



SEBC and SEBC Subcommittee Meetings (April 2026 Updates) *Get the Facts on What's Happening*

As the “administrative arm” of the State Employee Benefits Committee (SEBC), the Statewide Benefits Office (SBO), Department of Human Resources (DHR) is providing the following frequently asked questions document as a resource to employees and retirees, which includes facts on what’s being discussed related to the Group Health Insurance Plan (GHIP) at the SEBC and SEBC Subcommittee meetings and actions taken by the SEBC.

Learn more about the SEBC and SEBC Subcommittees, including committee members, meetings schedules, meeting recordings and meeting materials by visiting the [SEBC page](#) of SBO’s website. Each meeting is open to the public and provides an opportunity for public comment. In addition, suggestions, comments, and/or concerns can be sent to the SEBC at sebc@delaware.gov.

Frequently Asked Questions:

Financial Updates

Q. What is the status of the Group Health Insurance Plan (GHIP) Health Fund?

A. As of February 2026, the GHIP Health Fund had a projected cash balance of approximately \$172.1 million after accounting for February Fund experience. The SEBC projects that the Health Fund will end Fiscal Year 2026 with an ending cash balance of \$163.7 million and will continue to build toward an adequate surplus and minimum cash reserve of 4% to cover future health care costs.

Benefit Updates

Q. When will the 2026 Open Enrollment take place?

A. The State of Delaware’s [2026 Open Enrollment](#) for the non-Medicare health plans, dental, vision, and other employee benefits will take place from **Monday, May 4, 2026 through Friday, May 15, 2026**. Unless employees or retirees experience a qualifying event (marriage, birth, etc.), Open Enrollment is their once-a-year opportunity to enroll, cancel coverage, or change plans for themselves, their eligible spouse, and/or dependent children. 2026 Open Enrollment is also the opportunity for State Medicare Eligible retirees to enroll, make changes, or cancel coverage for their dental and vision benefits.

Q. What changes were approved regarding the FSA Dependent Care maximum contribution?

A. At the March 9, 2026 meeting, the Committee approved an increase in the Dependent Care Flexible Spending Account (FSA) maximum from \$5,000 to \$7,500, effective July 1, 2026, as authorized under recent federal legislation. The SEBC adopted the increased limit, but the plan must ensure compliance with applicable non-discrimination testing requirements. An increase provides an opportunity for employees to save additional money, on a pre-tax basis, to be used for dependent care expenses.

Q. What cost mitigating strategy did the SEBC approve related to coverage of GLP-1 medications for weight management?

A. At the March 9, 2026 meeting, the Committee discussed the options previously presented regarding coverage of GLP-1 medications for weight management, including elimination of coverage, implementation of a stand-alone copay of \$120, \$132 or \$200, implementation of an increased integrated copay of \$120, \$132 or \$200, maintenance of current coverage, or removing prior authorization requirements and implementing higher copays. The Committee discussion focused on the financial sustainability of continued coverage, the potential burden of increased copays on employees, copay assistance programs offered by the drug manufacturer, the role of prior authorization in ensuring safe use, long-term health outcomes of

continuing coverage, and investigating carving the medications out of the CVS Caremark formulary and issuing an RFP for vendors who could manage utilization.

The SEBC originally voted to cover weight management medications subject to utilization management on March 6, 2023. At that time, CVS Caremark estimated the incremental cost to the GHIP for FY2024 would be \$1.8 million. However, the FY2024 actual spend was \$14.2 million and FY2025 was \$53.3 million. The GLP-1 weight management medication spend is projected to be \$84.2 million in FY2026.

After considerable analysis, the Committee voted to maintain coverage of GLP-1 medications for weight management for active and non-Medicare retirees with an increased stand-alone copay of \$200 per 30-day supply. Stand-alone copay means the medication will be excluded from the current out-of-pocket maximums for prescription drugs. This decision maintains coverage for members while also providing an estimated pharmacy savings to the State of \$76.6 million for FY2027 – FY2029. It also decreased the premium rate increase for FY2027 to 2.2% as opposed to the anticipated increase of 4.2%.

