

**Senate Executive Committee**

152<sup>nd</sup> General Assembly

Tuesday, May 7, 2024

Senate Chamber/Virtual Meeting

4:10 p.m. – 6:39 p.m.

**Committee Members Present**

Senator Bryan Townsend, Vice Chair	<a href="mailto:Bryan.Townsend@delaware.gov">Bryan.Townsend@delaware.gov</a>
Senator Elizabeth Lockman, Acting Chair	<a href="mailto:Elizabeth.Lockman@delaware.gov">Elizabeth.Lockman@delaware.gov</a>
Senator Sarah McBride	<a href="mailto:Sarah.McBride@delaware.gov">Sarah.McBride@delaware.gov</a>
Senator Marie Pinkney	<a href="mailto:Marie.Pinkney@delaware.gov">Marie.Pinkney@delaware.gov</a>
Senator Gerald Hocker	<a href="mailto:Gerald.Hocker@delaware.gov">Gerald.Hocker@delaware.gov</a>
Senator Brian Pettyjohn	<a href="mailto:Brian.Pettyjohn@delaware.gov">Brian.Pettyjohn@delaware.gov</a> \

**Committee Members Absent**

Senator David Sokola, Chair	<a href="mailto:David.Sokola@delaware.gov">David.Sokola@delaware.gov</a>
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**Attendees**

*All public registrants, both in-person and virtual, are listed in Appendix A.*

**Agenda**

**I. HS 2 for HB 350**

## INTRODUCTION

Senator Lockman, serving as Acting Chair, brought the meeting to order at 4:10 p.m. and proceeded to conduct a roll call and confirmed a quorum was present.

### **I. HS 2 for HB 350 (Longhurst) AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO HOSPITAL COSTS.**

*Synopsis: This Act creates the Diamond State Hospital Cost Review Board, which will be responsible for an annual review of hospital budgets and related financial information. The Board will have 7 members: 6 appointed by the Governor and confirmed by the Senate, and the Executive Director of the Delaware Healthcare Association. This Act creates a requirement that hospitals submit yearly budgets, audited financial statements, and related financial information to the Board for review. Where a hospital fails to meet the state's budget benchmark for increases in hospital costs it is required to engage with the Board on a performance improvement plan. If the Board and the hospital cannot agree on an improvement plan or where the hospital fails to successfully implement a performance plan, the Board may require the hospital to have its future budget approved by the Board. The submission of hospital budget and financial information will begin in 2025 for calendar year 2026. In reviewing performance improvement plans or proposed budgets, the Board will consider adherence as closely to the spending benchmark as is reasonable given the hospital's financial position and associated economic factors, the promotion of efficient and economic operations of the hospital, and maintenance of the hospital's ability to meet its financial obligations and provide quality health care. As a temporary measure until the Board begins operations, hospitals are required to charge no more than 250% of Medicare costs to any payer for hospital services in calendar year 2025. This Substitute Bill incorporates all of the following changes which were incorporated into House Substitute No. 1 for House Bill No. 350: It provides additional detail regarding the operation of the Board, budget modifications, and provides an appeal right to the Superior Court. It changes the application of the definition of hospital to exclude psychiatric facilities. Because hospitals may have different fiscal years, the deadline for the Board to issue a final decision on a budget is changed to 90 days before the start of a hospital's fiscal year rather than a fixed date. The confidentiality provisions for hospital records have been updated. Technical corrections have been made. In addition, House Substitute No. 2 contains the following changes: It adds a performance improvement plan process as an interim step prior to requiring a hospital to submit a proposed budget for approval or modification by the Board. With this change, the Board will only accept and review budget information in its first year of operation in 2025. In 2026, it may direct hospitals to submit a performance improvement plan. It exempts hospitals that are exclusively rehabilitative hospitals. It changes the composition of the Board as set forth above. It exempts hospitals who derive 45% or more of their revenue or whose patient population has 5% or less Medicare patients from the 2025 reference*

*pricing provision. It extends the interim reference pricing period to include 2026 and prohibits balance billing in reference pricing period.*

Senator Townsend introduced and explained the bill. There continue to be ongoing discussions with the Delaware Healthcare Association, and he hoped to talk about an agreement being reached. In the House today, a bill was filed that would modify the Medicare reference pricing provision with the CPI formula that would exempt Nemours for the two years prior to review board standup. There is a persistent high-cost increase environment in health care in a very unsustainable way. There are a variety of measures that other states have implemented, and this bill represents one. Delaware is one of the top five high-cost states, yet ranks in bottom half of the country in health outcomes. The goal is to keep quality high and costs lower.

