

**Department of Legislative Services**  
Maryland General Assembly  
2019 Session

**FISCAL AND POLICY NOTE**  
**Enrolled - Revised**

Senate Bill 946

(Senator Griffith, *et al.*)

Budget and Taxation

Appropriations

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**State Prescription Drug Benefits - Retiree Benefits - Revisions**

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This emergency bill establishes prescription drug out-of-pocket (OOP) reimbursement or catastrophic coverage programs for specified State retirees, dependents, or surviving dependents who are enrolled in a Medicare prescription drug benefit plan. State employees hired after June 30, 2011, remain ineligible for prescription drug coverage from the State when they retire. By July 1 of each year, the Secretary of Budget and Management must notify specified individuals of their eligibility to enroll in the programs and provide other specified information. The Department of Budget and Management (DBM) must provide specified one-on-one counseling to Medicare-eligible retirees and provide specified reports to the budget committees.

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**Fiscal Summary**

**State Effect:** State retiree health liabilities increase by approximately \$2.36 billion over 30 years, which may negatively affect the State's AAA bond rating. Assuming favorable resolution of the pending federal lawsuit, State expenditures may initially decrease significantly in FY 2021, potentially by as much as \$80.0 million, which reflects savings from providing full prescription drug coverage under the federal injunction. State expenditures then increase by an estimated \$37.0 million in FY 2022 and are assumed to grow annually thereafter according to actuarial assumptions, reflecting the cost of providing reimbursement and catastrophic coverage to many Medicare-eligible retirees instead of terminating their prescription drug coverage altogether. Retiree health expenditures are assumed to be allocated 60% general funds, 20% special funds, and 20% federal funds. General fund expenditures increase by \$60,000 in FY 2020 for related procurement costs, by \$2.15 million in FY 2021 to administer the programs and provide one-on-one counseling services, and by \$3.5 million on an annualized basis thereafter. No effect on revenues.

**Local Effect:** None. The bill applies only to State retirees.

**Small Business Effect:** None.

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## Analysis

### Bill Summary:

#### *Prescription Drug Coverage Programs*

By January 1, 2020, DBM must establish three new prescription drug benefit programs for specified current and future retirees who are enrolled in a Medicare prescription drug benefit plan:

- the Maryland State Retiree Prescription Drug Coverage Program is available only to an individual who (1) retired from the State on or before December 31, 2019; (2) is enrolled in a prescription drug benefit plan under Medicare; and (3) is eligible to enroll and participate in the State Employee and Retiree Health and Welfare Benefit Program (State plan). It reimburses a participant for OOP prescription drug costs that exceed limits established in the State plan, which are currently \$1,500 for an individual and \$2,000 for a family;
- the Maryland State Retiree Catastrophic Prescription Drug Assistance Program is available to an individual who (1) began State service on or before June 30, 2011; (2) retired on or after January 1, 2020; and (3) is eligible to enroll and participate in the State plan. It reimburses a participant for OOP costs after the participant enters catastrophic coverage under the Medicare drug benefit plan; and
- the Maryland State Retiree Life-Sustaining Prescription Drug Assistance Program, which is provided automatically to an individual who (1) is eligible to enroll and participate in the State plan and (2) is enrolled in either of the two prescription drug cost reimbursement plans described above. It reimburses a participant for OOP costs for a life-sustaining drug that is covered under the State plan but is not covered under the individual's Medicare prescription drug plan.

For all three programs, a participating retiree may elect to cover a spouse and dependent children; surviving spouses and children of retirees are also eligible to participate in the three programs. The three programs may include a health reimbursement account (HRA) established in accordance with the Internal Revenue Code or another program that provides assistance with prescription drug costs. All three programs may set different OOP limits or

reimbursement amounts for retirees or beneficiaries who qualify for a partial State premium subsidy (rather than a full subsidy). Eligible participants may enroll in the Prescription Drug Coverage Program or the Catastrophic Prescription Drug Assistance Program during the open enrollment period or any special enrollment period; if they enroll in either of those programs, they are automatically enrolled in the Life-Sustaining Prescription Drug Assistance Program.

