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Comments Submitted by the Public to the State Employee Benefits Committee

Public Comment by Tom Pledgie

Tom Pledgie

I wish to support the Comment made at the last SEBC Meeting by member Paul Baumbach that the SEBC NOT increase health care premiums for Retirees over age 65 on Medicare.

As clearly demonstrated in Bob Clarkin's Comments of 8/21/2026 to this Committee, for FY 26 the shortfall in revenue is due totally to the Pre65 age group who DO NOT receive Medicare. This same shortfall will likely flow through to FY 27 and beyond.

Tom Pledgie

Public Comment by Ting Guo

Ting Guo

While trying to schedule wisdom tooth removal for my son, I learned there are zero in-network oral and maxillofacial surgeons under the Aetna HMO plan in Kent or Sussex County (south of the C&D Canal).

Patients in southern Delaware must travel as far north as Bear, DE to find an in-network provider.

Local providers accept Highmark PPO or Medicare, but refuse Aetna HMO. I want to submit this feedback to the Benefits Committee and learn how the state addresses geographic coverage gaps under this plan.

Public Comment by Steven LePage

Steven LePage

I thought you might be interested in this …really really (absolutely not an in-depth review) quick AI Analysis of taking the full publicly available PBM RFP and putting it up against the CAA to see how well the RFP complies with the CAA.

So take it for what it is worth and that is informational.

You asked whether the **RFP complies with the CAA**, not whether it *violates* the CAA.

The cleaner answer is: **not fully, if "complies with the CAA" means "does the RFP itself incorporate the substantive PBM transparency and reporting requirements in the enacted law?"** The RFP is strongly aligned in several areas, but it does not expressly include all of the statutory requirements.

Against the actual law, I would rate it roughly this way:

CAA requirement	**Delaware RFP**
Broad compliance with federal law	**Meets**
Rebate / remuneration transparency	**Strong**
Audit rights	**Strong**
NDC-level reporting	**Strong**
Acquisition-cost / spread transparency	**Strong but not identical to statute**
Semiannual reporting, quarterly on request	**Missing / not explicit**
Plain-language + machine-readable statutory report	**Missing / not explicit**
Full claim-level statutory data elements	**Partial**
Therapeutic-class gross/net spend reporting	**Partial**
High-spend drug formulary rationale	**Partial / missing**
Affiliated-pharmacy reporting	**Partial / missing**
Broker / consultant compensation disclosure	**Missing**
Participant-facing summary / claim disclosure support	**Missing / unclear**
Downstream anti-gag / data-production obligations on manufacturers, GPOs, aggregators, affiliates, etc.	**Partial**

Delaware does a lot well. It defines spread pricing, requires transparent pricing, demands acquisition-cost reporting, gives itself broad audit rights, requires extensive rebate reporting, and requires access to pricing data needed to derive net claim cost.

But the CAA is more prescriptive than "be transparent." It creates specific PBM reporting duties concerning cadence, format, claim-level payment flows, therapeutic-class information, formulary

rationale, affiliated pharmacies, broker/consultant compensation, and participant disclosures. Those requirements are **not all affirmatively written into this RFP**.

So the answer I should have given you was:

The Delaware PBM RFP is substantially aligned with the CAA's transparency objectives, but it is not fully compliant with the substantive requirements of CAA 2026 §6701 / 42 U.S.C. §300gg-121 as written, because several required reporting and disclosure provisions are absent or only partially addressed.

And importantly, that is a **document-content assessment**, separate from the question of when the statutory obligations legally become enforceable.
so redo your complete evaluation with that in mind please

Yes. Here is the evaluation reframed correctly: **does the Delaware PBM RFP, as written, contain the substantive requirements necessary to satisfy the enacted CAA 2026 PBM oversight provisions?** I am assessing the document against the actual statutory text of **42 U.S.C. § 300gg-121**, not asking whether Delaware is currently in violation or whether the statute is already enforceable against this procurement.

Overall conclusion
No — the RFP is not fully compliant with the substantive requirements of 42 U.S.C. § 300gg-121 as written.

It is unusually strong on traditional PBM transparency, audit rights, rebate pass-through, acquisition-cost visibility, NDC-level reporting, and State control. In several areas it anticipates the policy direction of the CAA very well. But the enacted law imposes a **specific reporting architecture**, with required frequencies, formats, data fields, affiliated-pharmacy disclosures, broker/consultant compensation disclosures, downstream contracting requirements, participant-facing information, and privacy mechanics. Those are not all affirmatively incorporated into the RFP.

