# Report of the State Employee Benefits Committee

**August 1, 2026**

To: The Honorable Matt Meyer, Governor
The Honorable David P. Sokola, President Pro Tempore of the Senate
The Honorable Melissa Minor-Brown, Speaker of the House of Representatives
Members of the General Assembly
Mark Cutrona, Director, Division of Legislative Services
Joel Rudnick, Legislative Librarian, Division of Legislative Services
Maegan Peterman, Director and State Archivist, Delaware public Archives

From: OMB Director Brian Maxwell, Chair
Treasurer Colleen Davis, Vice Chair

RE: State Employee Benefits Committee Report

The State Employee Benefits Committee (SEBC) is the governing body that manages employee benefit coverage including health, prescription, dental, vision and other employee benefit options. The SEBC upholds the mission of the Group Health Insurance Plan (GHIP) which is to offer State of Delaware employees, retirees and their dependents adequate access to high quality health care that produces good outcomes at an affordable cost, promotes healthy lifestyles, and helps them be engaged consumers.

We are pleased to submit this report, as required by Senate Substitute 1 for Senate Joint Resolution 7 (SS1 for SJR7) of the 153rd General Assembly.

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## SEBC Membership

Brian Maxwell, Director of the Office of Management and Budget, Chair
Colleen Davis, State Treasurer, Vice Chair
Kyle Evans Gay, Lieutenant Governor
Trinidad Navarro, Insurance Commissioner
Yvonne Anders Gordon, Secretary of the Department of Human Resources
Christen Linke Young, Secretary of the Department of Health and Social Services
Ashley Tucker, Deputy State Court Administrator
Ruth Ann Miller, Controller General
Jeff Taschner, Executive Director of the Delaware State Education Association
Paul Baumbach, President of the Delaware State Troopers Association Designee
Karen Peterson, State Retiree
Bill Oberle, State Retiree

## Executive Summary

This report is submitted pursuant to SS1 for SJR7 of the 153rd General Assembly and summarizes the actions taken and challenges encountered by the SEBC in implementing the prescription drug-cost containment strategies identified in the Resolution. These strategies are intended to promote transparency, enhance competition, and reduce pharmaceutical costs for State employees and retirees.

The SEBC's evaluation of these strategies occurred within the context of an active procurement process for pharmacy benefit management (PBM) services, which limits the ability to operationalize some strategies and report on the results of most. Nevertheless, the SEBC took deliberate steps to incorporate the intent of the Resolution into the procurement process. This included integrating relevant strategies into both the RFP questionnaire and minimum requirements, thereby signaling expectations related to transparency, pricing structures, and data access to prospective vendors.

In addition to procurement-related actions, the State engaged in exploratory efforts to evaluate alternative approaches to pharmaceutical cost containment. These efforts included direct engagement with pharmaceutical manufacturers and third-party vendors to assess the feasibility of direct contracting arrangements and alternative supply chain models. There was also legislative action to expand procurement flexibility, including the passage of legislation intended to enable future use of reverse auctions for the procurement of pharmaceutical benefits services.

The challenges and considerations identified in this report reflect both State-specific constraints and broader structural characteristics of the pharmaceutical supply chain. Nationally, there is increasing scrutiny of PBM practices, including recent federal actions such as the Consolidated Appropriations Act, which introduced new transparency and reporting requirements. While these developments signal progress toward greater accountability, they do not fully resolve the complexities faced by state-administered commercial health plans.

Across the strategies evaluated, several common themes emerged. A primary challenge is the limited transparency inherent in the current PBM model, particularly with respect to pharmaceutical pricing, rebate structures, and administrative costs. Contractual provisions, proprietary data systems, and confidentiality requirements often restrict the State's access to complete and actionable information. These limitations affect the State's ability to fully understand net drug costs, evaluate vendor performance, and implement data-driven cost-containment strategies.

At the same time, efforts to increase transparency must be carefully balanced with other critical objectives of the State's prescription drug program, including overall cost management, member experience, and the breadth and quality of program offerings. PBMs provide a range of services beyond pricing, including clinical management programs, formulary design, pharmacy network access, customer service, and utilization management. In some cases, greater transparency requirements may affect pricing structures, rebate arrangements, or vendor participation in bidding the State's contract, which could result in trade-offs impacting net costs, access to medications, or the availability of value-added services. As a result, the State must evaluate transparency initiatives within the broader context of total program value and member impact.

In addition, many of the proposed strategies, such as requiring full disclosure of PBM administrative expenses, accessing PBM-manufacturer agreements, or exercising expansive audit rights, are constrained by legal protections, including trade secret considerations and existing contractual obligations. Efforts to increase transparency must be balanced with these legal and market realities, which may limit the scope of feasible disclosure.

Operational and technical challenges also play a significant role. Strategies such as owning and managing pharmaceutical data, establishing an independent Pharmacy and Therapeutics Committee, or implementing alternative procurement models require substantial infrastructure, specialized expertise, and ongoing administrative capacity. In many cases, these approaches would represent a significant shift from the current PBM-administered model and would require careful planning and resource investment.

