark have financial and institutional protections that so far have allowed them to avoid the economic decline experienced by smaller hospitals in surrounding urban communities. University Hospital, the only remaining public hospital in New Jersey, receives state appropriations to support its mission of serving low-income populations. Another Newark institution, Newark Beth Israel Medical Center, benefits from its affiliation with the primarily suburban St. Barnabas system and from its cardiac care program and other specialty service lines that attract insured patients from beyond the inner-city Newark area. Similarly, Cathedral Healthcare operates three hospitals in Newark, including one with a highly respected

Changes in New Jersey's Charity Care Funding Pool

New Jersey substantially increased funding for the state's charity care pool in 2004, expanding the pool by 50 percent to a total of $583 million and also distributing funds more broadly across hospitals to account for the care non-safety net hospitals provide to the uninsured. Created in 1985, the pool is used to partially reimburse hospitals for providing uncompensated care to uninsured patients. The state hospital association lobbied to increase the size of the pool and change the distribution formula to raise the level of funding non-safety net hospitals receive. To build their case, community hospitals improved their ability to document the level of charity care they provide.

Northern New Jersey's hospitals have benefited to varying degrees from the growth in charity care pool funds. Newark's University Hospital, the state's only public hospital, continues to receive the largest share of charity care dollars of any facility in the state, but it did not benefit significantly from the pool expansion. Suburban hospital systems, including Atlantic and St. Barnabas, received significant increases in funding, but they continue to account for a small proportion of total charity care pool dollars.

New Jersey imposed new taxes to help fund the charity care pool increase, including a tax on ambulatory surgery facilities and an interim tax on health maintenance organization (HMO) premiums.

cardiac surgery program that generates revenues to subsidize the system's other clinical operations. Nevertheless, the large volume of uninsured and publicly insured patients served by safety net hospitals places considerable financial constraints on their ability to upgrade facilities and, in at least one hospital's case, adopt such care innovations as electronic medical records and quality improvement programs.

Overall, hospitals in northern New Jersey continue to struggle with gaps in the quality and efficiency of care they provide in comparison to national norms. In recent years a series of national studies have documented that patients in New Jersey hospitals are less likely to receive evidence-based standards of care such as aspirin upon admission for heart attack patients,[1] while these patients are more likely to receive costly services of marginal clinical benefit.[2] Moreover, hospital lengths of stay are considerably longer in New Jersey than in many other regions of the country, making it difficult to generate positive earnings from Medicare's inpatient prospective payment system and leaving hospitals vulnerable to private plans denying payment for longer-than-average hospital stays. The widening gaps in financial performance between urban and suburban hospitals suggest that urban facilities will have fewer resources to support quality and efficiency improvement activities that could enhance their economic viability.

Funding for Charity Care Increases But Barriers Persist

New Jersey invested heavily in expanding care for the uninsured during the past two years, but a sizeable state budget deficit raises concerns about the sustainability of these commitments. The state has increased funding for the state's charity care pool, which partially reimburses hospitals for providing uncompensated care and has expanded

Health System Characteristics

Northern New Jersey	*Metropolitan Areas 200,000+ Population*
Staffed Hospital Beds per 1,000 Population[1]	
3.2	*3.1*
Physicians per 1,000 Population[2]	
2.3	*1.9*
HMO Penetration (including Medicare/Medicaid)[3]	
26%	*29%*
Medicare-Adjusted Average per Capita Cost (AAPCC) Rate, 2005[4]	
$891	*$718*

Sources:

[1] American Hospital Association, 2002

[2] Area Resource File, 2003 (includes nonfederal, patient care physicians, except radiologists, pathologists and anesthesiologists)

[3] Interstudy Competitive Edge, markets with population greater than 250,000

[4] Centers for Medicare and Medicaid Services. Site-level payment rates refer to Medicare Advantage AAPCC Payment Rates by County (Part A + Part B Aged Rates). National figure is actual payment per capita, based on payments for Medicare Coordinated Care Plans and the number of Coordinated Care Plan enrollees in April 2005.

