# P U B L I C  H E A R I N G

before

## SENATE COMMITTEE ON INSTITUTIONS AND WELFARE

on

Senate Bill No. 330
(Licensing and Regulation of Medical Care Facilities)

Held:
March 25, 1970
Assembly Chamber
State House
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Joseph J. Maraziti (Chairman)

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# I N D E X


| | Page |
|---|---|
| Wayne Dumont, Jr.<br>Senator, 15th District | 1 - 34 A |
| Mrs. Anne Finlaw, President<br>New Jersey Assoc. of Homes for the Aged | 22 |
| C. Earle Armstrong<br>Christian Science Committee on<br>Publications for the State of New Jersey | 27 - 45 |
| Jack W. Owen<br>Executive Vice President & Director<br>New Jersey Hospital Association | 31 |
| W. Jefferson Lyon<br>Vice President<br>Hospital Service Plan of New Jersey | 47 |
| Richard J. Mellman<br>Vice President & Associate Actuary<br>Prudential Insurance Company | 1 A |
| Albert Kligge<br>New Jersey Nursing Home Association | 12 A |
| Leonard A. Coyle, Esq.<br>Attorney<br>New Jersey Nursing Home Association | 24 A |

SENATOR JOSEPH J. MARAZITI (Chairman): This public hearing will come to order. The purpose of this hearing, being held by the Senate Institutions and Welfare Committee, is to consider Senate Bill No. 330.

If anyone would like to testify, will you kindly give your name, address and the organization you represent, if you represent one, to the gentleman, Carl Moore, sitting at the front desk here and you will be permitted to testify. You may testify orally or you may submit a written statement, or do both.

At this time I would like to call the sponsor of the bill, Senator Wayne Dumont. Senator Dumont, proceed at will.

W A Y N E D U M O N T, JR: Thank you very much, Mr. Chairman, for this opportunity to speak on Senate Bill 330.

I want to go back, first, to the public hearing that was held by you as Chairman of the Senate Committee on Institutions, Public Health and Welfare, last May 2, 1969. At the very end of the transcript of that hearing you said: "We will adjourn the public hearing and we will look to Senator Dumont and Assemblyman Azzolina to come forth and produce a bill that will take care of the situation promptly."

Now in the almost 11 months that have elapsed I participated in, frankly, innumerable meetings, covering many hours of time, with virtually every group I know of in the State that has an interest in legislation of this type, and many changes have been made in last year's

Senate Bill 301, which was I dare say a stronger bill than Senate 330, in certain respects, in that it required, of course, uniform audits and uniform cost and accounting procedures, and therefore aroused the ire, to some degree, of the New Jersey Medical Society, the Hospital Association of New Jersey, and the Nursing Homes Association of New Jersey. I have had meetings with all of those groups, both separately and jointly, in the last year, or almost a year, and can therefore attest to what effort has gone into trying to revise this measure to make it more satisfactory to not only those groups but also to retain the basic element which would enable it to accomplish what it is designed to do in New Jersey.

And what Assemblyman Azzolina has done in the last year, only he can say, or someone in his behalf, because I know on several occasions, last summer and fall particularly, I informed him about meetings that we were having and asked him to be present but he did not attend any of those so I don't know exactly what his activities have been in connection with trying to resolve the problem.

I think I might continue with noting that not only this bill but six other bills which passed the Senate two days ago, on experience rating, expanded authority, shortening of the time of notice to subscribers, in regard to changes of rates, and a change in the corporate trustee set-up of Blue Cross - The Hospital Service Plan of New Jersey, are bills designed as a package, along with Senate 330 and four other bills that still remain in the Senate

Insurance Committee on subrogation and liens, to help stem the rising cost of hospital care in New Jersey, which is just plain getting to the point where it's getting out of reach of the man on the street and is, therefore, a very serious problem.

Just a few days ago the Hospital Service Plan of New Jersey released a statement, the annual statement of 1969, and I think it's significant to note that in 1965 Blue Cross, which has often been charged with simply paying costs of hospital care and not the charges on bills, although these are things that are negotiated either annually or almost annually by Blue Cross with its member hospitals, - that this statement points out that in 1965, only five years ago, Blue Cross paid member hospitals an average of $41.54 per day's hospital care; in 1968 that had risen to $60.35; and by the end of 1969 the Plan was paying an average of $67.34.

Now we know that a sizeable rate increase was granted to Blue Cross recently and will not become effective until May 1, 1970, but that's only about five weeks away, and that what that rate increase will accomplish is to cut down the deficit of almost $20 million in the reserve of Blue Cross to a deficit of $9 million. In other words, the rate increase that was just obtained, a very sizeable one, - it seems to me it was around 58 or 59% - will simply diminish the deficit, decrease the deficit, in the reserve from $20 million to $9 million.

This is all part of the climate, incidentally,

which has benefitted the passage of other bills that finally made it to the Senate on Monday, last, because some of those bills have been around since 1963, the change in the corporate trustee set-up and the experience rating bills since 1963, and each year they have been held back because of the opposition that they encountered. So it shows that the people themselves are becoming much more realistic because of the impact that rising hospital costs are having upon them in helping us here to pass legislation that may help to stem the rise in those costs through better planning than is being accomplished today, through being able to experience rate groups within the State, and through being able, also, through the expanded authority particularly, to stop what may be an unnecessary and excessive use of hospital beds where treatment could be administered and benefits paid by Blue Cross through the expanded authority bill, in the case of nursing homes and physical therapists and visiting nurses and other things, where today there is no clear authority whereby Blue Cross can pay benefits in those instances.

Now this is something we ought to all be interested in, in New Jersey, trying to hold down the costs of hospital care and health care generally, and the question is, how do you approach the subject to attain that objective best.

Senate 330, and I have no pride in the authorship of it, I'm just simply trying to get the job done that I think everybody admits has to be done but we don't seem to be in

agreement as to just how the best ends can be obtained, is a bill that would channel planning in various ways. For one thing, it would create within the Department of Health an agency that would be designated a Health Care Administration Board and consist of 17 members, some of whom would be Commissioners of various departments such as the Department of Health, the Department of - as it's referred to in the bill, and this is going to have to be corrected by amendment because we no longer have a Department of Banking and Insurance, we now have separate Departments of Banking and Insurance, and also the Commissioner of Institutions and Agencies. These three Commissioners, along with representatives of various groups, one or more representatives of various groups that are named in the bill, representing medicine, professional nurses, nursing homes, homes for the aged, boarding homes for shelter care, State Health Planning Council, Health Facilities Planning Council for New Jersey, and labor, and four members from the public at large,would be nominated by the Governor with the advice and consent of the Senate, and it would be in the Department of Health.

Now, herein lie two basic differences between Senate 330 and Assembly 200, which passed the Assembly by a vote of, I think, 56 or 58 to 2, on Monday, and has also been referred, Mr. Chairman, to your Committee in the Senate for consideration.

A-200 would actually leave a Commission of Hospital Care and Related Services, as it's called in the bill, in the Department of Institutions and Agencies, not

in the Department of Health. It would also provide that that particular Commission would be appointed by the Board of Control and not nominated by the Governor with the advice and consent of the Senate.

I've recommended on numerous occasions, as a matter of fact, to the Hospital Association and also to Assemblyman Azzolina that simply as a matter of practical consideration a board of this kind, in my humble opinion, would not pass the Senate embodied in a bill that did not require Senate confirmation.

SENATOR MARAZITI: I think that's a very practical observation.

SENATOR DUMONT: And, in addition to that, as you and I know from our years of experience here, any important agency is not going to be appointed without Senate confirmation and usually without being nominated by the Governor.

So that Assembly 200, of this year, contains that same, in my humble opinion, basic defect as last year's Assembly 200 also contained.

In addition to that, as I say, it leaves the licensing procedure in the Department of Institutions and Agencies. My own feeling - and this is one I'm not about to compromise on, although I've been asked by various sources to do so, - is that the licensing function ought to be taken out of Institutions and Agencies and transferred to the Department of Health.

In the first place, when you're talking about health

care, what makes more sense, logically, than that something ought to be in the Department of Health rather than in the Department of Institutions and Agencies, involving health care.

In the second place, I have here a letter from Lloyd Wescott, who is one of my most capable and distinguished constituents, I might add, and who has for years served the State of New Jersey in a great many different capacities without any monetary compensation whatsoever, and who is a wonderful citizen of this State doing a great deal of work, free of charge, for the people of the State. He wrote me on November 17, 1969, and I quote from his letter here: "As you know, I have always felt that in theory hospital licensing and the Hill-Burton Program should be in a Department of Health. This probably is more significant now in view of the fact that the Federal 749 legislation put comprehensive planning there. In making this recommendation, I want it clearly understood, however, that I am not being critical of Institutions and Agencies. My guess is that we have as satisfactory a licensing program for hospitals and nursing homes as any in the nation, and we have done as well with our Hill-Burton Program as has anybody else. And I would mind having the implication exist, if the switch were made to Health, that it was done because of any failure on the part of this Department or staff."

Now here's a man who heads the group that sets the policy for the Department of Institutions and Agencies

to be carried out by the Commissioner of that Department as the chief administrator of the Department. And he is saying that while he thinks the job has been done and done well - nobody questions that it's been done at least reasonably well in the Department of Institutions and Agencies, he's saying right here in cold language that it ought to be transferred, the licensing and the Hill-Burton Program, to the Department of Health. And I don't think you can get any better testimony for the transfer than the fact that the man who heads the Board of Control, has been Chairman of it for years, or President of it, believes that the time has come to transfer hospital and nursing home licensing over to the Department of Health and not continue to burden the Department of Institutions and Agencies with that.

Now all of us are aware of the fact that the Department of Institutions and Agencies is probably the largest department in State Government; that it must operate and regulate at least 30 different public institutions which are absolutely necessary to the well-being of the State of New Jersey and its citizenry; and that that ought to be enough for this Department to administer without also to have to carry on with the function of licensing and thus supervising hospitals and nursing homes.

So I think that A-200, in leaving this function in I&A, rather than transferring it to the Department of Health, is basically unsound.

Now I wouldn't quarrel at any time with the concept of a certificate of need, which is what A-200 is directed toward. As a matter of fact, that same certificate of need is also incorporated in S-330. We know that if planning is to be orderly in the future in New Jersey that a certificate of need ought to be required before a new hospital or an addition to an existing hospital or a nursing home should be constructed.

SENATOR MARAZITI: Senator, in other words, A-200 requires a certificate of need and you have no difference in this regard, and that's incorporated in S-330.

SENATOR DUMONT: That's right.

SENATOR MARAZITI: Is there anything else substantial in A-200? Does that do anything else besides requiring a certificate of need?

SENATOR DUMONT: It just requires a certificate of need. And while all of us recognize this is a necessity in New Jersey for the future, my problem with A-200 is that it stops right there.

SENATOR MARAZITI: Now, Senator, in connection with the certificate of need requirement, is the procedure for that certificate in A-200 basically the same as the procedure in your bill, or do you recommend a change in procedure?

SENATOR DUMONT: It's basically the same by virtue of certain amendments which we have been making to S-330 which, as a matter of fact, do not show up in the original print of S-330 because I didn't ask for an official copy

reprint. We've changed amendments so many times, we were making them, as a matter of fact, through last week, and we felt it would simply be a waste of money to get an official copy reprint of S-330 until we finally agree on everything that should be in it, and I'm not sure that we're going to be able to agree with some of the organizations that will testify here today. I have a feeling that at least one of those organizations really wants no regulation at all, governmentally speaking, and also wants to remain in I&A. These are things that I am not about to compromise on because I think it's a function that ought to be taken out of I&A, transferred to the Department of Health, and, at the same time, most of the provisions in regard to licensing that are in A-200, regardless of the certificate of need, either are already by way of amendment going to be incorporated in S-330 or are about to be. There is one particular provision that was raised by the Nursing Homes Association to me when I last met with Leonard Coyle on Monday, or last week, I guess it was last Thursday, as a matter of fact, and it had to do with the grandfather's clause - I haven't given the specific language of it here because I don't recall exactly what the specific language is, but I assured him that language that would reasonably accomplish what he wants would be included in Senate 330 by way of a grandfather's clause, so that those nursing homes that may not conform exactly to more recent requirements would not be hurt by virtue of the passage of S-330 as long as they were safe and provided a healthy atmosphere for people.

So I don't think that we are in any real disagreement about that provision, or most of the other things that are a part of A-200. And my quarrel with A-200 is not in the basic principle of it, I agree that we need certificates of need but I don't think these functions should any longer be kept in the Department of Institutions & Agencies. I think any board that's created ought to be nominated by the Governor and confirmed by the Senate, and I think A-200 is deficient in not going far enough.

SENATOR MARAZITI: Right. In other words, you agree with the certificate of need requirement; you agree basically with the procedure for that certificate; you disagree as to the Department - it should be, according to you, in Health; and you recommend that the Board be appointed by the Governor with the advice and consent of the Senate.

SENATOR DUMONT: Right.

SENATOR MARAZITI: And the other observation you have on A-200 is that although it does go part way and basically is a good thing as far as it goes, it does not go far enough, which S-330 picks up and continues. Perhaps you can tell us the additional features of S-330.

SENATOR DUMONT: Well, S-330 tries to relate itself to all planning for health care, not just the physical facilities. A certificate of need, for example, has to do only with the construction of physical facilities, it does not go into the other aspects of health care that are just as important.

SENATOR MARAZITI: Physical facilities, would that be --

SENATOR DUMONT: The building.

SENATOR MARAZITI: The building. It would include the equipment, too, I imagine?

SENATOR DUMONT: That's right. Well, actually, the equipment might come under other aspects of health care but I think some of the equipment, certainly big things, would probably be a part of the physical facility, to a large degree. My understanding of a certificate of need really relates to the building itself, that you should not overbed a particular area. We all agree with this. I remember when I sat as Chairman of a Legislative Commission that did its work between 1960 and 1962, which reported in November of 1962 and that report, incidently, included some of the bills that we passed in the Senate last Monday, March 23 of 1970.

But in there we listened to witnesses from other parts of the Nation who recommended that voluntary planning ought to be given a fair chance to work. And I would still like to see it work, 8 years later, although I'm not convinced there has been any great success up to this time. But we would still like to see it work.

And in S-330, the planning is directed along two lines, one is, we recognize the State Health Facilities Planning Council or the Health Facilities Planning Council for New Jersey, which is its proper name, technically, on which I have served, ever since it was created, as a Trustee. We recognize that Council and give it some not only recognition but authority in S-330, so that planning would

still start on building construction with the local regional councils which have been created to the extent of 12 of them, all over New Jersey, by the Health Facilities Planning Council of New Jersey, consisting of local citizens who make recommendations in the particular region, of which their council is comprised, as to whether or not they think a hospital, a new one or an addition to an existing one, is necessary in that particular region. Their recommendation then goes to the State Council, Health Facilities Planning Council for New Jersey, and in turn - and usually we follow the recommendations on the State Council from the Local Regional Councils - we transmit that to the Department of Institutions and Agencies which may or may not follow the recommendation of the State Council.