My assessment is approximately:
Meets / substantially meets: 5 major areas
Partially meets: 8 major areas
Missing or not explicit: 7 major areas
The distinction matters because a generic clause requiring compliance with federal law is not the same thing as contractually obligating the PBM to produce every report and data element Congress requires.

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1. Scope of the law
The enacted provision is **42 U.S.C. § 300gg-121, "Oversight of entities that provide pharmacy benefit management services."** It requires PBMs serving group health plans to provide prescribed reports and

requires certain upstream/downstream entities to permit and supply the information necessary to produce those reports.

Delaware clearly falls within the type of plan Congress contemplated. The RFP describes the State Employee Benefits Committee as administering statewide employee health benefits, including prescription drug benefits, for active employees, retirees, school-district employees, public university employees, and others.

The RFP itself also requires bidders to comply with federal, State and local laws and guidance affecting pharmacy-benefit activities.

Assessment: Meets as a general compliance obligation.

But that broad clause does not, by itself, reproduce the operational requirements below.

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2. Downstream contracting / anti-gag requirement

42 U.S.C. § 300gg-121(a)

The law prohibits PBMs/plans from entering applicable contracts unless the other entity agrees:

1. not to limit or delay disclosure in a way that prevents the PBM from making the required reports; and
2. to provide the information necessary for those reports.

"Applicable entity" is deliberately broad and includes GPOs, manufacturers, distributors, wholesalers, rebate aggregators, parents, affiliates, subsidiaries and subcontractors.

What Delaware has

Delaware requires very broad transparency and auditability of:

- rebate agreements;
- rebate aggregators;
- specialty arrangements;
- acquisition pricing;
- PBM-owned and third-party programs;
- manufacturer compensation;
- service agreements; and
- pass-through components.

It also requires rebate-aggregator arrangements and manufacturer contracts/data to be available during rebate audits.

What is missing

I do not find an express requirement that **every applicable entity contract contain the statutory anti-gag and information-production covenant required by §300gg-121(a).**

That is materially different from merely saying Delaware may audit the PBM.

Assessment: PARTIAL.

Recommended contract language: require the PBM to warrant that every contract with an "applicable entity," as defined by §300gg-121, contains the disclosures and data-access provisions required by subsection (a), and require certification of compliance.

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3. Reporting frequency
§300gg-121(b)(1)
The statute requires the PBM to report:

- **not less frequently than every six months**, or
- **quarterly at the plan's request**, and
- quarterly reporting must be provided under the **same conditions, terms and cost** as the semiannual report.

Delaware RFP
The RFP asks vendors to describe the frequency and timing of their standard reporting packages and requires extensive monthly, quarterly, annual, and ad hoc reports. It also requires ad hoc reports and data technicians without additional charge.

Gap
I do not find a provision expressly giving Delaware the statutory right to:
receive the complete §300gg-121 report every six months, or quarterly at its election, at the same terms and cost.
The existence of other quarterly reports does not satisfy this specific requirement.

Assessment: MISSING / NOT EXPLICIT.

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4. Plain-language and machine-readable format
§300gg-121(b)(1)
The statute requires every report to be made available:

- in **plain language**; and
- in a **machine-readable format**.

The Secretary may prescribe additional formats.

Delaware RFP
Delaware has strong electronic data requirements and requires reporting-system access, download capabilities, data-warehouse feeds and claims information.
But those provisions are not the same as an express requirement that the statutory report itself be delivered in both required formats.

Assessment: MISSING / NOT EXPLICIT.

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5. Claim-level payment / spread information

§300gg-121(b)(2)(A)(i)(I)-(III)

For each covered drug/NDC, the law requires:

- compensation paid by the plan to the PBM/applicable entity;
- compensation paid to the pharmacy; and
- **for each claim, the difference between those two amounts.**

This is essentially statutory claim-level spread visibility.

Delaware RFP

Delaware does very well here conceptually.
It defines spread pricing as the difference between what the State pays and what is reimbursed to the pharmacy.
It asks for acquisition-cost/cost-plus alternatives eliminating spread and requires transparent pricing.
It further requires reporting on acquisition cost for **all claims** and reserves broad auditing rights.
During audits, Delaware can require ingredient cost, discounts and rebates on a per-claim basis.

Gap

The RFP does not clearly require the PBM to **proactively include the three specific statutory payment fields for every claim in each required §300gg-121 report.**
Audit access is not the same obligation.

