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PAYERS COALITION FILES ANTI-TRUST ACTION AGAINST HOSPITAL AND ITS CONSULTANTS

The Health Care Payers Coalition has filed a lawsuit against St. Peter's University Hospital of New Brunswick, and consultants Prescott Associates and Medical Data Exchange Solutions (MD-X). The lawsuit alleges that the defendants have shared confidential pricing information, as part of a plan with other hospitals, to restrain trade and keep medical costs artificially high.

The action, brought in Middlesex County Superior Court, alleges, among other matters, that St. Peter's, in collusion with Prescott Associates and/or MD-X, has violated New Jersey Antitrust Laws through anti-competitive acts that affect the costs and markets for health care and hospital services.

Specifically, the suit contends that the defendants have engaged in a concerted manner to restrain trade by sharing pricing information with other hospitals that has resulted in reduced competition with respect to hospital reimbursement agreements and forced consumers to pay higher hospital charges.

The suit also charges that St. Peter's University Hospital knowingly violated the terms of its hospital reimbursement agreement with the Health Care Payers Coalition by disclosing the coalition's confidential pricing information.

According to allegations in the complaint, the defendants' actions have intentionally: a) reduced competition within the relevant health care services markets, b) fixed prices for health care services, and c) increased the likelihood of rising health care costs to consumers. The HCPC is seeking compensatory and treble damages from the defendants.

Edward Geisler, executive director of the HCPC, said the antitrust suit stemmed from testimony presented while the coalition was refuting unsubstantiated claims for retroactive payments brought by St. Peter's University Hospital. Geisler said it was during the discovery process regarding the complaint that the HCPC uncovered evidence that the consulting firms are obtaining and sharing pricing information between hospitals in New Jersey to enable the industry to set artificially high rates statewide.

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LOCAL GOVERNING BODIES JOIN HCPC TO SECURE COST & QUALITY CONTROLS

The Health Care Payers Coalition's continuing ability to offer its members a comprehensive purchasing network that combines high quality care with strong cost controls is beginning to attract the attention of municipal governing bodies in New Jersey.

HCPC marketing director Thomas Russo says the coalition has added six municipalities to its membership roster in recent years, including the City of Irvington, Wayne Township, West Caldwell Township, Hillsborough Township, Pequannock Township, and the Borough of Butler.

"As local property taxes and health care costs spiral out of control, more and more municipal governing bodies with self-funded benefit plans are searching for ways to contain costs while offering their employees wide access to quality care

providers," Russo states.

"With our purchasing network's member-friendly access fees, and the significant markdowns we're able to negotiate off actual provider charges, HCPC provides these governing bodies with what they are searching for – a preferred provider organization that emphasizes quality care, cost containment and accountability on the part of health care providers."

"To date, the feedback we have received from our municipal governing body members has been extremely positive and gratifying," Russo concluded. "Their third party administrators are nearly unanimous in their assessments that our access fees and agreed-to rates with hospitals, physicians and other ancillary care providers are among the lowest and very best in the health care industry."

FROM OUR VIEWPOINT

Co-Chairmen George R. Laufenberg & James C. Morford

Mandated coverage is one of the most complex and perplexing problems facing the health care industry today. We recognize that mandated coverage for specific illnesses is most often applied out of a sense of compassion for those who suffer from these conditions, and in some cases such coverage is necessary and appropriate.

Mandated benefits are also politically popular because they appear to be the humane course to follow at little or no cost to taxpayers and without budgetary consequences for government.

But, make no mistake about it, mandated benefits often result in a substantial increase in health care costs. Nationwide, the cost of providing mandated coverage, using 2002 dollars, is calculated at almost \$31 Billion. In 2001, the Health Insurance Association of America (HIAA) estimated that mandates were the reason that as many as one in four uninsured Americans lacked coverage.