Members using Wegovy have the option to reduce their out-of-pocket cost by using the Wegovy Savings Card offered by Novo Nordisk, which provides savings of up to \$100 per month at the pharmacy. Members can apply online using an enrollment questionnaire through the [NovoCare Wegovy](#) page. Members with questions or who need support enrolling in the savings program may call 1 888 793 1218, (1-833-4-WEGOVI), Monday through Friday, 9:00 AM to 6:00 PM ET.

For members who received a clinical exception for Zepbound, a similar Zepbound Savings Card is available through Lilly which provides savings of up to \$100 per month at the pharmacy. Members can apply through the Lilly website using the enrollment questionnaire available here: [Savings Card Forms](#).

The adjustment to the copay for weight management GLP-1 medications helped offset a portion of anticipated plan cost increases for FY2027.

Note: Individuals with a diabetes diagnosis who are prescribed a GLP-1 medication in the diabetes class (such as Mounjaro, Ozempic or Trulicity) will continue to pay the \$32 copay for a 30-day supply.

SEBC meetings are open to the public and provide an opportunity for public comment. Visit the [SEBC page](#) for meeting information and more. Members who would like to make public comment are encouraged to review the [SEBC Public Comment Protocol](#).

Q. Will there be State health plan premium (rate) increases for employees and retirees for Fiscal Year 2027?

A. At the March 9, 2026 meeting, the SEBC reviewed and voted on a health plan premium (rate) increase of 2.2% effective July 1, 2026 for active employees and non-Medicare retirees and January 1, 2027 for Medicare retirees. Employee contributions will increase by a range of \$0.96 to \$9.44 per month. For non-Medicare plan members, this translates to the following monthly increases:

Health Plan Name	Increase for FY2027 (individual – family plan rates)
Highmark First State Basic	\$0.96 - \$2.50 per month
Aetna CDH Gold	\$1.26 - \$3.28 per month
Aetna HMO	\$1.64 - \$4.30 per month
Highmark Comprehensive PPO	\$3.64 - \$9.44 per month

The rates will be communicated in 2026 Open Enrollment materials.

Q. Will there be dental plan premium (rate) increases for employees and retirees for Fiscal Year 2027?

A. As part of the RFP award recommendation approved by the SEBC in 2022, both Delta Dental and Dominion National have the ability to implement a premium increase of up to 3.00% for Year 5 of the contract. The SBO had requested that both vendors maintain the current rates and not implement the 3.00% increase, however, based on incurred claims analysis conducted by both vendors, they have opted to implement the available premium increase effective July 1, 2026.

There will be a 3.00% rate increase for the Delta Dental PPO plan for FY2027 with the increase ranging from \$1.16 for employee only coverage to \$3.86 for family per month. There will be a 2.99% rate increase for the Dominion National DHMO plan for FY2027 with the increase ranging from \$0.86 for employee only coverage to \$2.34 for family per month. All benefit changes, including this increase in dental plan premiums, will be communicated to members 2026 Open Enrollment materials.

Legislative Updates

Q. How would Senate Bill 1 impact the Group Health Insurance Plan (GHIP) if passed and signed into law?

A. On March 5, 2026, [Senate Bill 1](#) was filed in the Delaware General Assembly. This bill has two major components that impact the Group Health Insurance Plan (GHIP). Beginning in FY2029, the State of Delaware Group Health Insurance Plan (GHIP) must provide coverage through a carrier whose payment for covered services does not exceed 250% of the Medicare reimbursement rate for comparable services, which caps the amount the GHIP can pay providers for health care services. Additionally, GHIP members may only be charged copayments, coinsurance, and deductibles specified in their health plan, based on the provider's network status. Providers cannot bill members for amounts above the carrier's allowed payment. This protects GHIP members from balance billing. If no comparable Medicare reimbursement rate exists, reimbursement for GHIP services will be determined using Medicare rates for similar services, as reasonably determined by the SEBC.