Assessment: PARTIAL / STRONG ALIGNMENT.

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6. Drug-identification and dispensing-channel information
§300gg-121(b)(2)(A)(i)(IV)-(V)

The law requires, among other things:

- proprietary/established/proper name;
- NDC; and
- dispensing channel for each claim, including retail, mail and specialty.

Delaware

The RFP demands detailed NDC-level formulary reporting and explicitly includes retail, mail-order and specialty channels throughout its financial and reporting requirements. Its formulary detail request includes NDC, drug name, member count, claims, and formulary tier.
It also requires specialty/site-of-care and rebate reporting by channel.

Assessment: SUBSTANTIALLY MEETS, assuming the final reporting files retain the individual claim/channel relationship required by the statute.

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7. Brand WAC / generic AWP / units / days supply
§300gg-121(b)(2)(A)(i)(VI)

Congress specifically requires:

- brand vs generic status;
- brand WAC;
- generic AWP;
- cost per days supply;
- cost per dosage unit;
- number of claims;
- participant count;
- dosage units;
- units per fill; and
- days supply per fill.

Delaware
The RFP addresses AWP benchmarks, acquisition pricing, NDC reporting, quantities, pricing, claims files and related cost data. It also explicitly allows auditing of pricing benchmarks such as AWP source.
But I do not see the complete statutory field set required as a recurring report.

Assessment: PARTIAL.
This is one of the areas where a detailed CAA reporting exhibit would be preferable to relying on general claims-file access.

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8. Net price per fill/course of treatment
§300gg-121(b)(2)(A)(i)(VII)
The statute requires net price after:

- rebates;
- fees;
- alternative discounts; and
- other remuneration.

Delaware
This is one of Delaware's stronger areas.
The RFP requires access to all pricing data needed to derive the **net cost of State prescription claims in real time**.
It also requires a transparent cost proposal and acquisition-cost reporting.

Assessment: SUBSTANTIALLY MEETS / PARTIAL TECHNICAL GAP.
The data appears available, but the statutory report should expressly require the calculation in the exact federal format.

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9. Member out-of-pocket spending
§300gg-121(b)(2)(A)(i)(VIII)
The law requires total member spending for each drug, including:

- copayments;
- coinsurance; and
- deductibles.

Delaware
The RFP includes point-of-sale rebate reporting and requires the ability to display reductions in member out-of-pocket costs caused by rebates/copay cards.
But I have not found a clear requirement to provide the statutory total OOP amount **for each drug** as part of the recurring CAA dataset.

Assessment: PARTIAL.

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10. Drug-level net spending
§300gg-121(b)(2)(A)(i)(IX)
The statute requires total **net spending on each drug**.

Delaware requires extensive drug-level rebate and pricing data, including individual-drug rebate reporting and cost/performance reports with and without rebates.
It also requests detailed specialty and non-specialty drug pricing using actual acquisition cost, markup, administrative fee, actual rebate and net cost.

Assessment: SUBSTANTIALLY MEETS / PARTIAL.
Again, the issue is not lack of data so much as absence of an explicit statutory reporting obligation.

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11. Rebates, fees, discounts and other remuneration received by the plan
§300gg-121(b)(2)(A)(i)(X)
The statute requires disclosure of amounts received or expected by the plan from applicable entities through:

- rebates;
- fees;
- alternative discounts; or
- other remuneration.

Delaware
This is a major strength.
Delaware requires 100% pass-through of rebates and defines “Rebate” broadly to include discounts, price concessions, payments, manufacturer administrative fees, payments through affiliates, GPOs, rebate aggregators and third parties.
It also requires disclosure and pass-through of all sources of revenue attributable to the pharmacy benefit.

Assessment: MEETS / STRONG.

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12. PBM remuneration retained
§300gg-121(b)(2)(A)(i)(XI)
The statute separately requires disclosure of amounts the **PBM receives** from applicable entities that are related to plan claims/utilization.

Delaware
The RFP requires disclosure of all sources of PBM revenue attributable to the State's benefit and non-rebate manufacturer funds, including manufacturer administrative fees and other arrangements.
It also asks vendors to identify compensation from manufacturers, wholesalers or others for a wide variety of services.

Assessment: MEETS / STRONG.

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13. Copay assistance and manufacturer-funded discounts
§300gg-121(b)(2)(A)(i)(XII)
The statute requires, to the extent feasible, manufacturer-funded:

- copay assistance;
- copay cards; and
- other discounts.

