

Table of Contents

Comments Submitted by the Public to the State Employee Benefits Committee

Kristin Last	4
Karen Lasky	6
Meghan McCarthy	8
Stacy Semans	10
Alicia Lindinger	12
Anne Marie Higley	14
Stephanie Henderson	16
Jessica Perrine	18
Maria Sandford	20
Tom Pledgie	22
Emily Hufnal	24
Kaitlin Challis	26
Kathy Nedelka	28
Therese Graw	30
Dave Bradley	32
Lynda Hastings	35

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MARCH 23, 2026 - STATE EMPLOYEE BENEFITS COMMITTEE MEETING

Jennifer Semans 38

Melissa Beauchamp 40

Lauren Willoughby 42

Barbara Philbin 44

Rebecca Scarborough 46

Grace Kelly-Nask 48

Barbara Philbin #2 50

Kelli Bradley 53

Tom Pledge 56

Jeremy Ament 58

Robert Clarkin 60

Steven LePage 65

Steven LePage #2 69

Lynda Hastings #2 73

Kristin Buckmaster 75

Jeremy Arment #2 78

Jeremy Ament #3 80

Sharon Livingstone 82

Nancy Colley 84

Steven LePage #3 86

Steven LePage #4 89

Public Comment by Kristin Last

Kristin Last

I am very disappointed in the vote today regarding co-pays for GLP1 medications. These medications treat real conditions, which cannot always be controlled by willpower. I tried for many, many years to lose weight and improve my health, but did not experience real success until I began taking a GLP1. My health has greatly improved, leading to lower healthcare costs overall. I will not be able to afford this medication given this increase in co-pay, which will lead to other healthcare issues down the road.

I would like to thank Paul Baumbach, Jeff Taschner, Bill Oberle, and Karen Peterson for voting to support state employees and their healthcare needs.

Public Comment by Karen Lasky

Karen Lasky

I am writing to express my deep concern regarding the decision to increase the copay for GLP-1 medications. This shift in policy will effectively price many individuals, myself included, out of a life-changing treatment.

For those of us managing high blood pressure, sleep apnea, and high cholesterol, losing weight isn't just a lifestyle goal—it is a medical necessity. While my other medications are covered, they primarily treat the symptoms. My GLP-1 medication treats the root cause. For the first time, I have a tool that regulates my body's hunger signals and eliminates the cravings that previous weight loss programs never addressed. It isn't a matter of "trying harder"; it is a matter of biology.

Beyond weight management, the long-term health benefits of these drugs are well-documented.

According to Healthline, approximately 1 in 3 people with diabetes suffer from chronic kidney disease (CKD), often triggered by high blood sugar and high blood pressure. By effectively managing these factors, GLP-1s significantly reduce the risk of heart attack, stroke, and kidney failure.

From a purely financial standpoint, the cost of an increased copay is a drop in the bucket compared to the lifelong costs of dialysis, kidney transplants, or stroke recovery—all of which insurance will ultimately have to cover.

I would appreciate understanding the rationale behind this increase. Why is the decision-making body prioritizing short-term savings over the long-term health and preventative care of its members? I URGE THIS COMMITTEE TO OVER TURN THE VOTE.

I look forward to your response.

I would like to thank the people who voted NO for the increase in the GLP-1 copay. Paul Baumbach, Jeffrey Taschner, Bill Oberle, and Karen Peterson....thank you for standing up for the people who desperately need this drug, knowing that people will be priced out and won't be able to afford it. State employees should not be held financially responsible for the deficit that was created by the SEBC decisions and under-projection.

Sincerely,
Karen Lasky

Public Comment by Meghan McCarthy

Meghan McCarthy

I want to express my concerns and frustration with such an outrageous increase. Many of us state employees receive absolutely no raises to help us with the ongoing rise in the cost of living. This medication has drastically changed my life and skyrocketing it to \$200 for 30 days will immediately force me to stop receiving it. I have made a complete lifestyle change with my diet but with the medication I've kept off 70 lbs. There are more concerning things going on in the State than to do this to people. Enough is enough.

Public Comment by Stacy Semans

Stacy Semans

Good afternoon committee,

I just wanted to take a moment to express my extreme displeasure with your decision to increase the co-pays for GLP-1s from \$25-\$32 to \$200+ per month. This is astronomical for a family in today's economic climate. I have been on these medications for over a year. Last year, you made the decision to alter the brands covered. I suffered a setback in my weight loss, as well as an increase in my cholesterol and blood pressure as a result of the weight gain. My doctor was able to successfully win an appeal with CVS Caremark, and I am back on the correct medicine and showing positive moves in weight loss, lowered cholesterol and lowered blood pressure, only to receive news today that my co-pay will now increase by 8 times. I understand and recognize that these medications are often over-prescribed and mis-used by many, at a huge expense to the State of Delaware. I am not foolish enough to believe you could continue on that path. However, an increase to just \$100/month would have allowed me the ability to remain on the medicine and continue to improve my overall health. The \$200 price tag makes that impossible for my family.

I have to wonder if another option for prescription coverage was considered - possibly two differently tiered plans? Or perhaps a process could be used to determine who genuinely needs the medicine for health needs and who is using it as a shortcut to a slim waistline.

I genuinely hope you will reconsider the consequences of this choice when it comes to the health of your loyal employees.

Sincerely,
Stacy Semans

Public Comment by Alicia Lindinger

Alicia Lindinger

Good morning,

I wanted to share my experience and concerns about the GLP1s that are being voted on today. I am not sure if my data can be shared anonymously and if so I would appreciate that.

I wanted to share my experience taking GLP1s over the last year. After having my daughter I was at my highest weight over 300 pounds. I have struggled my whole life with gaining and losing weight. I was prediabetic, diagnosed with sleep apnea, and elevated blood pressure. I was on multiple medications for my health conditions.

I started when the GLP1s were on the tier plan and I started on Trulicity, then stepped up to Wegovy, and then Zepbound. I struggled in the beginning to obtain the medication from national shortages. So it was a yo yo effect stopping and starting, When I finally was able to take the medication consistently is when the magic happened. For once I was able to watch my diet, exercise, and obtain weight loss.

At this point, I had to go back on Wegovy because our insurance is no longer covering Zepbound. I have officially lost 70 pounds and still considered obese. I have not lost any weight since I was placed back on Wegovy. These meds definitely assist with weight loss and curb appetite. I have been able to stop taking my blood pressure medications per my doctors recommendation and I am no longer considered to be prediabetic. My concern is if I stop having access to my medications I will slip back into being morbidly obese and have to restart my medications. I calorie count every meal so its truly not diet related. I truly think its genetic and I have tried every diet and program to lose weight. I have wasted 1000s of dollars for everything to fail.

My concern for the future is:

1. Once medications are not available people will have a huge influx of previous medical conditions coming back which will sky rocket medical costs. Restarting medications or potentially being snowed into becoming diabetic cause these medications truly control blood sugar
2. People will be trying to purchase medications on the black market or through these programs that all are not FDA regulated. People may purchase what they think is legitimate medications and potential for side effects and hospitalization will soar.
3. Many families struggle to even pay \$32/month so what will happen if it goes to \$200/month. Most families are struggling to buy groceries or even buy the needed day to day medications.
4. if they do continue to cover the medications to not have them limited: the current insurance plan has denied the majority of exceptions to be able to take Zepbound. So people are taking medications that are not working to their full potential.

I appreciate you taking the time to review my experience and I hope that helps for giving some insight for the decision to continue to keep coverage.

Alicia Lindinger, RN
Compliance Nurse

Public
Comment by
Anne Marie
Higley

Anne Marie Higley

Please use the same language for the 2026 request as was used in the 2025 request for Medicare coverage. Thank you for your attention to this matter.

Anne Marie Higley

Public
Comment by
Stephanie
Henderson

Stephanie Henderson

Dear SEBC,

I am writing to respectfully express my support for maintaining coverage of GLP-1 medications within the State of Delaware employee health benefits program.

For many state employees, compensation is lower than what comparable positions offer in neighboring states and the private sector. As a result, the strength and stability of our benefits package—particularly health insurance—plays a significant role in both recruiting and retaining a dedicated workforce. Changes to coverage that reduce access to important treatments can have a meaningful impact on employees who rely on these benefits.

As outlined in the attached research-based memo submitted to the Employee Benefits Committee, current medical research indicates that GLP-1 therapies can play an important role in addressing several health conditions that disproportionately affect women and individuals struggling with obesity. These medications are associated not only with weight management but also with improved outcomes related to metabolic health, fertility conditions such as polycystic ovarian syndrome, bone density in post-menopausal women, and potential cancer risk reduction.