Additionally, the HIAA found that the number of state mandates increased nationwide at least 25-fold between 1970 and 1996, and that over 1,000 coverage mandates were in place in 1999. By the end of 2002, only three years later, the Blue Cross/Blue Shield Association found there were nearly 1,500 mandates in the 50 states. Since then, all of these statistics can only have increased exponentially.

At the state level, a recent study by **Accenture** into the financial health of New Jersey acute care hospitals reveals that New Jersey has an inordinately high number of benefit mandates that health insurance companies must include in every policy they offer. Since 1972, our state has enacted 31 mandated health benefits, coverage or reimbursement to providers. In addition, there are another 77 health mandate bills now under consideration in the Legislature (see accompanying article).

Various health care consultants and insurance executives have estimated that existing mandates, both in New Jersey and nationwide, add 15 to 20% to the cost of health insurance premiums.

Yes, it can be argued that coverage mandates are often in the public interest because they guarantee access to specific coverage, expand benefits and enhance quality of care. But, it is also important to recognize that mandates are not free. Their costs more often than not show up in premium increases and eventually may result in an overall loss of insurance coverage and a higher number of uninsured state residents.

Health care costs and insurance premiums have spiraled out-of-control in recent years, causing many employer and union benefit plans to either reduce coverage or, in some cases, cancel it altogether. In an environment where everything possible must be done to contain costs and insure broad accessibility to health care, it seems counter-productive to continually legislate costly mandates.

The members of our coalition believe the excessively broad range of coverage for some mandated benefits (such as S-807, the legislation now under consideration to cover a broad array of behavioral disorders) could have a harmful impact on efforts to control costs while maintaining wide access to quality care.

Every effort must be made to accurately and realistically assess the benefits of mandated coverage as compared to possible drawbacks. In New Jersey, the Health Care Mandates Advisory Commission was established to review and report upon this type of legislation. The members of our coalition believe that the Legislature is not currently making sufficient use of this important body. Its advisory and analytical powers and resources should be strengthened and expanded upon, so that legislators have a clear understanding of the full consequences of any health care mandate measures that they are considering.

NEW JERSEY HEALTH CARE MANDATES

New Jersey has an inordinately high number of health care mandates, which every health insurance firm in the state must include in all the policies they offer. New Jersey has enacted some 31 mandated health benefits, coverage, or reimbursements to providers. Another 77 proposed mandates are now under consideration in the State Legislature.

According to one managed care executive, interviewed for a study of acute care hospitals undertaken by **Accenture**, these mandates add 15% to 20% to the cost of health insurance premiums. New Jersey has enacted the following health care mandates:

- Alcoholism Treatment
- Any Willing Pharmacy
- Biologically Based Mental Illness
- Bone Marrow Transplants
- Childhood Immunizations, Lead and Hearing Screening
- Colorectal Screening
- Congenital Bleeding Disorders
- Dental Anesthesia
- Dental Benefits for the Disabled and Children Under 5 Years Old
- Diabetes
- Domestic Violence Injuries
- Food and Food Products for Metabolic Diseases
- Home Health Care
- Infertility Treatment
- Mammograms
- Maternity Without Regard to Marital Status
- Minimum Maternity Stay
- Minimum Mastectomy Stay
- Nonstandard Infant Formula
- Nursing Home Care
- Off-Label Drug Use
- Out-of-Network Services
- Pap Smears
- Pre-existing Conditions Under Certain Circumstances
- Prescription Drugs: Par/Nonpar, Retail/Mail
- Prescription Female Contraceptives
- Prostate Cancer Screening
- Reconstructive Breast Surgery
- Second Medical/Surgical Opinions
- Wellness Examinations
- Wilm's Tumor

PAYERS COALITION REPRESENTED ON UNIVERSAL HEALTH CARE STUDY GROUP

HCPC Co-Chairman George Laufenberg and trustees David Knowlton and Christine Stearns are members of a working group that is studying ways of instituting a universal health insurance program in New Jersey.

Preliminary proposals now under consideration would compel every state resident to obtain medical insurance – as all drivers now must have car insurance – and require taxpayers to file proof of such insurance with their state income tax returns. The study group is seeking to provide health insurance coverage for some 1.25 million uninsured residents.