Market dynamics further influence implementation feasibility. The PBM industry is highly concentrated, and pharmaceutical manufacturers operate within complex pricing frameworks that may not readily accommodate increased transparency or alternative negotiation strategies. As a result, the State may face trade-offs between achieving lower costs, maintaining access to rebates, and enhancing transparency.

Certain strategies, including aligning State drug pricing with Medicare-negotiated rates or pursuing an interstate compact for direct manufacturer negotiations, are additionally constrained by federal law, programmatic differences, and coordination challenges across jurisdictions. While these approaches may offer long-term opportunities, they are not readily implementable in the short term.

Despite these challenges, the actions taken to date demonstrate the SEBC's commitment to advancing the goals outlined in Senate Substitute 1 for Senate Joint Resolution 7. By incorporating these strategies into the current procurement process and engaging with vendors and manufacturers, the SEBC has taken steps toward improving transparency and strengthening oversight.

The SEBC remains committed to continuing these efforts and to identifying additional opportunities through future procurement cycles and evolving federal and state policy to provide cost-effective, high-quality prescription drug benefits for State employees and retirees.

## Report Background

During the 153rd General Assembly of the State of Delaware, SS1 for SJR7 was passed by both the Senate and House of Representatives and signed by the Governor. This Resolution directed the State Employee Benefits Committee (SEBC) and the Secretary of Human Resources to engage with independent consultants and other supply chain tactics for cost containment or prescription drugs for state employees and retirees' insurance programs. SS1 for SJR7 resolved that the SEBC shall consider specific strategies and policies consistent with applicable State and federal law when negotiating for pharmaceuticals to achieve better outcomes.

The Senate Joint Resolution directs the SEBC to prepare a report by August 1, 2026, to summarize any difficulties in implementing these policies and to submit the report to the Governor; the President Pro Tempore of the Senate and Speaker of the House of Representatives, for distribution to all members of the General Assembly; the Director and the Librarian of the Division of Legislative Services; and the Public Archives.

## Context: Procurement and National Landscape

### PBM Procurement

The State's contract with its PBM vendor was scheduled to expire on June 30, 2026 for the Commercial population and on December 31, 2026 for the Employer Group Waiver Plan (EGWP) population. The Commercial population includes active State employees, including school districts, charter schools and higher education instruction employees, and non-State groups that are allowed to participate in the GHIP according to Delaware Code such as municipalities and local fire departments. The EGWP population is made up of Medicare pensioners and qualified spouses.

Following the customary timeline for GHIP vendor contracts, work on the Request for Proposals (RFP) for PBM services began at the April 25, 2025 SEBC meeting to allow for sufficient time to conduct the procurement, contracting, and implementation activities ahead of the intended next contract effective date of July 1, 2026 for Commercial and January 1, 2027 for EGWP.

Almost concurrently with the initiation of the competitive procurement process for a new PBM contract, the introduction of the original resolution, SJR7, occurred on May 9, 2025. As a result, certain strategies in the Resolution could not be fully implemented, tested, or negotiated during the RFP period, however during the development of the RFP, as many strategies as possible were integrated into the RFP by the SEBC. In addition, the SEBC was working on the GHIP Strategic Framework, which is also inclusive of the strategies and tactics below. The GHIP Strategic Framework was approved at the April 20, 2026 SEBC meeting, which includes the following PBM-specific components:

- Explore PBM and pharmacy cost reduction strategies.
- Optimize vendor contracts to obtain optimal network discounts, administrative fees, and contract terms.
- Leverage the PBM RFP to minimize pharmacy spend and allow for direct contracting with manufacturers or other third-party vendors for certain drugs.
- Ensure payment integrity of carriers and PBMs to prevent waste, fraud, and abuse.

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- Perform medical and PBM claims audits and perform implementation audit after a vendor change.

At the October 10, 2025 SEBC meeting, the Statewide Benefits Office (SBO) informed the SEBC that following the approval and posting of the PBM RFP, 10 vendors submitted proposals for consideration. After separate proposal reviews were conducted by both the SBO and SEBC consultants, Willis Towers Watson (WTW), both the SBO and WTW concluded that none of the 10 vendors met all 25 minimum requirements as written by the SEBC in the RFP. After considering options, the SEBC voted to cancel the current PBM procurement, directed the SBO to promptly restart the procurement process and to explore extending the current contract for one year to ensure uninterrupted member benefits in the interim. The SEBC restarted the RFP development process and voted to approve the new RFP at the March 9, 2026 meeting, and the procurement is currently ongoing.

As the SEBC is currently amid the PBM procurement and it is important to maintain the integrity of the procurement process, the SEBC is unable to report out at this time about any vendor proposals or the status of the strategies included in SS1 for SJR7 as it relates to the current procurement.

**National Landscape**

This report is also informed by the evolving national landscape of PBM reform, including recent federal actions such as the Consolidated Appropriations Act, which introduced new transparency and reporting requirements going into effect in 2029 intended to improve transparency, oversight, and accountability within the prescription drug supply chain.