From a long-term perspective, continued access to these treatments may also help reduce the need for more complex and costly medical interventions associated with obesity and related conditions, including advanced cardiovascular care, fertility treatments, orthopedic procedures, and other chronic disease management.

Maintaining access to GLP-1 therapies would demonstrate a continued commitment to preventive care and the overall health of state employees and retirees. Supporting preventive and evidence-based treatments ultimately benefits both employees and the state by improving health outcomes while helping control long-term healthcare costs.

I appreciate the work the Benefits Committee and HR team do in evaluating healthcare options for employees, and I respectfully ask that continued GLP-1 coverage remain part of the State's medical benefits.

Thank you for your time and consideration.

Sincerely,
Stephanie Henderson
Fiscal Advisor V

Public
comment by
Jessica Perrine

Jessica Perrine

Were our comments given to the committee? This was a horrible decision and you all did not take the employees who have to pay this into consideration, you put a price on your employees health and wellbeing, this is highly disappointing and I wasn't even able to comment as a public member, I don't know about you all but I cant afford 200 dollars a month, my doctor already charges me 85 dollars just to call in the prescription. Is this the final decision in regard to this?

Were our comments given to the committee? This was a horrible decision and you all did not take the employees who have to pay this into consideration, you put a price on your employees health and wellbeing, this is highly disappointing and I wasn't even able to comment as a public member, I don't know about you all but I cant afford 200 dollars a month, my doctor already charges me 85 dollars just to call in the prescription. Is this the final decision in regard to this?

I was able to public comment, but it is still extremely disappointing that this is the decision that was made.

Public Comment by Maria Sandford

Maria Sandford

To whom it may concern: (public comment)

I am writing to express my concern that GLP1 medication coverage may be removed for state employees.

I would be in favor of stricter requirements and qualifications.

In my case: obesity, high blood pressure, family history of heart disease and diabetes

I believe these should be qualifying factors.

Please consider continuing coverage for those who truly need the preventative health care measures that this medication provides.

Thank you for your time,

Maria

Public Comment by Tom Pledgie

Tom Pledge

Dear Director Maxell:

I wish to personally express my opposition to your attempt today to reduce the time allocation to SEBC commenters from 3 to 2 minutes. After all of the issues raised with the last renewal of the Medicfill program a few years back, the in-put of the public should be encouraged rather than limited.

IF, the Lt Governor's concern today was about the 10 minutes of Public Comment in a 3 ½ hour SEBC Meeting, maybe she should look at how long she and her fellow politicians were talking.

Tom Pledge

Public Comment by Emily Hufnal

Emily Hufnal

I would like the voice my opinion for the recent approved change of increasing co-pays for important weight loss medications to \$200. This type of change will have severe negative impacts on many state employees. To start, we cannot afford a \$200 copay for medication at the salaries that we are provided, in addition to the rising costs of insurance. This would leave many employees having to hard stop a medication that has drastically improved their lifestyle, a lifestyle that includes job. To nickle and dime, and single out, users for a medication that has helped tremendously, is entirely unacceptable. I have spent my entire life struggling with weight loss, no life style change could help get me to a healthy weight. I started this medication, along with additional life style changes, and not only am I healthier... My mental health approved, my productivity at work improved, my home life with my family improved and many employees have a similar experience. Increasing to \$200 copay, would create more problems amongst employees than benefit them. DHR should be thinking about their employees wellbeing and not another way to nickle and dime our lives. Thank you for your consideration in this matter.

Public Comment by Kaitlin Challis

Kaitlin Challis

Good Afternoon, it has been brought to my attention that there was a recent meeting that increases the co-pays for GLP-1 medications. I would like to know the basis of this decision? I was put on a GLP-1 after having my son for numerous medical conditions, to include PCOS and being pre-diabetic. The medication has changed both mine and my kids lives. I would certainly hope there was more taken into consideration than simply what it is costing the state. This medication has helped so many state employees and increasing the price will create more problems than it solves. Much like myself, many state employees will not be able to afford their NECESSARY medication with this astronomical price increase. I hope this can be rectified.

Public Comment by Kathy Nedelka

Kathy Nedelka

Good morning,

My name is Kathy Nedelka, and I am here today as a voice for the thousands of Delaware state employees and retirees who have just been told their health is no longer a priority.

The decision to discontinue coverage for GLP-1 medications—drugs like Ozempic and Wegovy—is not just a 'budgetary adjustment.' For many, it is a medical eviction. We aren't talking about vanity; we are talking about people managing chronic, life-threatening conditions. We are talking about Delawareans who have finally found a way to regulate their metabolic health, reduce their risk of stroke, and keep their hearts beating. By cutting this coverage, the State is effectively telling its workers: 'We value your labor, but we don't value your longevity.'"

"The justification for this decision is cost. But let's look at the math. Chronic obesity and its complications—type 2 diabetes, heart disease, and kidney failure—are some of the most expensive burdens on our healthcare system.

By removing access to GLP-1s now, the State is opting for a 'pay later' plan. You might save a line item on this year's budget, but you are guaranteeing higher costs in the years to come through increased hospitalizations, surgeries, and long-term disability claims. Discontinuing this coverage is a classic example of being 'penny wise and pound foolish.' You are saving cents today at the expense of millions of dollars—and more importantly, lives—tomorrow."

Furthermore, this is a breach of the compact between the State and its workforce. Employees choose public service in Delaware because of the promise of stable, comprehensive benefits. Many of us have stayed in these roles, often for lower pay than the private sector, because we trusted that our health would be protected.

Abruptly pulling the rug out from under patients who are currently mid-treatment is medically dangerous. It causes metabolic whiplash and mental distress. It tells every state nurse, teacher, and administrator that their benefits are subject to change whenever the math gets difficult."

I urge the SEBC and our state leaders to reverse this decision. Do not treat healthcare like a luxury we can no longer afford. Look at the clinical data, look at the long-term savings of a healthier workforce, and most importantly, look at the people standing in this room.

Don't force us to choose between our financial stability and our physical health. Restore GLP-1 coverage and honor the commitment you made to the people who keep Delaware running. Thank you."

Respectfully,

Kathy

Public Comment by Therese Graw

Therese Graw

I am writing in reference to the State taking away coverage for GLP-1's. I understand these prescriptions are expensive but I believe the benefits to people taking them far out weigh the expense. Obesity leads to so many other long term co morbidities and having the option of having a drug that helps a person loose the weight would be so beneficial in the long run. The benefits of weight loss is both physically and emotionally beneficial to people. Please consider keeping the benefit of GLP-1's. Also, please look at the big picture (the future health of your employees) when making this decision

Thank you,

Therese Graw

Public Comment by Dave Bradley

Dave Bradley

Dear Committee Members,

I am writing as a retired state employee to express my deep anger and disappointment regarding the recent vote to raise the monthly copay for GLP-1 medications such as Wegovy to **\$200 beginning July 1**.

This decision raises the cost from **\$32 per month to \$200**, nearly a seven-fold increase for employees and retirees who rely on these medications to manage their health — many of us now living on fixed incomes.

For many state workers and retired members, this increase will effectively **price us out of treatment**.

I also want to address something that was implied during the discussion surrounding this decision — the suggestion that people who need these medications simply lack discipline or should rely on lifestyle programs instead.

The people I know who take these medications are not lazy. Many of us — including my wife and me — exercise regularly, eat responsibly, and have spent years working to manage our weight and improve our health.

For example, I pay for a YMCA membership because I take my health seriously. That is not a small expense for someone living on a public employee salary or pension. Many of us are already doing exactly what was suggested — exercising, dieting, joining programs, and making lifestyle changes. Yet, like many people dealing with metabolic and weight-related conditions, effort alone has not been enough.

That is precisely why medications like GLP-1s exist. **Obesity is recognized by the medical community as a chronic disease**, not a failure of willpower.

GLP-1 medications are not cosmetic or vanity treatments. They are **medical treatments for a chronic condition**. When people stop taking these medications, many regain the weight because the underlying disease remains. That is the nature of chronic illness.

To suggest that a YMCA program or a lifestyle class can replace medically prescribed treatment ignores the reality that most of us have already been trying those things for years.

This decision also sends another troubling message: when the health plan faces financial pressure, the solution is to **shift the burden directly onto employees and retirees who are already managing a chronic condition**.

State employees did not create the budget projections that underestimated the cost of these medications. Yet we are now the ones expected to absorb the consequences.