It is the intent of the General Assembly that DBM establish the reimbursement programs in a manner that allows retirees to receive reimbursement at the time when they purchase a prescription drug, through a mechanism such as debit cards.

DBM is authorized to carry out an emergency procurement for (1) staff to carry out the provisions of the bill and (2) a third party to administer HRA accounts. DBM must adopt regulations to implement the bill.

### *Counseling Services*

DBM must ensure that Medicare-eligible State retirees have access to one-on-one counseling that assists them in selecting a Medicare Part D prescription drug plan based on the retiree's specific medical and medication needs. DBM must develop a plan to communicate (1) the availability of the three reimbursement programs established by the bill and (2) services and information regarding prescription drug benefit plans under Medicare.

### *Implementation Schedule*

If the final resolution of the federal injunction (discussed below) occurs less than nine months before the beginning of the State's next open enrollment period:

- State-funded prescription drug benefits for Medicare-eligible retirees that were in effect prior to January 1, 2019, continue until the beginning of the *second* State health benefit plan year following the resolution of the injunction;
- the bill's three new prescription drug coverage programs take effect on the same day that existing coverage ends; and
- required notices must be provided to State retirees.

If the final resolution of the federal resolution occurs nine or more months before the beginning of the State's next open enrollment period, existing coverage ends and the new plans take effect on the first day of the *next* plan year following the resolution of the injunction.

### *Reporting and Notification Requirements*

By September 1, 2019, DBM must provide written certified notice of the bill's provisions to affected State employees and retirees.

By December 31, 2019, DBM must submit a report to the budget committees on the plan to implement the bill's provisions. The report must include:

- options for providing one-on-one counseling;
- plans for holding seminars in every county of the State;
- plans for providing access to an interactive website that provides related information; and
- plans for providing a toll-free hotline.

DBM must also submit quarterly status reports to the Governor and specified committees of the General Assembly on the implementation of the bill's provisions. It is the intent of the General Assembly that DBM attend at least one meeting each year of the Joint Committee on Pensions to provide an update on the implementation of the bill's provisions.

**Current Law/Background:** The State plan is established in statute to provide health insurance benefit options to State employees and retirees. The Secretary of Budget and Management is charged with developing and administering the program, including selecting the insurance options to be offered.

Health benefits provided to retirees are often referred to as Other Postemployment Benefits (OPEB) to distinguish them from pension benefits.

### *Eligibility for Coverage and Subsidies*

Upon their retirement, and provided they receive a retirement allowance from the State Retirement and Pension System, retired State employees may enroll and participate in any of the health insurance options provided by the State plan. Until the enactment of Chapter 397 of 2011, this had allowed retired State employees to retain the same health coverage they had as active employees. In addition, active State employees earn eligibility for a partial State subsidy of the cost of health insurance coverage when they retire.

Chapter 397 established new eligibility requirements for retirees to enroll in the State plan and qualify for the premium subsidy if they are hired on or after July 1, 2011. Therefore, the eligibility requirements to enroll in the State plan are different for those who began employment with the State before July 1, 2011, and those who began employment with the

State on or after that date. Employees hired *before* July 1, 2011, are eligible to enroll and participate in the group coverage when they retire if they have:

- retired directly from the State with at least 5 years of service;
- retired directly from State service with a disability;
- ended State service with at least 16 years of service;
- ended State service with at least 10 years of creditable service and within 5 years of retirement age; or
- ended State service on or before June 30, 1984.

Employees who began employment with the State *on or after* July 1, 2011, are eligible to enroll in the State plan if they:

- retire directly from the State with at least 10 years of service;
- retire directly from State service with a disability;
- end State service with at least 25 years of service; or
- end State service with at least 10 years of creditable service and within 5 years of normal retirement age.

Similarly, eligibility for the premium subsidy differs depending on when the retiree began employment with the State. A retiree hired *before* July 1, 2011, must have at least 16 years of service to receive the same subsidy of health insurance premiums that is provided to active employees:

- 80% of preferred provider organization (PPO) premiums;
- 83% of point of service premiums; and
- 85% of premiums for exclusive provider organizations (EPOs) and integrated health models.