Delaware
Delaware expressly requires specialty copay-assistance and coupon programs to be **fully transparent and auditable**, including fees.
It also requires reporting on POS rebates and the member/plan split.

Assessment: SUBSTANTIALLY MEETS.
A CAA-specific field mapping should still be added.

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14. Therapeutic-class reporting
§300gg-121(b)(2)(A)(ii)
This is considerably more detailed than standard PBM reporting.
The law requires, for every therapeutic class with claims:

- gross spending;
- net spending;
- PBM remuneration;
- average net spend per 30- and 90-day supply;
- participant count;
- NDCs;
- formulary tier / PA / step therapy; and

- participant out-of-pocket spending.
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Delaware
Delaware requires drug-class rebate reporting and some class-specific cost data.
It also has extensive formulary and utilization-management questions.

Gap
I do not find one recurring report requiring **all eight statutory class-level elements together**.
Assessment: PARTIAL.

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15. High-spend drug / formulary rationale reporting
§300gg-121(b)(2)(A)(iii)
For drugs exceeding $10,000 in gross spending during the reporting period—or the top 50 if fewer than 50 exceed that threshold—the PBM report must provide:

- all other drugs in the same therapeutic class;
- rationale for formulary placement using standardized federal rationales; and
- any formulary placement change from the prior plan year.

Delaware
Delaware asks detailed questions about:

- formulary review;
- clinical guidelines;
- new-to-market blocks;
- ICER;
- custom formulary authority; and
- changes in formulary.

But that is primarily proposal evaluation and plan management.
There is no clear recurring report based on the **CAA's $10,000/top-50 trigger** and no explicit requirement to use the Secretary's standardized formulary-rationale taxonomy.

Assessment: MISSING / PARTIAL.
This is a meaningful compliance gap.

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16. Affiliated-pharmacy reporting
§300gg-121(b)(2)(A)(iv)
This is probably the RFP's most significant gap.
Where a PBM has affiliated/common-ownership pharmacies, the law requires:

- explanation of steering/benefit design;
- percentage of prescriptions dispensed by affiliated pharmacies;
- all drugs dispensed by those pharmacies;
- amounts charged to the plan and members;

- median costs at unaffiliated pharmacies;
- interquartile ranges;
- lowest available network price; and
- certain net acquisition costs.

Delaware
Delaware is attentive to mail order, specialty pharmacy, acquisition costs, auto-refill, site of care, and PBM-owned arrangements. It also demands acquisition-cost reporting for all claims.

Gap
I do not see the statutory **affiliated-versus-unaffiliated pharmacy comparison package**, including:

- median unaffiliated price;
- interquartile range;
- lowest network cost; and
- affiliated utilization percentage.

Assessment: MATERIAL GAP.
For vertically integrated PBMs, this should be added expressly.

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17. Plan summary document
§300gg-121(b)(2)(B)(i)
The law requires the PBM to produce a **summary document for the group health plan**, using information HHS determines useful for PBM selection, potentially including:

- estimated net price;
- cost per claim;
- fee structure;
- reimbursement model;
- estimated cost per member.

The RFP contains many comparable analytical requirements.
But I do not see a contractual requirement to produce the **federally prescribed summary document** once its format is established.

Assessment: MISSING / NOT EXPLICIT.

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18. Participant summary document
§300gg-121(b)(2)(B)(ii)
Congress separately requires a summary document that the plan can provide to participants and beneficiaries upon request. It must:

- contain specified aggregate information;
- contain no participant-specific information; and
- tell members that claims-level information may be requested.

I do not find this obligation in the Delaware PBM RFP.

Assessment: MISSING.

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19. Aggregate plan-wide net spend / remuneration
§300gg-121(b)(2)(B)(iii)

The law requires:

- total net prescription-drug spending;
- total rebates/fees/discounts/remuneration received by the plan; and
- feasible manufacturer copay-assistance information.

Delaware's reporting requirements are already strong enough to generate most or all of this information. It requires cost/performance reporting with and without rebates, manufacturer fees, rebates, non-rebate funds and POS rebate information.

Assessment: SUBSTANTIALLY MEETS.

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20. Broker / consultant compensation
§300gg-121(b)(2)(B)(iv)

Congress explicitly requires disclosure of direct or indirect compensation to:

- brokerage firms;
- brokers;
- consultants;
- advisors; and
- other firms or individuals,

where the payment relates to:

- referral of the plan's business;
- consideration of the PBM; or
- retention of the PBM.