Those who do not currently have health care coverage would be required to join a state-administered managed care plan and pay affordable premiums and co-payments based on income and family size. Uninsured patients who visit an emergency room would be automatically enrolled. Employers who don't offer insurance to their employees would have to establish pre-tax accounts and deduct the cost of premiums from their workers' paychecks.

The proposal would also create a network of clinics to provide primary health care for some 447,000 illegal immigrants and the homeless.

"New Jersey, like every other state across the nation, is facing a crisis brought about by escalating health care and prescription drug costs and growing numbers of uninsured people who are draining our financial resources," said Laufenberg, who serves as Administrator of the NJ Carpenters Funds.

"We must do something to relieve this problem, but it won't be easy. Preliminary estimates say some form of universal care could cost taxpayers \$1.7 billion in the first year. Also, recent court decisions have ruled that "universal coverage" programs enacted in several other states are in violation of the federal ERISA law."

The study group was brought together by State Senate Health Committee Chairman Joseph Vitale (D-Middlesex) and includes legislators and representatives from organized labor, health policy agencies, and the hospital and insurance industries. Knowlton serves as President of the NJ Health Care Quality Institute, and Stearns is a Vice President with the NJ Business & Industry Association.

It's estimated that more than 45 million Americans currently lack medical insurance, and the burden of caring for them increasingly falls on the government, hospitals, and in the higher charges paid by those who are insured.

HCPC TAKES ANTI-TRUST ACTION (continued from page 1)

In papers filed with Middlesex County Superior Court, Lawrence Wertheim, a partner in the law firm of Himelman, Wertheim & Geller, said the discovery proceedings revealed that St. Peter's engaged Prescott Associates to gain information about health care pricing practices. The hospital then used this information to strategize pricing for its reimbursement agreements.

"A former hospital employee testified that the database St. Peter's obtained from Prescott contained 28 New Jersey hospitals," stated Wertheim, who represents the Health Care Payers Coalition. *"All 28 hospitals in Prescott's database were its clients, and in order for St. Peter's to obtain the information, it had to have its information included within that database. The testimony further revealed that hospitals use this information in their rate negotiations with insurance carriers."*

Court papers assert that, *"Prescott has engineered a combination and/or conspiracy among hospitals to share rate reimbursement schedules for the purpose of rate negotiations."* The allegations contend that the defendants have engaged in separate but parallel acts of conspiracy in providing pricing information to MD-X and/or Prescott.

Wertheim continued in court papers, *"The evidence adduced to date also supports allegations that the competing hospitals have an unspoken understanding amongst themselves to fix or control the prices they will accept under hospital reimbursement agreements. These actions tend to foreclose competition."*

Recent reports reveal that New Jersey hospitals set their gross charges higher than anywhere else in the nation – some 447% above what it actually costs them to provide care. This statistic is nearly double the national hospital average markup of 244%.

"The excessive cost of health care in New Jersey, as well as the actions of individual hospitals and their third party consultants to

set and control rates and reactivate long-settled claims, could force some benefit plans to reduce their benefits or drop coverage altogether," Geisler concluded, while noting that the NJ Hospital Association has endorsed the activities of MD-X.

"The Health Care Payers Coalition is forced to take this action to help ensure that our member plans will be able to maintain desperately needed health care coverage for workers and their families."



COMMISSION TO REPORT ON AVAILABILITY & FINANCIAL CONDITION OF HEALTH CARE SERVICES

Governor Jon Corzine has created a working commission and charged it with ensuring that New Jersey's hospitals and other health care services are appropriately configured to best respond to community needs for high quality, affordable and accessible care. In addition, the commission will seek to ensure that there is proper oversight and accountability of limited public funds.

Known as the **Commission on Rationalizing Health Care Resources**, the 11-member panel was created last fall by executive order and is being chaired by Uwe E. Reinhardt, Ph.D, a Princeton University professor and well-known authority on health care economics.