That is still a voluntary planning agency. It has no real existence in law today but it would be recognized under S-330 as a chain of approval for hospital and nursing home construction.

SENATOR MARAZITI: In other words, you would incorporate this existing setup into S-330.

SENATOR DUMONT: That's right.

SENATOR MARAZITI: May I at this time, Senator, interrupt you for just a moment to welcome the visitors in the gallery, the teachers and the parents.

SENATOR DUMONT: Surely.

SENATOR MARAZITI: We are very happy to have you here. I would like to explain very briefly what we're doing. We are sitting here as a Senate Institutions Committee and the

gentleman who is testifying now is Senator Wayne Dumont of the 15th Senatorial District. He is testifying on a bill that has been introduced by him in the Senate, having to do with regulating health facilities and related matters. We will hear testimony from others today and then the Committee will make a report and then the bill may or may not be considered by the Legislature. This is a part of the legislative process. We are very happy to have you here.

SENATOR DUMONT: Now in relation to other aspects of health care, we recognize also in S-330 the existence of the State Health Planning Council, which is a group of people, very distinguished citizens, from around the State, drawn from different walks of life and different backgrounds, existing today in the Department of Health. This particular group doesn't pass upon physical facilities, it does relate itself to all other kinds of comprehensive health care. This operates in a little different way. They have at the local level, the State Health Planning Council, what are known as comprehensive areawide health planning agencies which are much like the Regional Councils passing upon physical facilities, buildings that is, as designated by the Health Facilities Planning Council.

I recognize that these terms tend to get somewhat interlocked and it's not always easy to follow the chain of command, so to speak. But we tried in Senate 330 to say that from the local regions the recommendations will come to the new board that would be created in the Department of Health from, first, the regional councils with respect to

buildings and building construction, to the State Health Facilities Planning Council, and thence to the board that would be created under Senate 330. But other aspects of health care would start with the areawide Health Planning Agency, also created locally by the State Health Planning Council, of which, incidentally, I believe Martin Ulan, who is the Administrator of the Hackensack Hospital, is the present Chairman, and from their areawide local councils to their State Council, of which Mr. Ulan is the Chairman, would come the recommendations in regard to other aspects of health care and they, in turn, would be transmitted to the new board that would be created in the Department of Health.

So we would actually keep the voluntary agencies separated, one for physical facilities, the other for other aspects of health care, and thus cover the whole range which, again, A-200 does not do. It does recognize the Health Facilities Planning Council of New Jersey but I don't find in it any mention of the State Health Planning Council which shows that the bill therefore is basically confined to physical facilities and not to other aspects of health care in the State.

Now planning in respect to buildings is important but equally important is planning with respect to expensive equipment. Let's assume, for example, that there might be a half dozen or more hospitals in a given region, that each of those hospitals decides it would like to have expensive equipment, such as open heart surgical equipment or cobalt equipment, or whatever it might be, which costs a lot of

money; obviously, that's not good planning. The best way to plan is to perhaps have that equipment in one hospital in that particular region to which patients from other hospitals could be sent. But it doesn't make sense, if you're going to hold down health costs and the cost of these contracts of Blue Cross and Blue Shield to their subscribers who now total 3.5 million people in New Jersey and that's 50% of all the population of the State, it doesn't make sense to duplicate unnecessarily either beds, through hospital construction, or equipment that is highly expensive. We know that the main reasons why hospital costs rise are improved salaries - and certainly they were necessary because I can remember, being a Hospital Trustee myself for well over 15 years, that salaries were much lower than they had any reason to be, years back, and they have increased to a point where today they are not too bad, but with salary increases coming on and medicines and everything else costing more than they used to, and also materials for building construction, of course the costs are going to rise. But our responsibility is to try to hold them within reason and I think the only way we can do this is to attack the entire problem and not just one facet of it.

And while I have no quarrel at all or any objection to A-200 in the sense that it does go to one facet, that's the thing that I think is not right about the bill because we ought to be attacking the problem on a much broader basis and, in addition to that, we ought to be transferring from I&A to Health the functions that should be coordinated and

assembled in one agency.

And, incidentally, that simply carries out the policy laid down by the Congress of the United States in Public Law 89-749 which passed Congress in 1966 and is known as The Comprehensive Health Planning and Public Health Services Amendments of 1966.

That Act, among other things, said that there should be one central comprehensive responsibility in each state with respect to health planning, hospital and related health care services, and public and private institutions, whether state, county, municipal, incorporated or not incorporated, serving principally as boarding homes or other homes for the shelter care of adult persons or as facilities for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or other physical condition. And, therefore, it seems to me, instead of having the present proliferation that we have today in various departments we ought to assembly it all in one department, namely the Department of Health, and give it the responsibility and the obligation to take care of these things.

Now, aside from taking out of last year's 301 the provisions that irritated groups in respect to uniform audits and accounting procedures, we have also made it clear in Senate 330 something that was not done in S-301 of last year, that the Commissioner of the Department of Health, whoever he may be, will not be able to move without the concurrence of this board that would be nominated by the Governor and confirmed by the Senate, because I recognize

that one of the defects of S-301 of last year was it placed too much power in one person, however good he might be. So we have divided that by saying that the board, which would consist of 17 people, and has broader coverage than the 12 member board proposed in A-200, would have to concur in any recommendations made by the Commissioner of Health. And we have tried to get it in such manner that it no longer is objectionable because of its being perhaps too strong a bill to some of the groups that objected to 301 last year.

I think the best evidence of that fact lies right here in the Bulletin of the New Jersey Medical Society, dated March 5, 1970, which indicates, in relation to Senate 330, "approved." Last year's 301 was not approved by the Medical Society.

I don't think that the New Jersey Hospital Association and those of us who have been working, including Dr. Curtis Culp who has rendered a great deal of excellent service on amending S-330 and trying to get it into shape where it might be able to pass, - I don't think we're very far apart, in fact maybe not apart at all anymore because of some of the amendments that were added last week, with the Hospital Association. The Nursing Homes Association, as you will hear later, has objections to certain phases of the bill, one of them, they want to leave it in I&A, I am not willing to compromise on because I just don't think it ought to remain there.

So I think that basically this bill does more than the other bills and I also remember, from the version of

A-200 that was introduced in 1968 in the Assembly, that A-200 today is a much stronger bill than that first bill was and I think this has largely happened because of the pressure of stronger pieces of legislation also being introduced in the Legislature and thus we are getting closer and closer to a meeting of the minds.

I think it would be too bad if this were delayed any longer and I hope that this spring we can resolve the problem finally and get on with trying to help hold down the cost of health care to the point where the man on the street, so to speak, is going to be able to afford to be ill if that is necessary.

The Trenton Evening Times, for example, on October 28, 1969, had an editorial entitled Who Can Afford to be Sick? This is a real problem in the State and I think it's one to which we have to direct our complete attention until it is resolved and I hope that will be this spring.

Thank you very much, Mr. Chairman.

SENATOR MARAZITI: Yes, Senator. I wonder if you could assist me in several respects here.

SENATOR DUMONT: I'll try.

SENATOR MARAZITI: You referred to the hearing held last year and I recall that at that time an effort was made by the Committee and by yourself and others to attempt to get together and work out a bill that would encompass most of the provisions that the various interests and groups wanted. Now apparently you were not able to do this. Is that correct?

SENATOR DUMONT: I think in speaking I can only speak in my own behalf here. I think I tried to do that. These meetings go back to early last summer and this hearing that you held last year was on May 2. I can't recall them all but I know I met with representatives of Johnson & Johnson, who are active in the Hospital Association and supporting A-200, last July. I met with a group from the New Jersey Hospital Association last August. I met with the State Health Planning Council, which is in the Department of Health and which I mentioned previously, last October. I had one day of a meeting, a whole day of it, in Princeton, I think in December that was, with representatives of the Medical Society, the Nursing Homes Association, the New Jersey Hospital Association, the Association of Registered Nurses - I don't have the name exactly right - and with some other groups, for a day in Princeton trying to iron out the problems. This was in December.

I think I have met individually with the Nursing Homes Association representatives about four times, at least with Mr. Coyle in the last two weeks, as a matter of fact. And I have talked at great length to the representatives of the Hospital Association and, to a lesser degree, with the Medical Society which, as I've indicated already, supports 330.

In addition to that, I have had numerous conferences with Dr. Culp, representing the Department of Health, in respect to this bill, as to what they believe they could administer if the bill were passed. And I can't even recall

all the meetings and all the hours that have been spent, but they've been plenty.

SENATOR MARAZITI: I understand the basic purpose of this legislation is to correct a situation where we now have excessive numbers of facilities in one area and perhaps not sufficient in the other. Is this the factual background of the legislation?

SENATOR DUMONT: Well, we've been trying to correct that in the Health Facilities Planning Council of New Jersey which meets every month, incidentally, all through the year, and which has long been concerned with that problem. I think that we've come a long ways toward trying to eliminate excessive hospital bedding in certain areas. But, after all, it's any individual's or group's right to want to build a hospital or a nursing home or add to a hospital. The problem is, of course, if they don't get the approval of the various agencies through which they must go today they may very well not qualify for any federal funds. So that in that way I think we've probably made progress. But there is a great deal yet to be done. And, aside from the overbedding which can happen, it is just as important to hold down on the very expensive equipment and not have that in too many different hospitals in the same close proximity.

SENATOR MARAZITI: Like this cobalt set-up you mentioned.

SENATOR DUMONT: That's right.

SENATOR MARAZITI: Thank you very much, Senator. I wonder if you will be able to remain with us part of the

day because there may be some other points that may be raised that we would like to get your views on.

SENATOR DUMONT: Well, not only that but I would like to hear what the other witnesses have to say because if there are things that we've missed in our meetings that are very reasonable amendments, I would be more than happy to make them and listen to their objections and their criticisms and suggestions.

SENATOR MARAZITI: Thank you very much, Senator.

I will more or less proceed according to the order in which people have registered. However, if there is anyone here who must leave immediately, you may at this time come forward. Unless there is someone in that category, I will call Mrs. Ann Finlaw, President, New Jersey Association of Homes for the Aged.

Mrs. Finlaw, will you kindly give us your full name and address?

A N N F I N L A W: Yes. Senator Maraziti, ladies and gentlemen, I am Ann Finlaw, President of the New Jersey Association of Homes for the Aged, and our office is in Moorestown, 100 Colonial Avenue.

SENATOR MARAZITI: Thank you very much. We are very happy to have you here and you may proceed at your convenience.

MRS. FINLAW: Thank you.

I address my remarks to the Committee on Insitutions and Welfare, to members of the Senate and, in particular, to Senators Dumont, Maraziti and Forsythe, Sponsors of

Senate Bill 330.

On behalf of the Board of Trustees of the New Jersey Association of Non-Profit Homes for the Aged and its members, I wish to say that we are privileged in having a most cordial and meaningful relationship with Mr. Russo, Chief of the Bureau of Community Institutions, and with his excellent staff.

Our Association has had many meetings and each one has been informative and constructive. Mr. Russo and his staff have demonstrated their understanding of the philosophy of the non-profit homes for the aging, and they have been explicit in interpreting application of the new and complicated regulations.

The New Jersey Association of Homes for the Aged would deplore any severance of relationship with the present staff of the Bureau of Community Institutions.

If Senate Bill 330 becomes law and the Bureau of Community Institutions is transferred to the State Department of Health, including "such officers and employees as are necessary" our Association naturally will cooperate in every way to help accomplish the aims and the purpose of this transfer.

SENATOR MARAZITI: I see that Mr. Russo is a very important person.

MRS. FINLAW: Very definitely.

We do have attached one question and one recommendation. The question refers to page 1, section 2 - "The following words or phrases, as used in this act,

shall have the following meanings, unless the context otherwise requires:" Line 3 (a) "Medical care facility" Page 2, line 10, "intermediate care facility"

Now our understanding is that the intermediate care facility is non-medical. Now if we are going by the context would the intermediate care facility come under the medical care facility term, in their definition.

SENATOR MARAZITI: Your understanding is that intermediate care facility is non-medical and your question is, if it's non-medical would it come under medical care facilities.

Now Senator Dumont is right here and suppose we ask the Senator his interpretation of this section of the law.

In other words, Senator, on page 2, line 10, intermediate care facility referred to, and then on page 1, 3 (a) medical care facility defined. And I think your question is, intermediate care facility, will that come under medical care. Apparently it's set out right in the section, is it not? "Medical care facility means the facility or institution, whether public or private, engaged principally in providing services" and so on.

SENATOR DUMONT: Well the definition of medical care facility includes intermediate care facility. I would assume that's true but I think I probably ought to get an expert opinion.

MRS FINLAW: On the definition of the intermediate care facility.

SENATOR MARAZITI: Well I concur with the Senator's construction of the bill as drafted that - and I think it makes the point you have in mind - for the purpose of this bill and the status of the bill at the present time, medical care facility includes intermediate care facility. Now I might say that the purpose of the hearing is to discuss all aspects of the bill. In other words, it may be that there will be amendments made or suggested by the Committee or by the Sponsor or by others. And this is the purpose. In other words, if you feel that intermediate care facility should not be included, you know, give us your views.

MRS. FINLAW: Well, by the definition of the term intermediate care facility, we understand that this is a non-medical facility. However, it is in the process of being defined, the intermediate care facility, in the State of New Jersey so this may not be part of the medical care facility. And this is still in its infancy, even in definition of term, so you may wish to refer to this.

SENATOR MARAZITI: Thank you.

MRS. FINLAW: The second is a recommendation. On page 3, section 5, line 1, this refers to "a Health Care Administration Board shall consist of 17 members" with which we are all familiar. And Line 14, "One member shall be the administrator of a home for the aged." And at this time I would like to suggest this recommendation to read: "One member shall be the administrator of a member home of the New Jersey Association of Homes for the Aged."

SENATOR MARAZITI: Is your Organization the only organization that has a home for the aged?

MRS. FINLAW: Our Association is the Association for the non-profit homes for the aged in New Jersey.

SENATOR MARAZITI: Oh, I see. Your Association encompasses the group.

MRS. FINLAW: These are the governmental, the fraternal and the religious associations that are non-profit.

SENATOR MARAZITI: In other words, am I correct in assuming that most of the homes for the aged in the State belong to your Association?

MRS. FINLAW: No, this is not correct.

SENATOR MARAZITI: About how many?

MRS. FINLAW: We have approximately 60%.

SENATOR MARAZITI: About 60%.

MRS. FINLAW: Yes.

SENATOR MARAZITI: Do you know approximately how many homes for the aged there are in New Jersey, in round figures?

MRS. FINLAW: Oh, roughly 120.

SENATOR MARAZITI: 120. Thank you.

MRS. FINLAW: Thank you very much, Senator.

SENATOR MARAZITI: Thank you very much. I certainly appreciate your appearing here today and also appreciate your very specific analysis and specific recommendations. I think they are very helpful. Speaking for the Committee, this is the kind of testimony we like because you get right down to the heart of the matter and you make your

recommendations and suggestions. Thank you very much for appearing.