Health Care Utilization

Northern New Jersey	*Metropolitan Areas 200,000+ Population*
Adjusted Inpatient Admissions per 1,000 Population[1]	
201	*197*
Persons with Any Emergency Room Visit in Past Year[2]	
16%	*18%*
Persons with Any Doctor Visit in Past Year[2]	
77%	*78%*
Persons Who Did Not Get Needed Medical Care During the Last 12 Months[2]	
3.5%#	*5.7%*
Privately Insured People in Families with Annual Out-of-Pocket Costs of $500 or More[2]	
47%	*44%*

# Indicates a 12-site low.

Sources:

[1] *American Hospital Association, 2002*

[2] *HSC Community Tracking Study Household Survey, 2003*

funding for community health centers. However, the state now faces a fiscal year 2005 budget deficit of approximately $4 billion. The state has used a variety of one-time strategies in the past two years to balance its budget, including securitizing future tobacco settlement payments to receive a portion of the revenue up front, so it now finds it difficult to identify solutions that do not involve service reductions or increased taxes.

The state budget difficulties are occurring as demand for safety net services increases. Many safety net hospitals and health centers in northern New Jersey reported growth in patient volume of up to 10 percent over the last two years, including increases in the number of uninsured and growth in immigrant populations and low-income patients displaced by recent hospital closures. Moreover, the freeze on new adult enrollment in the state's Family Care Medicaid expansion program has resulted in a steady decline in public insurance coverage. The program currently serves only half of the adults it did before the 2001 freeze, although the state recently passed a law to gradually open enrollment to a limited number of parents.

The safety net in northern New Jersey historically has struggled with financial difficulties and limited primary care capacity. Growing numbers of low-income patients have sought care from hospital emergency departments. Patient volume at University Hospital's emergency department increased by approximately one-third between 2002 and 2004, resulting in large increases in admissions that have caused capacity pressures throughout the hospital. The hospital's outpatient primary care is limited to a single on-campus clinic, where three-month waits for appointments are reportedly common. Newark Beth Israel Medical Center, part of the St. Barnabas Health Care System, has experienced a similar growth in emergency department utilization, along with an increased proportion of uninsured patients.

In an effort to expand primary care capacity, the state has increased financial support for community health centers in recent years. This funding has enabled the development of several new health centers, along with expansions at existing centers, with the total number of health center sites in New Jersey increasing from 52 sites two years ago to 80 sites currently. Additionally, acting Gov. Richard Codey is expected to sign a bill to permanently dedicate funds from an existing assessment on hospital revenue to grants for health centers across the state. This funding source has existed for years, but the funds often have been used for other health care purposes. This policy change is expected to approximately double the amount of state funding available for community health centers.

Access to specialty physician care remains difficult for low-income people. Private physicians' willingness to treat low-income patients reportedly has declined over the past two years, in part because of rising malpractice insurance premiums and the increasing number of adults who have lost coverage from the state's Family Care Program. Newark's University Hospital offers a full range of specialty clinics, but appointment wait times can be long. Private physicians generally do not receive reimbursement from the state charity care pool for treating uninsured patients. However, some hospitals have begun to pass through some of their charity care funds to their affiliated physicians for providing specialty—especially surgical—services to uninsured patients.

The recent increases in state funding for hospital charity care and community health centers should aid safety net providers in serving low-income people in northern New Jersey. Nevertheless,

observers remain concerned that funding and safety net services may not keep pace with the growth in demand for these services, especially in light of the state budget shortfall.

Physicians Compete and Collaborate with Hospitals

Physicians in northern New Jersey reportedly had been slower than their counterparts in many other areas of the country to seek new revenue sources through the development of specialty ambulatory facilities and services, but the recent growth in these activities has begun to strain physician-hospital relationships. Ambulatory surgery centers have emerged across the market and have begun to divert privately insured patients from hospital-based facilities. Additionally, most noninvasive heart testing has moved to physician offices and physician-owned facilities in recent years. Hospital systems have responded to these developments in different ways, with some systems partnering with physicians and others competing with the physician-owned ventures.