On February 3, 2026, Congress enacted, and the President signed, the Consolidated Appropriations Act, 2026 (CAA 2026). The law includes a comprehensive package of PBM reforms that will significantly restructure PBM operations and transparency, with provisions taking effect in 2029 for the State of Delaware pharmacy plans. This includes a new level of transparency around reporting for group health plans. The law requires PBMs to provide plans with detailed reports on a semiannual basis (or quarterly upon plan request) covering the following categories of information:

- Gross and net prescription drug spending by the plan.
- Manufacturer rebates, fees, and other remuneration the PBM receives in connection with the plan's drug utilization.
- Spread pricing arrangements with network pharmacies and pharmacy network reimbursement amounts, including drug-level detail and the type of pharmacy (e.g., retail, mail, specialty) dispensing each drug.
- Formulary structure and prescription drug benefit design.
- Drug dispensing through PBM-affiliated pharmacies, including an explanation of any benefit design parameters that encourage or require members to fill prescriptions at mail order, specialty, or retail pharmacies.
- Member out of pocket cost metrics.
- Summary documents, tailored by plan-client type, for plan clients to provide to their members.

This law allows for a civil monetary penalty of $10,000 for each day that the information is not reported by the PBM. The SBO receives some, but not all, of this information already, and most of the reporting requirements of this law are actually already reflected in the PBM RFP the Committee approved at the March 9, 2026 meeting, but we believe these new federal requirements will certainly help the SBO in their constant efforts to ensure transparency among all aspects of the GHIP, including pharmacy.

## Summary of Strategies Considered, Action Taken and Implementation Challenges

Upon introduction of the Resolution, and prior to passage and signing, the SEBC immediately began reviewing actions that could be taken on the strategies included in the Resolution as it related to the PBM RFP development. Each strategy, implementation challenges, opportunities, actions taken, and results are listed below.

### Data Ownership and Point-of-Sale Transparency

**SS1 for SJR7 Strategy:**

***The SEBC should own and control all necessary pharmaceutical data for transparency and cost containment. The State should obtain data in the form of real-time point-of-sale pricing. This will arm the State with in-depth knowledge to prevent PBM's abusive practices.***

**Implementation Considerations:**

While increased data ownership and transparency are central to the State's cost-containment goals, existing PBM contractual structures, proprietary data systems, and market dynamics present challenges to obtaining real-time, complete, and actionable pharmaceutical data. These challenges include:

1. **Contractual Limitations:** Contractual provisions governing PBM services often restrict the State's ownership and use of pharmaceutical data. In many cases PBMs maintain proprietary rights over key data elements or provide access only to aggregated or summary-level reporting.
2. **Rebate Transparency:** PBMs commonly derive revenue from manufacturer rebates, administrative fees, and other contractual arrangements that may not be fully disclosed or are reported only in aggregate form. This lack of detail makes it difficult for the State to determine the true net cost of pharmaceuticals and to assess whether pricing arrangements are aligned with the State's cost-containment objectives.
3. **Restrictions on Data Sharing with Third Parties:** Contracts may limit the State's ability to share pharmaceutical data with independent consultants, auditors, and alternative vendors. Although audit rights are often included in PBM arrangements, they may be subject to scope limitations and restricted access to underlying manufacturer contracts and are challenging to dispute.
4. **Market Leverage and Vendor Resistance:** The PBM market is highly concentrated with a small number of dominant vendors. As a result, the State may face limited willingness from PBMs to agree to enhanced data transparency and may be required to balance transparency objectives against pricing guarantees.

**Opportunities and Action Taken:**

An opportunity exists to increase transparency through the PBM procurement that is currently ongoing. WTW recommended incorporating this strategy into the PBM RFP Questionnaire under the transparent pricing section. Following the submission of bids and the full RFP process, WTW recommended that this is discussed

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between the selected vendor(s), SEBC, and WTW to evaluate bidder capabilities. Below is the language added to the Questionnaire portion of the RFP:

| |
|---|
| Please confirm your organization's ability to provide the State with access to all pricing data necessary to derive net cost of State prescription claims, in real-time. |

**Result:**

The SEBC is unable to report on any result of the strategy being incorporated into the RFP due to the ongoing PBM procurement process.

## Independent Pharmacy & Therapeutics Committee and Formulary Management

**SS1 for SJR7 Strategy:**

***An independent Pharmacy and Therapeutics Committee (P&T Committee) should provide benefit by working solely on behalf of the SEBC to develop a formulary designed to provide an ongoing review of all the medications contracted by the SEBC. An independent formulary consultant should be paid based on their ability to provide drugs at the lowest cost and recommend generic medications at a lower price when there is no therapeutic advantage to using a brand name.***

**Implementation Considerations:**

Several legal, operational, and market-based considerations must be evaluated in pursuing the establishment of an independent Pharmacy and Therapeutics (P&T) Committee. Some of these considerations are listed below:

1. **Fiduciary and Structural Considerations:** The establishment and governance of an independent P&T Committee present important fiduciary and structural considerations. The State would need to define the committee's authority, membership qualifications, conflict-of-interest standards, and decision-making processes. Ensuring that the committee operates independently, aligns with State policy objectives, and maintains clinical integrity requires careful governance design and ongoing oversight.
2. **Resource Intensive:** The development and maintenance of a State-directed formulary is a resource-intensive undertaking. It requires continuous clinical review of medications, evaluation of therapeutic alternatives, and ongoing monitoring of safety, efficacy and cost. This would require specialized clinical expertise, data analytics, and administrative support. Building or procuring this capacity would likely involve significant costs and operational complexity. In addition, access to the necessary data to support formulary decision-making may be constrained.
3. **Market Dynamics:** PBMs leverage their scale and relationships with pharmaceutical manufacturers to negotiate rebates and discounts that are tied, in part, to formulary placement decisions. A State-directed formulary may affect rebate arrangements, pricing guarantees, or manufacturer participation. The State may need to assess trade-offs between increased control over formulary design and the financial advantages associated with the scale advantage of a PBM-managed formularies.

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4. **Legal and Regulatory Considerations:** Formulary design and administration are subject to various State and federal requirements., including coverage mandates, nondiscrimination provisions, and coordination with federal programs. Ensuring compliance would require additional legal review.
5. **Member Experience:** Implementation of an independent P&T Committee may have implications for member experience and access to medications. Changes to formulary structure, prior authorization requirements, or preferred drug lists could affect continuity of care and require robust communication and transition planning to minimize disruption for State employees and retirees.

**Opportunity and Action Taken:**

An opportunity exists to maintain the ability to explore the implementation of a P&T Committee through the PBM procurement that is currently ongoing. WTW recommended incorporating this strategy into the ongoing PBM RFP Minimum Requirements with the language below.

Confirm that the State will maintain the ability to carve-out specialty dispensing and management to an outside best practice entity of its choice should the State decide to take an alternative specialty approach.

WTW also recommended adding this strategy to the ongoing PBM RFP Questionnaire with the language below.

Can you support custom changes to the formulary at the request of the client including the support of a fully custom formulary?

Please confirm that your organization will support a Pharmacy and Therapeutics Committee (P&T Committee) working solely on behalf of the SEBC to develop a formulary designed to provide an ongoing review of all the medications contracted by the SEBC

**Result:**

The SEBC is unable to report on any result of the strategy being incorporated into the RFP due to the ongoing PBM procurement process.

## Alternative Negotiation and Supply Chain Tactics

**SS1 for SJR7 Strategy:**

***Any negotiation strategy to reduce drug costs, like reverse auctions, transparent committees, or other supply chain tactics should be used on the part of the formulary best suited for such action. The longer-term strategy should be to own the pharmaceutical database that will provide knowledge on cost containment.***

**Implementation Considerations:**

The use of reverse auctions, transparent evaluation committees, and other alternative procurement or supply chain strategies has been identified as a potential approach to achieving greater cost containment in the provision of PBM services. These approaches may offer opportunities to enhance competition and pricing transparency, but some challenges must be considered. These considerations are listed below:

1) **Effectiveness:** Reverse auctions are generally most effective in procurement environments where goods or services are highly standardized, and pricing can be evaluated on a clear, comparable basis. In reverse auctions, vendors compete by lowering a single comparable price. PBM services are complex and multi-dimensional, encompassing not only drug unit pricing via various models but also rebate arrangements, formulary management, network access, clinical programs, and administrative services. Many of these components are offered in a bundle, are interdependent, and not easily reduced to a single pricing metric.
2) **Oversimplification of Vendor Proposals:** There are a variety of PBM business models. For some PBMs, the administrative fee is their only source of revenue while others may have many other revenue streams available to them throughout the supply chain. A reverse auction could disadvantage the PBMs without additional revenue streams since some PBMs could bid a low administrative fee and subsidize that with other revenue areas not part of the auction. In addition, net cost is often not known up front because PBM pricing depends heavily on rebates tied to future member utilization, formulary placement, and manufacturer contracts. As a result, structuring a reverse auction in a manner that accurately captures total cost and value to the State can be difficult and may risk oversimplifying vendor proposals. In a reverse auction, you need real-time comparable pricing and PBMs often cannot or will not guarantee true net cost in that format. PBM pricing models as it relates to rebates, spread pricing, and administrative fees are often proprietary and may be structured differently across vendors. In a typical RFP procurement, evaluators can normalize and model the differences. In a reverse auction, vendors are forced into a standardized bid structure that may not reflect reality and tend to overweigh price at the expense of factors such as clinical quality, pharmacy access, customer service and implementation capability. These factors are not always weighted in the scoring.
3) **Operational:** Operational considerations may complicate the implementation of alternative procurement strategies. Designing and administering these processes may require specialized expertise and would take time to implement.

**Opportunities and Actions Taken:**

Due to the timing of the PBM procurement, these alternative procurement strategies could not be implemented due to the time required to design and implement these processes, as well as the State's current lack of the technology and systems required to administer a reverse-auction style procurement. However, the 153rd General Assembly passed Senate Substitute 1 for Senate Bill 134 (SS1 for SB134) which modernized the definition of reverse auctions and allows for the Government Support Services Section of the Office of Management and Budget to use reverse auctions in the procurement of professional services for or related to pharmaceuticals or pharmacy benefits management services. This bill made this form of procurement possible in the future.