I appreciate the committee members who spoke up and recognized that a \$200 copay would push many employees out of treatment. Their willingness to acknowledge the real human impact of this decision mattered.

But to those who voted in favor of the increase, I ask you to consider the message your vote sends.

It tells thousands of state employees that **their health is negotiable**.

It suggests that stigma around weight still influences policy decisions.

And it communicates that balancing a budget has taken priority over ensuring employees have access to medically necessary care.

Behind every prescription is a real person trying to improve their health, prevent future disease, and live a longer life for their families.

We deserve better than to be treated as a budget problem.

I urge the committee to reconsider this decision and its consequences. A \$200 monthly copay will not simply “encourage alternatives.” It will force many state employees and retirees to stop medically necessary treatment altogether. A health plan should exist to support the well-being of the people it serves, not place life-changing care out of reach. I hope the committee will revisit this decision and work toward a solution that protects both the sustainability of the plan and the health of the employees and retirees who depend on it.

Sincerely,

Dave Bradley

Public Comment by Lynda Hastings

Medical Third-Party Administration (TPA) Services RFP

Comments by Retiree Lynda Hastings

Summary of My Comments on Medicare Supplement language in the RFP

The language on Page 9 in section 5. must be changed to have complete clarity about what is expected in the proposal. Delete the entire current section 5 language and replace it with the language from the last RFP which many of us have been sending to you. Under no circumstances should you ask for an explanation of any deviations, since no deviations are acceptable.

Rational

In reviewing the most recent language in the RFP, I have found four sections that are of special relevance to Medicare retirees. I will comment in red on each section.

The section of page 5 which provides additional information about plan designs and premiums found on the SBO website is acceptable as a reference.

“Highmark Delaware plan enrollees – Medicare pensioners:

<https://dhr.delaware.gov/benefits/medicare/highmark.shtml>”

Page 9 - ... “The Medicare Supplement plan being solicited must duplicate the current Medicare Supplement plan in full, without any deviations.”.... Since this sentence is embedded in the middle of a paragraph about a variety of other services, it is acceptable as is.

Page 12 5. Here is where you must use language which makes it absolutely clear what is expected in the contract proposal. Use this:

“Proposals are being requested from interested bidders that can administer a self-funded employer sponsored Medicare Supplement plan offered to current and future Medicare retirees that duplicates the current Medicare Supplement plan without deviation; for the quoted Medicare Supplement plan, bidders should duplicate the plan design (copays and other out-of-pocket costs to the plan participant at the point of care), provider network (i.e., all providers who accept Medicare assignment), and administrative set-up including coordination of benefits. This plan requires no prior authorization of services and mirrors CMS requirements under Original Medicare. Bidders should note that prescription drug coverage will continue to be provided through the State’s Employer Group Waiver Plan (EGWP). All Medicare-eligible pensioners will have the same plan for the duration of the contract awarded in this RFP. Bids for any other arrangement are not being solicited and will not be considered by the SEBC.”

The current proposed language (below) repeats what is on Pages 5 and 9 (above) but does not add additional clarity. It is especially problematic that a sentence has been added at the end which seems to allow for deviations. This entire section should be deleted and replaced with the quote above.

“Confirm your organization will administer a Medicare Supplement plan that duplicates the current Medicare Supplement plan design without deviation – for further details, see the Special Medicfill Medicare Supplement plan booklet available here:

<https://dhr.delaware.gov/benefits/medical/documents/highmark/spec-medicfill-2024.pdf> . If you cannot duplicate the current plan design without deviation, please explain.”

Page 23 “27. Exceptions to the RFP - Any exceptions to the RFP, or the terms and conditions, must be recorded on Attachment 3. Acceptance of exceptions is within the sole discretion of the State.” This part of the contract is OK for everything else, but it is ONLY acceptable for Medicare retirees if Page 12 makes it clear that no deviations will be accepted for the Medicare Supplement portion of the proposal.

Public Comment by Jennifer Semans

Jennifer Semans

I am currently a special education teacher at a district in Delaware. I am 48 years old, and I have one child. Most of my life, I have been characterized by obesity. I have never been skinny and always had low self-esteem because people would make fun of my weight. Every doctor I went to said I was not at the weight I should be, which was a struggle. I tried every diet to lose weight and have been on Weight Watchers numerous times. I lost weight but gained it all back. I also have been on blood pressure medicine for most of my life due to being so high. Two years ago, I went to a new doctor who helped me get on Wegovy due to my BMI being high. The price with my health insurance was affordable for me since I am taking care of an 18-year-old and going back to school to get my master's degree in special education. Since I've been on Wegovy, I've lost 50 pounds, and my blood pressure has been at its best it's ever been, as my cardiologist says, as I am at a lower dosage. I have a different mindset about eating that has helped me tremendously. My self-confidence has improved, and I can move around more in the classroom to keep up with my preschool special education students. I have recently heard the price for Wegovy might be going up to \$200 a month. This is not affordable for me due to college loans I have to start paying in May and my son's college expenses beginning in the fall. This makes me nervous because I don't want my health to decline because of it. Please do not increase the price of this medicine that helps me not only emotionally but also physically.

Public
Comment by
Melissa
Beauchamp

Melissa Beauchamp

To Whom It May Concern,

I am writing to express my serious concern regarding the proposed increase in cost for GLP-1 medications to \$200 per month. As someone who has struggled with weight management for many years due to insulin resistance and a higher A1C level, these medications have been life-changing for my health.

For years, I have done everything that medical professionals recommend. I have followed structured diet plans, exercised consistently, and worked with nutritionists in an effort to lose weight. Despite these efforts, my progress was always extremely limited. It has been frustrating and discouraging to do all the right things and see so little change.

Since starting a GLP-1 medication, for the first time in many years I have been able to lose weight in a sustainable way. I continue to exercise regularly and maintain a healthy diet, but this medication has finally helped my body respond to those efforts. It has allowed me to make real progress in improving my health and lowering my risk of developing diabetes and other serious complications.

That is why the proposed increase to \$200 per month is so concerning. At \$2,400 per year, this cost is extremely difficult to sustain—especially on a teacher’s salary. Many educators accept lower salaries because the benefits, particularly health insurance, help balance that reality. Increasing the cost of a medically necessary treatment to this level undermines that support.

From a broader healthcare perspective, I also struggle to understand the reasoning behind such a significant increase. Preventative care—like treating insulin resistance and reducing A1C levels—helps avoid much more expensive medical complications in the future. If I am forced to stop this medication due to cost, the likelihood of developing diabetes and other related health conditions increases. The long-term medical expenses associated with those conditions would far exceed the cost of maintaining access to this treatment.

It took years of documented medical history, appointments, and advocacy to finally receive approval for this medication. Now that I have found something that is working and improving my health, it is disheartening to see the cost potentially rise to a level that may make it inaccessible.

I respectfully ask that you reconsider this price increase and work toward a more reasonable and affordable option for those of us who rely on this medication for our health. Access to effective preventative treatment should not be out of reach for those who need it most.

Thank you for your time and consideration.

Sincerely,
Melissa Beauchamp

Public
Comment by
Lauren
Willoughby

Lauren Willoughby

I am deeply unsettled to learn of a price increase in GLP-1 medications covered by the State of Delaware. The continued increase in the price of essential medications is deeply concerning and places an unnecessary burden on those who rely on them for their health and well-being. Access to necessary medicine should not become more difficult due to rising costs.

At the same time, it is increasingly frustrating as a loyal state employee to see benefits continually reduced or stripped away. Many employees dedicate years of service with the understanding that their benefits are part of the overall compensation for their commitment and hard work. When those benefits are repeatedly diminished, it creates a sense that the loyalty and dedication of state employees are not being valued.

Together, these issues highlight the growing financial and emotional strain placed on workers who are simply trying to maintain their health while continuing to serve their communities. I am deeply disappointed and disturbed that this was not considered.

Public Comment by Barbara Philbin

Barbara Philbin

SEBC Members,

This comment is in reference to the discussion that will take place at the March 23, 2026 meeting concerning whether it makes sense for SEBC members to require an “exact duplication” of the Medicifill plan “without deviation” out of fear that it might “limit fair procurement competition”.