MRS. FINLAW: Thank you for the privilege.

SENATOR MARAZITI: May I ask you one question. In other words, if the Bureau is transferred to the Health Department you have no objection. Is that right?

MRS. FINLAW: No, sir.

SENATOR MARAZITI: Thank you very much. I think Mr. Russo must be doing a very fine job.

SENATOR DUMONT: He is.

SENATOR MARAZITI: Now I have here next on the list Earle Armstrong, Christian Science Committee.

Mr. Armstrong, we are glad to have you here. Let's have your full name and address and, of course, the name of the organization you represent.

C. E A R L E A R M S T R O N G: My name is C. Earle Armstrong. I am Christian Science Committee on Publication for the State of New Jersey. By way of explanation, it's a committee of one, I'm it. The address is 28 West State Street in Trenton. I have a statement and copies of it which I should like to leave with you.

SENATOR MARAZITI: Yes. I wonder if you could let us have whatever copies you have and I will see that the other members of the Committee receive copies.

Thank you.

MR. ARMSTRONG: This is a statement to Senator Maraziti and Associates in a public hearing on S-330.

It is my understanding the Federal legislation

giving rise to Senate 330 is Public Health Law 90-174, Partnership for Health Amendments of 1967.

Our legislative offices in Washington and Boston informed me in October of 1968 that legislative action at the State level implementing this Federal legislation could be expected. We have one point of concern. Let me present briefly the background on that point of concern.

Public Law 90-174, Partnership for Health, and its predecessor, Public Law 89-749, extend the United States Public Health Services programs for grants for public health services by the states and grants for comprehensive health planning. The law requires states which seek federal aid to assist any "health care facility...to develop a program for capital expenditures...consistent with an over-all State plan developed in accordance..." with federally-determined criteria. This law does not define "health care facility" and it was therefore possible for the term to be interpreted to include Christian Science institutions. If this were the case, our institutions might have had their capital expenditures for construction, erection, alteration, improvement and extension in many or all states controlled by standards under the Department of Health, Education and Welfare. These standards could be tightened even further by state health departments. At our request, the House of Representatives' report on the bill contained a statement explaining that a facility such as those provided by the Christian Science Church would not be included as a "health care facility" within the meaning of the program.

A copy of the report of the House of Representatives on this bill is attached. And, Senator Maraziti, it's attached only to the copy I have which I will see that you get.

SENATOR MARAZITI: If you let us have that for a little while, later on we can xerox several copies for the Committee and we will return the original to you.

MR. ARMSTRONG: Very good.

On page 21 of this House of Representatives' report is a statement explaining that a facility such as those provided by the Christian Science church would not be included as a "health care facility" within the meaning of the program.

You will find attached to these comments a copy of the regulations implementing this law. Both the report and the regulations contain the provision in which we are interested which reads:

"PROVIDED, That such term shall not include facilities operated by religious groups relying solely on spriitual means through prayer and healing and in which health care by or under the supervision of doctors of medicine, osteopathy, or dentistry is not provided."

Unfortunately, this provision uses the phrase "spiritual means through prayer and healing" rather than "spiritual means through prayer for healing" which is more accurate, but I do not think this will confuse anyone here.

The House of Representatives' report and regulations on Public Law 90-174 show the Federal intention to exempt

Christian Science institutions where reliance is solely on spiritual means through prayer for healing.

In the light of this Federal intention and gratefully aware that New Jersey always treats Christian Scientists fairly, may I respectfully request favorable consideration of an amendment to S-330, copies of which are in your hands and which I will now read.

Page 5, section 7, after line 13, this amendment would add the paragraph I am about to read:

"In the case of an application by a medical care facility established or operated by an association or corporation composed of members of any church or religious denomination, the needs of the members of such church or religious denomination for care and treatment in accordance with their religious or ethical convictions may be considered to be a public need."

That's the end of my statement.

SENATOR MARAZITI: You have a copy of your amendment with you?

MR. ARMSTRONG: It's attached.

SENATOR MARAZITI: It's included with your written memorandum.

MR. ARMSTRONG: Right.

SENATOR MARAZITI: In other words, if I can analyze your testimony, if this amendment were included, you would have no objection to Senate 330?

MR. ARMSTRONG: Right.

SENATOR MARAZITI: All right. Thank you very much.

We appreciate your appearing here. If you will let Mr. Moore have what you referred to - is it very long? How many pages is it?

MR. ARMSTRONG: The page on which the provision appears is just a single page.

SENATOR MARAZITI: What is that provision, again?

MR. ARMSTRONG: It is in the Report of the House of Representatives, and then attached to what you have are the regulations concerning the law. Both the report and the regulations concern this proviso for the Christian Science exemption.

SENATOR MARAZITI: All right. If you will let Mr. Moore have that sheet, he will make ten copies and give you several copies and give the rest to the Committee.

MR. ARMSTRONG: Thank you very much.

SENATOR MARAZITI: Thank you very much for appearing.

Now we have Mr. Jack Owen listed here, Executive Vice President and Director, New Jersey Hospital Association.

We are very happy to have you here again. We know you well but, for the record, let us have your name and the organization you represent.

J A C K W. O W E N: Thank you, Senator. My name is Jack W. Owen, I am Executive Vice President and Director of the New Jersey Hospital Association.

The Hospital Association represents all voluntary non-profit hospitals in the State as well as governmental,

proprietary, and a number of extended care facilities.

My purpose in appearing today is to present to you some of the concerns which our Association has with Senator Dumont's Bill, Senate 330. I recognize that we have limited time available for your hearing and the number who have requested to be heard and, therefore, I am going to limit my remarks to a few of the more important considerations which I believe must be emphasized.

I would like to start off by referring to some of the Senator's remarks at the start of this hearing.

Number one, I think in the package of bills approved by the Senate I would like to have known for the record that the Association was very much in favor of the change in corporate setup of Blue Cross. We, too, believe that public members should be on that Plan's Board.

I am a little bit dismayed, though, to hear, for the record, that the other bills, such as the experienc rating, are going to stem the rising hospital costs. There is nothing in these bills which will affect the hospital costs, as such, but will only, in effect, be a different way in which Blue Cross collects its money. It has no effect on the hospital whatsoever and I think it would be a mistake to let the public think that by giving Blue Cross experience rating it is going to change the hospital cost. It's not. And there are going to be a lot of people very upset who are going to have to pay a lot higher Blue Cross payments.

SENATOR MARAZITI: Well, I want you to have an opportunity to express your opinion on other legislation

because Senator Dumont referred to it, however, basically we are interested in 330, but I do understand that you want to make your opinion known.

MR. OWEN: Now, one thing that was mentioned in regard to A-200, which I think also has to be corrected, and that is that Mr. Azzolina did work on this bill during the summer and although he didn't meet with Senator Dumont there were some changes made, as per your request. And if you will look on page 3 of A-200, if you have a copy, you will see the Commission we are talking about is appointed by the Governor upon advice and consent of the Senate.

SENATOR MARAZITI: That's on page 3?

MR. OWEN: On page 3 of A-200. This change was made. Since you refer to it as an important change, we agree with you. Under Section 4: "The State Board of Control shall appoint a Commission on Hospital Care...members appointed by the Governor upon recommendation of the Board of Control with the advice and consent of the Senate."

SENATOR MARAZITI: Well, all I can say is that that makes one less thing that we will have to concern ourselves with.

MR. OWEN: The other thing is certificates of need.

SENATOR MARAZITI: This is the Official Copy Reprint that you're referring to?

MR. OWEN: Yes, I'm talking about the bill that was passed Monday in the Assembly.

The other, of course, is a certificate of need, the implication being that certificates of need were only for

facilities, which is not the case at all. But it is spelled out very clearly that the services, medical care services, means health services provided by a medical care facility such as diagnosis, treatment and care. So that we are talking about open-heart surgery, we're talking about cobalt, we're talking about any other service which a hospital renders; we're not talking just about building facilities. So there is not a difference between 330 and A-200 on either of these points.

Now, to get into S-330 --

SENATOR MARAZITI: Let me say this. You heard Senator Dumont's testimony --

MR. OWEN: Correct.

SENATOR MARAZITI: -- to the effect that he concurs basically with A-200 insofar as a certificate of need being required. He suggested, and it's apparently satisfactory with Assemblyman Azzolina and the Assembly, that the Board be appointed by the Governor with the advice and consent of the Senate. I think there's a difference in the number. You have 12 members in A-200 and Senate 330 has 17, I believe.

MR. OWEN: Twelve members appointed by the Governor upon recommendation of the Board of Control with the advice and consent of the Senate, and in addition, to serve ex officio, with vote, would be the Commissioner of Institutions and Agencies, the Commissioner of Banking and Insurance, Commissioner of Health, Commissioner of Labor and Industry and the President of the State Board of Medical Examiners.

SENATOR MARAZITI: Correct. And it leaves the Board in I&A. That's another difference.

MR. OWEN: That's right.

SENATOR MARAZITI: Now you say, to go into Senate 330. We will go into some of the features of 330 that we don't have in A-200. In other words, basically A-200 is, as you have explained it and as Senator Dumont has, a certificate of need.

MR. OWEN: Certificate of need, that's right. I'm going to skip some of this prepared statement --

SENATOR MARAZITI: Go right ahead, anyway you wish.

MR. OWEN: We believe that Senate Bill 330, as we see it here today - now I understand there are some amendments which we have not seen -- we believe that Senate Bill 330 does not provide the proper kind of legislation which will allow the hospitals to operate in a voluntary health care system regulated in a proper fashion by the State. Although there are a number of corrections and amendments in this legislation over Senate 301, we still believe that weaknesses exist. And recognizing that S-330 and A-200 are complicated pieces of legislation and that some of these changes are difficult to evaluate, we would like to point out some of the deficiencies which we think exist.

For example, the interest of the Legislators should be to secure an impartial decision on the need for proposed new projects and services. Yet, under S-330 the final decisions will still be made by a Board which is dominated by representatives of the affected agencies or institutions.

Now you may think that's strange for me to say that

but, to us, even though we represent many of these institutions, such a situation would not be in the public's interest.

We believe that a Board composed of people representing the industry should only be a recommending board and that the final decision should be made by a citizen's body which gives the responsibility, for instance in A-200, to the State Board of Control.

Now here's a basic difference. Both of these boards that we're talking about, the old licensure board and the new board under 330 are appointed by the Governor with the advice and consent of the Senate. However, if it remains in I&A the final decision is made by the State Board of Control which is a citizens' board. This is absent in 330 so that the final decisions are made by a group of providers of service primarily.

Now fundamental to such legislation is planning at the community and state level. Planning is an effective device to channel limited resources to those areas which have the greatest need. Experience has shown us that to be effective the planning process must be kept as simple as possible so that decisions can be rendered and a valid community need met without unnecessary delay. Otherwise, it can destroy that which it is trying to help. We believe that A-200 meets these criteria. However, in S-330 the planning process outlined on page 5 is far too complicated and involved to be effective. Before the proposed new Board can act it must consult and secure

recommendations from as many as four separate, independent, planning bodies. These are the local planning council, the areawide comprehensive planning council, the state health facilities planning council and the state health planning council. Furthermore, each of these bodies must wait for recommendations of the preceding group before taking any action. The time involved to secure the approval of all of these bodies could be almost unlimited. Yet, there is no restriction in the bill as to the amount of time that any of these agencies can take in arriving at a decision even though in many situations unnecessary or unreasonable delay could be disastrous to the community involved.

Now I think we've gone over this with Senator Dumont and I think he understands why we are concerned on laying out the planning process.

We believe that S-330 again ignores the vital and critical role that must be played by local citizens through a local planning body. It is only at this level that the initial sorting out of various community needs and the establishment of valid priorities can take place. In S-330 all of the emphasis is on planning at the state or large regional basis. Even the decision as to what should constitute an acceptable local body is left to the Health Facilities Planning Council. There is no provision for any state involvement in this important decision, which there is in A-200. It is generally recognized that one of the factors which leads to successful planning is a willingness of the parties involved to accept negative

decisions. One way of insuring this acceptance is to permit these parties to question any negative decision that has been made and to secure an explanation. One would assume that if the local planning body is expected to play an important role in the planning process it should be entitled to such an explanation. However, S-330 specifically excludes them and only recognizes that the applicant and the appropriate state body is entitled to such an explanation. Such a situation could not help but destroy the interest and willingness of community leaders to serve on local planning councils.

Now it appears to us that transferring a portion of the functions performed in the Department of Institutions and Agencies to the Department of Health will create an additional cost burden to the State. Since the Department of I&A still has the responsibility for Medicaid and other programs affecting hospitals, there will have to be additional staff employed in the Department of Health. It is unclear to us whether the present licensing board would be eliminated and all of its duties transferred to the Department of Health or whether it would have to remain in the Department of Institutions and Agencies to carry out other functions. If this is the case, we would have a duplication of a board and all of the expenses that that would entail. At a time when the State of New Jersey is in a desperate need for additional money, it seems unwise to us to create additional expenses when the problem could be solved without incurring additional expenditures of money.

The final point which we believe should receive serious consideration is the condition of the existing licensing law for hospitals, nursing homes and other institutions. The present law which has been in effect for a number of years has been amended and reamended until it is extremely difficult, if not impossible, to work with. A-200 repeals the existing law and replaces it with a new clean piece of legislation. S-330, however, merely offers amendments to the existing law and perpetuates the unworkable situation. In other words, we are just moving a whole hodgepodge over there, not really spelling out what needs to be done.

We admire Senator Dumont's reasons for recommending this legislation and we are in complete accord on the certificate of need. We are not in disagreement at all with the requirements for certificates of need and we believe that unless this legislation, 330, is rewritten and unless the State is willing to agree to expenditures of monies, which are questionable to obtain the results desired, then this legislation should not be passed.

Now I heard the Senator say this morning there were a great many differences between A-200 and S-330. There were a great many differences between the old 200 and 301. I don't think there are many differences that now exist between these two. The basic difference seems to be, one is in the Department of I&A, the other is in the Department of Health. 330 does not give any more power, as far as planning is concerned, than A-200 does.

They both require a state agency to make the final determination, although under 330 it's almost unworkable unless that's changed because there are just too many groups involved.

SENATOR MARAZITI: Explain that a little more. In other words, too many groups involved?

MR. OWEN: All right, I'll give you an example. Let's say I've got a hospital now. You know that the courts have ruled that hospitals are public bodies and a good example is right in your district, Senator, in which All Souls Hospital was refused to be allowed to be closed. Now the question is, suppose we want to make a change in that institution and 330 is law. We go the Commissioner of Health and say we want to add another wing, put an intensive care unit on, the Commissioner of Health refers us to the Health Facilities Planning Council who refers it to the Local Planning Region up in Sussex-Morris County. After that, I make my recommendation to that Planning Council, it goes to Health Facilities Planning Council for approval, it goes to the Commissioner of Health, he refers it to the State Health Planning Council who refers it to a B agency who refers it back to the State Health Planning Council, back to the Commissioner of Health and then to a Board. By this time nine months have gone by, if there's no problem; if there's a problem, you're talking of a year, at least, before any kind of planning can take place. This is unworkable. Something has to be done, we couldn't live with that kind of a situation.