The second part of this legislation focuses on primary care transformation and investment. Beginning in FY2029, the GHIP must increase primary care spending by 1% from the higher of the prior two plan years, then increase spending by 1% each year until primary care spending reaches 11.5% of total medical costs. Currently, the GHIP is just below 6.0% for primary care spend as a portion of total medical expenditures. Primary care investment can be increased and achieved in multiple ways. The Office of Value-Based Health Care Delivery under the Department of Insurance (DOI) leads this work for the State's commercial market. This bill would now include the GHIP in those spending requirements, which will come at a significant cost to the GHIP, however, the savings achieved through the 250% Medicare reimbursement cap, would offset this cost and would achieve significant savings to the GHIP, including savings expected by improved health outcomes due to improved primary care and disease management. In total, the projected net savings to GHIP from the legislation are \$159 million for FY2029 – FY2034.

Senate Bill 1 was reported out of the Senate Health and Social Services Committee on March 18, 2026 and has now been assigned to the Senate Finance Committee for consideration. The SBO continues to monitor Senate Bill 1 and other legislation that may impact the SEBC or employee benefits.

Request for Proposals (RFP) Updates

Q. What is the status of the calendar year 2026 Request for Proposals (RFPs)?

A. The SBO is managing six RFPs at various stages. The chart below details each RFPs' status, upcoming actions involving SBO, SEBC, or Proposal Review Committees (PRCs), as well as the anticipated contract effective dates.

Request for Proposals (RFPs)	Life Insurance	Vision Insurance	Pharmacy Benefit Management (PBM) Services	Health Data Warehouse	Medical Third-Party Administrator (TPA)	Dental Insurance
Current Stage	A contract has been signed between the State of Delaware and Securian Financial for a three-year initial contract term with two one-year optional renewals for administration of the Group Universal Life Insurance Benefit.	The PRC recommendation was presented to the SEBC for review at the February 13, 2026 SEBC meeting. The SEBC voted in favor of the recommendation and instructed that the SBO begin negotiations with the recommended vendor.	The initial PBM RFP, as approved by the SEBC earlier this year, has been cancelled as decided at the October 10, 2025 SEBC meeting. The SEBC voted to extend the current contract with CVS for one additional year. The SEBC voted to approve the new RFP at the March 9, 2026 meeting.	The PRC recommendation was presented to the SEBC for review at the March 9, 2026 SEBC meeting. The SEBC voted in favor of the recommendation and instructed that the SBO begin negotiations with the recommended vendor.	The SEBC began reviewing the Medical TPA RFP Scope of Services at the November 25, 2025 meeting and has continued discussion through the March 9, 2026 meeting.	The SEBC began reviewing the Medical TPA RFP Scope of Services at the March 23, 2025 meeting.
Next Steps	The SBO will continue working with Securian Financial to implement the terms of the new contract ahead of the July 1, 2026 effective date.	The SBO will continue contract negotiations.	The RFP was posted on March 25, 2026. Intents to Bid are due by April 1, 2026 at 11:00 am and the bid deadline is April 27, 2026 by 1:00 pm.	The SBO will begin contract negotiations.	The SBO will incorporate feedback from the SEBC into the RFP as it is developed. The Committee will continue to discuss the RFP, and it is anticipated that the SEBC will vote on the Medical TPA RFP for approval at the April 20, 2026 SEBC meeting.	The SBO will incorporate feedback from the SEBC into the RFP as it is developed. The Committee will continue to discuss the RFP, and it is anticipated that the SEBC will vote on the Dental RFP for approval at the May 11, 2026 SEBC meeting.
Anticipated Contract Effective Date	July 1, 2026	July 1, 2026	July 1, 2027	July 1, 2026	July 1, 2027	July 1, 2027