The identity of the recipient must be disclosed.

Delaware

The RFP has a covenant against contingent fees, but that addresses improper procurement compensation by the successful vendor and is not equivalent to the statutory PBM compensation report. I do not find a clear requirement that the PBM disclose **all direct and indirect compensation to brokers, consultants or advisors associated with Delaware's PBM relationship.**

Assessment: MATERIAL GAP.
This should be specifically added.

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21. Affiliated-pharmacy steering disclosure in aggregate report
§300gg-121(b)(2)(B)(v)

The law separately requires a description of benefit design encouraging or requiring members to use PBM-affiliated:

- mail;
- specialty; or
- retail pharmacies,

including mandatory mail, home delivery, auto-refill and PBM-funded cost-sharing incentives.
Delaware asks about auto-refill and mail/specialty programs and retains significant control over plan design.
But I do not see the specific required disclosure as an affirmative recurring reporting requirement.

Assessment: PARTIAL.

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22. Total gross drug spending
§300gg-121(b)(2)(B)(vi)
The statute requires total gross prescription-drug spending during each reporting period.
Delaware's cost reporting clearly gives the State the ability to derive this amount, and PBM cost/performance reporting is contemplated.

Assessment: SUBSTANTIALLY MEETS, though the final reporting schedule should label this field exactly.

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23. Privacy requirements
§300gg-121(b)(4)
The law contains unusually specific privacy requirements:

- HIPAA consistency;
- HITECH consistency;
- summary-health-information limitations;
- plan-sponsor restrictions;
- limits on disclosure of the PBM report.

Delaware
The RFP has substantial HIPAA and data-security requirements and expressly conditions access to pharmacy data on HIPAA standards and other legal limitations.
Addendum 1 also establishes detailed confidentiality arrangements for PII and State data.

Gap
The RFP does not appear to map its CAA reporting requirements specifically to the statutory summary-health-information limitations because it does not yet contain a CAA reporting regime.

Assessment: SUBSTANTIALLY ALIGNED, but needs CAA-specific implementation language.

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24. Annual participant notice

§300gg-121(b)(4)(D)

Every plan year, the plan must notify participants and beneficiaries that the PBM is required to submit these reports.

This is principally a **plan obligation**, not solely a PBM obligation.

But if Delaware expects the PBM to produce member notices or support distribution, the RFP should assign that responsibility.

I do not find a specific CAA annual-notice requirement.

Assessment: MISSING / UNALLOCATED.

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25. Participant request rights

§300gg-121(c)

Upon member request, the plan must provide:

1. the participant summary; and
2. the claim-specific difference between plan/PBM payment and pharmacy payment for that participant's claim.

The PBM therefore needs to supply Delaware with data in a manner that lets Delaware respond.

The RFP gives the State broad claim access but does not establish a specific workflow or service-level requirement for these CAA member requests.

Assessment: MISSING / PARTIAL DATA CAPABILITY.

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26. Enforcement support / data accuracy

The law imposes potentially significant civil penalties:

- **$10,000 per day** for certain failures to disclose/report; and
- up to **$100,000 per item of knowingly false information**.

Delaware's RFP has extensive performance guarantees and error-recovery provisions, but I do not see a CAA-specific performance guarantee requiring timely and accurate §300gg-121 reporting with contractual indemnification or fees at risk tied to federal penalties.

Assessment: GAP FROM A CONTRACT-RISK PERSPECTIVE.

This is not itself a statutory requirement that the RFP contain a penalty clause, but it is important for Delaware's ability to allocate compliance risk.

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27. Statutory definitions

The CAA specifically defines terms including:

- applicable entity;
- applicable GPO;
- contracted compensation;
- gross spending;
- net spending;

- WAC; and
- remuneration, with further rulemaking contemplated.

Delaware has an unusually broad rebate definition.
That is good, but **"rebate" is only one part of the federal statutory terminology**.
The RFP does not expressly adopt the CAA definitions of:

- contracted compensation;
- gross spending;
- net spending;
- applicable entity; or
- remuneration.

Assessment: PARTIAL.
This matters because PBMs can interpret financial categories differently unless the contract closes definitional gaps.