SENATOR MARAZITI: Your idea is that there are too many steps in there?

MR. OWEN: Yes. If you look at page 5 of S-330, you will see that it spells out just exactly what needs to be done. It's line 15, section 8, at the bottom of the page. It spells out just where the application will go, with no time limit involved.

SENATOR MARAZITI: Line 15.

MR. OWEN: Yes.

SENATOR MARAZITI: Now what do you have in A-200?

MR. OWEN: I think we have a 60 day time limit.

SENATOR MARAZITI: Oh, you have a time limit but you have the same --

MR. OWEN: No, we do not have the four agencies. We don't think it's necessary.

SENATOR MARAZITI: What do you have?

MR. OWEN: We have two, a local planning council and the State planning --

SENATOR MARAZITI: Where is that in A-200, please.

MR. OWEN: Do you have A-200 there?

SENATOR MARAZITI: Yes, I have it.

MR. OWEN: All right. That's spelled out actually in the definitions on page 2,"'Authorized area planning council' means a voluntary, non-profit organization, of which there shall be at least 7," that's at the top of page 2, which spells out what it's made up of, "formed for the purpose of planning for health facilities in a definite geographic area." Then, further down, we talk about the

State planning council, on line 37, which means "the existing Health Facilities Planning Council or any successor organization" because we don't know whether that thing is going to ever continue. As the Senator said, maybe there is a question whether a voluntary system can do it. We think it needs teeth. "having the same characteristics as an area planning council but which is formed for the purpose of planning for health facilities on a State-wide basis."

So, in effect, there are only two planning councils, a local planning council, which we all agree is needed, and then a State-wide planning council which, in effect, would do this - let's give an example. Let's say that up in Morris County we want to put a hyperbaric chamber and there is no other hyperbaric chamber in Morris County and it sounds like a good idea.

SENATOR MARAZITI: I wish you would put one there. I understand it's very helpful treatment. Go ahead.

MR. OWEN: But very expensive, Senator. But we find that there's another one just over here in Essex County. So that's why you need a State council to coordinate what's done between local planning councils.

SENATOR MARAZITI: You would have basically two groups.

MR. OWEN: Two groups. That's right, local and State-wide. Then the State has the final say on the recommendation.

SENATOR MARAZITI: And then the Board, that Board that you referred to.

MR. OWEN: Right. A citizens' board, really.

SENATOR MARAZITI: Well, you've mentioned the two basic differences, then, are there any other differences between --

MR. OWEN: Well, there are other little things in there. For instance, the significance of the term "the Board shall" in 330, and the State Commissioner of Health with the approval of the Board shall. It may be that these two can and should be interchangeable or there may be a reason for changing it but through the bill, one time it says the commissioner shall and the next time it says the board.

In A-200 the Chairman of the Commission is defined. In S-330 it doesn't say how the Chairman of this is going to be selected.

In the composition of the Board, we have representation from governmental agencies, like Labor and Industry and Board of Medical Examiners, because these are governmental groups which have an effect on the cost of hospital care. When the Department of Labor says that the minimum wage is going to be such-and-such, it's going to affect the hospital care, so he should be sitting on a board where he knows what's going to happen and have a say at that point. In 330 it's just a representative of labor.

I think that the other thing we're concerned about is, in A-200 we have clearly stated the hearing procedures and the rights of appeal, while 330 only states in general terms that an applicant shall be given reasons for negative

decisions. It doesn't really spell out what kind of hearing there will be.

Other than that, I think there are small things that just need to be corrected but these are basically what our feelings are on both of these bills. We are in agreement, Mr. Senator, on --

SENATOR MARAZITI: I have a number of questions.

In connection with - let's take All Souls Hospital, as an example. Do you think this is an example of too many hospitals in an area? I know that this is probably a very difficult question for you to answer but does this illustrate one of the problems that A-200 and S-330 are trying to correct, an over-supply of hospital facilities and then one hospital not being able to cope.

MR. OWEN: Well, yes and no, because the beds up there were approved but that same district represents one of the things and that is that there is a desire to build a hospital at Hackettstown. Now it would seem from logic that this ought to be some kind of a satellite hospital because we have the problem in Morris County with All Souls Hospital. So that - well A-200 would certainly help correct this situation.

SENATOR MARAZITI: Now is there anything in S-330 over and above A-200? In other words, S-330 goes further than A-200.

MR. OWEN: I'm not sure that that's true. I don't know where it goes further. The Senator stated that it goes further but I'm not sure where it does, other than it brings

in comprehensive planning which brings in two more planning companies. It does go further in the fact that it moves this over to the Department of Health. Now, if that's going further, it doesn't exactly --

SENATOR MARAZITI: No, I don't mean that. I mean, basically both bills cover a certificate of need and A-200 limits itself to that, basically. In your opinion, S-330 does not go beyond that.

MR. OWEN: Not anything that I can find in there that indicates it goes that far beyond it.

SENATOR MARAZITI: All right. Thank you very much, Mr. Owen. I appreciate your appearing here.

I understand Mr. Armstrong would like to elaborate briefly on his prior testimony and perhaps this is the time to ask Mr. Armstrong to return. We are always very happy to hear your views.

MR. ARMSTRONG: You are very kind, Senator Maraziti.

Just before I left the position here you asked me if we had any other objection to the bill and I said, no. I think I should elaborate just a little.

The Christian Science Facility in New Jersey, Ten Acre Foundation in Princeton, has been in operation for some 50 years now, always under the Department of Institutions and Agencies. And during that period of time a relationship has been built up, a relationship of understanding and consideration for which we are most grateful. And, of course, we can adjust to whatever may come but we view a little uncomfortably the thought that our affairs will be under

the Department of Health. It will necessitate a type of thinking on their part that they have not to date, perhaps, have had to consider. And I want to make this a part of the record. We, as I say, can and are willing to adjust to whatever situation may come but I want everyone to know that our relationship with the Department of Institutions and Agencies has been something that has been a very helpful one and one for which I would commend them and one that we are going to treasure.

SENATOR MARAZITI: As I understand it, what you're saying is that you found your experience with the Department of Institutions and Agencies' personnel to be highly satisfactory and you're addressing yourself now more to the matter of personalities involved and you find that the association has been a good one.

MR. ARMSTRONG: The Association has been splendid. I wasn't thinking too much of personalities as that over the years the concept of a Christian Science Institution, as being different from medical institutions, has, of course, grown --

SENATOR MARAZITI: Different from what?

MR. ARMSTRONG: Different from medical institutions. The Christian Science Sanatorium is a non-medical facility. Healing is purely through prayer. And in the operation and regulation of this non-medical facility, over the years the Department of Institutions and Agencies has handled our affairs, we think, well, and we think in fairness to every citizen of New Jersey. And this change, if it should come

about, would mean a plunging into an area by the Department of Health into which they have not heretofore had to give consideration. And that would involve adjustments on our part and on their part, which we're happy to make, but nonetheless it would be a great change. And while, as I said, we have no objection to the bill, I am very much aware of this implication in it.

SENATOR MARAZITI: Thank you very much.

Mr. Jefferson Lyon. We are glad to have you here, Mr. Lyon. Will you identify yourself and your organization.

W. J E F F E R S O N L Y O N: Thank you. My name is W. Jefferson Lyon. I am Vice President of the Hospital Service Plan of New Jersey, better known as Blue Cross.

The New Jersey Blue Cross Plan, on behalf of its 3.5 million members, supports Senate Bill No. 330 by Senator Dumont.

We believe that this bill, as will other bills affecting Blue Cross introduced by Senator Dumont, which he discussed this morning, will contribute toward the stabilization of the economics of health care in New Jersey. Indeed, since S-330 deals with the very roots of the problem - hospital planning and management - it is one of the most important of the bills that Senator Dumont has introduced based on a decade of very close study of health economics in our State.

As we testified before your Committee at your earlier hearing on hospital regulatory legislation held May 2, 1969, the situation respecting Blue Cross rate

problems in New Jersey adds a sense of urgency to the matter your Committee has under consideration. Since hospital costs are continuing to rise, the situation remains urgent and we respectfully suggest that time is running out and a decision should be made.

S-330 mandates approval by independent health facilities planning bodies before health care institutions may undertake new building programs or significant expansion of services, as we've heard. This is in line with --

SENATOR MARAZITI: Mr. Lyon, let me ask you a question at this point.

I know we're assuming it and I, personally, have begun to believe it. Apparently there is a feeling that hospital costs have risen and will continue to rise because in some areas there will be an excess of health care facilities and in other areas perhaps not enough. Now where there is an excess then one particular hospital is not operating at full power, so to speak, full implementation and, therefore, the costs would be higher than they would if the hospital were completely used, facilitywise. We're assuming this. I believe it to be so.

Now, do we have now or could you provide the Committee with statistical information that there is an overabundance of hospital facilities in certain areas? I am satisfied, personally, there is but I haven't heard anything at all today, maybe it has been established previously, that we have this situation of too many hospitals going up or maybe too many trying to go up, apparently being controlled to some

extent now by the voluntary arrangement that Senator Dumont referred to. But I can see the importance of this type of legislation if we can regulate the construction of hospital facilities, and I also would like to show to the people of this State that there is a problem here. You may not have the figures right at your fingertips but perhaps you can tell us something about this and furnish to us, if you can, some tangible evidence that we do have the problem.

MR. LYON: I think probably, Senator, with all due respect to your question, it's better directed to the Health Facilities Planning Council. That is their job. It is a voluntary organization but it is established with the assignment of surveying the State of New Jersey and seeing if there are such duplications in existence and recommending what may be done about it. And they do have subsidiary local councils with certain geographic areas throughout the State. And the studies that have resulted and the statistics I think you're seeking have been done by these organizations.

SENATOR MARAZITI: Health Facilities Council.

MR. LYON: Health Facilities Planning Council. It's a voluntary organization that is headquartered in Princeton.

SENATOR MARAZITI: Fine. Thank you. I'm sorry I interrupted you.

MR. LYON: To continue with what we were saying before, I would like to point out that the approval standards in Senate 330, Mr. Dumont's bill, are in line

with the recommendations of the Ward Committee nearly five years ago, that studied Blue Cross; it's in line with the special message on health submitted to the Legislature almost a year ago by Governor Hughes, and with the report of T. Girard Wharton, Esq., the Public Rate Counsel in last year's Blue Cross rate application.

Voluminous testimony was presented during the public hearings on Blue Cross rates supporting this concept of planning approval as a condition of licensure. The New Jersey Hospital Association itself, as we heard this morning, supports this concept, though there are differences of opinion remaining as to how it should be administered.

We believe that the method proposed through S-330, which would transfer regulatory authority from the Department of I&A to the Department of Health, would best accomplish the purposes of these recommendations. The bill's provisions for hearings, and its establishment of a qualified supervisory Board, provide in our opinion adequate safeguards for the protection of the public and the health care institutions. Worthy and necessary growth in institutional facilities and services, we feel, would be approved, while unnecessary and thereby inflationary additions would be guarded against and the regulatory authority would have the tools at hand to bar them.

Such is not the case today. There do indeed exist voluntary citizen planning bodies which study the plans of health facilities and make recommendations regarding them. However, these recommendations may or may not be heeded by

the institutions. Review bodies such as the Health Facilities Planning Council for New Jersey have at their disposal only minimal sanctions to discourage unnecessary expansion.

Only Blue Cross, through its criteria for contracting hospitals adopted in 1965, has been able to strengthen the Council's recommendations where we refused to participate in the cost of any hospital project, through the reimbursement formula, unless the project has the blessing of the Council and the regional councils.

This economic sanction, standing alone, as it does, has not been fully effective in the face of willingness of lending agencies to provide financing, encouraged by the commitment of other major third party payors such as Medicare, to reimburse interest and depreciation charges.

We believe S-330 would put teeth in the heretofore voluntary requirement for review and approval by voluntary planning bodies. As a condition of licensure, these recommendations would be made meaningful to institutions and the cloak of authority would be provided for the protection of the public against unnecessary and duplicative projects.

It is significant to note that Section 1 of S-330 states, and I quote from the bill, Senator:

"It is hereby declared to be the public policy of the State that hospital and related health care services of the highest quality of demonstrated need, efficiently provided and properly utilized at a reasonable

cost are of vital concern to the public health."

We believe S-330 makes a significant contribution to the planning function through requiring a finding of need as a condition of licensure by the State. We endorse it, Senator, as a significant step toward controlling hospital costs in the state, and we urge your favorable recommendation.

Thank you.

SENATOR MARAZITI: Thank you very much.

Now you concur, basically, with Senate 330, as I understand it.

MR. LYON: Yes, that's right.

SENATOR MARAZITI: And you heard the testimony pro and con on whether it should be in I&A or the Health Department.

MR. LYON: Yes, sir. I think Senator Dumont gave some pretty cogent reasons of uniformity to transfer it to the Department of Health where a good deal of this responsibility already rests. We agree with him.

SENATOR MARAZITI: Now there has been some discussion about A-200 and S-330, insofar as area encompassed. Is it your opinion that 330 includes basically A-200 and goes further?

MR. LYON: I think the statement, section 1 which I just read, gives the Commissioner a little broader power to get into economic areas, fiscal areas, - the Commissioner subject to the Health Care Administration Board's approval, of course. He is charged, and the Board is charged, with seeing that hospital and related health care services are

not only demonstrated to be needed in that particular area but they should be efficiently provided and properly utilized.

SENATOR MARAZITI: Properly utilized.

MR. LYON: Right.

SENATOR MARAZITI: In other words, you're getting into operation there.

MR. LYON: A little bit, it seems to us.

SENATOR MARAZITI: Now do you have this in A-200?

MR. LYON: The statement in A-200 is a little bit different. I think the philosophy is probably the same. A-200, Article 1, declares the public policy of the State to be "That the construction and expansion of medical care facilities, and the institution of additional medical care services, shall be accomplished in a manner which is orderly, economical and consistent with the effective development of necessary and adequate means of providing for the health care of the people of New Jersey."

I think there can be seen to be a little difference in the philosophical approach there.

SENATOR MARAZITI: Yes. All right. Thank you very much, Mr. Lyon. I appreciate your appearance here today.

MR. LYON: We're at your service. Thank you.

SENATOR MARAZITI: It's five minutes to one and there are several other witnesses. I think what we ought to do is take a short luncheon recess until 1:30.

I have listed here the Nursing Home Association and Prudential Life Insurance Company, two more groups to testify. Are there any others besides these two, Prudential and Nursing Home Association? (No response)

We will recess until 1:40.

(Recess)

Afternoon Session

SENATOR MARAZITI: The hearing will come to order. Is anyone here from the New Jersey Nursing Home Association? [No respose] They were here earlier, but I guess they have not returned.