I believe the above concern to mean that “limiting fair procurement competition” implies that a “without deviation plan” is too restrictive and could/would potentially result in 0 bidders and that substituting “comparable” is a more reasonable way to encourage fair-competition as stated in HB 377

No fear SEBC members: there is an easy answer to this dilemma since the market has already answered your question and confirmed that it can meet this requirement with firm evidence to prove it. Because in the 2023 RFP, using this exact “without deviation” language in its RFP, the State received, not zero, but 4 competitive bids from Highmark Aetna, Brighton and Trademark. Certainly no problem attracting bidders or impeding “fair procurement competition with the “no deviation” bid.

Therefore, in conclusion, our question has been answered with certainty. There is no reason to lower our standard or introduce “comparable” loopholes in this year’s RFP because it would not be reasonable.

Please then SEBC members follow your wise predecessors course and vote unanimously to extend our present Medicifill plan “without deviation”. Not just for our (retiree) satisfaction but because it is the most stable and reasonable path moving forward. Moving from “identical” to “comparable” will only create a new window of challenges without closing the door on the conflict and friction that already exists now to the detriment of both: the State and retirees the State serves.

Thank you for listening to my comment and for all you do for all Delawareans.

Barbara Philbin

DOE Retiree
DRSPA member
SEBC Observer

Public Comment by Rebecca Scarborough

Rebecca Scarborough

Dear SEBC Members,

I am urging you to include in your final draft of the Medicare Supplement RFP the exact duplication of the language in our current Medicfill Plan with no deviations. This will protect State retirees hired before January 1, 2025 as codified in HB 377 and passed by the 152nd General Assembly. Bob Clarkin and many others have already advocated for such wording to be included, as most recently has the Delaware Retired School Personnel Association (DRSPA), which is the largest group of State retirees.

As a DRSPA Board member I have been a long-time SEBC Observer, an RHBAS Observer, and even before that latter committee, an observer of the deliberations of the earlier Governor's Committee, the Retiree Benefits Study Committee (RBSC). I am concerned about the addition to the RFP of a High Deductible Health Savings Account (HDHSA) as an option for the bidders. I remember when the RBSC spent a lot of time discussing a Health Reimbursement Arrangement /Individual Marketplace plan with an annual \$5,100.00 tax free HRA that could be carried over year after year. As an octogenarian, I was terrified when I realized that as a possible high utilizer I wouldn't have the funds to purchase a more expensive plan as a result of my age. Are you trying to revive this type of plan for vulnerable State retirees who in their senior years may not even have the know-how or ability to manage such a plan? I certainly hope not!

In addition, I find very suspicious the inclusion of the statement to vendors asking them to explain why they wouldn't be able to duplicate our present plan. To me, this sounds like a cop-out, technically known as a procedural out! Please delete that statement and replace it with, "Bids for any other arrangement are not being solicited and will not be considered."

Lastly, I was disturbed that a proposal has been made to shorten public comments to the SEBC from three minutes to two minutes. With healthcare being such a vital benefit to senior retirees living on fixed incomes, I feel that this indicates a lack of sensitivity to dedicated former public servants who depend on a dignified and safe retirement.

Rebecca Scarborough

Former Teacher of Latin and English in the Caesar Rodney School District

Retired Education Associate of World Languages

Delaware Department of Education

SEBC Observer

Public Comment by Grace Kelley- Nask

Grace Kelly-Nask

Good morning,

My name is Grace Kelley-Nask and I am a current Delaware state employee. I was prescribed Wegovy at the beginning of February after struggling with my weight my entire life and then being diagnosed with Polycystic Ovary Syndrome (PCOS) in recent years, trying every diet and workout routine imaginable specifically for individuals with PCOS. This medicine has been the only thing to definitively change my life, both mentally and physically.

Currently, I am able to afford the \$32 a month copay on my state salary, and I believe I could even afford up to \$100 a month copay by redistributing anything I am currently able to save each month, because this medicine is truly that necessary for me. With no guarantee for the continuation of Novo's discount on copays, raising the monthly copay to \$200 is not feasible. It is especially disheartening that this decision is due to GLP-1 companies' desire to increase profit, and yet everyday citizens are the ones to yet again, suffer the consequences.

To my knowledge, the increased copay for GLP-1's from \$32 to \$200 a month does not apply to individuals with diabetes. I'm writing today for the SEBC to consider including PCOS diagnoses as an exception to the increase in GLP-1 monthly copays.

Thanks

Public Comment by Barbara Philbin #2

Dear Ms. Tucker,

As a member of the State Employee Benefits Committee (SEBC), your role in representing the Judiciary is vital to ensuring that the Committee's actions are grounded in the rule of law and administrative consistency. I am writing to urge you to support the requirement for "**Exact Duplication**" of the current Special Medicfill plan in the upcoming Medicare Supplement RFP.

In fact, this is my preference for how the standard language might be incorporated into the second paragraph of a RFP motion since "exact duplication" sets the standard while 377 establishes the floor.

"To ensure the comparable standard of HB 377 is met, the RFP must mandate a 100% duplication/replication of the current Special Medicfill benefits, including all current co-pays and out of pocket costs, provider networks that accept Medicare assignment and the complete absence of prior authorization."

Now back to the components of my reasoning,

1. The New Legal Framework of HB 377

While the Delaware Supreme Court previously affirmed the SEBC's general authority to manage benefit plans, the landscape has fundamentally shifted with the enactment of **HB 377**. This legislation explicitly requires the State to offer a plan "**comparable**" to the current Special Medicfill plan for retirees hired before January 1, 2025.

State of Delaware News (.gov) +1

2. "Identical" as the Only Standard for Compliance

The SBO's suggestion to discuss HB 377 as a loose interpretation of "comparable" introduces significant legal ambiguity into the RFP. In the context of standardizing healthcare benefits, "comparable" can be interpreted as a floor. However, the SEBC formally voted on March 25, 2024, to provide a plan "**identical to the design of the current Special Medicfill Plan**". Deviating from this "identical" standard now would not only undermine the Committee's own administrative record but also risk a new wave of litigation over whether the State is circumventing the specific protections codified in HB 377.

Delaware Online

3. Minimizing Risk and Ensuring Administrative Finality

As a representative of the Judiciary, you are uniquely positioned to recognize that an RFP based on "**Exact Duplication**" provides a clear, objective benchmark for bidders. A vague "comparable" standard invites:

- **Vendor Bid Protests:** Subjective evaluations of what is "comparable" are easily challenged in court.

- **Retiree Litigation:** If "comparable" is used to introduce prior authorizations or managed-care hurdles (which do not exist in the current plan), it will likely be viewed as a violation of the legislative intent of HB 377.

PolicyEngage +1

Conclusion

The most legally "safe" and compliant path for the SEBC is to uphold its prior commitment to an **identical plan design**. I respectfully ask that you cast your vote to ensure the RFP requires **Exact Duplication**, thereby honoring the latest statutes passed by the 152nd General Assembly and protecting the State from avoidable legal error.

Thank you for your consideration and all you do for all Delawareans. It is very much appreciated.

Also, I am introducing this correspondence into the SEBC public record to comply with, I believe, a new SEBC rule?

Sincerely,

Barbara Philbin
DE DOE Retiree
SEBC Observer

Public Comment by Kelli Bradley

Kelli Bradley

Dear Committee Members,

I am writing as a retired state employee to express my deep anger and disappointment regarding the recent vote to raise the monthly copay for GLP-1 medications such as Wegovy to **\$200 beginning July 1**.

This decision raises the cost from **\$32 per month to \$200**, nearly a seven-fold increase for employees and retirees who rely on these medications to manage their health — many of us now living on fixed incomes.

For many state workers and retired members, this increase will effectively **price us out of treatment**.

I also want to address something that was implied during the discussion surrounding this decision — the suggestion that people who need these medications simply lack discipline or should rely on lifestyle programs instead.

The people I know who take these medications are not lazy. Many of us — including my husband and I — exercise regularly, eat responsibly, and have spent years working to manage our weight and improve our health.

For example, I have a Peloton bike because I take my health seriously. That is not a small expense for someone living on a public employee salary or pension. Many of us are already doing exactly what was suggested — exercising, dieting, joining programs, and making lifestyle changes. Yet, like many people dealing with metabolic and weight-related conditions, effort alone has not been enough.

That is precisely why medications like GLP-1s exist. **Obesity is recognized by the medical community as a chronic disease**, not a failure of willpower.

GLP-1 medications are not cosmetic or vanity treatments. They are **medical treatments for a chronic condition**. When people stop taking these medications, many regain the weight because the underlying disease remains. That is the nature of chronic illness. Menopause has also been a factor in weight gain and having Wegovy has helped me tremendously to lose weight, feel healthier and have a better mindset.