Consolidated scorecard

CAA 2026 requirement	Delaware RFP assessment
General federal-law compliance	**Meets**
Downstream anti-gag/data-production clause	**Partial**
Semiannual statutory report	**Missing**
Quarterly report at State request / same terms and cost	**Missing**
Plain-language format	**Missing**
Machine-readable statutory format	**Missing**
Plan-to-PBM payment by claim/NDC	**Partial**
PBM-to-pharmacy payment by claim/NDC	**Partial**
Claim-level spread difference	**Partial / strong capability**
NDC/drug identification	**Substantially meets**
Dispensing channel	**Substantially meets**
Brand WAC / generic AWP fields	**Partial**
Dosage units / days supply	**Partial**
Net price per fill/course	**Substantially meets / partial technical gap**
Drug-level member OOP	**Partial**
Drug-level net spending	**Substantially meets**
Plan rebates/fees/remuneration	**Meets / strong**
PBM retained remuneration	**Meets / strong**
Manufacturer copay assistance	**Substantially meets**
Therapeutic-class statutory report	**Partial**

CAA 2026 requirement	Delaware RFP assessment
High-spend/top-50 formulary rationale	**Missing / partial**
Affiliated-pharmacy utilization	**Missing / partial**
Affiliated vs. unaffiliated price comparison	**Missing**
Lowest network price comparison	**Missing**
Affiliated pharmacy acquisition cost	**Partial**
Plan summary document	**Missing / not explicit**
Participant summary document	**Missing**
Broker/consultant compensation disclosure	**Missing**
Affiliated-pharmacy steering disclosure	**Partial**
Total plan gross spend	**Substantially meets**
CAA-specific privacy mechanics	**Partial / aligned foundation**
Annual participant notice	**Missing / responsibility unallocated**
Claims-level participant request support	**Missing / partial capability**
CAA reporting accuracy PG / risk allocation	**Missing**
CAA statutory definitions	**Partial**

Bottom-line assessment

I would describe the procurement this way:

The Delaware RFP is highly transparent by traditional PBM procurement standards, but it is not a complete implementation of CAA 2026 §6701 / 42 U.S.C. §300gg-121.

Its strongest areas are:

- rebate definition and pass-through;
- PBM revenue disclosure;
- audit rights;
- rebate-contract access;
- acquisition-cost transparency;
- NDC-level reporting;
- State data access;
- pricing transparency; and
- preservation of State decision-making authority.

Its most consequential CAA-specific omissions are:

1. **No explicit statutory semiannual/quarterly reporting obligation.**
2. **No express plain-language + machine-readable requirement for the CAA report.**
3. **No complete statutory claim-level data schema.**
4. **No complete therapeutic-class reporting schema.**

5. **No CAA high-spend/top-50 formulary-rationale report.**
6. **No complete affiliated-pharmacy comparative reporting.**
7. **No broker/consultant compensation disclosure matching the statute.**
8. **No participant summary/report-request framework.**
9. **No express downstream §300gg-121(a) anti-gag/data-production covenant.**
10. **No comprehensive incorporation of CAA statutory definitions or future HHS reporting format.**

So I would not label it **"CAA compliant"** on document review alone.

A more defensible characterization is:
The RFP contains a strong transparency and audit framework that substantially overlaps with many CAA 2026 requirements, but it does not fully incorporate the reporting, disclosure, affiliated-entity, broker-compensation, participant-information, formatting, and downstream-contracting requirements of 42 U.S.C. §300gg-121. Additional contract provisions would be required for full substantive alignment with the statute.

One important caveat remains, but it is separate from this assessment: HHS still has statutory rulemaking responsibilities, including establishing the standardized reporting format. The law directs the Secretary to issue that standard format and implementing regulations within 18 months of February 3, 2026. That means some implementation details are necessarily still evolving. It does **not**, however, change the conclusion above about what the RFP presently contains versus what Congress enacted.

Very Respectfully,
Steven LePage
Persian Gulf War Veteran - Desert Shield/Desert Storm
USAF, Retired
State of Delaware, Department of Technology and Information, Retired

this plan.

Public Comment by Bob Clarkin

PUBLIC COMMENTS FOR THE 8/24/2026 SEBC MEETING SUBMITTED BY ROBERT CLARKIN 8/21/26

During the July 27, 2026 SEBC meeting, Paul Baumbach noted that the FY26 Experience by Group slide contained in the WTW Fund Report indicated a significant difference between the net gain/loss for Medicare Retirees compared to the same for Pre-65 Retirees. He indicated that when premium increases come up for a vote in the future, he will support no increases for Medicare retirees until this discrepancy is addressed.