**Result:**

No results to report.

## Interstate Compacts and Direct Manufacturer Negotiations

**SS1 for SJR7 Strategy:**

***An interstate compact to negotiate directly with drug manufacturers for high-end priced drugs, which would leverage economies of scale to achieve lower costs and could provide a consumer offering to all Delawareans.***

**Implementation Considerations:**

The concept of an interstate compact to negotiate directly with pharmaceutical manufacturers for high-cost drugs could leverage collective purchasing power and achieve more favorable pricing through economies of scale. While this approach has the potential to enhance negotiating leverage and there has been reported interest on the part of some states, the SEBC is not aware of an interstate compact at this time to directly negotiate with drug manufacturers that the State could join. Developing the legal framework, securing participation from other states, and implementing the necessary infrastructure could take several years to achieve. Implementation considerations include:

1) **Coordination:** Significant coordination would be required among participating states, including decision-making authority, financial commitments, and program design. States may differ in their statutory authorities, procurement requirements, benefit structures, and policy priorities, making it a challenge to establish a unified approach to drug selection, pricing strategies, and contract terms.
2) **Drug Manufacturer Willingness:** Manufacturers may be reluctant to engage in direct negotiations with a multi-state entity if it disrupts existing pricing and rebate arrangements managed through PBMs. In addition, manufacturers may impose conditions that reduce the anticipated savings, particularly if the compact lacks sufficient scale.
3) **Data and Administrative Infrastructure:** Data and administrative infrastructure requirements represent another consideration. Effective negotiation and management of high-cost drugs require detailed data on utilization, pricing, and clinical outcomes across participating states. Establishing systems to aggregate, standardize, and analyze this data across multiple jurisdictions could be complex and resource intensive. Ongoing administration of the compact, including things like contract management and financial oversight, would also likely require dedicated staffing and governance structures.
4) **Member Access and Program Design:** Participating states would need to determine how drugs negotiated through the compact are incorporated into their respective formularies and how coverage decisions are communicated to members. Differences in population needs, provider networks, and existing coverage policies would require careful coordination to avoid disruption to patient care. In addition, the number of pharmaceutical manufacturers operating and high-cost medications that come to market on a monthly basis could become a resource constraint.

**Opportunities and Action Taken:**

The SBO has individually met with pharmaceutical manufacturers Lilly and Novo Nordisk and attempted direct negotiations for GLP-1 medications, a class of pharmaceutical medications that is a major cost driver for the GHIP. Currently, drug manufacturers are not currently willing to negotiate with employers, especially

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employers of the State's size. The State of North Carolina attempted to do the same with their plan of 750,000 members and were not successful.

However, drug manufacturers have begun direct-to-employer programs for GLP-1 medications that utilize third-party vendors. The SBO has also met with a number of these vendors to explore their services. To take advantage of these programs a separate procurement process would be required. In addition, implementing these services requires a tradeoff of eliminating traditional utilization management such as prior authorizations in return for lower unit pricing. Eliminating prior authorizations would likely increase utilization and allow for off-label prescribing.

An opportunity exists to maintain the ability to continue to examine direct contracting programs and interstate compacts that may develop. WTW recommended incorporating this strategy into the ongoing PBM RFP Minimum Requirements with the language below.

- Confirm that the State will maintain the ability to carve-out specialty dispensing and management to an outside best practice entity of its choice should the State decide to take an alternative specialty approach.

WTW also recommended incorporating this strategy into the ongoing PBM RFP Questionnaire with the language below.

- Confirm the ability and flexibility to support State of Delaware with a strategy for direct contracting of select drugs with select manufacturers (e.g., direct negotiations with a pharmaceutical manufacturer for the pricing of one of their products, conducted by State of Delaware or its representative) at any time during the term of this agreement.
- Describe your willingness to allow the administration and fulfillment of specific drug classes, including GLP-1s, to be carved out to another vendor.
- Confirm the ability and flexibility to support State of Delaware, or an intra-state compact if the State chooses to join other states, with a strategy for direct contracting of select drugs with select manufacturers (e.g., direct negotiations with a pharmaceutical manufacturer for the pricing of one of their products, conducted by State of Delaware or its representative) at any time during the term of this agreement.

**Result:**

The SEBC is unable to report on any result of the strategy being incorporated into the RFP due to the ongoing PBM procurement process.

## Medicare Price Alignment

**SS1 for SJR7 Strategy:**

***The State should pay no higher price for all drugs negotiated by Medicare.***

**Implementation Considerations:**

Medicare drug pricing is governed by federal law and is administered under a distinct statutory and regulatory framework that differs fundamentally from commercial plans. For the EGWP benefit, the lowest Medicare negotiated pricing would apply and be required for the plan to stay compliant with CMS. Recent federal initiatives for negotiated prices are not universally available across all drugs and are not automatically extended to commercial purchasers. PBMs negotiate pricing and rebates on behalf of plan sponsors within the commercial market, and their contracts are structured around market-based pricing benchmarks rather than federally negotiated rates. PBMs may not have access to the lowest possible price available for every drug as there are numerous channels and sources.