Since 1985, financial problems have forced 20 hospitals in New Jersey to shut their doors, 10 in the past seven years alone. Nearly half of the state's 81 acute care hospitals reported losses in 2005, according to the NJ Hospital Association, and the remaining earned less than a 1 percent profit. Hospitals represent the fifth largest industry in New Jersey, with some 150,000 jobs.

A 1999 report by the Advisory Commission on Hospitals claimed that a surfeit of empty beds was one of the main reasons contributing to the fiscal crisis in state health care services. Governor Corzine has suggested that closing struggling hospitals and reinforcing others might be one way to resolve the ongoing crisis.

In signing the executive order, Gov. Corzine acknowledged that *"there has been no comprehensive planning in more than a decade to assure an ongoing appropriate correlation between hospital capacity and demand for hospital services statewide."*

He added, *"Government and industry have a compelling interest in supporting a structured, rational assessment of in-patient capacity and primary care outcomes in order to support continued access to care and to promote better health outcomes."*

The commission will perform the following functions:

- Assess the financial and operating condition of New Jersey's acute care hospitals and analyze the characteristics of the state's most financially distressed hospitals to identify common factors contributing to their distress.
- Map existing health services statewide, project future demand for physicians, hospitals, federally qualified health centers and other ambulatory care providers, and compare future demand with existing capacity.
- Develop criteria for the identification of essential acute care hospitals in New Jersey to determine whether a financially distressed hospital at risk of closing is essential to maintaining access to hospital care for the residents of New Jersey.

- Develop criteria for the appropriate level of oversight and accountability where state assistance is being provided to financially distressed hospitals.
- Develop and publish a State Health Care Resource Allocation Plan that promotes the rational use of state and private healthcare resources, labor, and technology and serves as the basis for reviewing and approving the development and/or redeployment of healthcare assets and services around the state.
- Make recommendations to strengthen state oversight and ensure greater accountability of state resources.
- Issue a written report of its findings and recommendations no later than June 1, 2007.

ON AGAIN, OFF AGAIN — CONVERSION TALKS ARE ON AGAIN

State officials are at it again – holding talks with Horizon Blue Cross/Blue Shield about the possibility of converting it into a for-profit company.

The prospect has been discussed off-and-on for over a decade, because of the potential financial windfall it would mean for the state. Any decision to make the state's largest health insurer into a profit-making business would require an agreement to repay the state for nearly 70 years of tax breaks that it has received as a non-profit venture – a figure that could amount to as much as \$2 billion.

It's also estimated that company executives could receive huge bonuses by making Horizon an attractive takeover candidate. With 3.2 million subscribers, BCBS is easily New Jersey's largest health insurer.

According to a Star-Ledger article of January 31st, a Department of Banking & Insurance spokesman confirmed that Commissioner Steven Goldman has met with Horizon officials *"to confirm to Horizon the appropriate procedures to be followed in the context of a conversion, should Horizon wish to pursue one."* To date, no application has been filed.

While some legislators favor a conversion because of the "found" revenue it would provide to our cash-strapped state, others oppose it. Assembly Financial Institutions & Insurance Committee Chairman Neil Cohen says his research into conversions in other states indicates that corporate bonuses could reach as much as \$100 million. He opposes any conversion on the grounds that it could shortchange both consumers and doctors, especially if Horizon is then taken over by a larger firm.

The last bid by the insurer to convert to a stockholder company was abandoned in June 2005.

HCPC LEGISLATIVE REPORT

(S-807/A-2512) HCPC opposes this legislation, which would require employers to provide virtually unlimited insurance coverage for a wide variety of behavioral disorders, as well as alcohol and other substance abuse treatments. S-807 was approved by the Senate (29-9) on December 4, 2006, and referred to the Assembly Appropriations Committee where it is yet to be considered. The measure would apply to the 12 state regulated health insurance companies and the plans that cover state and local government employees (roughly 2.5 million people). It would provide parity coverage for non-biologically based mental health and alcohol and drug addiction treatment. Individuals with an addiction problem would receive coverage for as long as needed, instead of the current coverage for a limited number of days of in-patient or out-patient care.