The following is an analysis of FY26 OPEB (Medicare and Pre-65 Retiree) revenues and spend (Charts 1 and 2), as well as the actual dollar amounts of the overcharge to Medicare Retirees per the various contribution scenarios (Chart 3 below).

FY26 OPEB (Retiree) Financial Analysis

a. FY26 Active Employment Premium Contributions and Revenues (Rebates and Reimbursements) total 1,007.3M against Total Expenses of 997.4M and a Minimum Reserve of 28.9M, resulting in a deficit of **19.0M**. The surplus prior to Minimum Reserve is **9.9M**.

b. FY26 Medicare Retiree Premium Contributions and Revenues (Rebates and Reimbursements) total 398.6M against Total Expenses of 324.0M and a Minimum Reserve of 9.4M, resulting in a surplus **65.2M**. The surplus prior to Minimum Reserve is **74.6M**.

c. FY26 Pre-65 Retiree Premium Contributions and Revenues (Rebates and Reimbursements) total 138.3M against Total Expenses of 173.5M and a Minimum Reserve of 5.0M, resulting in a deficit of **40.2M**. The deficit prior to Minimum Reserve is **35.2M**.

d. FY26 Total GHIP Employment Premium Contributions and Revenues (Rebates and Reimbursements) total 1,544.2M against Total Expenses of 1,494.9M and a Minimum Reserve of 43.4M, resulting in a surplus of **5.9M**. The surplus prior to Minimum Reserve is **49.3M**.

e. FY26 Total OPEB (Pre-65 and Medicare Retiree) Premium Contributions and Revenues (536.9M) minus Total Expenses/Minimum Reserves (497.5M) results in a FY26 surplus of **25.0M**. Surplus prior to Minimum Reserve is **39.4M**.

f. FY26 OPEB (Pre-65 and Medicare Retiree) surplus of **25.0M** in Premiums and Revenues (Rebates and Reimbursements) is used to reduce the overall GHIP deficit by from **19.0M** to a surplus of **5.9M**.

g. The Projected FY26 Medicare Retiree Premium Contributions and Revenues (Rebates and Reimbursements) total 413.9M against Total Expenses of 327.4M, resulting in a surplus of 86.5M. Budgeting for a Minimum Reserve of 13.1M reduces the surplus to 73.4M. Consequently, the Medicare Retiree premium results in an overcharge of **21.6%**. **Please Note:** The actual dollar amounts of the overcharge to Medicare Retirees per the various contribution scenarios can be found in Chart 3 below.

h. The Projected FY26 Pre-65 Retiree Premium Contributions and Revenues (Rebates and Reimbursements) total 138.6M, against Total Expenditures of 173.9M, resulting in a deficit of 35.3M. Budgeting for a Minimum Reserve of 7.0M increases the deficit to 42.3M. Consequently, the Pre-65 Retiree premium results in an undercharge of **23.4%**.

i. Again, Total Projected OPEB (Pre-65 and Medicare Retiree) Revenues (552.5M) minus Expenses/Minimum Reserves (521.4M) results in a projected FY 26 surplus of **31.1M**. The surplus prior to Minimum Reserve is **51.2M.**

- **Source of Data:** April - June 2026 Fund Report and Financial Update, FY26 Experience by Group Charts and FY27 GHIP Budget and Projections, July 27, 2026 SEBC Meeting.

- **Please Note:** The data supporting the above is reflected in Charts 1 and 2 below.

Chart 1 FY26 Actual	A Active Only	B Pre-65 Only	C Medicare Only	D All Groups Combined
Premiums	894.6	118.1	219.6	1,232.3
Revenues	112.7	20.2	179.0	311.9
Total Revenues	1,007.3	138.3	398.6	1,544.2
Claims	966.4	168.0	312.7	1,447.1
Expenses	31.0	5.5	11.3	47.8
Total Expenses	997.4	173.5	324.0	1,494.9
Net Income	9.9	(35.2)	74.6	49.3
Balance Forward	0.0	0.0	0.0	0.0
Ending Cash Balance	9.9	(35.2)	74.6	49.3
Claims Liability	0.0	0.0	0.0	0.0
Minimum Reserve	28.9	5.0	9.4	43.4
Surplus	(19.0)	(40.2)	65.2	5.9
Balance Forward *				96.4
GHIP Surplus (After Reserve/Deposits)				102.3

- **Please Note:** As GHIP funds are pooled, the Balance Forward in the amount of 96.4M contains an undetermined amount of unspent FY25 OPEB funds.