If a retiree has fewer than 16 years of State service (but at least 5 years), the benefit is prorated. A retiree hired *on or after* July 1, 2011, must have 25 years of service to receive the same subsidy as that provided to active employees. If a retiree has fewer than 25 years (but at least 10), the benefit is prorated.

#### *State Retiree Prescription Drug Benefits*

As noted earlier, Chapter 397 made changes to OPEB coverage provided to State retirees, particularly in the area of prescription drug coverage. First, it authorized the State to establish health insurance benefit options for retirees that differ from those for active State employees. In addition, Chapter 397 increased the share of the premium for prescription

drug coverage paid by retirees from 20% to 25% (it remained 20% for active State employees) and raised OOP limits for retirees to \$1,500 for a single retiree and \$2,000 for family drug coverage (previously, the limit had been \$750 for single or family coverage for both active employees and retirees). Finally, it eliminated State prescription drug coverage for Medicare-eligible retirees in fiscal 2020. Fiscal 2020 was the year that improvements to Medicare Part D prescription coverage enacted by the federal Patient Protection and Affordable Care Act (ACA) were to be fully phased in, allowing Medicare-eligible retirees to get comparable prescription coverage through Medicare instead of from the State.

In response to the new authority to establish separate coverage for retirees, DBM established a new Employer Group Waiver Plan, effective January 1, 2014, to provide prescription drug coverage to Medicare-eligible retirees. Employer Group Waiver Plans are authorized under the 2003 Medicare Prescription Drug Modernization Act and essentially “wrap” employer coverage around the Medicare Part D prescription drug coverage. Participating retirees do not have to actively make any change in their coverage because all interactions between the State plan and Medicare are handled administratively.

In accordance with Chapter 397, State prescription drug coverage for Medicare-eligible retirees was to end July 2019. However, because the improvements to Medicare Part D coverage under the ACA were accelerated, and because the State plan year begins on January 1 of each year, Chapter 10 of 2018 (the Budget Reconciliation and Financing Act) accelerated the date coverage would end to January 1, 2019. Chapter 10 also clarified that a non-Medicare-eligible spouse, surviving spouse, dependent child, or surviving dependent child of a Medicare-eligible retiree may remain enrolled in the State prescription drug plan even if the retiree is no longer eligible. Finally, it required the Secretary of Budget and Management to provide written notice to individuals affected by the change in the State prescription drug plan.

### *Federal Lawsuit*

In response to the notice of the impending expiration of the State prescription drug benefits, several retirees filed a lawsuit in federal court challenging the State’s action on the grounds that it is an unconstitutional breach of contract. On October 16, 2018, the federal court issued a temporary restraining order and preliminary injunction preventing the State from terminating coverage until the lawsuit is resolved. As a result, State prescription drug coverage is currently in effect.

State and federal courts have not consistently recognized a contractual obligation that protects retiree health benefits from diminution or infringement when they are established in statute. In the absence of relevant case law in Maryland, a 2005 opinion of the Maryland Attorney General concluded that “the statute does not create a contractual obligation and

the General Assembly remains free to amend the law that provides such benefits.” It also found that cases in other states had reached various conclusions, including, in some cases, recognizing a vested right to health benefits for retirees. But the Attorney General advised that such cases had limited application in Maryland because they were based on particular state constitutions, collective bargaining agreements, or circumstances in other states. In 2014, a federal district court in California ruled against retired employees of Orange County, finding that county ordinances, resolutions, and other documents did not create an implied vested right to a specific health benefit.

### *Medicare Part D Coverage Model*

The standard Medicare Part D coverage model includes a \$415 deductible that must be paid before coverage begins. The plan then requires a participant to pay a 25% coinsurance on all prescription drugs until OOP costs reach the catastrophic coverage threshold of \$5,100 in a calendar year (including the deductible). However, because participants get credit for prescription drug rebates negotiated by Medicare, *actual* OOP costs are about \$3,000 before reaching the catastrophic coverage threshold. Under catastrophic coverage, participants pay a 5% coinsurance indefinitely.