The legislation involves hospitals submitting annual financial information to the Diamond State Hospital Cost Review Board. If the cost growth exceeds the benchmark, there's a process in place for the board to review. There were amendments in the House to give the hospitals an opportunity to propose changes that would enable them to meet the obligations under the benchmark. If that were not to work, there would then be the process of the Review Board having several different options to work with the hospital to figure out why they are exceeding the benchmark. Fundamentally, this is about transparency in a sector that is tremendously important, and the legislation proposes a very reasonable mechanism for review and enforcement that is a blend of other states that have long implemented these kinds of programs.

Jeff Taschner, SEBC member and member of RHBAC was asked by Sen. Townsend to provide remarks at 4:16 p.m.

Mr. Taschner said he is the Executive Director of the Delaware State Education Association (DSEA). He offered his background: a member of the State Employee Benefits Committee (SEBC) from April 2017 through February of 2023. He's been a member of the Retiree Health Benefits Advisory Subcommittee since that time. In 2015, he was a member of the state employees health plan task force. He is also the vice chair of the State Workers United for a Better Delaware (SWU). SWU formed in 2009 when Gov. Markell proposed an 8% pay cut. They were successful in negotiating that down to 2% a cut with furloughs. In May 2010, the Governor announced a plan to deal with health and pension protection. He was the lead negotiator along with other union leaders which led to HB 81, which made changes to the pension and health care systems. The projected savings were \$71.17 million over 5 years, \$327.8 million over 15 years, \$56.8 million over 5 years, 15 years - \$212.06 million - for combined savings to the state of \$539M over 15 years while not greatly diminishing health care benefits. They thought they had time and breathing space, but then found that the group health insurance plan was in dire straits. The fund was being exhausted, and from there came the joint task force. That was the first time hospital costs were noted.

A report of the task force revealed that our hospital costs are greater than surrounding states. This was based on a presentation from Highmark DE that showed that the hospital market is dominated by a single hospital in each region, hospital acquisitions of physician practices have accelerated the increased cost to the system, hospital payments per case mix are significantly

higher in DE than other Highmark markets, and payments for Medicaid and Medicare are significantly lower than commercial payments for similar services.

Highmark showed that our market was 146% of PA market average and 145% of the WV average. If you take a look at the task force report, they recommended the creation of a hospital services review commission among other payment reforms. However, no progress was made prior to the filing of HB 350. During that period, we have had continual warning signs of the challenge and problem of the price of hospitals and healthcare in Delaware.

In Feb 2020, the Johns Hopkins Bloomberg School of Health made a presentation to the SEBC. Their findings: in 2017, private sector cost in DE for an inpatient basket of common services was 2.41x the Medicare price in DE, compared to the national average of 2.13, in PA 1.91, and in MD 1.35. The median overall hospital margin in DE was 11% compared to a national median of 3.6%. Hospital profit margins are high in DE when compared to other states. Hospital level spending on community benefits was lower in DE – 6.96% of overall expenses compared to the 9.28% national average. A smaller percentage is being spent on charity care and unreimbursed Medicaid costs among our hospitals when compared nationally. In April 2023, DOI, Office of Value Based Care made a presentation to SEBC. This revealed that our commercial hospital prices are among the highest in the nation. DE ranks 11<sup>th</sup> in the nation for inpatient facility and 9<sup>th</sup> for outpatient facility. In comparison, we pay our physicians only 115% of Medicare, which is the lowest in the nation. Our hospital prices in DE are simply too high.

David Bentz, DHSS, Deputy Director of Healthcare Reform, was asked by Sen. Townsend to provide comments on the bill (4:25 p.m.) This policy has been used in other places around the country. In 2018, DE established through Executive Order, the healthcare spending benchmark, and in 2022 that was codified by the General Assembly. Delaware Economic and Financial Advisory Council (DEFAC) will set the health care spending benchmark and then DHSS will measure total spend in the state and what the growth is relative to the benchmark. Categories include inpatient and outpatient cost and pharmaceutical. Year after year, the state healthcare spending benchmark has not been met. Instead, it's typically been twice the benchmark. We haven't seen the progress of moving healthcare costs toward the benchmark. This legislation is a response to that. There has been no mechanism for the state to engage with hospital partners and start moving positively toward that benchmark. HB 350 has pulled from other states that have had a similar process and a tested policy. The two states that have a robust history and results are Massachusetts, which has been quite successful in moving toward their benchmark. Vermont is another state that has been conducting budget reviews of hospitals for some time now. We know this can be done in a way that has the ability to work and does not disrupt the hospital industry. We have cost drivers in health care, and this is an effort to get at one of those cost drivers. This is not meant to be an attack at the hospitals, but rather to develop a policy to address costs.

Sen. Townsend emphasized that there are other cost drivers of health care in DE, such as pharmaceutical costs. We should be committed to patient care and wellness as we see a continuing shift in acquisition and independent practices going away. This bill doesn't micromanage that, but until we have transparency it is difficult to understand these issues. He

hopes we can advance this legislation, which provides for flexibility for the different hospitals across Delaware. We need to bring better efficacy and fairness to this.