1) **Legal Constraints:** The State has limited ability to directly access or require Medicare-equivalent pricing and manufacturers are not obligated to offer the same pricing terms to non-Medicare entities.
2) **Structural Plan Differences:** Medicare and commercial plans are structurally different, and these differences affect how prices are negotiated, applied, and reconciled.
3) **Manufacturer Willingness:** Pharmaceutical manufacturers are likely unwilling to extend Medicare-level pricing to commercial plans, as doing so could disrupt existing pricing strategies and rebate structures across the broader market. Manufacturers may seek to preserve higher prices in the commercial market to offset discounts provided under government programs.
4) **Leverage:** The State has limited leverage to compel such pricing without broader market or federal changes.
5) **Provider Impact:** Medical providers who purchase and administer drugs directly, such as in an outpatient clinic, are often reimbursed based on drug acquisition cost plus a small fee as negotiated with Third-Party Administrators (TPAs). If the SEBC were to mandate reimbursement at Medicare-negotiated prices for all available pharmaceutical drugs, including those billed under the medical plan, providers could lose money on expensive drugs if their acquisition cost is higher than the capped reimbursement. Because of this, providers may need to use lower-cost or alternative drugs even when clinical evidence favors a more expensive option, which could impact patient outcomes. If a provider or health systems loses revenue from high-cost drug reimbursements, they may be forced to cut costs elsewhere (reducing staff, limiting services, downgrading technologies, etc.). As Delaware already faces a significant provider shortage, decreasing provider reimbursement could exacerbate this issue. This would impact smaller practices more than larger health care systems.

**Opportunities and Action Taken:**

While current limitations constrain the State's ability to align commercial plan pricing with Medicare-negotiated rates, future federal and market developments may expand opportunities to leverage Medicare benchmarks more effectively. Should federal drug price negotiation apply to a broader set of medications

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increased pricing transparency and the establishment of publicly available reference prices may provide a foundation for incorporating Medicare-aligned pricing into procurement strategies or contract negotiations. In addition, continued national focus on PBM reform and drug pricing transparency may enhance the State's negotiating leverage with manufacturers and PBMs. Monitoring these developments will be important to positioning the State to take advantage of opportunities as they emerge.

WTW recommended incorporating this strategy into the ongoing PBM RFP Questionnaire with the language below to inquire about existing services to ensure that members have access to the lowest net cost pricing available.

Given that low-cost providers and pharmacies (e.g., Civica, Mark Cuban Cost-Plus Drugs, GoodRx) continue to come to market, confirm how you will allow members to access drugs through these more affordable suppliers and pharmacies, especially in situations where the member can determine your price is significantly higher.

**Results:**

The SEBC is unable to report on any result of the strategy being incorporated into the RFP due to the ongoing PBM procurement process.

## PBM Disclosure and Bidding Requirements

**SS1 for SJR7 Strategy:**

***PBMs working with the State should disclose their complete administrative expense for all pharmaceutical drugs contracted.***

**Implementation Considerations:**

The State would be enabled to more accurately assess the total cost if the PBM would disclose their complete administrative expenses. PBM administrative expenses are often embedded within complex multi-layered pricing structures and may include a combination of per-claim fees, program management fees, clinical service charges, data and reporting costs, and indirect revenue streams such as spread pricing or retained rebates. Some implementation considerations include:

1) **Definitional Ambiguity:** PBMs often do not consistently define administrative fee components, at times making it difficult to clearly identify, isolate, and compare administrative expenses across PBMs.
2) **Proprietary Nature:** Many PBMs consider elements of their administrative cost structure to be proprietary and PBMs may be resistant to disclosure of detailed expense information on the basis that it reveals pricing strategies, vendor relationships, or competitive positioning.
3) **Contractual Limitations:** The State's ability to require comprehensive disclosure may be restricted due to contractual limitations. PBM contracts often include confidentiality provisions that govern the sharing of financial and pricing information and may not obligate the PBM to provide detailed breakdowns of administrative expenses. Renegotiating these terms could be challenging and may require trade-offs in other areas of the contract.

4) **Legal Limitations:** Certain financial arrangements between PBMs and third parties, including pharmaceutical manufacturers or network pharmacies, may be subject to confidentiality protections. These constraints may limit the extent to which detailed administrative expense information can be disclosed or shared.
5) **Verifying Accuracy:** The State would need to have the capacity to audit and validate the information provided about administrative costs.
6) **Market Dynamics and Vendor Willingness:** The PBM industry is concentrated, and not all vendors may be willing to agree to comprehensive administrative cost transparency. Requiring such disclosures would likely limit the pool of responsive bidders in a procurement process or result in higher up front administrative fees as PBMs adjust pricing models to account for increased transparency.

**Opportunities and Action Taken:**

Over time, the State could evaluate the feasibility of expanding disclosure requirements as market practices evolve and as federal and state-level transparency initiatives continue to develop.

Language regarding passing through all admin fees paid by pharma manufacturers is contained in the State's Minimum Bid Requirements for the PBM RFP.