To suggest that a YMCA program or a lifestyle class can replace medically prescribed treatment ignores the reality that most of us have already been trying those things for years.

This decision also sends another troubling message: when the health plan faces financial pressure, the solution is to **shift the burden directly onto employees and retirees who are already managing a chronic condition**.

State employees did not create the budget projections that underestimated the cost of these medications. Yet we are now the ones expected to absorb the consequences.

I appreciate the committee members who spoke up and recognized that a \$200 copay would push many employees out of treatment. Their willingness to acknowledge the real human impact of this decision mattered.

But to those who voted in favor of the increase, I ask you to consider the message your vote sends.

It tells thousands of state employees that **their health is negotiable**.

It suggests that stigma around weight still influences policy decisions.

And it communicates that balancing a budget has taken priority over ensuring employees have access to medically necessary care.

Behind every prescription is a real person trying to improve their health, prevent future disease, and live a longer life for their families.

We deserve better than to be treated as a budget problem.

I urge the committee to reconsider this decision and its consequences. A \$200 monthly copay will not simply “encourage alternatives.” It will force many state employees and retirees to stop medically necessary treatment altogether. A health plan should exist to support the well-being of the people it serves, not place life-changing care out of reach. I hope the committee will revisit this decision and work toward a solution that protects both the sustainability of the plan and the health of the employees and retirees who depend on it.

Sincerely,

Kelli Bradley

Public Comment by Tom Pledgie

Tom Pledgie

Dear SEBC Members:

I understand that the RFP for the Medicfill TPA will shortly be released. I am particularly concerned that there be NO 'back door option' where a bidder can deviate from the core principals found in the 2023 Medicare Supple Plan RFP:

“Proposals are being requested from interested bidders that can administer a self funded employer sponsored Medicare Supplement plan offered to current and future Medicare retirees that duplicates the current Medicare Supplement plan without deviation; for the quoted Medicare Supplement plan, bidders should duplicate the plan design (copays and other out-of-pocket costs to the plan participant at the point of care), provider network (i.e., all providers who accept Medicare assignment), and administrative set-up including coordination of benefits. This plan requires no prior authorization of services and mirrors CMS requirements under Original Medicare. Bidders should note that prescription drug coverage will continue to be provided through the State’s Employer Group Waiver Plan (EGWP). All Medicare-eligible pensioners will have the same plan for the duration of the contract awarded in this RFP. Bids for any other arrangement are not being solicited and will not be considered by the SEBC”.

IF AN INSURER HAS TO DEVIATE, THEY SHOULDN'T SUBMIT!

Tom Pledgie

Public Comment by Jeremy Ament

Jeremy Ament

It is an absolute disgrace to drastically change to copay for weight loss medications. These medications benefit so many people in ways that most do not understand. It may be expensive to cover but it is no different than any chronic disease that people take medications for (diabetes, heart disease,...). The long-term benefits of weight loss reduce and sometimes eliminate other debilitating illnesses such as liver disease and heart disease and prevent diabetes. Assisting your employees in coverage is negligible compared to the long-term benefits of maintaining a healthy weight. There is a misnomer that people are taking these medications as a vanity project, which I am sure some are, but the reality is the vast majority have hormonal imbalances that prevent weight loss. The studies are coming out in abundance stating these facts and I can personally attest to it. I spent a year and a half dieting and exercising and lost 25 pounds and my body would go no further despite drastic and probably dangerous changes. My doctor prescribed me Wegovy and with no other changes to my diet or exercise program I was able to lose 50 more pounds and have never felt emotionally and physically better. I am a better employee who is healthy and able to come to work daily with no issues. I am better service provider for the people I serve of Delaware because my health is better. My labs are the best the ever have looked because of this medication. It is wildly short-sighted to claim the costs are too much or that this medication is any different than any other long-term health condition medication that is covered. I sincerely hope this decision is reversed sooner than later. There will be people that this severely effects and will leave employment with the state over these costs. Health insurance is already wildly expensive and difficult enough to manage without adding more roadblocks. I am happy to discuss my personal experience with this medication with anyone that needs to understand it better. Thank you.

Public Comment by Robert Clarkin

PUBLIC COMMENTS FOR THE 3/23/2026 SEBC MEETING SUBMITTED BY ROBERT CLARKIN, 3/19/2026

1) PUBLIC COMMENT TIME LIMIT

During the March 9, 2026 SEBC meeting, Director Maxwell suggested under Agenda Item 14, Other Business that the SEBC consider reducing the time limit for public comment at the end of meetings from three minutes to two minutes as is the standard for Joint Finance Committee public comments. Based on the history of the volume of public comments at the end of SEBC meetings, I find this suggestion somewhat perplexing. As indicated below, during the last ten SEBC meetings, there have been a total of 22 public comments - an average of 2.2 comments per meeting. Given the three minute time limit, this equates to a total of 66 minutes over ten meeting, for an average of 6 minutes and 36 seconds per meeting.

- 03/09/26 Meeting: 2 Comments
- 02/13/26 Meeting: 5 Comments
- 12/16/25 Meeting: 2 Comments
- 11/25/26 Meeting: 1 Comment
- 10/28/25 Meeting: 2 Comments
- 10/10/25 Meeting: 1 Comment
- 09/29/25 Meeting: 3 Comments
- 09/02/25 Meeting: 4 Comments
- 07/29/25 Meeting: 1 Comment
- 06/27/25 Meeting: 1 Comment
- Total: 10 Total: 22

With the complexity of the healthcare and financial issues that are tackled by the SEBC, I find it already next to impossible to cogently comment on these issues within the current three minute limit, let alone a two minute limit. And how much will you really gain by reducing the average time per meeting from six minutes to four minutes? — just two minutes. If, at the end of a future meeting there is an extraordinary number of members of the public seeking to make public comment, I agree with Senator Peterson’s suggestion that the time limit could be adjusted at that particular meeting to give voice to the public. While some may argue that the public will talk to fill up whatever time they are given, I argue that a three minute time limit is reasonable and vital to keep the SEBC in touch with the voices of the active employees and retirees which it serves. On the other hand, in order to foster the meaningful, relevance of the voice of the public, I would like to see “Public Comment” moved up in the SEBC agendas to right after the “Statewide Benefits Office Director’s Report” item. This would allow the public to comment on SEBC agenda items before they are discussed by the committee, rather than at the end of the meetings when decisions/votes have already occurred without the benefit of public comment.

2) HIGH DEDUCTIBLE, HEALTH SAVINGS ACCOUNT (HDHSA) PLANS BACKGROUND

- Page 5 of the Medical TPA Request for Proposals (RFP) summary presentation during the 12/16/25 SEBC meeting mentions “Including an option to evaluate the addition of a HDHP (High-Deductible Health

Plan) with HSA (Health Savings Account) under “Considerations for the next Medical TPA RFP scope of services” section.

- Page 2 of the Draft Scope of Services for the Medical TPA RFP presented during the same meeting mentions “Support introduction of an HSA qualified plan” under “Support GHIP’s programs and plan offering” .
- While evaluating and introducing a High Deductible Health Savings Account (HDHSA) plan are mentioned (printed) in the above WTW presentation slides, a review of the minutes and meeting recording for the 12/16/25 meeting indicates that including a request for a HDHSA plan in the RFP was neither discussed nor approved by the committee.
- Page 11 of the Medical TPA Request for Proposals (RFP), Minimum Bid Requirements and Questionnaire presentation during the 3/9/26 SEBC meeting mentions an “2026 RFP Consideration” reading “Medical TPA to quote High Deductible Health Plan (HDHP) with Health Savings Account (HSA) plan option”, as well as a “WTW Recommendation” reading “Recommend adding RFP (questionnaire, pricing, and plan design) and evaluate as part of overall scoring”.
- While a HDHSA was mentioned (printed) in the Minimum Bid Requirements and Questionnaire presentation, a review of the meeting recording (the minutes are not yet available) indicates once again that including a request for a HDHSA plan in the RFP was neither discussed nor approved by the committee. When a committee member questioned why a HDHSA plan option has not been discussed and approved by the SEBC, the member was told it has been “mentioned” (actually just printed).
- A review of previous Medical TPA RFP’s indicates language similar to the following is placed in the RFP, Scope of Services: “The SEBC is responsible for the design of the medical plans available to GHIP’s participants and setting premium rates that can support the projected expenses of the GHIP Additional information about plan designs and premiums can be found on the SBO website”. Links are then provided to detailed information about each of the current active employee and non Medicare plans and the Medicare pensioner GHIP plans for Highmark Delaware and Aetna plan enrollees.