Senator Lockman invited questions from the members of the Committee.

Sen. McBride asked about the decision-making processes regarding the models used. The original legislation was more in line with VT, but we've moved into a hybrid of VT and MA. Why is this?

Sen. Townsend said the issue of basing things just on fines is problematic in two ways – it monetizes these decisions that impact families and individuals. Part of the challenge is the amount of the fine – it doesn't get at the opportunity to dig deeper and do better. The heart of it should be a collaborative approach to address the core problem.

Sen. McBride asked if we see a substantive difference in outcomes between the VT and MA models?

Sen. Townsend said the original bill had the VT model. HS 2 has the performance review processes, which was in coordination with the hospitals.

David Bentz said there are good arguments to be made for both models. They heard the belief that VT's was more of an invasive process, reaching into a budget and marking it up, revising it, versus pulling from another model that allows the hospitals to be the first ones to identify ways to slow their own growth. As they've worked with the stakeholders, they have developed a tiered process where it's placed on the hospitals to identify savings where they can find them, with the back end being like the VT model.

Sen. McBride asked about lines 118-119, which states "Adhere as closely to the spending benchmark as is reasonable given the hospital's financial position and associated economic factors", and how the authors of the legislation envision the decision-making process and examples of unreasonable expenses above the benchmark.

David Bentz said that part of the bill is important because it's trying to avoid an arbitrary decision; rather it's about trying to make an informed decision about where savings can be found. The hospitals will note factors outside of their control, and this language is meant to account for that.

Steven Costantino, DHSS, Director of Health Care Reform and Financing, said MA has been doing this for about 13 years and has had one fine. There are sometimes legitimate reasons for expenses. There was a hospital that was over the MA benchmark, and they said they had not received an increase from their insurers in eight years. There is a rationale to all of this that there are reasons for being over a benchmark. The fact that they have such a public process in MA, the hospitals have been aggressive in maintaining close to that benchmark generally. Pharmaceuticals is another area where cost drivers might be beyond an entity's control. On the

VT side, the proposed process is one fourth of what the Green Mountain Care Board does. That Board can go to the rates and drop them. This DE board would not have that authority.

Sen. Townsend said there is a lot we can learn from things we can do together, in a collaborative way. The Executive Director of the Delaware Hospital Association (DHA) would be a member of this review board.

Sen. Pettyjohn asked how many hospitals have closed down since these reviews have been instituted in the other states.

David Bentz said there are 14 hospitals in VT with a population the same as DE. They have been having budget review processes since 1983. They don't see anything significant occurring there.

Sen. Townsend said VT does have hospitals with financial challenges, as there are in DE, but that is not necessarily linked to these review boards. This is much more about what do we do about hospitals that aren't in that position, but Delawareans deserve to know what is happening.

Sen. Pettyjohn said transparency is key for operations that serve the public. He said in VT, one hospital closed, 11 are operating in the negative, and 4 in immediate danger. In MA, 3 have closed since 2014 and some others announced closures recently. He's concerned as to whether the benchmark is realistic. What have we heard from the hospitals as to why we are exceeding the benchmarks?

Sen. Townsend said they raise pharmacy and labor costs in particular. Capital costs are mentioned occasionally. This bill says the finances are unsustainable in ways that impact not just the state budget but also everyday Delawareans. It's important to have conversations on why costs are going up. It's about the transparency and keeping costs in a sustainable place.

Sen. Pettyjohn asked Sen. Lockman if he could call some individuals forward to testify.

Sen. Pettyjohn asked Brian Frazee, President and CEO, from the DHA to provide comments on the bill. He asked what the hospitals see as the financial impact of HB 350. (4:54 p.m)

Mr. Frazee said their fundamental concern is when you have a board of six political appointees, they have the authority to modify and approve hospital budgets. There is no other private sector employer who has that type of authority. It is important that the healthcare benchmark is that – and not the *hospital* benchmark. Some costs are out of their control. They do support a lot of the provisions, but on a benchmark that you are held accountable to, there is still unprecedented authority to have a board that can step in. It is also a direction that other states are not pursuing. We are one of 9 states that has a benchmark. None of them are considering stepping into the governance as an enforcement mechanism. The governance piece is the big sticking point at this time.

Sen. Pettyjohn asked what will the impact be on the health of constituents in the communities?

Mr. Frazee said this is a clear way that DE is unique. We are not like MA and VT. We have the 5<sup>th</sup> oldest population in the country. We have a big access problem. This model would disincentivize expanding access through the growth of our health systems. The enforcement mechanism is draconian, and the appointees may not understand the complexities of the governance of a hospital system.

Sen. Pettyjohn asked if hospital profits are capped by the state, what would that do for the ability to borrow what hospitals have above their cash reserves.