There are other signs of increased tension between hospitals and physicians. Increasingly, specialists want to be paid for taking emergency department call because of the combination of uninsured patient volume and continuing high malpractice liability insurance premiums. Emergency department coverage is particularly difficult for hospitals facing growing emergency patient visits, ongoing federal Emergency Medical Treatment and Labor Act (EMTALA) obligations and the unique challenges posed by mentally ill and substance abuse patients. Some hospitals also reported that physicians are seeking compensation for their work on hospitals' medical staff committees.

The problem of medical malpractice insurance premiums, which reached a crisis stage with physicians two years ago, has stabilized to a significant degree. In 2004, the state established a premium assistance fund to provide subsidies for certain specialties to protect them against liability insurance premium increases. Physicians continue to press for substantial tort reforms to hold down premiums, and some are pressing to be included in hospital malpractice self-insurance arrangements that hospitals provide for employed physicians. Most hospitals have not accommodated physician requests for inclusion, providing another source of tension between doctors and hospitals.

Physician Contract Terminations Challenge Health Plans

The contracting environment between physicians and health plans has grown increasingly turbulent during the past two years as physicians pursue strategies to increase revenue. Increasing numbers of specialty physicians reportedly are demanding large payment rate increases from insurers—in some cases far in excess of Medicare rates—and then terminating their contracts if these demands are not met. According to several health plans, some physicians are able to maintain or even increase their revenue by dropping out of health plan networks because many plans continue to base payments to out-of-network providers on a percentage of the usual, customary and reasonable (UCR) charges that prevail in the region—which may exceed a plan's established fee schedule for in-network providers. These relatively generous payments for out-of-network care have weakened health plans' negotiating leverage with providers. As a result, health plans are faced with the prospect of losing prominent specialty physicians from their networks and incurring higher out-of-network costs unless they acquiesce to specialists' payment demands.

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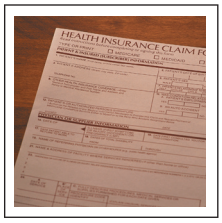

Health plans' contracting difficulties underscore relatively weak negotiating leverage with specialty physicians and hospitals and their corresponding difficulties in containing health care costs.

enced similar difficulties with physician-owned outpatient surgery, diagnostic and imaging centers. According to health plans, these centers often are developed by in-network physicians but operated as out-of-network facilities so their physician owners can receive higher out-of-network facility payments. Patients may assume mistakenly that the facilities—like their referring physicians—participate in their plan's network, only to learn after the visit that they are responsible for significant out-of-network cost sharing.

Health plans recently have initiated efforts to limit payments to out-of-network providers to contain costs and make contract terminations less attractive to providers. Several of the largest plans—including Horizon Blue Cross Blue Shield—have instituted caps on out-of-network payments to hospitals, ambulatory surgery centers and ancillary providers over the past year and expect to introduce similar caps for out-of-network physician payments. In most cases, the caps are based on Medicare rates, potentially allowing health plans to limit their out-of-network costs. However, these caps may expose patients to substantially higher out-of-pocket costs since patients typically are required to pay the remainder of any out-of-network provider charges not covered by plan payments.

Health plans' contracting difficulties underscore their relatively weak negotiating leverage with specialty physicians and hospitals and their corresponding difficulties in containing health care costs. No single health plan dominates the commercial insurance market in northern New Jersey, and strong consumer preferences for broad and inclusive provider networks have limited health plans' ability to secure price discounts from providers through selective contracting.

One of the largest insurers in the market, Horizon Blue Cross Blue Shield, has considered conversion to for-profit status in recent years—a move that many hospitals and physicians fear would result in acquisition by a national health plan that would pursue more aggressive efforts to constrain provider payments. State legislation permitting a for-profit conversion was passed in 2003, but Horizon eventually declined to exercise this option because of concerns about the financial implications and regulatory requirements entailed in the conversion. Some observers speculated that state officials have renewed their interest in a Horizon conversion because of possible conversion proceeds that could be used to offset the state budget shortfall, but Horizon officials maintained that conversion is not under consideration at this time.