So at this time, I would like to call on the representative of the Prudential Life Insurance Company, whoever is going to testify. Is it Richard Mellman?

R I C H A R D J. M E L L M A N: Mr. Chairman, my name is Richard J. Mellman. I am Vice President and Associate Actuary of the Prudential Insurance Company. I am pleased to have the opportunity to appear before this group today.

I also speak on behalf of the Health Insurance Association of America, which is a trade association of over 300 insurance companies which together write almost all of the total private health insurance written by insurance companies.

In addition to my work in Prudential, I have some knowledge of hospital operations because I am a trustee of the Newark Beth Israel Medical Center, although I am not speaking for that institution.

Senate 330, the bill under consideration, includes many features that will serve the public interest in helping to deliver quality hospital care at reasonable cost. Certainly, proper planning for the expansion of health care facilities vitally affects the total cost structure.

No issue in the health care field is receiving so much attention as the continued escalation of costs, particularly

hospital costs. The hospitals are caught in a three-way pincer between inflation, costly new techniques, and public demand for more and better services. The public is concerned about the ability of the individual to finance his family's hospital care and certainly demand is now growing for a closer governmental scrutiny of the way in which hospitals are run.

We are not in opposition to the objectives of S 330, although we do feel that it needs to be clarified and strengthened, and that certain modifications would be desirable.

The bill requires a hospital to secure a certificate of need before constructing or expanding a medical facility and in certain other situations. My first comment is addressed to Item 4 of Section 8 (g) which appears on page 6, lines 60 and 61.

SENATOR MARAZITI: Could you hold that for one minute. Page 6, lines 60 and 61, near the bottom, Item 4. [Senator Maraziti identifies the section in the bill.]

MR. MELLMAN: Item 4 refers to "the adequacy of financial resources and the sources of future revenue." This is one of two portions of the bill which is of particular interest to insurance companies.

This phrase does not spell out the necessary requirements as to future revenue sources. It permits continuation of the present inequitable system in which Blue Cross is charged less than its fair share of total hospital costs whereas insured and self-paying patients are charged more than their fair share.

It is no secret that we have a dual standard of

hospital charges in New Jersey. However, it is so difficult to get precise information on just how great this differential between charges to Blue Cross patients and other patients is, that few people fully understand the nature of the difference. First of all, the Blue Cross reimbursement formula does not provide for the inclusion of certain legitimate expenses incurred by a hospital, with the result that these expenses must be charged to and shared by the remainder of the patients.

May I quote from the report of the Public Defender to the Commissioner of Banking and Insurance on the recent request for a Blue Cross rate increase. This report was dated January 14, 1970 and was prepared by Mr. T. Girard Wharton. On page 68 he states, and I quote:

> "Testimony adduced during the course of the public hearings pertained to rising hospital costs and the amounts Blue Cross required in premiums to meet its obligations with respect to such costs. The attention of the individual, however, when entering the hospital as a patient is directed to hospital charges rather than costs. These charges are always higher than the costs which Blue Cross pays, as some items which are unrelated to the cost of services provided Blue Cross patients are not reimbursable by Blue Cross. Hospitals add these amounts into their charges to nonsubscribers (that is, to those patients who are not covered by Blue Cross) to help provide a reserve for future needs, such as new buildings, new services, indigent care and depreciation at levels over and above that allowed by

Blue Cross.

"There is apparently no authority for the Commissioner" - that means the Banking and Insurance Commissioner - "to deal with the charges which hospitals may establish to their patients and the elements of such charges, except insofar as they are reimbursable by Blue Cross."

That's the end of the quote.

Hospitals have accepted the reimbursement levels imposed by the negotiated cost arrangements with Blue Cross and similar formulas established by governmental reimbursement programs, such as Medicare and Medicaid. The net result is that the rest of the patients, that is, the people who pay their own bills or who have private insurance, are expected to bear the full load of those costs that are not recognized by Blue Cross and government, other than amounts that are made up by private philanthropy.

Today a typical hospital patient load might be about 50 per cent Medicare and Medicaid, a little more than 25 per cent Blue Cross, and a little less than 25 per cent, private insurance or self-pay. This means that under the present system, the charges that are not recognized by the government and Blue Cross reimbursement formulas must be borne by that remaining 25 per cent of the patients who either pay their own way or are covered by a commercial insurance plan.

Some idea of the magnitude of this mark-up was revealed in recent newspaper stories about the unfortunate young man who died a few months ago in a hospital shortly after an auto accident, and his family was billed over $2100 for seven

hours care. A Newark News editorial on February 9th stated that "The need for a state agency, or its designate, to analyze and supervise hospital costs and charges is underscored again by a controversy involving (that hospital)."

In the wake of discussion of this case, the Hospital Administrator revealed that while Blue Cross was paying $43 a day per patient, the average daily charges which were being made to other customers not covered by Blue Cross were $72.69.

Now if you divide $72.69 by $43, you come out with a 69 per cent mark-up. I don't want to imply that the mark-up is as great in most hospitals. My impression is that a typical mark-up would be about 30 per cent. Again, this is because the patients who are not covered by Blue Cross or government programs are bearing practically the full burden of the cost that is not picked up through private philanthropy of such items as: first of all, non-subsidized research; second, care of charity patients; third, courtesy allowances; and fourth, bad debts.

To give you an example, Senator, of how this works, let's assume that if everybody paid his bill in a hospital - paid the full bill - the cost would run $75 a day. The effect of this reimbursement formula is that Blue Cross will pay perhaps $70 a day and that extra $5 is passed on and borne by the other patients. So they are not up to, let's say, 80. Now in addition, a certain number of people will not pay their bills and that entire bad debt is passed on to the non-Blue Cross

patient. So on the average, it works out that they are being charged between $90 and $95 a day. Or to take another example, let's assume that we have two patients who go to the hospital, one with Blue Cross, the other with either private insurance or a good-sized wallet, and both of these people get identical treatment. Let's assume that Blue Cross does not cover the entire bill. The individual either stays in the hospital beyond the maximum number of days or uses a private room and his Blue Cross coverage pays full semi-private, let's say. And let's assume that his private insurance or his wallet pays the same amount for the same amount of coverage that Blue Cross would pay.

Now at this point, the excess treatment in my hypothetical example is not paid for by Blue Cross and the individual who has paid for his own or paid through insurance has run out of money. The amount of the bill not covered by Blue Cross or by that patient for those two patients is then loaded on to the charge for the one patient who had private insurance or was self-paid. So the net effect is that that less than 25 per cent of the population is being asked to pick up the entire bad debt from the rest of the population.

The reason I have been emphasizing this point is that Section 8 (g) of the bill calls for the Board to look into the adequacy of financial resources and sources of future revenue, which clearly includes revenue from all patients. We believe that it is fundamental that the bill should spell out in some detail the necessary requirements as to future revenue sources and provide for some uniform system of charging to all private

patients, so as to put an end to the present inequitable practice of charging different rates, which is presently victimizing the non-Blue Cross patients. It is particularly important that there be a uniform charging system if Blue Cross secures the expanded authority and the right to experience rate which are now under consideration and which would in effect make Blue Cross another insurance company.

What is the answer? We think that hospitals should, on an accounting basis, be able to plan and project their financial needs prospectively so that they can uniformly charge and at the same time receive an equal level of payment from all paying patients, whether it be Blue Cross, private insurance or self-pay.

The American Hospital Association has endorsed this basis. One can only logically conclude that it is time for some uniform basis of cost allocation whereby charges are properly allocated equitably to all patients. Now there are a number of ways in which this can be done. In Indiana, for example, they have a system known as "controlled hospital charges." In South Carolina, the legislature solved the problem two years ago by passing a law which required that hospitals grant the same discount as is afforded Blue Cross to all insurance companies and all individuals who pay their bills in full promptly. This,in effect, has forced the Blue Cross reimbursement level up to a self-supporting figure and eliminated the subsidy from other paying patients.

The other section to which I would like to specifically comment is Section 12, which is on page 8 of the bill. It is

about two-thirds of the way down the page. This section provides that no government agency and no hospital service corporation may make reimbursement to an institution unless the institution is licensed. This is the only penalty in the bill, namely, that an unlicensed hospital may not collect from Blue Cross or government agencies if a certificate of need was not granted or a hospital license was revoked. This language, of course, is silent as to the protection afforded the other interested parties who used the facilities. For example, a self-pay patient or the privately insured patient is not afforded similar equity or rights under the proposed bill. In this sense, the provision would appear to be not only inequitable, but discriminatory, as far as the public interest is concerned. If a hospital is not licensed or if its license is revoked, equity should prohibit it from charging anybody for its services. In other words, in a nutshell, we urge that the health care administration board should protect all paying patients not just that half of the population who are Blue Cross subscribers. We have seven and one-half million people in New Jersey, of whom three and one-half million are Blue Cross subscribers.

The question has been asked: Why don't insurance companies also bargain with hospitals for a cost reimbursement formula similar to Blue Cross's that would be lower than charges? The answer is that as a matter of policy we don't want to. If insurance companies also got the discount, the full burden of paying for the non-included elements would fall on that very small percentage of the patients who are classified

as self-pay. And the net effect would be that they wouldn't be able to carry the burden and that the hospitals would become insolvent. We want to carry our fair share of all legitimate costs, but not more than our fair share.

The present system of hospital charging is not one that will be changed voluntarily. We have seen that there is apparently no authority for the Commissioner to deal with the charges which hospitals may establish to their patients and the elements of such charges, except insofar as they are reimbursable by Blue Cross. It will, therefore, take some legislative action.

One of the deterrents to legislation establishing a uniform system of hospital charging is that you may feel it would raise the cost of hospital coverage for Blue Cross subscribers. But the other side of the coin is that it would correspondingly lower the charges made by the hospitals to the people who are not Blue Cross subscribers. You will recall in my example we were talking about a $70 average charge to Blue Cross and perhaps $90 to $95 for others, and with a uniform charging system perhaps it would come out about $80 for everybody. You have an opportunity to provide for such equity in this bill and I urge you to do so.

Thank you very much.

SENATOR MARAZITI: Thank you. You have two suggestions in connection with the bill. One has to do with 8 (g) and the other with Section 12.

MR. MELLMAN: That's right.

SENATOR MARAZITI: You recommend in effect that

there be legislation to establish a uniform system of hospital charging and that would in effect in essence be establishing the hospital costs or fixing the costs by a certain mechanism.

MR. MELLMAN: There are a variety of ways, I believe, in which this could be done.

SENATOR MARAZITI: Indiana is doing this now apparently.

MR. MELLMAN: Indinan is doing this now, yes.

SENATOR MARAZITI: They have controlled hospital charges. Then in South Carolina hospitals grant the same discount as is afforded Blue Cross, the same discount to all insurance companies and individuals, so that in effect forces the price to be uniform.

MR. MELLMAN: If in effect the hospital charges the same amount to everybody who pays --

SENATOR MARAZITI: They have to charge the full amount so they don't lose out.

MR. MELLMAN: That's right. Someone has to pick up the amount on the people who don't pay and the only way to do that is to spread it to everybody.

SENATOR MARAZITI: Well, that is one mechanism there. The other one, the Indiana one, is a little different and you recommend the Indiana method, or some method. You don't recommend any particular method.

MR. MELLMAN: We are not specifically recommending any method. But we think that there should be some method built into the law.

SENATOR MARAZITI: Right. Now would you recommend

that one of these bills, Senate 330 or A 200 - let's say Senate 330 - be amended in that regard or do you suggest separate legislation?

MR. MELLMAN: Well, I think that's a matter of technique, Senator. I am not qualified to speak to that. Perhaps either of the two bills could be amended or a separate bill introduced.

SENATOR MARAZITI: In other words, you concur basically with S 330 as far as it goes, with these suggested amendments on the two sections.

MR. MELLMAN: Yes, sir.

SENATOR MARAZITI: But you feel that S 330 will help in keeping down hospital costs, but your position is basically that you want a further step to keep down hospital costs or to equalize them, as you put it, so that all pay basically the same.

MR. MELLMAN: Right.

SENATOR MARAZITI: As I understand it, you do not have any specific mechanism, but you suggest that there be one to accomplish this end.

MR. MELLMAN: Yes, sir. We think there should be some mechanism and that it be done with some legislation. Perhaps the legislation need not spell out all the details. But there should be some legislative support for it.

SENATOR MARAZITI: Are you familiar with a report issued several years ago I think by Dr. Brady? I may be wrong on the name. Are you familiar with that report? I think it was submitted to the Governor of the State.

MR. MELLMAN: Dr. Brady. No, I am not.

SENATOR MARAZITI: I may have the name incorrect. Are you familiar with any report that recommended the fixing of hospital costs here in New Jersey?

MR. MELLMAN: Not in New Jersey, other than Mr. Wharton's recent report to the Insurance Commissioner.

SENATOR MARAZITI: What was the name?

MR. MELLMAN: Mr. Wharton, the Public Defender, in his report to the Insurance Commissioner in February. There was some discussion of this when Senator Dumont had his hearings a number of years ago on the broad package of bills to enlarge the scope of Blue Cross, etc. This goes back to the Ward Committee, I believe, five or six years ago.

SENATOR MARAZITI: That's the name. Well, perhaps Senator Dumont can give us that information a little later. I would like to hear a little about that. I do understand there was some suggestion in that report along these lines, but I am not sure.

Thank you very much for your suggestions. We appreciate your appearing here this afternoon.

Would anyone else like to testify on behalf of Prudential or do we have just the one gentleman? [No response]

I see the Nursing Home Association personnel and you may come forward. Will you kindly let me have your full name and the organization you represent.

A L B E R T K L I G G E: My name is Albert Kligge and I am representing the Licensed Nursing Home Association of New

Jersey.

I appreciate this opportunity to again appear before this committee to discuss legislation vital to the future of health care in New Jersey. I had the opportunity to testify before this committee on May 2, 1969 on legislation similar to that under consideration today.

At that time, I expressed the New Jersey Nursing Home Association's opposition to legislation then pending in both houses of the Legislature. We and other witnesses were advised by the legislators in attendance to undertake a series of meetings designed to achieve support of legislation reflecting the views of the various elements in our state's health care field. We believe we have reached such a conclusion; regrettably, this view is not encompassed by Senate Bill 330 in its present form. On the other hand, we have been able to support Assembly Bill 200 - designed to achieve results similar to those sought by S 330 - and note that A 200 was approved in the Assembly last Monday.

Our support of A 200 represents a substantial change from the position I presented almost a year ago. At that time, the New Jersey Nursing Home Association opposed the issuance of certificates of need for the construction of privately-operated health care facilities. It was our opinion that the investment of private funds should be governed by the traditional judgments of the marketplace. However, our experience with governmentally-supported programs such as Medicare and Medicaid now indicates that important public considerations must apply. A major function of nursing homes - proprietary,

non-profit and governmental - is the care of beneficiaries of governmentally-supported programs. It is now clear that over-availability and thus under-utilization of health care facilities must result in higher patient care costs under these programs and higher levies on the taxpayer. In short, overbuilding of nursing homes as well as hospitals will surely produce higher per diem costs, whether the patient is serviced by Medicare, Medicaid, Blue Cross or any other program. Thus we have come to the conclusion that we must support the main thrust of both S 330 and A 200 that there must be some public control in the construction of new health care facilities.