A fiscal report released by the state Division of Pension & Benefits estimates that the cost to state and local government health plans in FY 2007 would be some \$15.6 million with increases in following years.

(A-3827 & A-3861) Introduced by Assemblyman Neil Cohen, these bills would expand the scope of the "Prompt Health Claims Authorization Processing & Payment Act" to include claims by occupational therapists, physical therapists and speech language pathologists (A-3827), and diagnostic centers and imaging centers (A-3861). The latter bill would further limit a payer's ability to evaluate and contest certain claims by reducing the time frame in which they could review a request for prior authorization to provide services from 15 to two days. Both bills have been referred to the Assembly Finance & Institutions Committee.

HCPC opposes this legislation on grounds that it places an unfair financial burden on payers, gives providers an advantage in adjudicating contested claims, and places severe restrictions on a health plan's ability to perform case management and claim reviews.

(S-477/A-1705) There has been no recent change in status of this legislation. Co-sponsored by State Senators Stephen Sweeney and Joseph Vitale, and Assemblymen John Burzichelli and Douglas Fisher, this measure would require large New Jersey employers with 1,000 or more employees to spend a specified amount per hour in health benefits for each employee who works at least 15 hours

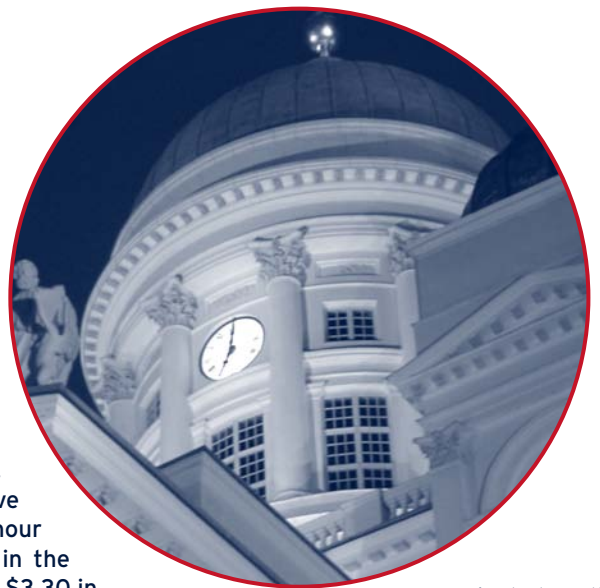
a week. Any employer who falls short of that mark would have to pay the balance through a special surcharge to a health care fund to be used to fund the FamilyCare Program.

Senate Bill 477 was reported out of the Senate Labor Committee on May 11, 2006 and referred to the Senate Budget Committee, where it remains. Under the bill, designated employers would have to contribute at least \$1.65 an hour per employee in health benefits in the first calendar year, and \$2.50 and \$3.30 in the second and third years respectively. Afterwards, contributions would be indexed to medical inflation rates. The bill's provisions would exclude independent contractors, high school students and college students who work part-time. A-1705 is in the Assembly Labor Committee.

(A-2951/S-2307) The Prescription Drug Right-to-Know Act. Sponsored by Assemblyman Herb Conaway and Assemblywoman Linda Greenstein, and State Senators Barbara Buono and Loretta Weinberg, this measure would require pharmaceutical companies to publicly disclose clinical trial data to the Department of Health & Senior Services. The bills are in the Assembly and Senate Health Committees.

(A-320/S-1291) Legislation provides for the regulation of pharmacy benefit management companies (PBMs) and requires that they be certified by the State Dept. of Banking & Insurance. It also requires that disclosures be made to the sponsors of health benefit plans that purchase PBM services and to individuals who are covered by those plans. Among other information, the PBM must disclose any revenues, rebates or discounts related to a purchaser's contract that it receives directly from a pharmaceutical manufacturer, labeler or other entity. The bills are in the Assembly Appropriations and Senate Commerce Committees. The sponsors are Assemblypersons Neil Cohen and Linda Greenstein and State Senator Nia Gill.