HIGH DEDUCTIBLE HEALTH SAVINGS PLAN DESIGN Having served for a number of years as the Manager of Planning and Policy for the Delaware Department of Labor, Division of Employment and Training, it seems very odd to me that the SEBC would include a request for HDHSA proposals in an RFP without first establishing the detailed design and features of such an option and planning for the implementation of same. Below are just a few of the design and feature items that I believe need to be considered prior to placing a request for a HDHSA plan option in the RFP. Once these considerations have addressed, they should be referenced in the RFP Scope of Services.

- Considering the pros and cons of offering a HDHSA option with emphasis on balancing potential cost reductions to the state with providing access to quality and affordable healthcare to those served by the SEBC.
- Surveying active employees and non-Medicare pensioners regarding their interest in participating in a HDHSA option.

- Establishing whether an HDHSA plan option will be in addition to the four existing options or will it replace one or more of the existing options.
- Establishing the amount of the Deductible for an individual and family plan.
- Establishing the amount of the Out of Pocket Limit for an individual and family plan.
- Establishing the total premium and employee premium share for Employee, Employee and Spouse, Employee and Child(ren), and Family coverage.
- Establishing co-pay amounts.
- Establish in-network and out-of-network costs.
- Establishing the amount that the state will contribute to the HSA.
- Establishing that the state will continue to contribute to non-Medicare retiree HSA's and that pensioner contributions can be processed through pension payments.
- Establish whether the investment options of the funds in the HSAs will be managed by a third party or by active employees and non-medicare pensioners.
- Establish training options for educating employees and non-medicare pensioners regarding IRS HSA rules and income tax reporting requirements.

3) REIMBURSEMENT RATES

The State of Delaware GHIP is self-insured with the state assuming the risks associated with the ever rising cost of health care services. The state does not negotiate reimbursement rates with health care providers. The state reimburses health care providers for services rendered, with the exception of Medicare reimbursements, by relying on the reimbursement rates negotiated between health care service providers and the applicable contracted Third Party Administrator. Under the states' Medicare Supplement plan, the reimbursement rates are established by the federal Center for Medicare and Medicaid Services (CMS), with the state plan covering 20% of the CMS rate irregardless of what the service provider bills. The CMS rates are for the most part significantly lower than the service provider billing amounts. This is a very transparent and straight forward payment system. As the state is self-insured and does not negotiate reimbursement rates, the state compensates non-Medicare medical service providers based on the rates negotiated by their TPAs - currently Aetna and Highmark Delaware. Now, the obvious question to ask here is what are the negotiated rates? One might also ask, how often do the rates change over the life of a TPA contract? Does the state have any influence over reimbursement rate increases? Are the rates a multiple of the CMS rate, individually negotiated rates, or a rate pegged to the providers bill? Are the negotiated reimbursement rates reviewed and compared during the RFP proposal review process? In reviewing the requirements within previous Medical TPA RFPs, as well as the public documents describing the requirements of the current RFP, I do not see any references to TPA negotiated reimbursement rates. Similar to the Medicare model, non-Medicare medical service providers submit bills to our TPAs and the TPA reimburses the provider based on negotiated reimbursement rates. These rate appear to me to be a key to controlling costs. Once again,

regardless what the provider bills, the TPA reimburses at the negotiated rate. In the end, regardless of medical provider billings, the cost to the state is determined by the TPA negotiated reimbursement rates. So, there seems to be a large hole in the RFP requirements and the proposal review process when the determining factor of GHIP non-Medicare health care costs are TPA negotiated reimbursement rates and the RFP is silent about the rates.

Public Comment by Steven LePage

The bullet point

Does not align with the recently passed HB377, which requires future Medicfill plans be comparable to the current Special Medicfill plan design, not duplicative.

<https://dhr.delaware.gov/benefits/sebc/documents/2026/0323-med-tpa-rfp.pdf#page=6>

This is an incorrect interpretation for the following reasons.

If a law says your replacement car must be **comparable to your 2020 Honda Accord**, that does not mean they can give you a bicycle simply because it also gets you from point A to point B. It means a car that matches the Accord in the ways that matter, such as size, safety, features, and performance. In the same way, when HB 377 requires a plan **comparable to the Special Medicfill plan on October 1, 2024**, the replacement plan should match that plan in the features retirees actually experience, including benefits, cost sharing, provider access, and the absence of prior authorization.

Timeline Explaining HB 377, the Medicfill Plan, and the RFP Language

- **2022** – The State awarded a contract to move Medicare retirees to a Medicare Advantage plan.
- **2022** – Implementation of the Medicare Advantage plan was challenged in court and stopped.
- **2023** – The State issued a Request for Proposals for a Medicare Supplement plan that required bidders to **duplicate the existing Special Medicfill Medicare Supplement plan without deviation**, including the same plan design, access to **all providers who accept Medicare, no prior authorization, and no alternative arrangements**.
- **2023–2024** – The existing **Special Medicfill Medicare Supplement plan remained in effect** while the State completed the procurement process.
- **October 1, 2024** – **HB 377 became law** and required that eligible pensioners receive a plan **comparable to the Special Medicfill Medicare Supplement plan offered under §5202 on the effective date of the Act**.
- **October 1, 2024** – On that date, the plan in effect for Medicare pensioners was still the **Special Medicfill Medicare Supplement plan**.
- **January 1, 2025** – The new contract resulting from the **2023 RFP** became effective.

Because HB 377 requires a plan **comparable to the plan that existed on October 1, 2024**, the **benchmark for comparison** is the **Special Medicfill Medicare Supplement plan that was in force on that date**. The **2023 RFP** provides the clearest written description of that plan, because it required bidders to **duplicate the existing plan without deviation** and stated that **bids for any other arrangement would not be considered**.

For that reason, the next RFP should use the **same language, or language of equal strength**, when describing the Medicare Supplement plan. Allowing bidders to propose deviations from the current plan design could create uncertainty about whether the resulting plan would still be **comparable as required by HB 377**.

House Bill 377 requires that eligible pensioners first employed before January 1, 2025 be provided a plan that is **comparable to the Special Medicfill Medicare Supplement plan offered under 29 Del. C. §5202 on the effective date of the Act, which was October 1, 2024**. Because the law uses the word “**comparable**” and ties it to the plan that existed on a specific date, the meaning of that word is important when drafting the next Request for Proposals for the Medicare Supplement plan.

In ordinary usage, when something must be comparable to a specific item at a specific point in time, it means it must match that item in the ways that matter. **Think of it this way**. If a law says your replacement car must be **comparable to your 2020 Honda Accord**, that does not mean they can give you a bicycle simply because it also gets you from point A to point B. It means a car that matches the Accord in the ways that matter, such as size, safety, features, and performance. In the same way, when HB 377 requires a plan **comparable to the Special Medicfill plan on October 1, 2024**, the replacement plan should match that plan in the features retirees actually experience, including benefits, cost sharing, provider access, and the absence of prior authorization.

On **October 1, 2024**, the plan in effect under §5202 for Medicare pensioners was still the existing **Special Medicfill Medicare Supplement plan**. The contract resulting from the 2023 procurement did not become effective until **January 1, 2025**. However, the Request for Proposals issued in **2023 required bidders to duplicate the existing Medicare Supplement plan** and described in detail what that plan had to look like.

The 2023 RFP required a plan that **duplicates the current Medicare Supplement plan without deviation**, requires the same plan design and cost sharing, allows access to **all providers who accept Medicare assignment**, requires **no prior authorization of services**, mirrors **CMS requirements under Original Medicare**, and states that **bids for any other arrangement would not be considered by the SEBC**.

It is also important to note that the language used in the 2023 RFP does not prevent the plan from changing when Medicare itself changes. Because the RFP required that the plan mirror CMS requirements under Original Medicare, the plan automatically adjusts when Medicare rules change, while still maintaining the same structure as the existing Special Medicfill Medicare Supplement plan. Using the same language in the next RFP would therefore allow necessary updates required by Medicare while still ensuring that the coverage remains **comparable** as required by **HB 377**.

The draft RFP language currently under consideration states that bidders must duplicate the current Medicare Supplement plan design without deviation, but then asks bidders to explain if they cannot do so. This differs from the language used in the **2023 RFP**, which required duplication of the existing plan without deviation and did not provide for exceptions. Because HB 377 requires a plan comparable to the plan that existed on **October 1, 2024**, the standard used in the 2023 RFP is the clearest written description of that coverage.