Mr. Frazee said the average operating margin of their members was -2.55%. They do need some cushion in fund balance in order to maintain their bond ratings. This does impact the expansion that many of their networks are planning. You have to have a certain amount of cash on hand. They just had a mass cyber-attack. Members had to use reserves just to make payroll. They operate ready for any disaster that may happen, and that's why it's important to have that cushion.

Sen. Pettyjohn said the rising of costs is of concern. What are some of the factors that drive the health care costs for hospitals specifically?

Mr. Frazee agrees that something needs to be done about rising costs. They are willing to have that accountability. The reason it is so expensive is pharmaceuticals and labor. DEFAC met several weeks ago to set the healthcare benchmark. Pharmaceuticals and long-term care had the greatest cost increase. It is very volatile, and when they are held to a benchmark on things that are out of their control combined with the ability to step into their governance, they believe that is the wrong approach.

Sen. Pinkney asked of efforts from members to curb healthcare costs.

Mr. Frazee said plan design through CMS, recruiting and retaining health care providers is important to them to keep people healthy on the front end. They spend \$1 billion on their community-based care - health equity, behavioral health, and other programs each year. We don't have good health outcomes but believe the way to achieve that is to work across the healthcare continuum.

Sen. McBride said an analogy made is that this industry is like public utility oversight. She asked for Mr. Frazee's opinion of that.

Mr. Frazee said they are different. Public utilities have a mandated return they are guaranteed. Their rates are regulated, but their budgets are not regulated. This model would allow stepping into the budget and modifying. Utilities are also guaranteed a monopoly.

Sen. McBride said there are boards that make these decisions who have a responsibility to the entities. Are those individuals ones who have been selected based on expertise in healthcare? How different is a state board different from a board that is appointed by the entity itself?

Mr. Frazee said the local boards understand the needs of that community. What is proposed is a statewide board of six people with no geographic requirements, It's the enforcement piece and other mechanisms that they believe would be more in line with how other states are addressing this.

Sen. Hocker said the first witness gave us a lot of comparisons of figures. He asked if Mr. Frazee disagrees with any of them. There is such a doctor shortage in communities in his district; at least 100 doctors short in Sussex County. Do other states have that doctor shortage?

Mr. Frazee said there are significant differences between the needs of DE and other states, particularly VT and MA. Healthcare costs are not going down in VT. There is no collaboration with the board there; they are not seeing the outcomes they anticipated. We are not viewed as a strong state for physicians. They have ideas of what they can do with the Medical Society of DE to address that. *(Mr Frazee submitted written testimony, which is included in Appendix B.)*

Sen. Pettyjohn asked if Dr. John Brumsted could testify. He is virtual. (5:16 p.m.)

Dr. Brumsted said DE is considering a structure similar to VT's. He is a board-certified OB/GYN and endocrinologist. He spent his career in active clinical practice, teaching, and healthcare administration in rural areas of VT and NY. In 2011, he became CEO of the academic medical center in Burlington. In 2022, he retired. During his time, they grew the network to include 3 hospitals in VT, 4 in northern NY. The Green Mountain Care Board has been the health care regulator in VT. They have been regulated throughout his tenure. They have had hospital budgets presented in a much more collaborative format until the formation of the Green Mountain Care Board which came into existence in 2011 with a stated purpose to operate a statewide publicly financed single payer system. When that was determined not to be viable, that plan was dropped. They were left to regulate hospital budgets. Since 2015, the board has been solely focused on the cost piece. Increases in rates have been kept artificially low, below the rate of inflation and almost always below what the hospital's budget making process has produced. The Board is set up as independent with no oversight. The results have been declining hospital and health system margins. One hospital declared Chapter 11 bankruptcy. If there's no margin, there's no capital reinvestment. Access in VT is very difficult with decreased services available at local hospitals and with an aging population. VT is a collaborative place and the noncollaborative environment of their regulatory structure is evident.

Sen. Pettyjohn asked how DE's proposed legislation would affect the recruitment of doctors and other healthcare professionals in Delaware.

Dr. Brumsted said he can't speak to the specific legislation but anything that reduces an appropriate margin will impact recruitment and retention.

Sen. Pettyjohn asked what he would suggest for us to control healthcare costs in DE.



Dr. Brumsted answered that it has to be a collaborative environment with all stakeholders coming together and approach value-based care that budgets for populations. Kaiser has done that. They had some early success in VT with the Center for Medicare and Medicaid Innovation (CMMI). It has to be done with everyone in the room and without a pejorative mechanism to restrict what the true costs of healthcare are.

Sen. Pettyjohn asked if the model being used here is included in what CMMI has proposed in terms of a value-based healthcare system.

Dr. Brumsted said CMMI have put out demonstration projects that have helped to control healthcare costs. Those models require state oversight, but they do not require rate setting that the Green Mountain Care Board has engaged in in VT.