- **Source of Data:** April - June 2026 Fund Report and Financial Update, FY26 Experience by Group Charts and FY27 GHIP Budget and Projections, July 27, 2026 SEBC Meeting.

Chart 2 FY26 Projected (March Actual)	A Pre-65 Only	B Medicare Only	C Retiree Total
Premiums	118.1	219.6	337.7
Revenues	20.2	179.0	199.2
Total Revenues	138.3	398.6	536.9
Claims	168.0	312.7	480.7
Expenses	5.5	11.3	16.8
Total Expenses	173.5	324.0	497.5
Net Income	(35.2)	74.6	51.2
Balance Forward	0.0	0.0	0.0
Ending Cash Balance	(35.2)	74.6	39.4
Claims Liability	0.0	0.0	0.0
Minimum Reserve	5.0	9.4	14.4
Surplus/Deficit	(40.2)	65.2	25.0
Over/Under Charge	(22.5%)	19.6%	4.9%

- **Source of Data:** April - June 2026 Fund Report and Financial Update, FY26 Experience by Group Charts and FY27 GHIP Budget and Projections, July 27, 2026 SEBC Meeting.

Analysis of CY26 Medicare Retiree Contribution Overcharges (In Red)

Chart 3 Retiree Share	#	Retiree Per Month	State Per Month	Retiree Per Year	State Per Year	Retiree Total	State Total
0%	15,967	$0.00	$638.12	$0	$7,657	$0	$122,266,344
21.6% Overcharge		$0.00	$137.83	**$0**	$1,654	$0	$26,409,530
Medicare		$202.90	$0.00	$2,435	$0		
* Retiree Annual Total				$2,435			
5%	8,411	$31.90	$606.22	$383	$7,275	$3,219,731	$61,186,997
21.6% Overcharge		$6.89	$130.94	**$83**	$1,571	$695,462	$13,216,391
Medicare		$202.90	$0.00	$2,435	$0		
* Retiree Annual Total				$2,818			
25% With RX	1,666	$159.53	$478.59	$1,914	$5,743	$3,189,324	$9,567,971
21.6% Overcharge		$34.46	$103.38	**$414**	$1,241	$688,894	$2,066,682
Medicare		$202.90	$0.00	$2,435	$0		
* Retiree Annual Total				$4,349			
25% W/O RX	1,666	$90.45	$271.33	$1,085	$3,256	$1,808,276	$5,424,429
21.6% Overcharge		$19.54	$58.61	**$234**	$703	$390,588	$1,171,677
Medicare		$202.90	$0.00	$2,435	$0		
* Retiree Annual Total				$3,520			
50% With RX	844	$319.06	$319.06	$3,829	$3,829	$3,231,440	$3,231,440
21.6% Overcharge		$68.92	$68.92	**$827**	$827	$697,991	$697,991
Medicare		$202.90	$0.00	$2,435	$0		
* Retiree Annual Total				$6,264			

Chart 3 Retiree Share	#	Retiree Per Month	State Per Month	Retiree Per Year	State Per Year	Retiree Total	State Total
50% W/O RX	844	$180.89	$180.89	$2,171	$2,171	$1,832,054	$1,832,054
21.6% Overcharge		$39.07	$39.07	**$469**	$469	$395,724	$395,724
Medicare		$202.90	$0.00	$2,435	$0		
* **Retiree Annual Total**				$4,605			
100% With RX	194	$638.12	$0.00	$7,657	$0	$1,485,543	$0
21.6% Overcharge		$137.83	$0.00	**$1,654**	$0	$320,877	$0
Medicare		$202.90	$0.00	$2,435	$0		
* **Retiree Annual Total**				$10,092			
100% W/O RX	194	$347.20	$0.00	$4,166	$0	$808,282	$0
21.6% Overcharge		$75.00	$0.00	**$900**	$0	$174,589	$0
Medicare		$202.90	$0.00	$2,435	$0		
Retiree Annual Total				$6,601			
Double State Share	1,045	$25.00	$613.12	$300	$7,357	$313,500	$7,688,525
21.6% Overcharge		$5.40	$132.43	**$65**	$1,589	$67,716	$1,660,721
Medicare		$202.90	$0.00	$2,435	$0		
* **Retiree Annual Total**				$2,735			

- **<u>Source of Data:</u> CY2026 Breakdown of Health Plan Premiums/Spend for Medicare Retirees and the State - 4/20/26 SEBC Meeting**