Based on Medicare-eligible retirees’ claims costs in calendar 2017, DBM estimates OOP costs increase under Medicare Part D for 36,223 Medicare-eligible retirees, spouses, and dependents, with almost 40% of all retirees and beneficiaries experiencing an annual increase of less than \$500; however, 267 participants see their OOP costs increase by more than \$10,000. Conversely, 8,946 State retirees and beneficiaries (almost 20%) will pay less under Medicare Part D coverage. **Exhibit 1** provides the breakdown of expected OOP changes to Medicare-eligible retirees as a result of the transition to Medicare Part D coverage.

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**Exhibit 1**  
**Effects of Transition to Medicare Part D on Retiree Out-of-pocket Costs**  
**for Medicare-eligible Retirees**  
**Calendar 2017 Claims Data**

	<u>Participants</u>	<u>% of Retirees</u>
Lower Out-of-pocket Costs Under Part D	8,946	19.8%
<b>Out-of-pocket Cost Increases</b>		
\$0-\$500	17,894	39.6%
\$500-\$1,000	7,116	15.8%
\$1,000-\$1,500	4,005	8.9%
\$1,500-\$2,000	2,163	4.8%
\$2,000-\$5,000	3,525	7.8%
\$5,000-\$10,000	1,253	2.8%
Over \$10,000	267	0.6%
<b>Total</b>	<b>45,169</b>	<b>100.0%</b>

Note: Numbers may not sum to total due to rounding.  
Source: Department of Budget and Management

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*Prescription Drug Coverage Under Medicare Part B*

Medicare Part B, which generally provides insurance coverage for outpatient medical care, also provides coverage for some prescription drugs not covered by Part D. Specifically, Part B reimburses 80% of the cost of, among other drugs:

- specified injectable and infused drugs;
- drugs used with an item of durable medical equipment;
- oral end-stage renal disease drugs; and
- specified oral cancer drugs.

Under current State plan requirements, Medicare-eligible State retirees must participate in Medicare Part B as a condition of maintaining their medical coverage under the State plan because the State plan serves as a supplement to Medicare Parts A and B. DBM advises that many drugs not covered by Part D that likely qualify as “life-sustaining drugs” under the bill are covered by Part B. Moreover, retirees enrolled in the State PPO plans are reimbursed for half of their OOP costs for those medications (*i.e.*, half of their 20% coinsurance payment), and those enrolled in the EPO plans are reimbursed for all of their OOP costs for those medications.

## **State Fiscal Effect:**

### *Other Postemployment Benefits Liabilities*

The decision to terminate prescription drug coverage for Medicare-eligible retirees under Chapter 397 was driven by concerns about the long-term sustainability of the program if the State's long-term OPEB liabilities were not reduced. Chapter 397 successfully reduced these liabilities. Prior to the Act, the State's total unfunded OPEB liabilities were calculated at \$15.9 billion over 30 years and were consistently noted as a negative factor by bond rating agencies. As the State does not prefund OPEB costs in the same manner that it does pension obligations, the liabilities loomed as a costly future obligation that the State could not afford over the long term. The provision of prescription drug coverage to Medicare-eligible retirees represented one of the single greatest components of that long-term liability. Following the enactment of Chapter 397, which included other liability-reducing provisions, the State's OPEB liabilities dropped by almost half, to \$8.2 billion. The Medicare prescription drug provisions accounted for about \$5.5 billion of the total \$7.7 billion reduction.

Since then, the Governmental Accounting Standards Board (GASB) has changed the way OPEB liabilities are calculated, and health care costs have continued to climb. Together, these two factors have caused the State's OPEB liability to increase since Chapter 397 was enacted. As of July 1, 2018, the State's *net* OPEB liability is \$10.7 billion (and the *total* OPEB liability is \$11.1 billion), which accounts for the continuation of prescription drug coverage for the second half of fiscal 2019 due to the federal court injunction.

DBM's consulting actuary projects that the provision of prescription drug reimbursement coverage and catastrophic coverage under the bill increases the State's net OPEB liability by \$2.36 billion. Under the new GASB accounting rules, the full liability is reflected on the State's balance sheet so an increase of that magnitude has the potential to negatively affect the State's AAA bond rating. Any such effect is not reflected in this analysis but could be meaningful.