Confirm your organization will agree to pass through 100% of all rebates received from pharmaceutical manufacturers as a result of the State utilization, including manufacturer administration fees. " Rebate" means a discount or other price concession, or a payment that is:
(i) based on utilization of a prescription drug; and
(ii) that is paid by a manufacturer or third party, directly or indirectly, to a pharmacy benefits manager, pharmacy services administrative organization, or pharmacy on or after a claim has been processed and paid.

**Results:**

The SEBC is unable to report on any result of the strategy being incorporated into the RFP due to the ongoing PBM procurement process.

**SS1 for SJR7 Strategy:**

***The SEBC should request a PBM to bid based on the lowest pricing source for each pharmaceutical drug, not on the average wholesale price of a pharmaceutical drug.***

**Implementation Considerations:**

Requesting a PBM to bid based on the lowest pricing source for each pharmaceutical drug, rather than relying on traditional benchmarks such as Average Wholesale Price (AWP) would align pricing more closely with actual acquisition costs and reduce reliance on inflated or artificial benchmarks. Implementation challenges and considerations are listed below:

1) **Identifying Lowest Pricing Source:** Identifying and defining the "lowest pricing source" for a given drug is inherently complex. Pharmaceutical pricing varies across multiple channels, including wholesalers, manufacturers, specialty pharmacies, and federal pricing programs. Prices fluctuate frequently based on market conditions, supply availability, and contractual arrangements. Establishing a consistent and verifiable definition of the lowest available price at any given time would require access to comprehensive, real-time market data that may not be readily available. Some pricing sources are not publicly available and may require a separate subscription, which can make validating and auditing difficult.
2) **Legal Considerations:** This strategy may not be consistent with Delaware law. In Delaware, NADAC (National Average Drug Acquisition Cost) is a key benchmark for pharmacy reimbursement, especially for Medicaid and other government health benefit plans. The state's Pharmacy Benefit Manager (PBM) law, HB219, effective October 26, 2021, sets specific NADAC-related requirements for PBMs and pharmacy networks. PBMs may not pay or reimburse a pharmacy or pharmacist for the ingredient drug product component of pharmacist services less than the national average drug acquisition cost, or if the national average drug acquisition cost is 289 unavailable, the wholesale acquisition cost.
3) **Vendor Willingness:** PBMs may not be willing to consistently source drugs at the absolute lowest available price across all channels. PBMs typically rely on established pharmacy networks, wholesaler relationships, and manufacturer agreements that are structured to balance cost, access, and operational efficiency. Requiring sourcing from the lowest price point for each drug may not be feasible in all cases, particularly for specialty drugs, limited-distribution medications, or drugs with restricted supply chains.
4) **Comparability:** The use of lowest-pricing source as a bidding basis could be challenging in ensuring comparability across PBM proposals. AWP-based pricing, despite its limitations, provides a standardized reference point, lowest-price sourcing may vary depending on each PBMs network configuration, contracting strategy, and access to supply channels. This variability can make it difficult to conduct consistent comparisons during procurement and may complicate evaluation of overall value.
5) **Administrative Complexity:** Implementing a lowest-price sourcing model would require enhanced processes to identify, validate and apply the lowest available price at the point of sale.
6) **Trade-Offs:** There may be trade-offs between achieving the lowest unit price and maintaining broader program objectives. For example, sourcing drugs solely based on lowest price could limit patient access to preferred pharmacies, affect pharmacy network stability, or reduce the effectiveness of clinical management programs tied to formulary design. This could cause member disruption and potential delays in filling prescriptions. PBMs may also adjust other components of their pricing models, such as administrative fees or rebate arrangements to offset reduced margins from lowest-price sourcing.
7) **Market Dynamics:** Pharmaceutical manufacturers and supply chain intermediaries may not uniformly offer their lowest prices across all purchasers, and certain pricing arrangements may be contingent on volume commitments, formulary placement, or other conditions. As a result, the lowest available price in one context may not be replicable within a State administered plan.

**Opportunities and Action Taken:**

An opportunity exists to pursue lower cost sourcing through the PBM procurement that is currently ongoing. The SEBC consultant, Willis Tower Watson (WTW), recommended incorporating this strategy into the PBM RFP by requesting both acquisition cost and transparent cost proposal in the Minimum Bid Requirements.

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Confirm that your organization will provide an acquisition cost/cost plus pricing proposal to the State. An acquisition cost pricing proposal should include those medications dispensed at Mail Order and Specialty and the full pass-through of all pricing components, with minimum guarantees.

Confirm that your organization will provide a transparent cost pricing proposal to the State. A transparent pricing proposal should include the full pass-through of all retail and should also include rebate components from all channels including retail, mail order, and specialty, with minimum guarantees.

The SEBC also added a new requirement to the RFP that allows the proposal evaluation team to look at the net cost by bidder of the top 50 specialty and top 50 non-specialty drugs of the GHIP.

**Results:**

The SEBC is unable to report on any result of the strategy being incorporated into the RFP due to the ongoing PBM procurement process.