(S-2205/A-3834) Introduced by Senators Joseph Vitale and Thomas Kean, and Assemblywoman Linda Stender, this legislation would require health insurers and the State Health Benefits Plan to provide mental health benefits for eating disorders. The bill amends the definition of "biologically-based mental illness" to



include "all eating disorders, including but not limited to anorexia, bulimia and binge eating disorder." The bills have been referred to the Senate and Assembly Health Committees. The Pension & Health Benefits Commission has recommended against enactment of the measure.

(S-2308/A4045) This legislation, which is in the Senate & Assembly Health Committees, would require hospitals and nursing homes to implement infection-control practices that incorporate Society for Healthcare Epidemiology of America (SHEA) guidelines. It is designed to reduce health care facility-acquired infections, especially infections due to antimicrobial-resistant organisms such as Methicillin-Resistant Staphylococcus Aureus (MRSA) and Vancomycin-Resistant Enterococcus (VRE).

SHEA guidelines include a three-pronged approach to infection control: 1) screen and isolate carriers of MRSA and VRE, 2) adhere strictly to hand washing and hygiene guidelines, and 3) use antimicrobial agents prudently. Recent cost estimates for treating hospitalized patients with MRSA in the U.S. range between \$3.2 and \$4.2 billion a year. The federal Centers for Disease Control and Prevention found MRSA infections accounted for only 2% of staph infections in 1974, but more than 60% by 2004.

(S-2204/A-3454) Sponsored by Senator Joseph Vitale and Assemblyman Neil Cohen, this measure would require employers who employ 11 or more people to pay \$500 per year per employee for each of their employees who do not receive health care coverage through the employer, or through another source such as Medicare. All revenues would be deposited in the General Fund to help defray charity care, Medicaid and FamilyCare costs. The bills are in the Senate & Assembly Labor Committees.

REPORTS FOCUS ON STATUS OF NEW JERSEY HOSPITALS

A pair of recent reports reveal that New Jersey hospitals are financially stressed by inadequate government reimbursements for care, too many hospitals in the market, and for-profit outpatient facilities that cherry-pick insured patients.

One study by **Avalere Health**, a strategic advisory firm, places blame for many of the problems on hospitals themselves and the physicians who send them patients, and concludes that the quality of care in New Jersey hospitals doesn't justify their high charges.

The other study, commissioned by the NJ Hospital Association and undertaken by **Accenture**, focuses on how New Jersey hospitals are shortchanged by Medicare, Medicaid and the state charity care system for uninsured patients.

"Both reports are not only accurate but excellent," said David Knowlton, president and chief executive officer of the NJ Health Care Quality Institute and a founding member of the Health Care Payers Coalition. *"The Avalere report says that New Jersey's hospitals are exorbitantly expensive and that there is a wide variation around the state in hospital charges for the same procedures."*

According to the Accenture report, the Medicare and Medicaid programs and the state charity care subsidy program together cover 58% of all hospital patients treated in-state, but only pay between 73% and 92% of the hospital costs for these services, leaving a multi-billion dollar shortfall each year.

The Avalere Report, funded by Horizon Blue Cross/Blue Shield and the Robert Wood Johnson Foundation, notes that New Jersey physicians admit more people to hospitals than the national average, yet there are still too many patient beds and duplicative services in the state.

The NJ Hospital Association/Accenture Report disclosed the following statistics:

- Hospitals operating at a loss nationwide – 18%
- Hospitals operating at a loss in New Jersey – 42%
- Hospital bed occupancy, U.S. average – 65%
- Hospital bed occupancy, NJ average – 73%
- Days spent in hospital in last 6 months of life, U.S. average – 11.7 days
- Days spent in hospital in last 6 months of life, NJ range – 13.8 to 30 days
- Days spent in ICU in last 6 months of life, U.S. average – 3.2 days
- Days spent in ICU in last 6 months of life, NJ range – 1.9 to 12.8 days

DRUG INDUSTRY ADVERTISING AFFECTS PATIENT/PHYSICIAN RELATIONSHIPS

The results of a recent survey reveal the growing influence that the drug industry's direct-to-consumer advertising is having on patient/doctor relationships.