The major difference between S 330 and A 200 appears to be in the assignment of responsibility for health care facilities. S 330 places this responsibility in the Department of Health and, under A 200, it remains with the Department of Institutions and Agencies. Since the State assumed administrative jurisdiction for the licensing and inspection of health care facilities, that activity has been a function of the Department of Institutions and Agencies. With regard to nursing homes, New Jersey can be proud that its operating and physical standards are the highest in the nation. The field of nursing home care in New Jersey has made substantial progress under these standards. At the same time, the Department of Institutions and Agencies and the legislators and governors of this State have recognized and made allowance for natural difficulties that accompany each upgrading in standards. We are confident that nursing home care will continue to progress under the supervision of the Department of Institutions and Agencies, and,

therefore, strongly oppose the transfer of functions that would be effected by S 330.

If S 330 could be amended to permit supervision of health care facilities to remain with Institutions and Agencies, we are certain that our other objections could be worked out. If such an amendment is impossible, we cannot see our way clear to support this particular bill.

I also would point out that the transfer would raise substantial new difficulties for the institutions which supply health care under public programs and the citizens who must pay the cost. The Medicaid program, it is quite clear, will remain in Institutions and Agencies. That Department, in establishing standards for health care institutions, must bear in mind the cost effect on Medicaid. If the Department of Health which has no responsibility for meeting the costs of this program, establishes the standards, substantial new cost burdens could be imposed on the taxpaying public of New Jersey with little or no forewarning.

I now raise a series of questions regarding specific provisions of S 330.

The bill authorizes the Commissioner of Health to enter into contracts with governmental and non-governmental agencies where the only yardstick is to "effectuate the provisions and purposes of this act." We think that the intent of this provision is to enable the Commissioner to seek outside specialized assistance. But the broad language of this section could lead to an unintended delegation of administrative and

quasi-legislative authority. We think the authority to employ outside assistance should be more sharply defined.

S 330 ignores the long-standing recognition in New Jersey law of health care institutions operated by religious denominations which subscribe to the theory of active healing by prayer. We think provision for such institutions in both the issuance of certificates of need and in licensing should be made in this bill.

S 330 in its present form tends to inhibit the voluntary upgrading of existing health care facilities. We do not think a certificate of need should be required for the replacement of existing beds providing that the new construction meets criteria existing at the time. We think there should be an automatic right for the administration of any nursing home to replace existing facilities with more modern accommodations. This should even be done without the necessity of obtaining a certificate of need or with the statutory right of a summary granting of such a certificate.

We think a most serious flaw exists in S 330's proposed structure for the review of applications for certificates of need. The system sets up two redundant avenues of review - one through the statewide Health Facilities Planning Council and local planning councils, and the other through the State Health Planning Council and its affiliated Comprehensive Health Planning Agency. Not only does this unduly lengthen the process, but S 330 provides no sure means for resolving differences in the conclusions reached by these agencies. And we can all be certain that there will be differences on

specific applications. Indeed, the bill does specify criteria for determining need but no bill can clearly define the application of these criteria.

Another serious shortcoming is the fact that S 330 does not provide that an applicant may be represented by counsel of his own choosing, subpoena witnesses and evidence, and examine and cross-examine witnesses and be furnished with a definitive written decision in the proceedings before any of the agencies or boards established in the review procedure dictated by this bill. The only right granted an applicant is a public hearing before the Health Care Administration Board, at which he can submit a statement. We submit that these applications are of such vital importance that every element of due process should be respected.

In another area, S 330 is in direct conflict with existing sections of the Hospital-Nursing Home Licensure Act which provides that no change in standards can compel structural changes which result in a reduction or expansion of patient care facilities. We think this safeguard must be included in S 330. We are heartened by the verbal assurance of the sponsor that he intends that this provision be included. We also would note that the sponsor has informed us that the time limitation within which licensees presently must comply with new standards will be incorporated in this bill with language identical to that now existing.

We also hope that this bill will be amended to provide for a hearing before revocation or suspension of license and that existing sections of the licensing statute pertaining to

the imposition of fines and penalties be incorporated. Presently S 330 permits the Health Care Administration Board, on its own motion, to revoke or suspend a license without a hearing for a period of 30 days. For all practical purposes, such a procedure would represent a permanent closing of a health care facility since it would result in dispersion of staff as well as patient population.

We think that a most essential amendment to S 330 is a statutory guarantee that the review agency consider all existing health care beds in an area in establishing need. This would guard against an all-too-common practice of ignoring available beds as "non-conforming" and thus establishing an artificial need for new facilities where none exists. We do not propose the perpetuation of sub-standard facilities, but we feel that so long as a facility is recognized under our high standards, it should be recognized as an available resource. Otherwise the entire thrust of S 330 - its concept of planning for actual need - can be negated. We feel that lack of a smiliar provision is a shortcoming of A 200 and we hope that it will be amended in the Senate to provide this essential safeguard.

We feel that S 330 is most unclear with regard to which sections of Title 30 are retained and which are repealed. By implication, it would seem that no fewer than 30 sections are repealed and only two are retained. But good legislation should not rest on implication. We feel that the title of S 330 should clearly spell out which sections of the existing law are repealed and which sections are retained. Otherwise those

so vitally affected by this legislation cannot know its full implications.

I want to thank you for this opportunity to testify before you. Senator, if you have any questions I can answer for you, I will try. If not, Mr. Coyle has some additional comments he would like to make.

SENATOR MARAZITI: One thought that occurs to me is on page 5, you suggest an amendment to both S 330 and A 200, that the reviewing agency consider existing health care beds in an area in establishing need, and I imagine take into consideration non-conforming beds.

MR. KLIGGE: Right.

SENATOR MARAZITI: In other words, you want a guarantee in there that this would be done. But I am wondering --

MR. KLIGGE: May I clarify the non-conforming bed definition.

SENATOR MARAZITI: I am wondering if this is an administrative function instead of statutory unless you wanted to guard against excluding the non-conforming beds, if they could exclude them. Well, go ahead.

MR. KLIGGE: We feel that this is quite important that it be included. A non-conforming bed doesn't necessarily mean that this bed is a sub-standard bed. There are very minor reasons for declaring a bed non-conforming. There could be a lack of six inches in a corridor width. This has happened in a hospital with which I am personally acquainted where their corridor was 7 and 1/2 feet instead of 8 and most of their beds for this reason are non-conforming. So it has no

effect actually on patient care. We are not advocating sub-standard facilities.

SENATOR MARAZITI: I see your point. I think it is a point. I think it is good that you pointed it out. But I am wondering if this is anything that we have to be really seriously concerned about because I imagine if we had a board, a reviewing agency, made up of qualified, sound, substantial citizens, I think they would take that into consideration. They might not. And by putting it the way you say, you guarantee that they must. But then where would you draw the line? Suppose you had a non-conforming bed in a hall 4 and 1/2 feet wide.

MR. KLIGGE: We take the position that either the facility is licensed or it isn't. If the State approves it by licensing this facility as being in full compliance with their requirements, then the bed should be accepted as such. In other words, we don't want a bed that is available for use because it is licensed and not be included in the count.

SENATOR MARAZITI: In other words, your point is that these facilities are now licensed and are now in use so they can't be too far out.

MR. KLIGGE: That's right.

SENATOR MARAZITI: And if they are licensed, they should be accepted in a sense --

MR. KLIGGE: -- as a bed available --

SENATOR MARAZITI: -- in calculating need.

MR. KLIGGE: That's right. The reason we bring this up is because we went through this particular problem a few

years ago and it took us quite a while to get this situation straightened out before it was recognized as an existing bed.

SENATOR MARAZITI: Well, could it be that at the present time some facilities are non-conforming but considered suitable for licensing because of some technical situation where - well, they were approved because they were there - and still may not be up to the standard that we want? Are there any really bad cases? Apparently there may not be.

MR. KLIGGE: This is something that I would be unable to answer, Senator. But our position is and always has been, if a facility is substandard to the degree where it is a hazard to the life and health and safety of the patient, then this facility should not be licensed.

SENATOR MARAZITI: Your point is if it is licensed, say, as to number of beds and other factors, even if it is technically in some other respects non-conforming, these beds should be counted in considering whether there is need for additional facilities.

MR. KLIGGE: Exactly.

SENATOR MARAZITI: Otherwise if they don't count them and they allow the building of additional facilities, it might be an unnecessary thing and might cause a great financial loss to the existing facilities.

MR. KLIGGE: Well, not only to the existing facilities, but here again it goes into the matter of cost to the public, regardless of the source of payment. In a partially-used facility costs will be much greater per patient than one that is completely utilized.

SENATOR MARAZITI: Well, if you had a new facility, you would still continue to allow the so-called non-conforming facility. And if you allow that, you ought to count it.

MR. KLIGGE: That's right.

SENATOR MARAZITI: I think you have a point there. Now in your opinion neither bill has this provision in there.

MR. KLIGGE: That is correct.

SENATOR MARAZITI: You are suggesting there be an amendment.

MR. KLIGGE: To either bill or to both bills, there should be this amendment.

SENATOR MARAZITI: You know Senator Dumont has mentioned that he is not referring to the official copy reprint or hasn't had one because he has made amendments. I don't know whether any of these subjects that have been discussed this afternoon have been contemplated by the Senator. Perhaps they have. Perhaps they haven't. But he may be able to shed some light on some of these things.

I believe you point out that you feel the only basic difference or the fundamental difference between the two bills is that one retains jurisdiction in Institutions and Agencies and Senate 330 transfers it to Health. That is a problem with your group.

MR. KLIGGE: That's right.

SENATOR MARAZITI: And then there are other items that you mentioned, but you feel they could be worked out.

MR. KLIGGE: Yes. I think that this is the major conflict that we have.

SENATOR MARAZITI: Well, let me ask you this question, and certainly if it isn't a question you would like to answer, it's all right too - I'm just searching for information: Forget the question of where it is - I and A or Health. Forget that for a minute. Apparently S 330 covers a greater area than 200 because you have raised more points. Which bill would you prefer if the question of jurisdiction were not involved? If you want to answer - I'm not trying to put you on the spot.

MR. KLIGGE: Actually that is the major difference that we feel is contained in the two bills and we have some very concrete reasons for that. One of the major reasons, I have already pointed out in this statement, is that it is a question of payment, the source of payment and the regulating agency. We feel it is a much more efficient situation to have both under the same department. Prior to Medicaid, we had the welfare program. And it took us many years to get a reconciliation between the Department of Welfare and the requirements of the Department of Institutions and Agencies. When new regulations are put into effect, in most cases the cost of operations increases and the department who is paying the bill has to be very aware of this and both departments must work rather closely together. With the Medicaid program in the Department of Institutions and Agencies, certainly I think it is much more advantageous for those two departments to be under the same jurisdiction, so that requirements and reimbursements are under the same Commissioner because then we get some cohesive action; whereas if it is split between two departments, it may be a

little difficult.

SENATOR MARAZITI: Thank you very much. I think Mr. Coyle would like to make a statement. Mr. Coyle, would you state your full name and address and then you have a little prepared statement here - a chart.

L E O N A R D A. C O Y L E: For the record, Senator, my name is Leonard Coyle. I am attorney for the New Jersey Nursing Home Association.

I am not going to repeat any of the material that was covered in our prepared statement which was presented by Mr. Kligge today. But for your information and the information of the Committee, I have made out a rough form or chart which would indicate to you and to the members of your Committee the procedures which are established under S 330 in its present form.

I made up this chart to show you not only the procedures, but how cumbersome it would be for a person following this administrative structure to obtain a certificate of need.

If you will look at the chart you will find that the applicant must first obtain necessary papers and then submit them to the Commissioner of the Department of Health. The Commissioner then sends the application and any other papers accompanying it to the Health Facilities Planning Council of New Jersey, who then must send it to the Local Health Facilities Planning Councils, which are various councils throughout the State covering different areas of the State. The application is then initially acted upon by the Local Health Facilities

Planning Council involved, sent back to the Health Facilities Planning Council of New Jersey. They review it, make their own supplemental report and recommendation and then send it on, hopefully, to the Commissioner of the Department of Health.

From there, the Commissioner of the Department of Health takes the recommendations of the Health Facilities Planning Council, their supplementary reports, the recommendations of the Local Health Facilities Planning Councils and sends it on down to the State Health Planning Council. The State Health Planning Council gets all this material and, assuming that they approve it or come up with a recommendation, in turn send it over to the Health Care Administration Board, which is the board constituted in S 330 with the advice and approval of the Senate. If the Health Care Administration Board then acts on this particular application and all the supplemental data that is submitted to it, the applicant may be informed of the decision of the Health Care Administration Board.

Now you will note on the righthand side of this chart beneath the State Health Planning Council, there is another group called the Comprehensive Area-Wide Health Planning Agencies. Very little is said in S 330 about the Comprehensive Area-Wide Health Planning Agencies, except for a very small reference that the State Health Planning Council shall be the coordinating agency for the Comprehensive Area-Wide Health Planning Agencies.

The composition of the Area-Wide Health Planning Agencies is not known. The bill is silent. The bill is also

silent on the State Health Planning Council. It recognizes the State Health Planning Council through this legislation and asks the Legislature to recognize it as a body which has been appointed pursuant to Federal legislation.

In my interpretation of the bill, it is possible that the power of the Commissioner of the Department of Health is purely discretionary in what agency he will recognize as a planning agency. He may recognize the Health Facilities Planning Council of New Jersey and their subsidiary Local Health Facilities Planning Councils or he may recognize the State Health Planning Council and their subsidiary the Comprehensive Area-Wide Health Planning Agencies or he may recognize both.

But looking at the chart, some very serious questions arise not only in the procedure but in the manner in which a person or an applicant might be qualified eventually to receive a certificate of need. Certificates of need referred to in this bill go far further than the mere issuance of a certificate for the purpose of putting up a new building or adding an extension to an existing building. Certificates of need according to this bill would be required even to the most minute things, such as, renovation, extension, addition of new equipment. I would assume this means hospital beds and all the other usual types of equipment which might from day to day be replaced or added in a medical institution. The bill is very comprehensive in its definitions in that regard.

You have asked on several occasions previous witnesses the major differences between A 200 and S 330 and what the

similarities are. Well, I can this - in my opinion the only similarity between S 330 and A 200 is the same similarity that exists between a giraffe and a horse. They both have four legs and a tail and the similarity ends at that point. Neither bill intends to accomplish more than the other. S 330 provides for issuance of certificates of need and also provides for regulation of facilities by licensure. A 200 does the same thing.