**SS1 for SJR7 Strategy:**

***The SEBC should be entitled to all agreements between the PBM and the pharmaceutical manufacturing company pertaining to any drugs contracted on behalf of the SEBC. Agreements between the PBM and the SEBC may be kept confidential, if needed.***

**Implementation Considerations:**

The State having access to all agreements between its PBM and pharmaceutical manufacturers for drugs contracted on its behalf may enable more comprehensive oversight of pricing and rebate arrangements. Implementation challenges and considerations are listed below:

1) **Confidentiality of Agreements:** Typically, PBM-manufacturer agreements are considered highly confidential and commercially sensitive. These agreements often contain proprietary pricing terms, rebate structures, market share incentives, and other negotiated conditions that manufacturers and PBMs consider proprietary to maintain competitive advantage. Such requirements would likely limit the willingness of vendors to participate in State procurements or affect the terms they are willing to offer.
2) **Contractual and Legal:** Existing contracts between PBMs and manufacturers typically include confidentiality clauses that prohibit disclosure to third parties without express consent. These agreements may also be protected under secret trade laws.
3) **Resources:** Reviewing and interpreting complex, highly technical agreements that often vary by drug, class and market conditions would require specialized expertise and additional administrative resources.
4) **Lack of Full Transparency:** Access to these agreements may not necessarily guarantee full transparency into net drug costs. Financial arrangements may involve multiple layers, including performance-based

rebates, bundling across drug classes, and indirect compensation structures making it difficult to isolate the financial impact of individual agreements or directly attribute cost savings to specific contractual terms.

5) **Trade-Offs:** Manufacturers may be unwilling to extend the same rebate or pricing terms if broader disclosure is required, particularly if such transparency could influence negotiations with other purchasers. This could result in less favorable pricing or reduced rebate opportunities for the State.

**Opportunities and Action Taken**

The new PBM provisions in the Consolidated Appropriations Act taking effect in 2029 will require greater transparency into PBM economics and increased audit rights. In addition, an opportunity exists to increase transparency through the PBM procurement that is currently ongoing. WTW recommended requesting access to all agreements between PBM and pharmaceutical manufacturers in the audit rights Minimum Bid Requirements. The auditor may be able to receive access to those agreements, though they would likely not be shared directly with the SEBC.

Confirm your organization will allow the State the right to audit all aspects of the State's pharmacy program managed by you with an auditor of the State's choosing including, but not limited to, financial terms, claims payments, the specialty program, service agreements, administration, guarantees, ability to view pharmaceutical contracts and all transparent and pass-through components including rebates as defined above in 15 and acquisition cost pricing, as applicable.

**Results:**

The SEBC is unable to report on any result of the strategy being incorporated into the RFP due to the ongoing PBM procurement process.

## Audit Authority and Oversight

**SS1 for SJR7 Strategy:**

***The State should have the right to audit anything it believes is needed for transparency and clarity. The SEBC should contract with an outside consultant to perform the audit.***

**Implementation Considerations:**

Having the right to audit any aspect of PBM operations deemed necessary for transparency and clarity would likely strengthen oversight and ensure accountability in the administration of the prescription drug benefit. Implementation challenges and considerations are listed below:

1) **Contractual Agreements:** While PBM contracts often include audit provisions, these are generally scoped to specific data elements, timeframes, and audit methodologies. The ability to expand audit

authority to encompass anything the State believes necessary would be unlikely as PBMs may seek to limit audit scope to protect proprietary information.

2) **Legal:** Access to certain information may be restricted legally. PBMs maintain agreements with pharmaceutical manufacturers, pharmacies, and other entities that often include strict confidentiality provisions and trade secret protections.
3) **Resource Intensive:** The execution of broad audit rights would likely require specialized expertise in pharmaceutical pricing, rebate structures, and claims adjudication processes.
4) **Market Dynamics:** PBMs will likely be less willing to agree to broad and open-ended audit provisions, particularly if such provisions exceed industry norms. This could affect the competitiveness of the procurement process or result in pricing adjustments.

**Opportunities and Action Taken**

The new PBM provisions in the Consolidated Appropriations Act taking effect in 2029 will require greater transparency into PBM economics and increased audit rights. In addition, an opportunity exists to expand auditing rights through the PBM procurement that is currently ongoing. WTW recommended including this into the PBM RFP Minimum Requirements with the below language:

Confirm your organization will allow the State the right to audit all aspects of the State's pharmacy program managed by you including, but not limited to, financial terms, claims payments, the specialty program, service agreements, administration, guarantees, ability to view contracts and all transparent and pass-through components including rebates and acquisition cost pricing, as applicable.

Confirm your organization's understanding that the State may audit all components of the plan at any time after the effective date of the contract including up to 3 years following the termination of the prescription benefit agreement at no cost to the State. The review of all aspects of the pharmacy program may include, but will not be limited to: paid claims, the claim processing system, rebate agreements, performance guarantees, retail network, acquisition pricing, Medicare Part D reconciliations, transparency, pricing benchmarks (e.g., AWP source), onsite assessments and customer service call monitoring.

**Results:**

The SEBC is unable to report on any result of the strategy being incorporated into the RFP due to the ongoing PBM procurement process.