Sen. Pettyjohn asked for former DHSS secretary Kara Odom Walker to offer testimony. He asked what she sees as some of the issues with the VT model in relation to what is proposed in DE. (5:30 p.m.)

Dr. Kara Odom Walker, Nemours, Chief Population Health Officer, She has served on the University of VT Health Network Board. They have had the challenges Dr. Brumsted spoke about. The environment was intended to create collaboration, but that didn't happen. It meant they had to close certain access points in rural areas. People have not been able to access necessary surgeries.

Sen. Pettyjohn asked if it's possible that a lack of access to care will lead our state's patients who can afford to, to go to other out of state health systems, and he asked her to compare various state health models (Maryland v Vermont v other states).

Dr. Walker agreed and said that may mean long wait times. She said the intention behind the MA model was to create value through innovation. In VT the intention was to move to single payer. That did not create the outcomes. In PA, their efforts have been collaborative. They do want to create a focus on health care costs. It requires collaboration. We need to come together with the right mission and direction and incorporating all the costs of healthcare. If we are going to think solely of health care costs, we are going to lose sight. We want to make sure that access points exist and that we create opportunities for robust services. We need flexibility and resources to make that happen.

Sen. Pinkney asked Sen. Townsend about other efforts the Legislature has taken to try and curb healthcare costs.

Sen. Townsend said the primary care reform collaborative is among them. Fundamentally that involved finding a way to push all venues in DE to investing more in our primary care system, which is much more cost effective. We have the lowest reimbursements for primary care. We tried to move the system to invest more in primary care to keep people well at a lower cost. It

wasn't micromanaged to determine how many practices, etc. It has not moved in that direction or worked so well. They are trying to serve patients but are operating in a very uncompetitive dynamic and with the dominance of the hospitals, it is difficult for PCPs. The system is not set up to direct money to keep people well, and that is a problem. The transparency and conversations that can come from this legislation can only serve to improve the issue of how to invest more to keep people well on the front end.

Sen. Pinkney said we are trying to address hospital costs from a variety of angles, not just oversight.

Sen. Townsend said that pharmaceutical costs is certainly part of it and ways to address are needed and forthcoming, although not likely prior to the end of this current legislative session.

Sen. Pinkney asked about several lines in the bill. She asked if other states have the CPI approach. She also asked how we are addressing the outreach from the hospitals as to why they would be cutting jobs or programs. By removing the Medicare capping and replacing it with the CPI are we addressing the cuts that hospitals say they would have to make from their budgets.

Sen. Townsend said those lines exempt Nemours from the reference pricing provision. There is a house bill or amendment to this bill that would substitute that reference pricing for a CPI formula. The CPI is similar to the benchmark framework. It is meant to be a 2-year formula. The conversations around the benchmark happen at the DEFAC subcommittee level. There has been agreement at looking to calculate it differently. It is important to find proper middle ground there. As to the issue of inequities and consequences of the bills, he thinks the constituent outreach did not include full disclosure of information that was important for them to have about the core of the problem, which is the affordability of healthcare. The status quo cuts down access, yet an argument made against this bill is that its impact would be to cut access and cut programs. The hospitals' stated reason for the cuts they'd need to make will be removed either in this bill or in a separate House bill. He heard that reference-based pricing was the source of the cuts hospitals said they'd need to make, and that provision is now going to go away.

Sen. Pettyjohn asked about clarification of global CPI versus the medical index for CPI.

David Bentz offered that what is being referred to is core CPI+1, the regional core CPI, plus 1, which is currently the cost control mechanism around primary care. It is a proposal that came from the hospitals as an alternative that is being included.

Sen. Hocker said this is important legislation and wants to make sure we do this right, and that it is not detrimental to the healthcare profession in the state.

Senator Lockman opened the floor for public comment. (5:53 p.m.)

Christina Haas, Delaware Department of Insurance (DOI), representing Office of Value Based Care said they represents the more than 115,000 residents and business who purchase insurance

regulated by DOI and who will benefit from this bill's ability to lower their cost. Insurers are required to pay 80% or more of premiums toward health care services. When we address system costs, we lower premiums and save consumers and businesses. Many times those costs are unjustified - up to 6x higher than a non-hospital facility would charge for the same service. A majority of the \$42 million invested in primary care has gone to these same systems. *(DOI submitted written testimony which is contained in Appendix B.)*

Mark Marcantano, President of Delaware Valley, Nemours Health, thanks the sponsors for consideration of the reference pricing. He said that the legislation does feel punitive, such as the artificial price cap, politically appointed board, a flawed benchmark, and the seizure of assets.

Terry Murphy, Bayhealth, President and CEO, said his boards are chosen on their competency. Their board includes one nurse and six physicians. They know best because they are closest to the organization. Hospital costs went down even though utilization went up. Pharmaceutical and other costs went up. It's important to understand the data. When you compare state to state, it's not the same.