Employers Take Modest Steps to Rein in Health Care Costs

Compared with counterparts in many other communities, northern New Jersey employers have been slower to shift costs to employees through higher deductibles, copayments and greater premium contribution shares. A strong union presence and a relatively robust labor market have contributed to the persistence of generous health benefits. Nevertheless, during the past two years, employers have taken small but significant steps to increase patient cost sharing and introduce other changes to health plan designs in an effort to constrain growth in health care spending. For example, some employers have changed from fixed copayments of $5 or $10 for office visits or prescription drugs to coinsurance where patients pay, for example, 20 percent of the cost of the service. Other employers have recently adopted models that require higher copayments for specialist visits than for primary care visits. Still other employers have added in-network deductibles to their plans for the first time or introduced lifetime maximum benefit levels.

Smaller employers increasingly have switched to health insurance products with more limited provider networks in an effort to constrain spending. For example, Oxford Health Plan, which

merged with UnitedHealthcare in 2004, has experienced significant growth in demand for its Liberty provider network, which includes about 10 percent fewer primary care physicians than its standard provider network and consequently offers somewhat lower premiums. This limited provider network has become Oxford's most popular network option. Larger employers so far have remained reluctant to limit provider choice through these kinds of product designs, instead opting to increase employee cost sharing.

Nevertheless, two national health plans have recently introduced health insurance designs with high-performance provider networks that attempt to differentiate providers based on measures of quality and efficiency and have begun piloting these products with large, self-insured employers in northern New Jersey. Aetna launched a product in early 2005 that uses measures of quality and efficiency in 12 different specialty areas to identify a preferred tier of physicians in each specialty, The product allows employers to establish differential cost-sharing levels that encourage patients to seek care from the high-performing physicians. UnitedHealthcare introduced a similar network design, known as its Premium network, to a limited number of national employers in northern New Jersey in late 2004. Some employers express a willingness to consider such product designs if they prove effective in containing health care costs, but so far few employers have purchased the new designs.

Issues to Track

Key issues to track include:

- How will suburban hospital expansions and new physician-owned ventures influence health care costs, quality of care and relationships between physicians and hospitals?

- How will urban hospital closures and capacity pressures at inner-city safety net hospitals affect access to care for low-income people in urban areas? Will these developments widen the existing disparities in care for urban vs. suburban populations?

- Will health insurers succeed in discouraging physicians from dropping out of plan networks and reining in the rising costs associated with out-of-network providers? Will health plans achieve greater negotiating leverage with providers through the development of high-performance networks and/or revised payment strategies?

- How will New Jersey's budget challenges affect the state's newly expanded investments in hospital charity care and funding for community health centers?

Notes

1. Jencks, Stephen F., Edwin D. Huff and Timothy Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-99 to 2000-01," *Journal of the American Medical Association* (Jan. 15, 2003).
2. Fisher, Elliot S., et al.,"The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine* (Feb. 18, 2003). Geographic detail available in appendix at *http://www.dartmouthatlas.org/annals/fisher03.php*.

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Northern New Jersey is one of 12 metropolitan communities tracked through site visits by the Center for Studying Health System Change.

Authors of the northern New Jersey Community Report:

Glen Mays, University of Arkansas for Medical Sciences
Robert Berenson, Urban Institute
Thomas Bodenheimer, University of California at San Fransisco
Laurie Felland, HSC
Anneliese Gerland, HSC
Lydia Regopoulos, HSC

Community Reports are published by HSC:

President: Paul B. Ginsburg
Director of Site Visits: Cara S. Lesser
600 Maryland Avenue SW • Suite 550 • Washington, DC 20024-2512
Tel: (202) 484-5261 • Fax: (202) 484-9258

www.hschange.org

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