Some 78% of primary-care physicians interviewed for the survey said they are asked by their patients for specific drugs they've seen advertised on TV. Published in the February issue of *Consumer Reports*, the survey further found that 67% of doctors concede that they at least sometimes grant their patients' requests.

The magazine said such tendencies are troubling and cautioned patients that the pharmaceutical industry, *"spends billions of dollars a year trying to get you to pester your doctors for expensive, new brand-name drugs."*

Dr. William Plested, a cardiovascular surgeon in California and president of the American Medical Association, said that while it's good that people are taking more responsibility for their own health and treatment, a little knowledge can be a dangerous thing. He said there are risks when patients play doctor, which millions do daily with the click of a mouse.

"There's no question that people 'doctor shop,' if their own doctors don't give them what they want," Plested said. *"Many doctors are so time-crunched that they may cave in too easily to their patients' pleas."*

The magazine further reports that 40% of doctors surveyed believe direct-to-consumer ads by the pharmaceutical industry are a disservice to the public, and 41% of doctors feel patients are poorly informed.

Broadcast and print advertisements accounted for some 94% of the \$4.2 billion spent in 2005 on direct-to-consumer ads, according to a recent report by the federal Government Accountability Office. It said that such ads are increasing by about 20% a year and that the spots are obviously working, increasing the profits of drug companies and providing more money for research.

The federal Food & Drug Administration is charged with regulating direct-to-consumer ads, but the GAO report said the agency is able to review only a *"small portion"* of them. The FDA has the power to issue warning letters to drug companies about misleading or false ads, but seldom does so. In 2006, only two warnings were issued, said a FDA spokeswoman.

GROWTH IN U.S. HEALTH CARE SPENDING SLOWS

The growth in U.S. health care spending slowed in 2005 for the third consecutive year, reflecting a slowdown in the rise of prescription drug spending, according to a federal government report.

The study, the most comprehensive tally of the nation's annual health spending, found that the U.S. spent almost \$2 trillion, or \$6,697 per person, on health care in 2005, the latest year for which data is available. That represented a 6.9% rise from 2004, and the lowest growth rate since 1999. Costs rose 7.2% between 2003 and 2004.

Authors of the report, undertaken by the Centers for Medicare and Medicaid Services and published in the journal **Health Affairs**, assert that health care spending is dictated by factors such as the aging of our population, the development of new technology, and utilization patterns by patients and doctors.

The slowdown in prescription-drug spending has been notable. It increased by 5.8% in 2005, down from 8.6% in 2004 and a peak of 18.2% in 1999. The report stated that the drop was partly

caused by a sharp deceleration in drug expenditures by Medicaid, the state-federal program for the poor.

Drug spending by Medicaid rose only 2.8% in 2005, compared with average annual increases of 15.4% from 1994 to 2004. To restrain costs, states have worked together to get higher rebates on certain drugs and steered recipients to the use of those drugs. Medicaid also pushed for the use of less expensive generic drugs.

Even though the growth of prescription-drug spending has slowed, spending for other sectors, such as hospital, physician, and clinical services grew at rates similar to 2004, according to the authors. Hospitals accounted for 31% of all dollars spent on health care.

Despite the overall slowdown in health care spending, the study found that the percentage of personal income going for health care is rising. Out-of-pocket spending for health care grew to almost \$250 billion in 2005, compared with \$236 billion in 2004. One in five out-of-pocket dollars went to pay for prescription drugs.