Dr. Janice Nevin, ChristianaCare, President and CEO, representing 13,000 caregivers at ChristianaCare. They work daily to save lives and heal individuals. This includes significant investment in health equity. They are a national leader in health transparency. If approved HB 350 sends their hospitals in the wrong direction. We can reduce the cost of health care when we work together. Dr. Nevin urges the committee to vote no on HB 350.

Penny Short, President, TidalHealth Nanticoke said they serve western Sussex County and many underserved families. They have to have flexibility to have the revenue to gain access they need to put into important community driven services. The Sussex County members deserve good healthcare. In Seaford, they have to pay more than in other areas to attract healthcare workers. It is an important issue for rural hospitals.

Sharon Urban, Saint Francis Hospital, Chief Nursing Officer, said they oppose HB 350 in its current form. They are concerned about the negative impacts on staffing, programs, and services, as well as access to care. They look forward to working with all parties to reduce healthcare costs.

Dr. Rosemary Wurster, Bayhealth, Chief Nurse Executive, opposes HB 350, on behalf of their nurses. They invest in their patient outcomes in part by their ability to apply innovation for the better care of Delawareans.

Dr. LeRoi Hicks, Executive Director of Wilmington's ChristianaCare campus and former Chief of Hospital Medicine at the University of Massachusetts, said we should ask why we'd pass the bill without fixing it with the amendments proposed. Communities of color have suffered in MA, MD, and VT. Those services that need to be invested in fall off the list when healthcare

financing is not thoughtfully constructed. (*Sen. Pettyjohn submitted an article written by Dr. Hicks, which is included in Appendix B.*)

Dr. Aaron Carpenter, Nemours, Chief Nursing and Patient Operations Officer, said he understands the desire to curb healthcare costs but limiting hospital budgets will have a negative impact on needed capital and operational decision making. They are Delaware's only pediatric trauma center, only level 4 newborn ICU and provide lifesaving pediatric transplant services. These services require significant capital investments. Without sustainable margins, investments in value-based care prevention efforts, the best healthcare providers, and quality programs cannot be made.

Dr. Meg Frizzola, Nemours Children's Health, Chief Medical Staff. She emphasized the importance of assuring they can provide high quality access to care and allowing clinicians to maintain the right to make decisions about how they reinvest dollars into that critical care. This bill has the potential to negatively impact that. The importance of recruiting gifted and talented staff is challenging. We need to invest dollars into these talented providers. This bill puts that at risk if we cannot grow and spend in the way they deem important.

Dr. Bhavin Dave, assistant program director for internal medicine at BayHealth, said this bill has the potential to reduce the number of primary care doctors. This makes people more likely to go to the emergency room for non-urgent care. When we look at benchmarks, it will make it more difficult for hospitals to recruit specialists.

Dr. Omar Khan, Christiana Care, Chief Scientific Officer, said he has seen the Green Mountain Care Board in action. Please vote no on HB 350. We know what causes healthcare to go up – social determinants of health and things at the federal level that have not been controlled. They are ready to do things in a collaborative fashion. The changes caused by this bill will be catastrophic for a lot of communities. Please let them continue to service their communities.

Dr. David Brousseau, pediatric emergency medicine at Nemours, said they provide care to the sickest and most vulnerable children. Turning spending decisions to a board that is not connected to patients is not in the best interest of Delaware's children. He trusts their professionals' expertise.

Dr. Sarah Beebe, GME simulation lab manager at BayHealth, said this bill is not evidence based. Everything they do in healthcare has to be evidence based. The data on cost is real, but the data on the models that we are basing this on do not support this bill adequately. VT and MA have had over a decade to show the outcomes and neither have improved healthcare and costs are still high. Research supports collaboration and this bill does not show that.

Dr. Megan Lines, interim Chief of Psychology at Nemours, said this bill has the potential to curb hospital budgeting and growth in areas where it's needed most. They have gone from 7 to 40 psychologists and 30 trainees every year. Without dollars to grow and put into quality behavioral

health providers, they cannot serve patients well. They need to grow to build and have clinical leaders weigh in on how that looks. If this bill passes as is, behavioral health becomes one of the clinical services that is put most at risk.

Dr. Mike Katz, pediatric critical care anesthesiologist and former State Senator. He hopes HB 350 will be tabled and a work group formed instead. While the bill is well meaning, it only focuses on the finances of health delivery and not the root causes of expensive care such as social determinants and labor costs. He has seen little effort to address these issues.

Elisa Diller, RISE Delaware, supports HB 350. RISE got into this because of the retiree healthcare issue. Hospital costs are a major driver of healthcare issues. 130,000 retirees and state employees are impacted. You need the data, and its unacceptable that people are not willing to be transparent about this.