Allowing bidders to propose deviations from the current plan design could create uncertainty about whether the resulting plan would still be comparable as required by statute. For that reason, the final RFP should use the same bidder requirements as the 2023 RFP and should remove the provision

allowing bidders to explain why they cannot duplicate the plan without deviation, while still permitting changes required by Medicare or CMS rules.

Using the same language, or language of equal strength, in the next RFP would be the most straightforward way to ensure that the Medicare Supplement plan remains **comparable to the Special Medicfill plan as required by HB 377**.

Very Respectfully,

Steven LePage

Persian Gulf War Veteran - Desert Shield/Desert Storm

USAF, Retired

State of Delaware, Department of Technology and Information, Retired

Public Comment by Steven LePage #2

Complete Review of WTW Slide: Medicfill Supplement RFP Language — Committee Feedback Slide

<https://dhr.delaware.gov/benefits/sebc/documents/2026/0323-med-tpa-rfp.pdf#page=6>

Bullet 1: "Support from some Committee members to maintain current plan design and not consider comparable alternatives"

No Comment

Bullet 2: "Requiring exact duplication of the current plan may be seen as predetermining the incumbent as the only viable bidder, significantly limiting competition"

This is a procurement concern, not a legal one, and it should be evaluated on that basis. The State's obligation under HB 377 is a legal requirement that exists **independent of procurement preferences**. Whether a particular RFP structure is competitively optimal is a separate question from whether it satisfies the statute, **and the two should not be conflated.**

On the procurement question itself, the concern is overstated and unsupported by experience. **The 2023 Request for Proposals used language requiring duplication of the existing Special Medicfill plan without deviation and explicitly stated that bids proposing any other arrangement would not be considered. That procurement nonetheless proceeded as a competitive process and did not predetermine the incumbent as the only viable bidder.** Multiple carriers offer Medicare Supplement products in Delaware, and **a detailed plan specification does not prevent competition — it simply defines what competitors must be capable of delivering. Many state and federal procurements specify detailed performance requirements without being considered anti-competitive.** The question is not whether the specification is detailed, but whether the market contains vendors capable of meeting it. In the Medicare Supplement market, it does.

Characterizing a well-defined plan specification as inherently anti-competitive sets a standard that would call into question any detailed RFP requirement across state government. **If anything, a clearly defined specification benefits competition by giving all bidders an equal and objective standard against which to price and propose.**

Bullet 3: "Mandating an identical plan design removes flexibility for alternative approaches that could deliver comparable or greater value, potentially at lower cost"

This is a policy preference argument, not a legal one, and it cannot override the State's statutory obligations. House Bill 377 establishes a legal floor for the Medicare Supplement plan provided to eligible pensioners first employed before January 1, 2025. That floor is tied to a specific plan as it existed on a specific date. **The statute does not authorize the State Employee Benefits Committee to trade away plan features in exchange for cost savings, nor does it invite a cost-benefit analysis as a basis for departing from the required standard.** Whatever flexibility might exist in a purely procurement-driven context, that flexibility is constrained here by law.

Bullet 4: "As a result, the State may exclude qualified vendors capable of offering different but equivalent solutions, reducing competitive tension and limiting future options"

The phrase "different but equivalent" is used without definition, and that ambiguity is precisely the problem. Allowing bidders to propose their own interpretation of equivalency creates legal uncertainty about whether the resulting plan would satisfy the statutory comparability requirement. The 2023 RFP addressed this directly by requiring duplication without deviation, which gave the State a clear and defensible standard for evaluating bids. **Replacing that clarity with an open-ended equivalency standard does not enhance competition — it introduces legal risk and reduces the State's ability to ensure statutory compliance.**

Bullet 5: "Does not align with the recently passed HB377, which requires future Medicfill plans be comparable to the current Special Medicfill plan design, not duplicative."

This bullet misreads the statute and reaches the wrong conclusion. House Bill 377, codified at 29 Del. C. §5203(b)(1)(c)(1), requires that eligible pensioners first employed before January 1, 2025 receive a plan that is comparable to the Special Medicfill Medicare Supplement plan offered under that section **on October 1, 2024. The word "comparable" does not appear in isolation — it is anchored to a specific plan as it existed on a specific date. That date-specific anchor is legally significant. It freezes the benchmark and eliminates the open-ended flexibility that "comparable" might otherwise suggest.**

On October 1, 2024, the plan in effect for Medicare pensioners was still the existing Special Medicfill Medicare Supplement plan. The 2023 RFP provides the most detailed written description of that plan's requirements, having mandated duplication without deviation, universal provider access, no prior authorization, and alignment with Original Medicare. **Because HB 377 requires comparability to that specific plan, the 2023 RFP language represents the clearest available standard for what the new RFP must deliver.**

The slide's assertion that HB 377 supports a more flexible approach inverts the statute's meaning. The law does not say the State may offer something broadly similar to a Medicare Supplement plan. It requires a plan comparable to a defined benchmark on a defined date. **Using RFP language that allows bidders to propose deviations from that benchmark creates a real risk that the resulting plan will not satisfy the statutory standard, exposing the State to legal challenge and leaving affected retirees without the coverage the General Assembly intended to protect.**

In Conclusion

The first four bullets raise procurement and competition policy concerns that, while worth considering in a purely administrative context, **do not override the State's legal obligations under HB 377.** The fifth bullet **mischaracterizes the statute** in a way that, if acted upon, could result in a plan that fails to meet the legal standard the General Assembly established for pre-2025 retirees.

The most legally defensible approach is to use RFP language consistent with the 2023 procurement, which remains the clearest written expression of the plan HB 377 requires the State to match.

Very Respectfully,

Steven LePage

Persian Gulf War Veteran - Desert Shield/Desert Storm

USAF, Retired

State of Delaware, Department of Technology and Information, Retired

Public Comment by Lynda Hastings #2

Lynda Hastings #2

Retiree Steve LaPage has written an excellent point-by-point review of the flawed rationale being used by WTW in setting up the discussion of our Medicare Supplement for the Monday meeting. He submitted it to you today. You should consider all of his points very carefully. If you do, I believe that his conclusion is the only correct one:

The most legally defensible approach is to use RFP language consistent with the 2023 procurement, which remains the clearest written expression of the plan HB 377 requires the State to match.

Lynda Hastings

State Retiree

Public
Comment by
Kristin
Buckmaster

Kristin Buckmaster

Good Afternoon members of the State Employee Benefits Committee,

First, thank you for volunteering your time to serve our state. Although I disagree with the latest vote to increase the cost of GLP-1 medications, I do recognize your efforts in balancing cost and benefit.

I am a teacher who has struggled with my weight since having my second child in 2013. I woke up at 4 a.m. and worked out before having to be at school by 7:15. I have limited my eating and refined my diet to unhealthy extremes. I practice martial arts. For the majority of my 30's I was obese and bordering on morbidly obese. In September 2022, while testing for my red belt in karate, I jumped up and landed in a way that my weight caused me to break my ankle and tear my ACL, both menisci, and sprain my MCL. This led to two weeks off from work until I could get clearance to enter the building on a non-motorized scooter. Then I had surgery in January which led to 2 more weeks away from teaching, followed by a full year of physical therapy (PT). The cost of this single injury, which likely could have been prevented by weight loss was probably astronomical for our insurance providers. In February 2023, I started Wegovy and lost 20 lbs. My doctor then suggested Zepbound, on which I lost another 50 lbs. When CVS Caremark stopped covering Zepbound, I switched back to Wegovy and have lost an additional 10 lbs. This is a total of 80 lbs. My blood pressure has improved, my A1C is lower, and my resting heartrate is lower. I make better food choices. The food noise is off. I've noticed that when I miss a week of taking Wegovy, my brain is louder with food noise and I simply know that I need to stay on Wegovy for the remainder of my life to maintain a healthy weight.

I have several issues with statements made in the meeting last night:

1. The connotation is that people who take GLP-1 medications simply don't work hard enough to lose weight. Most of us have worked so hard throughout our lives that GLP-1 medications are the only viable option left aside from surgery. It is unfathomable to me that people who are supposed to represent my interests think I am lazy.
2. I am 45 now. If I live to be 80, I will likely purchase this medication for the next 35 years. The rise from \$32 a month to \$200 a month increases the lifetime cost of this medication from a total of \$13,440 to \$84,000. This is a huge increase!
3. The decision to increase the cost of this medication only considered short-term financial concerns. If I stop the medication and regain the weight back, my health could decline, costing insurance companies significantly more money to treat resulting obesity-related diseases such as heart disease, kidney dysfunction, and diabetes. The cost for me to continue on the GLP-1 medication must be lower than the cost of treating the long-term health conditions stemming from obesity. But no one mentioned the long-term financial considerations.