COST OF TREATING ILLEGAL IMMIGRANTS

The New Jersey Hospital Association estimates that the state's 81 acute care hospitals will spend between \$275 million and \$300 million treating uninsured illegal immigrants in 2007. While that figure is less than 2% of the \$14 billion that hospitals spend to treat patients, hospital officials claim it is another factor pushing them into the red, and it hits urban facilities the hardest.

There are currently an estimated 11 million people living in the U.S. illegally. Immigration opponents say caring for unauthorized immigrants is a massive financial drain that threatens to bankrupt hospitals across the nation. Immigration advocates and some economists call such claims overblown and cite studies showing the typical illegal immigrant has far smaller health care bills than the average U.S. citizen.

Under federal law, hospitals must treat patients for emergencies, regardless of their ability to pay or their immigration status. While the state charity care fund reimburses hospitals for about half the cost of caring for uninsured U.S. citizens, illegal immigrants are not eligible for that money. That means unless illegal immigrants pay their own bills, the hospital usually winds up footing the entire cost.

The Medicare Part D Prescription Drug Act of 2004 allocated \$250 million to reimburse health care providers for treatment of undocumented immigrants. However, most of that money went to states along the U.S.-Mexico border, and New Jersey is eligible to receive just \$5.2 million a year.

A state working group is currently studying means of bringing universal health care to New Jersey. One proposal under consideration would set up a separate network of clinics for an estimated 447,000 undocumented immigrants and homeless people.

"If you say every (citizen) is going to have health insurance, which is the idea behind universal care, the only ones left will be the undocumented," says David Knowlton, president and chief executive officer of the New Jersey Health Care Quality Institute, and a founding member of the Health Care Payers Coalition.

"You have to begin with the premise that you can't not treat them, because of both federal law and moral obligations."

HCPC PURCHASING NETWORK & CASE MANAGEMENT SERVICES PROVIDE SIGNIFICANT SAVINGS FOR PARTICIPATING MEMBERS

Although confronted by hospital rates that increased some 5%, the Health Care Payers Coalition's purchasing network continued its superior record of savings in 2006, offering participating members an average 57% markdown off actual provider charges. The average markdown matched the percentage figure achieved in 2005, but the overall monetary savings of \$70 million in 2006 outpaced the 2005 total of \$55 million by some \$15 million.

In addition, participating member plans saved an average \$35 off actual charges for every dollar they paid to access HCPC's Purchasing Network in 2006. Access fees amounted to just 3% of total savings, which represents one of the highest margins of return for value in the health care industry today.

Final statistics for 2006 show that the purchasing network negotiated over \$70 million in savings off a total of some \$122 million in actual charges for inpatient and outpatient hospital care, treatment by physicians, ancillary care services and other outpatient charges.

At the same time, the coalition's case management and utilization review program continued to provide significant savings in 2006 by negotiating adjusted payments on provider claims for services that were either non-existent, over-priced, or unnecessary. On contested claims, HCPC's case management program saved participating members more than \$1.63 million off total charges of \$2.04 million, (or an 80% savings). This figure far exceeds the \$370,000 in savings that the program accumulated in 2005.

"The ongoing efforts of our purchasing network and case management services demonstrate that quality care and provider accountability can be obtained in New Jersey at reasonable rates," noted HCPC executive director Edward Geisler. *"I would also urge all of our member plans to take advantage of our case management and utilization review services on a regular basis, or when they come across a claim that doesn't seem right."*



"Under the direction of manager Diane Glancey, our Case Management Department has proven to be extremely adept at uncovering abusive and excessive billing practices, and then negotiating sizeable discounts. In some instances, claims are withdrawn altogether. This service can be a valuable resource for our membership."

HCPC savings in major health care categories in 2006 included:

- **\$42.5 million** off inpatient hospital charges (69%).
- **\$5.7 million** off outpatient, same day surgery charges (61%).
- An estimated **\$14.5 million** off physician charges (42%).
- An estimated **\$1.54 million** off ancillary care services (50%).
- An estimated **\$4.4 million** off other outpatient charges (38%).



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