In A 200 we have three boards - the Local Health Planning Council, the Health Facility Planning Council of New Jersey and the State Board under the State Board of Control. It is a very simplified procedure whereby a certificate of need could be issued. Under 330 we have a very cumbersome procedure where it may take as long as six months to two years or longer or never before a certificate of need might be issued.

I have been informed by Senator Dumont that there is recognition that there is no time limit within which the various agencies must act upon an application which has been forwarded to them and, therefore, he has consented to put in a limitation of 60 days in which their recommendations must be made known. However, the proposed amendment which I have received indicates that while action must be taken in 60 days, these recommendations must be then forwarded to the Commissioner of the Department of Health. There is nothing in the bill nor anything proposed that commands the Commissioner of Health to pass the recommendations and the application and supplementary reports down to the Health Care Administration Board for their

action. There is nothing in the bill which commands the Health Care Administration Board to act once they receive the recommendations of all these various councils. And I would seriously question under the present posture of the bill the right of an applicant to compel this particular board by way of prerogative writ under the ancient writ of mandamus to issue a decision on an application which has been submitted to them. In effect, in my opinion, the Commissioner of the Department of Health can pocket veto any application that is made for a certificate of need and every single one of these agencies created in S 330 can also pocket veto every application which is sent to them. There is nothing to command that they act upon applications once they are received.

I further question the inclusion and the necessity of including the State Health Planning Council and the Comprehensive Area-Wide Health Planning Agencies in this bill. I see no purpose to it. They perform no function. The State Health Planning Council is asked to make a review of everything that has been reviewed previously by two other boards and will again be reviewed by the Health Care Administration Board.

I see no need for the Comprehensive Area-Wide Health Planning Agencies because they are given no duties in this bill. They are given no powers. And I assume that this bill is recognizing them to give them statutory authority or statutory recognition in New Jersey so that they might implement the powers which have been given to them under Federal legislation. If such is the case, I think those powers should be

spelled out so that those who are asked to vote upon this bill will know exactly what it is they are voting on.

We are very concerned over the fact that more than 30 sections of the existing statute affecting nursing homes and hospitals will be repealed in my opinion by implication with the passage of S 330. And of great concern to us in the implied repeal of these sections is that section particularly which deals with definitions in Chapter 11 of Title 30. Chapter 11 of Title 30 defines hospitals. It defines patients. It defines various types of facilities. And these definitions have come about since the first act of the Legislature was passed in New Jersey in 1924, almost 50 years ago, regulating and licensing nursing homes.

Under 330 these statutory definitions would by implication in my opinion be repealed and the Health Care Administration Board would have the authority to implement by administrative fiat, by administrative regulation, the various definitions of these categories of institutions and category and definition of a patient, which heretofore has been statutorily defined in a very satisfactory manner.

SENATOR MARAZITI: You refer to repeal by implication, right, not outright repeal?

MR. COYLE: This is a repeal by implication because there is no reference either in the title of the bill or otherwise that any sections of the existing statute in Title 30, Chapter 11, are being repealed.

SENATOR MARAZITI: Take Paragraph 2 of Senate 330 - "The following words or phrases, as used in this act," (repeats

"as used in this act") - "shall have the following meanings,..." In my opinion that would confine these definitions and these phrases to this act, "medical care facility." I would interpret that to mean that for the purpose of this act, these phrases, "medical care facility" and "health care service" and "board," etc. mean certain things.

MR. COYLE: That's correct, Senator.

SENATOR MARAZITI: Wouldn't you say that?

MR. COYLE: That's correct. The definition of medical care facility is contained in 330. What I am pointing out is that where there are certain definitions of various terms contained in 330 ---

SENATOR MARAZITI: Well, could you point one out? I see the point you are trying to make. In other words, you want to make sure that certain sections of Title 30 are not repealed by implication and you want it clarified and I can see that point. Maybe you could point out one of these terms where you think that may occur.

MR. COYLE: Certainly. There is no definition in this bill of the word "patient."

SENATOR MARAZITI: There is no definition of the word "patient." Now if there is no definition in this bill of the word "patient," I don't think that would have the effect of repealing the definition of the word "patient" in Title 30. I agree with your concern that we don't want to repeal anything that we don't know about by implication. But in that particular case, I don't think there is a problem. If there is, it can be clarified.

MR. COYLE: Senator, the patient, you see, is covered under health care service under Paragraph (b) of page 2, and the types of services are spelled out.

SENATOR MARAZITI: Where is that, Mr. Coyle?

MR. COYLE: Page 2, Paragraph (b), line 16. It defines what constitutes a health care service.

SENATOR MARAZITI: All right. "Out-patient" - "in-patient" - well, they don't define the word "patient." But that does not have the effect of repealing a definition of patient in some other act.

MR. COYLE: What I am trying to say, Senator, is that if this bill were to pass and the functions were transferred over to the Department of Health, the present Title 30 currently has all of those sections under the Hospital Licensing Board in the Department of Institutions and Agencies. Now the Hospital Licensing Board is being repealed by the passage of this bill. All of their duties are being repealed by the passage of this bill. And all of the other sections where this bill is in direct conflict with existing statutes in Title 30 will by implication be repealed.

SENATOR MARAZITI: Maybe you have a point there. Where would it be in conflict? It would not be in conflict on a definition of medical care facilities?

MR. COYLE: Well, yes, it would.

SENATOR MARAZITI: No, because this definition is limited as used in this act.

MR. COYLE: Senator, under "medical care facility" there is lumped various groupings of various types of physical

plant facilities in this State and they are called in this bill and defined as a medical care facility. Later on in the bill, 330, the Health Care Administration Board is permitted to classify various types of institutions and facilities. Now under the existing statute each of these facilities are specifically defined. Here they are lumped under one definition under the title "medical care facility" and the definition of this type of facility will then be left to administrative discretion. I don't see how it could be implied in any other way other than a direct repeal of existing definitions in the present statute.

SENATOR MARAZITI: I think I interrupted you. If you can find out where you left off, go ahead.

MR. COYLE: What we were concerned about principally in this chart, Senator, is to present to you graphically an idea of the procedures which would have to be followed by anyone who wishes to obtain a certificate of need.

SENATOR MARAZITI: I have this chart and in connection with that - your point is - I am looking at it and certainly get that impression - that there are too many steps involved here and you are recommending therefore, what?

MR. COYLE: I would say that the procedures outlined in Assembly Bill 200 --

SENATOR MARAZITI: A 200?

MR. COYLE: Yes. -- are streamlined and simplified. There are two steps before it gets to the major board within the Department of Institutions and Agencies, subject to approval of the State Board of Control.

SENATOR MARAZITI: In other words, in place of what you have in this chart, you recommend that we use what is in A 200.

MR. COYLE: That's correct.

SENATOR MARAZITI: And A 200 has a provision in there compelling a decision whereas 330 does not?

MR. COYLE: It is a 60-day provision.

SENATOR MARAZITI: In A 200?

MR. COYLE: Yes.

SENATOR MARAZITI: And 300 does not?

MR. COYLE: With respect to 330, I understand from the sponsor he is willing to put in a 60-day provision as far as the State Health Planning Council and the HFPC is concerned, but there is no time limitation on any of the other councils.

SENATOR MARAZITI: I understand. But I do understand that the sponsor has some amendments which are not in the original bill. I don't know what they are.

MR. COYLE: Senator, I would like to say I have sat with Senator Dumont on numerous occasions on 330 and I am well aware of his concern in this bill and in obtaining passage of this type of legislation. We are very much in favor of obtaining some type of planning legislativewise whereby these goals can be achieved and I do hope that we can sit down and work out our differences. We have worked out many of them and I would like to say that Senator Dumont has been most gracious in consenting to many of the amendments which we have recommended.

SENATOR MARAZITI: Thank you very much, Mr. Coyle.

MR. COYLE: Thank you.

SENATOR MARAZITI: Is there anyone else who would like to be heard at this time?

Senator Dumont, there have been a number of points mentioned here and I know you have made observations as the rest of us have. Perhaps you would like at this time to express your viewpoint on some of these points that have been made, some of the suggestions, and perhaps you might want the opportunity to clarify what you consider to be within the terms of Senate 330. So if you will, we would appreciate your comments on what has been said.

W A Y N E D U M O N T, J R.: Thank you very much, Mr. Chairman, for giving me this opportunity to comment on the comments that have been made.

I also want to thank the people who appeared here today regardless of their feelings on the bill because it is the only way that perhaps we can arrive at a final answer to the problem which certainly is a real one.

Let me take them up one by one.

Mrs. Finlaw who testified on behalf of the Homes for the Aged raised a question of a definition of intermediate care facility, something that I think is answered in the bill under the definition of medical care facility, but I would like to be sure about that and certainly it is a point that ought to be clarified.

Secondly, she questioned whether the representative of the Homes for the Aged should not be designated in the bill as

representing her association. We considered this in the question of designating various groups. Our fear is that if we pick out in any one group that has representation a particular unit, we are going to have to do that in all of them and not all of these groups by any means, particularly let's consider labor, are represented wholly by one association or one organization. It would seem to me it would be better for the Governor to make a selection. Undoubtedly names would be submitted to him by all the organizations in every group and then he would have to decide, along with receiving Senate confirmation on that name, who should be the one representing a particular classification, if not a particular organization. While I know in some legislation we have occasionally pinned it down by naming the organization that would designate the representative, I think that in this case of a large group of 17 people, some of whom would represent different classifications, he ought to have a little more flexibility than just being tied down to one organization in a class.

I am concerned that she indicated, for example, that her association represents about 60 per cent, I think she said, of the Homes for the Aged. Well, this would mean then that the other 40 per cent who maybe ought to belong to her association, but do not at the present time, would really not necessarily be represented by the person chosen from her particular association. This is why we stayed away from that generally in the bill.

Mr. Armstrong's suggestion - I don't see any problem with that. I would think that could be included and to me it

makes sense that it should be.

Mr. Owen testified next on behalf of the Hospital Association. I want to say first of all to him that I am apologetic of the fact that I did not read carefully apparently page 3 of A 200 where it talks about the Commission being appointed by the Governor with the advice and consent of the Senate.

He also mentioned that he feels that A 200 on page 5, line 28, where it talks about the need for special equipment and services in the area would take into consideration more than the actual building or construction of a building. He may well be right about that point too. But there is no question about the fact that this bill, A 200, does leave the licensing procedure in I and A where even, as I pointed out this morning, in a personal letter to me the President of the Board of Control of I and A thinks it ought to be transferred out of that department into the Department of Health. And I don't think there is any better testimony than a man who has served so long as President of the Board of Control and who has such a vast background of knowledge in the whole institutional field as a matter of fact.

If you will bear with me just a moment here because I am trying to review these statements.

He raised the question which is the same point that Mr. Coyle raised about what they think is a cumbersome procedure under S 330. Let me say that by amendment which has been placed into S 330, although there is no official copy reprint - but in Section 4 of the bill - it's not a new Section 4 but it is

a clarification of Section 4 - it points out that the Health Facilities Planning Council for New Jersey, which is a group on which I have served as trustee ever since it was started - and incidentally it was started by Mr. Owens' predecessor as Executive Director of the New Jersey Hospital Association, namely, the late Harold Johnston -- we say very clearly that the Health Facilities Planning Council shall act as the coordinating agency for the Local Health Facilities Planning Councils.

Let's take this diagram that Mr. Coyle presented here. That means that you start off as far as building construction goes with the Local Health Facilities Planning Councils, of which there are 12 today and they cover every single section of New Jersey. You go from there to the State Council and then in A 200, as I understand it, to the Board. Well, there is no difference between S 330 and A 200 in that respect. We start with the Local Planning Councils on building needs, go to the State Council and then to the Commissioner because the Commissioner cannot operate without the concurrence of the Board under S 330. And incidentally I might add that that was very clearly spelled out in this year's bill at the request of the Hospital Association of New Jersey and the Nursing Home Association so that the Commissioner of Health would not have the single authority that he had under the old S 301 of last year. So there is no difference in that procedure.

The only thing that we do in S 330 is recognize the State Health Planning Council, which obviously the Hospital Association and the Nursing Home Association want to discard

entirely. This, as I pointed out this morning, is a very eminent group of citizens who actually were created in the Department of Health after the Ward Commission made its report a few years ago - in 1967, I think it was. One of our colleagues, Mr. Chairman, Senator Forsythe, serves as a member of the State Health Planning Council, and its distinguished Chairman is Martin Ulan who, as I mentioned this morning, is Administrator of the Hackensack Hospital.

Now that Health Planning Council which has to do with things other than buildings and construction of buildings in health care uses a local group known as Comprehensive Area-wide Health Planning Agencies. So if this chart were carried out properly, there should be an arrow between the State Health Planning Council and the Comprehensive Area-Wide Planning Agencies, which incidentally for the information of some who said it wasn't defined, is defined at the bottom of page 2 - I think it is still the bottom of page 2 - of S 330. Anyway it is in Section 2 (g) where it says a "'Comprehensive Area-wide Health Planning Agency' means the officially recognized health planning agency formed under the provisions of Public Law 89-749." That's in 2 (g). I think it is. I have so many amendments here, but I think that's still the right place. So that is defined in S 330. It is not an undefined type of agency, as pointed out by Mr. Coyle, and it simply is the same in respect to other aspects of health care as the Local Health Facilities Planning Councils are with respect to building construction. There is no difference.

We simply say in S 330 - and this again I want to clarify because I don't think that the Hospital Association presented this properly - that where we are talking about buildings, we go to Health Facilities Planning Councils, both local and State, and they would be new hospital buildings, additions to existing hospital buildings, nursing homes - talking about buildings - construction of buildings.

Then when we go into the other aspects of health care, we simply say you take the same three steps from the Comprehensive Area-wide Health Planning Agency to the State Health Planning Council already existing in the Department of Health, and then go to the Commissioner of Health who again when he makes a decision on that point has to have the concurrence of the Board created in S 330. It is not a matter of having four different agencies involved. You have two agencies - one, two steps to the Commissioner for buildings - one, two steps to the Commissioner for something other than buildings. And it gives recognition not only to the existing Health Facilities Planning Council and the regional councils at the local level, but also to the existing State Health Planning Council and the Area-wide Health Planning Agencies at the local level of that particular council and they exist too at the present time.

I don't see anything confusing about that because let me say as a charter trustee of the Health Facilities Planning Council of New Jersey - and Mr. Owen is also a trustee on it so I am sure he knows this - that that council does not want to get involved in anything other than buildings in planning

for the future and it has so expressed itself on numerous occasions at the regular monthly meetings of the council that are held in either Princeton or in Newark. Now that is a matter of common knowledge among all of us who serve as trustees. They don't want to be involved in anything other than building construction so far as planning is concerned. As a matter of fact, I think our charter - we are not incorporated in the sense of being recognized by legislation unless one of these bills passes and then we might be recognized because each of them mentions the council -- in the charter of incorporation of the Health Facilities Planning Council for New Jersey, I think it makes it very clear that it is concerned only with building construction and not with other aspects of health care. Thus the reason why we have the State Health Planning Council in here is to take in an already existing voluntary agency in other aspects of health care.