I implore you and the committee to reconsider your vote last night. These medications have been life changing for many people, and pricing them at \$200 a month forces me to choose between my long term health and my family's financial well-being. This is just another way for state employees, especially teachers, to feel they must put themselves last yet again.

Thank you for your time. I hope you choose to reconsider the outcome of last night's vote.

Sincerely,

Kristin Buckmaster

Public Comment by Jeremy Ament #2

Jeremy Arment #2

Again I apologize for writing so often but this an issue I feel very strongly about. The changes in weight loss medication coverage are unacceptable to those that use it for the right reasons and not for vanity. One of the things my doctor explained to me is that once people get over 40 years old their hormones and internal biology change. He explained it is the reason I could not lose weight like I did in my twenties and thirties. I could manage my weight with diet and exercise when I was younger. I did see-saw throughout my life but I could always get it together when I tried. After 40 the diets and exercise did not work barely at all. My blood pressure was high, my BMI was dangerously high, I was risk for cardiac issues and stroke, and diabetes. Nothing I was doing was working. My doctor explained the benefits of trying Wegovy to help. He also explained that Ozempic and Mounjaro do not work for everyone and his patients had better results and less side effects on Wegovy so I chose that medicine. Not for vanity but because my body would not let me do it on my own. And now my employer wants to punish me for that and that makes no sense to me. Make coverage exceptions. Younger people do not need it. People that were not obese and are not being regularly monitored by a physician like they should do not need it. That I can get behind. But a blanket statement of my insurance and my employer complaining about the costs I cannot. There has to be a middle ground somewhere and exceptions that can be made. I have a medicine that works for me that is helping me manage other chronic issues that I could be on a bunch of different medications for that would need to be covered and just as expensive. I guess you would prefer me to get surgery? Be on diabetes medications and need strips and monitoring constantly? Cardiac meds? Stroke prevention meds? Those are all okay? As opposed to one medicine now that prevents all those things. Makes no sense. Thank you yet again.

Public Comment by Jeremy Ament #3

Jeremy Ament #3

While I understand the rising costs of weight loss medication coverage and the increased amount of people utilizing the medications, it seems wildly irresponsible to not factor in the savings that one medication has on others. It also seems wildly irresponsible to not factor in people that have cardiac issues and were pre-diabetic or had dangerously high BMIs as the reason they started the medication. Managing your weight and being healthier reduces long term risk of cardiac disease (very expensive for insurance) and long term diabetes treatment (very expensive) and expensive surgeries for weight management. It would be easy enough to exclude people that did not have pre-disposing factors for starting the medication from coverage and not lump in everyone. I understand people are all on the hype train and there are lots of people taking the medication for vanity but not all fall under that category. Everyone already pays high premiums and the cost of living is astronomical and only getting worse. There are many other medications that people take for vanity that do not seem to be an issue. How about we look at cutting Viagra as it is wholly unnecessary, and millions of men take it and it costs a ton for coverage. That is just one example. It makes no sense to punish people whose biology is different than others and whose bodies do not respond to traditional healthy eating and exercise routines. Personally, I was doing everything right and it made little difference. My BMI was dangerously high, I was prediabetic, and hypertensive. I had tried everything and could not make improvements. Wegovy is saving my life and my employer wants to argue coverage costs with me. All of the issues I had a year ago are under control because I can keep my weight under control. It is offensive to think I cannot get the medicine I need because of others' abuse of it. How about making it only covered at the premium coverage levels? I would happily pay the higher premiums to maintain my coverage. Ozempic and Mounjaro are no different but their coverage is continuing? It is just a matter of which the body responds to when it comes to the GLP-1s. I understand what the FDA has approved these medicines for but not everyone responds to the others. I know these things because I have a good doctor who explained this to me and monitors me through this process. Maybe that is part of the solution as well. People that are not seeing their doctors and are not being monitored should be excluded. Pre-authorization and continuous monitoring are all part of starting the medication. This decision to increase costs is going to hurt people. Not everyone takes the medicine for vanity. Most of us do not. So, when your costs for all the other medications skyrocket because people cannot afford their Wegovy, I guess we can expect those medications all to become wildly more expensive and unattainable as well. It makes no sense to pay for surgeries and multiple medications for people to manage chronic diseases relate to being overweight when there is one medication that can prevent it all and helps people manage the issue forever. I am sorry for ranting, and I wish I would have realized this discussion was even on the table for change. I would have spoken up much sooner. Thank you. Please reconsider the changes.

Public Comment by Sharon Livingstone

Sharon Livingstone

This decision also sends another troubling message: when the health plan faces financial pressure, the solution is to shift the burden directly onto the employees who are already struggling with a chronic condition.

State employees did not create the budget projections that underestimated the cost of these medications. Yet we are the ones now expected to absorb the consequences.

I appreciate the committee members who spoke up and recognized that a \$200 copay would push many employees out of treatment. Their willingness to acknowledge the real human impact of this decision mattered.

But to those who voted in favor of the increase, I ask you to consider the message your vote sends.

It tells thousands of state employees that their health is negotiable.

It tells us that stigma around weight still influences policy decisions.

And it tells us that balancing a budget is more important than ensuring employees have access to medically necessary care.

Behind every prescription is a real person trying to improve their health, prevent future disease, and live a longer life for their families.

We deserve better than to be treated as a budget problem.

Sincerely,

Sharon Livingstone

Public Comment by Nancy Colley

Nancy Colley

I am a Retiree who is concerned about the Medicare Supplement portion of the RFP. You should use the language from the 2023 RFP to comply with the meaning and intent of the legislation which directed the continuation of our good health care that was then in place.

Respectfully,

Nancy Colley

Advanced Practice Registered Nurse

Public Comment by Steven LePage #3

HB 377 became law on **October 1, 2024**. The bill passed with unanimous support in both the House and the Senate, with only absent members not voting.

Chamber	Result	Date	Vote Type	Yes	No	Not
Senate	Passed	6/20/24 3:40 PM	SM	17	0	0
House	Passed	6/13/24 4:36 PM	SM	40	0	0

The statute requires that eligible pensioners be provided a plan **comparable to the Special Medicfill Medicare Supplement plan offered under §5202 on the effective date of the Act**, which was **October 1, 2024**. Because the law ties the comparison to a specific plan and a specific date, the question becomes what plan was actually in effect at that time.

The **2023 RFP** did not establish a new plan design. It described the plan that was already in place. Because it required bidders to **duplicate the existing Special Medicfill Medicare Supplement plan without deviation**, the RFP necessarily spelled out the features of that plan in detail. For that reason, when HB 377 refers to the plan in effect on **October 1, 2024**, the **2023 RFP provides the clearest written description of what that plan actually was** and what future plans must be comparable to.

The SEBC approved the award recommendation for the Employer-Sponsored Medicare Supplement Plan on **March 25, 2024**, with the following vote:

Voting Yes – Thomas Brackin, Karen Field Rogers, Secretary DeMatteis, Director Cade, Chief Justice Seitz, Commissioner Navarro, Controller General Miller, Treasurer Davis, Secretary Manning

Please note that several of those members continue to serve on the SEBC today.

Because the **2023 RFP language was reviewed, voted on, and approved by the Committee prior to the passage of HB 377**, it provides the **clearest written description of the plan design that was in place leading up to October 1, 2024**. Using that same language, would appear to be the most direct way to ensure that the next RFP remains consistent with the statute’s requirement that future coverage be **comparable to the Special Medicfill plan in effect on that date**.

It is also worth noting that the **2023 RFP did not prevent competition**. Multiple organizations submitted an intent to bid, including:

- Highmark Blue Cross Blue Shield Delaware
- Aetna Life Insurance Company
- Lucent Health
- Allegiance Benefit Plan Management (Cigna)

This indicates that using the same plan specifications does not prevent competitive bidding while still maintaining consistency with the plan referenced in **HB 377**.

Very Respectfully,

Steven LePage

Persian Gulf War Veteran - Desert Shield/Desert Storm

USAF, Retired

State of Delaware, Department of Technology and Information, Retired

Public Comment by Steven LePage #4

Steven LePage #4

As a follow-up to my previous email.

I would also suggest that the Committee speak with the bill's sponsor and author, former Representative Paul Baumbach, who currently serves on the SEBC, to clarify the intent of the legislation, as he would be in the best position to explain how that language was intended to be applied.

Who better to ask?