Mary Graham, legal liaison for RISE Delaware, and also practiced before the Public Service Commission. It would be catastrophic to not do something about hospital charges. They are a monopoly, and they are a limited public resource just like a utility. Oversight is needed. All medical claims of state employees and retirees are paid by public dollars and a lot of that money is going to the hospitals.

Rev. Bob Hall, RISE, has an interest in health and health care because his constituency is aging. He is encouraged because he has seen members of the General Assembly concerned about healthcare costs. We do need healthcare reform. Some of his parishioners go to Maryland because costs here are too high.

Dr. Dina Vendetti, President, Central Delaware Chamber of Commerce and also representing the Association of Chambers of Commerce of DE. They have serious concerns about HB 350. The bill promotes an unnecessary overreach of authority. The perception is that this legislative body is seeking to operate outside of its lane. The bill seems to focus on budget, but fiscal control can and will lead to systematic control. Our hospital systems have a great history of collaboration. That will be where this problem is solved. Please table the bill. *(Dr. Vendetti submitted written testimony, which is included in Appendix B.)*

Christopher Otto, DE Nurses Association, Executive Director. As written, they oppose HB 350 and ask it not be released from committee. The financial stability of hospital partners allows nurses to access resources to ensure patients' needs are met. Innovation drives change and thinking outside the parameters of prescriptive care to meet the needs of each community member. Please do not release the bill from committee.

Dr. Leah Orchinick, Delaware Psychological Association, State Advocacy Chair, said they oppose HB 350. This legislation will likely have a negative impact on quality of care and access to care. Cuts to hospital budgets also mean cuts to budgets and community outreach. We need

focus on integrated medical and behavioral health. High-quality, cost-effective care comes from designing evidence-based programs, not from eliminating budgets at the top.

Tyler Micik, Delaware State Chamber of Commerce, said this is a challenging issue for their diverse organization. Healthcare is a top concern among their members, who make regular use of doctor visits, drugs, pay premiums, etc. For small manufacturers, retailers and businesses in between, this is not something they are experts on. They understand the premise behind the proposal, but there are many pieces to this complicated puzzle, and they oppose HS 2 for HB 350.

Joe Fitzgerald, New Castle County Chamber of Commerce. The chamber opposes the bill as written. They note that healthcare economics and policies are among the most complex in our country. The Chamber is concerned about the price controls and the timely access to quality healthcare. They oppose government control and final approval over decisions made by hospital directors and managers.

Jane Brady, Chair of A Better Delaware, competition is the bottom line in terms of what will improve healthcare – cost access and quality. The Legislature could eliminate the Certificate of Need, adopt something like CMS did regarding transparency in billing and adopt Delaware regulations and the cost of common surgeries. She is concerned about our corporate standing. We are jeopardizing our standing, and she expressed concern for liability issues. The legislature is not being a good partner if it is demanding accountability and cost reductions for others, while the state's own annual budget increases.

Mary McDonough, RISE Delaware, said she appreciates the dedicated service of healthcare providers and supports HB 350. Transparency and oversight of hospital costs are important values for consumer protection.

Denise Clendenning, asked the committee to vote no on HB 350. The testimony from medical experts outweighs support for this legislation. This legislation will cause major shortages in medical professionals. Needed programs will be cut. This bill is mirrored from VT which has had hospitals closed. There are many more in extreme danger of closing. This is government overreach dictating to healthcare providers. This puts people at risk of being denied the services they need.

Patricia Sigler, a retiree and resident of Seaford, said she is opposed to HB 350. This penalizes hospitals for doing well and prevents them from investing and is severe government overreach. We need more facilities and more personnel. This bill will destroy medical services that already exist, especially in Sussex County. The state cannot meet their own budget. *(Pat provided written testimony, which is contained in Appendix B.)*

Sue Ryan, Executive Director, DE Coalition Against Domestic Violence. For many victims their first responder is a healthcare provider. They are concerned about the impact of HB 350 on

hospitals' community health services, and the state having oversight governance of a nonprofit organization's budget. They encourage the state to continue to partner with the entire healthcare community.

Steven LePage, supports HB 350. He has looked at all the 990s of every hospital. One hospital has \$416 million in losses in investment, and yet the cost of healthcare went up. Should we be paying for their investments? He notices things in other states on their 990s, and nothing should be off the table. He does agree that the Certificate of Need should be removed.

Dale Swain, RISE Delaware, said he appreciates that the hospitals want to do something to improve healthcare costs but the concern is that there is an effort to say we want to collaborate but hold off on this bill so that nothing gets done. He hopes they will work with the sponsors on additional amendments if necessary to make this work to show they are doing their best to control costs.

Carina Slater, said constituents are not ill informed. We have heard testimony from countless healthcare professionals. This bill shows gross governmental overreach. She urges the committee to vote no, table HB 350, and instead engage in further collaboration.