As to the question of time limitation, I don't blame Mr. Owen for not knowing about this. We told him that such an amendment would be made, but I don't think he has seen a copy of it yet. The amendment says - and I'll read it - it's very short - it is in Section 8 (d) - "The recommendations concerning the application for a certificate of need shall be made by the Health Facilities Planning Council and the State Health Planning Council (that's within their respective jurisdictions) and such recommendations together with all applicable documents shall be forwarded to the State Commissioner of Health within sixty days."

Now the other time limitations mentioned by Mr. Coyle

as to what the Commissioner and the Board would do are not in the bill, but neither are they in A 200. All A 200 says at the bottom of page 5 is that such recommendations, that is, from the area planning council and the State Planning Council, whether favorable or unfavorable, shall be forwarded to the commission within 60 days of the date of referral of the application. It doesn't say when after that the Commissioner or the Commission, itself, has to rule upon those applications. There isn't anything in A 200 that has a time limitation in that respect. So I don't know why any complaint should be lodged against S 330 when the supporters of A 200 don't have it in either.

Mr. Owen also indicated in his statement on page 5 that New Jersey is in desperate need of additional moneys, and we are all well aware of that, and it would be unwise to create additional expenses. There are no additional expenses that would be involved in S 330. I have it from a very high representative in the Department of Health that there are funds there now that are not entirely necessary for the purpose for which presumably they came into the State - there are some Federal moneys for one thing - and they can be used to take care of any funding that may be necessary. Really there is not going to be any extra burden or expense to the taxpayers of New Jersey in any way, shape or form involved in S 330. So I don't consider that an accurate statement.

Now regarding Mr. Lyon's testimony who supported the bill, I don't think there is any comment necessary there because he didn't mention any particular suggestions or other

points that ought to be clarified.

I would say as to Mr. Owen's point, going back to him just briefly, that where there is any conflict in language between "the board shall" and "the commissioner shall," that ought to be revised so as to be clear and be uniform in each case.

I think what we have here basically is something that is not new. It is a difference in philosophy. As a hospital trustee, if I were not active in government, I probably might resent some intrusion on the part of government. Being active in government, I don't feel any problem at all with that, being also a hospital trustee. Because I think that hospital trustees even those that do not serve in government should realize today that if we are not all concerned and if we don't do something promptly, with not just this bill but a series of bills such as some of those that passed the Senate on Monday, in trying to hold down the cost of health care, not just hospital cost but health care as a whole, as has been pointed out and as I mentioned in this one editorial from the Trenton Evening Times, who can afford to be sick? It is just as simple as that. So there is going to have to be some giving in to government intervention because we tried the voluntary way for years. The costs still continue to rise and soar sharply, as a matter of fact, each year. And thus we can't do any worse by having some government intervention. We might do a lot better.

Thus I think this is a basic difference in philosophy that exists and probably always will because the bill which started out and which ultimately became A 200 was about as weak a piece of legislation in 1968 as you could have and still

have any legislation. Gradually A 200 has been strengthened considerably, solely under pressure from other pieces of legislation that are before the Legislature and are much stronger and always have been much stronger than that particular bill, with all due respects to it.

Mr. Mellman in his statement on behalf of Prudential spoke about the fixing of rates and I know that there is some sentiment in the Legislature toward that point. As a matter of fact, what we had in S 301 last year went much farther toward that particular objective than the present S 330 goes. It was that very point that aroused particularly the opposition last year of the Hospital Association and of the Medical Society and of the Nursing Home Association to some degree, perhaps to a lesser degree than the other two.

I don't see how you can just talk about fixing rates unless you are also going to fix costs because the rates inevitably are the results of the costs. They have to be. S 301 of last year really went pretty far toward the actual fixing of costs. So it seems to me that in opposing that bill but in some suggestion being made this year of fixing rates to everybody, there is no particular consistency in positions. And I would be the first one to admit that no legislator, certainly including myself, is always consistent. But at the same time I would like to point out that I think there is an inconsistency here in the position taken a year ago in respect to the previous bill and what they desire this year.

One more thing - I don't follow the argument of

the insurance companies as outlined by him as to why they don't want to negotiate with hospitals the same as Blue Cross does. Now this isn't something we are fixing as a requirement by legislation. Blue Cross and the member hospitals are free to bargain and negotiate year after year as to what Blue Cross is going to pay by way of benefits, and they do that. If the hospitals don't like the fact that, as they say, Blue Cross pays only costs and not actual charges, then I am sure that that can be a subject of negotiation also and perhaps it ought to be. But I am not sure that it ought to be set by legislation as a definite requirement. Nor do I see any reason why these insurance companies could not do the same thing that Blue Cross does if they want to do it. They are certainly free to do it. And I don't agree that the net effect of that would be to make hospitals insolvent. As a matter of fact, what it probably would do is encourage if not put a considerable amount of pressure on people who now don't have any insurance because they can pay their own bills perhaps to take out insurance for the future.

I have no objection at all to his recommendations about trying to clarify Section 8 (g), although I wish that Prudential would provide us with an actual amendment on that score, that is, language, nor do I take any issue with his point about Section 12, which incidentally is the old Section 12. Under the amendment, it would be a new Section 20. It would simply be renumbered, that is, as Section 20.

Where he says that the only penalty in the bill is that the unlicensed hospital may not collect from Blue Cross

or government agencies if a certificate of need is not granted or a hospital license revoked - it may well be that there ought to be more in penalties in S 330, but here again I would like some recommendations from him definitely as to what they ought to be.

SENATOR MARAZITI: At this point, Senator, I would interrupt you and may I suggest, Mr. Mellman, if you have a specific recommendation, you submit it to the Commission.

MR. MELLMAN: We have none at this moment. We would be pleased to try to draft something and submit it to you.

SENATOR DUMONT: Fine.

Now Mr. Mellman mentions at the end of his statement that establishing a uniform system of hospital charging might raise the cost of hospital coverage for Blue Cross subscribers. I think that is definitely true. So the question is, therefore, whether in raising the cost to three and one-half million people, it would correspondingly lower the charges for those who are not Blue Cross subscribers. Again all of those people are free to subscribe to Blue Cross or to one of the commercial carriers. My understanding is that Prudential has approximately 10 per cent of the non-subscribers; in other words, about 300,000 people carry their health coverage with Prudential. Then the other commercial carriers make up the balance of all the people with the exception of those who don't have any coverage at all.

I think also if we get into the question - and I know that both Prudential and the New Jersey Hospital Association have a proposed piece of legislation in mind that would

regulate rates in New Jersey - again the difficulty comes in the definition of all the things that they would like to have included as costs and as part of the rate structure, some of which incidentally have not met with the approval of Dr. Culp, at least, from the Department of Health - some of the items that have been mentioned. So we would have problems, I think, working that out but it is not an insoluble problem at the same time.

Getting finally to the Nursing Home Association other than the points that I have already covered with respect to that, I would just like to go through them quickly. Actually the basic difference here between favoring and opposing S 330 on the part of the Nursing Home Association is exactly what was stated at the beginning of the statement, they just don't want to transfer out of the Department of Institutions and Agencies to the Department of Health and I have expressed the reason why I think this is necessary as well as desirable. I am sure that Mr. Russo and his group could very easily be transferred from one department to the other. I don't see any problem with that, as suggested by the first witness this morning. And, therefore, we ought to get out of that department, as expressed again by the President of the Board of Control who sets the policy for that department - we ought to get it out of there and put it in a department where it really belongs. And I don't see how we are going to resolve that basic difference as a matter of fact.

SENATOR MARAZITI: Maybe you have the idea - transfer Mr. Russo.

SENATOR DUMONT: It is a very deep issue apparently. I don't intend to compromise on that point. Probably the Nursing Home Association doesn't either, in which case we just have to fight it out when the legislation is passing, if either of them does.

Some of the other specific points raised by the Nursing Home Association - we have already covered the question that was raised by the Christian Science representative.

SENATOR MARAZITI: One thing that Mr. Coyle raised, Senator, I wanted to ask you about. Perhaps you have a note on it. We discussed it briefly with him. He seemed to be concerned about definitions and an implied repealer of certain sections of Title 30 that he was concerned about. Do you see a problem there?

SENATOR DUMONT: There could be a problem and I talked to him only last Thursday for over an hour about this point and some other points and told him that rather than leave it up to any implication by way of repealer, I thought we ought to state specifically in here what sections of Title 30, Chapter 11, would be repealed and what would specifically be left in operation. As a matter of fact on that very morning, he told me that he thought 30:11-3 and 30:11-4 should be repeated in S 330. I said, well, we are incorporating them by reference and that is often done in legislation. Why should we go through all the detail of repeating the language of each section in the bill? It is perfectly clear that they are being incorporated by reference so we don't need to repeat them word for word.

SENATOR MARAZITI: No.

SENATOR DUMONT: So he finally agreed to that. But he may have a point on these other things. I will certainly look into that in detail.

SENATOR MARAZITI: In other words, it is not your intention to imply the repeal of any sections of Title 30 by implication and accidentally, so to speak. And that can be clarified.

SENATOR DUMONT: That's right.

SENATOR MARAZITI: Senator, some reference was made to the Ward Report. Is that the report that recommended the fixing of charges or hospital costs?

SENATOR DUMONT: Yes. As a matter of fact, that Commission - I don't have a copy of the report here - but it made a very definite recommendation that there should be uniform audits of hospitals, there should be uniform cost accounting procedures established by a State agency, and that Commission also recommended very clearly that everything be centralized in one department, in an agency in one department, and not be left scattered around various departments.

I have talked to Mr. Ward at some length about this because he also, incidentally, serves as a member of the State Health Planning Council, the group that the Hospital Association and the Nursing Home Association, as I gather from their testimony today and reading A 200, would like to eliminate. Because Mr. Coyle said, if I recall his words, that he didn't see that the State Health Planning Council was really accomplishing very much. I don't think the people involved in that Council

would appreciate that because they really do a lot of work and put in a great deal of effort and they are all fine people.

Basically all of these specific things that have been suggested by the Nursing Home Association on several pages of their statement have either been corrected by amendments that I gave to Mr. Coyle last Thursday or will be corrected. The only thing that I don't like, aside from their position on the transfer from one department to another, is this question of S 330 not spelling out all of the rights to which witnesses and applicants are entitled. Frankly, they are all spelled out in the Constitution of the United States and the Constitution of the State of New Jersey. I don't know why we have to re-spell them in every single piece of legislation. We all know as attorneys what those rights are. We know that you can't avoid them because the Constitution wouldn't let you and there isn't any reason to spell them out in detail in a piece of legislation.

Finally, there was discussion this morning on my statement that I thought S 330 was a much more comprehensive bill than A 200. I think that Section 6 goes into the details of what the Commissioner of Health, with the approval of the Board, may do, most of which are not spelled out at all in A 200, such as, the rules and regulations that may be passed by the Board only after public hearing, the Commissioner of Health with the approval of the board having the power to inquire into the operation of medical care facilities and conduct periodic inspections of facilities with respect to the fitness and adequacy of the premises, the equipment, the personnel, the rules and bylaws, the health care service and

records to effectuate the provisions and purposes of this act. A 200 doesn't spell out that sort of thing. It is directed primarily toward construction with some implication that it goes into equipment. But it doesn't go into all the other things that would be placed by way of powers in the Commissioner of Health with the approval of the Board, which are set forth in several paragraphs of Section 6 of S 330.

Just one more comment here, I mentioned this morning that the Medical Society has approved S 330 and I might say the Medical Society again in this bulletin of March 5, 1970, with respect to A 200 recommends no action. And by "no action" they mean this - and this is in their own words, the Medical Society - "considered but not regarded as significant or relative to the proper interests of the Society." So that is the position of that group.

I don't think I can add anything more. I have just about run out of comments, I believe.

SENATOR MARAZITI: Could I ask one question, Senator?

SENATOR DUMONT: Yes, sir.

SENATOR MARAZITI: In other words, on the question of cost as testified to by Mr. Mellman, as I take it you are not necessarily opposed to the fixing of costs or charges or anything of that type, but you feel that that is not the subject of legislation that should be included in S 330 or in A 200. Is that your position?

SENATOR DUMONT: Well, actually, we had regulation of cost in Senate 301 a year ago which led to the opposition of

these various groups, not necessarily the opposition of Prudential. I don't recall what the position of Prudential was with respect to S 301. I do know that that particular regulatory power in S 301 was objected to strenuously by the Hospital Association, by the Nursing Home Association, although perhaps not as much by them as by the Hospital Association, and by the Medical Society. So it was taken out and not included in this year's bill. Now in the draft of the legislation that the Hospital Association and Prudential are desirous of having sponsored in the Legislature, they talk about the fixing of rates, the theory being that that way there couldn't be any so-called discount to Blue Cross which after all is being extended only as a matter of negotiation anyway between Blue Cross and the hospital and that everybody, the subscribers of Blue plans, the non-subscribers and the self-pay people,would therefore all pay the same charges to the hospitals.

When I raised the question of why if the Hospital Association were now recommending the fixing of rates they objected a year ago to the provisions of S 301, the reply I got was that that bill fixed costs. I don't know how you can possibly fix rates unless you also at least impliedly and indirectly get into the fixing of costs. And that is a matter of conversation as to what should be included in costs and in rates which could lead to a wide difference of opinion. Aside from that, we know that the commercial carriers, such as Prudential, can do the same type of negotiating with the member hospitals as does Blue Cross. There is nothing to

stop any one of them from negotiating.

SENATOR MARAZITI: What I meant was, Mr. Mellman recommended that the Legislature pass legislation setting up a mechanism of controlling hospital charges, hospital costs. I am not suggesting that this be incorporated in this bill. My understanding is that your position is that it should not be incorporated in this bill. But do you have an objection to it or don't you have an objection to it?

SENATOR DUMONT: I really don't have any particular objection to it. As a matter of fact, it was taken out of this bill because of the objections that were made to last year's bill. My feeling is that if you are going to talk about the difference between fixing rates and fixing costs, that is more a matter of semantics than anything else because I don't know how you can arrive at rates unless you take into consideration all the costs first.

So it seems to me that S 301 with a provision going into the question of regulating costs maybe was right in the first place. But we took it out in order that we might have a piece of legislation that could pass because the best piece of legislation in the world - and I am not saying S 301 was that by any means - is of no value to anybody unless it can pass the Legislature.

SENATOR MARAZITI: That's right.

SENATOR DUMONT: So I am perfectly willing to consider that.

SENATOR MARAZITI: You did have that in S 301.

SENATOR DUMONT: Yes, sir.

SENATOR MARAZITI: Thank you very much.

SENATOR DUMONT: Thank you very much, Mr. Chairman. We appreciate it.

SENATOR MARAZITI: We appreciate all of you attending the hearing today. I am sure these suggestions will assist the Committee and the Legislature. And I again want to thank you for appearing before us. The hearing is adjourned.

[Hearing Concluded]