Sen. Townsend offered final comments. He emphasized that they have been told by stakeholders that the bill is workable except for the referenced based pricing provision. He hopes people understand there is a lot of collaboration that has gone into this in conjunction with the DHA over the past couple of months. He appreciates the public discussion and debate.

Sen. Lockman, seeing no further public comment, circulated the legislation among committee members for signature.

**HS 2 for HB 350 was reported out of Committee: 0 Favorable; 5 On Its Merits (Sokola, Townsend, Lockman, McBride, Pinkney); 0 Unfavorable.**

Senator Lockman thanked the Committee and entertained a motion to adjourn the meeting.

Senator Pettyjohn motioned to adjourn.

Senator McBride seconded the motion.

The meeting was adjourned at 6:39 p.m.

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## Meeting Minute Preparation

Valerie McCartan, 5/17/2024

## Approval of Meeting Minutes

Motion made by Sen. Pettyjohn; Second by Sen. Sokola, Senate Executive Committee meeting, 6/12/2024

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## **Appendix A: Attendees**

### **Virtual Attendees:**

Denise Clendenning

Jennifer Rambo

Patricia Sigler, citizen

AnRea MacDonald, ROMA

Barbara Philbin, DRSPA

Sam Gaertner

Mariann Kenville-Moore, DE Coalition Against Domestic Violence

Michael Fiore, First State Orthopaedics

James Engler, ChristianaCare

Sue Ryan, DE Coalition Against Domestic Violence

Steven LePage

Robert Meade

Betsy Price, Delaware LIVE

Carina Slater

Andy Lippstone, Lippstone Law, LLC

Connie Merlet, ROMA

Judy Chaconas

Kathleen Rutherford, A Better Delaware

Chris Morris, Nemours

Mary McDonough, RISE

Mary Kate McLaughlin, Barnes & Thornburg, LLP

Sarah Wootten, Maven Strategies

Kendra Brumfield-NaWangna, Wilmington City Council

Jim Chaconas

Dale Swain, RISE

### **In Person Attendees:**

Jeff Taschner, SEBC/RHBAC member



David Bentz, DHSS  
Steve Costantino, DHSS  
Christina Haas, DOI  
Jill Karpinski, citizen  
Brian Frazee, Delaware Healthcare Association  
Mark Marcantano, Nemours  
Terry Murphy, Bayhealth  
Janice Nevin, Christiana Care  
Penny Short, TidalHealth  
Sharon Urban, Sain Francis Hospital  
Dr. Kara Odom Walker, Nemours  
Rosemary Wurster, Bayhealth  
Dr. LeRoi Hicks, ChristianaCare  
Dr. Aaron Carpenter, Nemours  
Dr. Meg Frizzola, Nemours  
Dr. Bhavin Dave, Bayhealth  
Dr. Omar Khan, ChristianaCare  
Dr. David Brousseau, Nemours  
Dr. Sarah Beebe, Bayhealth  
Dr. Meghan Lines, Nemours  
Lavaida Owens-White, DRHMN  
Rose Kakoza, ChristianaCare  
Mahamed Alimulla, ChristianaCare  
Cynthia Cavett, ChristianaCare  
Kert Anzilotti, ChristianaCare  
Dr. Mike Katz, citizen  
Elisa Diller, RISE  
Mary Graham, RISE  
Bob Hall, RISE  
Dina Vendetti, CDCC  
Christopher Otto, DE Nurses Assoc.

Brian diSabitino, Business Roundtable

Dr. Leah Orchinik, DE Psychological Assoc.

Tyler Micik, DSCC

Joe Fitzgerald, NCCC

Jane Brady, A Better Delaware

## Appendix B: Written Testimony

### Written testimony was received from:

1. Brian Frazee, Delaware Healthcare Association (DHA), President & CEO
2. Chris Haas, Department of Insurance (DOI), Senior Policy Advisor
3. Dr. Dina Vendetti, Central Delaware Chamber of Commerce, President
4. Pat Sigler, Seaford, DE
5. Ann Fallon, Wilmington, DE
6. Joint letter from Delaware organizations and community leaders, submitted by Christina Crooks Bryan, Delaware Healthcare Association (DHA)
7. Libby Gregg, Hockessin, DE
8. Starr Lynch, BSN RNC-OB, Bayhealth Kent Campus
9. Bob Meade
10. Peggy Mika, Freelance writer/editor
11. Sheila Bravo, Delaware Alliance for Nonprofit Advancement, President and CEO
12. Connie Merlet, Newark, DE
13. Gail Feather
14. cas3443@comcast.net

In addition, committee member, Sen. Brian Pettyjohn, submitted an article for members' review: *"This is a critical moment: Delaware must not go backward in health equity"*, LeRoi S. Hicks, M.D., MPH, FACP