### *Life-Sustaining Prescription Drug Assistance Program*

Many of the drugs likely to qualify as life-sustaining drugs under the bill are quite expensive, sometimes costing more than \$5,000 for a one-month supply. However, as noted above, DBM advises that many of the life-sustaining drugs not covered by Medicare Part D are covered by Part B. Together, Part B and the State plan cover either 90% or 100% of the cost of these drugs. Thus, the State's actuary assumes that the full cost of life-sustaining drugs is covered by either Medicare Part B or Part D, and that the State does not incur any additional cost for those prescriptions. To the extent that retirees incur some

OOP costs for those prescriptions, the State may incur some additional costs to reimburse retirees for those expenses, but any such liability is not expected to be meaningful.

### *Annual Costs of Prescription Drug Coverage Programs*

Calculation of the bill's effect on the State's expenditures for retiree prescription drug coverage is complicated by two factors. First, the federal injunction requires the State to maintain coverage despite current State law, and the injunction remains in effect for an indeterminate amount of time (until the lawsuit is resolved). Second, the State plan year begins on January 1, but the State fiscal year begins on July 1. In accordance with the implementation schedule in the bill, this analysis assumes that changes in coverage are made only at the beginning of each plan year, so any change in coverage levels and expenditures affects only half of the first fiscal year.

The bill requires the State to establish the new programs effective January 1, 2020; until then, the injunction is likely to remain in effect, so the bill has no immediate fiscal effect. Assuming that the lawsuit is resolved in the State's favor before April 2020 (*i.e.*, more than nine months before the 2021 plan year), the new programs will take effect for the second half of fiscal 2021 (January 1, 2021, through June 30, 2021) at a prorated (half-year) cost of approximately \$18.0 million. The current coverage maintained by the injunction is projected to cost approximately \$98.0 million for a half year of coverage in fiscal 2021, so the bill would represent a considerable savings in fiscal 2021.

In fiscal 2022, the coverage programs in the bill are expected to cost approximately \$37.0 million on an annualized basis. As current law in the absence of the injunction anticipates no State costs for Medicare-eligible retirees, State expenditures increase by approximately \$37.0 million in fiscal 2022 and are assumed to increase annually according to actuarial assumptions. If the lawsuit is resolved in the plaintiff's favor, the bill has no effect because the State must maintain existing coverage. If the lawsuit is not resolved prior to April 2020, any potential fiscal effect is delayed and contingent on a favorable ruling for the State. In general, State retiree medical costs are assumed to be allocated 60% general funds, 20% special funds, and 20% federal funds.

### *Program Administration and Counseling Services*

DBM advises that the annual cost of contracting for the administration of HRAs for approximately 50,000 plan participants is estimated to be \$3.5 million (based on per-member fees ranging from \$60 to \$80). In fiscal 2021, HRAs are needed only for half the year at a cost of \$1.75 million; beginning in fiscal 2022, the annualized cost is \$3.5 million.

DBM further advises that the cost of providing one-on-one counseling services to Medicare-eligible retirees is approximately \$400,000 in the first year for start-up costs. Assuming that affected retirees must enroll in Part D beginning January 1, 2021 (as discussed above), counseling is assumed to begin July 1, 2020, providing a six-month lead time for all 50,000 Medicare-eligible participants to decide which Part D plan is best for them. Therefore, general fund expenditures increase by \$400,000 in fiscal 2021. To the extent that the timeline for retirees to enroll in Part D is delayed, the cost is delayed; out-year costs are assumed to be minimal as the number of new retirees requiring counseling will decrease substantially. If full State prescription drug coverage is maintained as a result of the court's decision, these costs are not incurred.

DBM anticipates a one-time cost of \$60,000 in fiscal 2020 for its consulting actuary and plan administrator to assist in the development of an emergency procurement to administer HRAs.

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### **Additional Information**

**Prior Introductions:** None.

**Cross File:** HB 1120 (Delegate Carey, *et al.*) - Appropriations.

**Information Source(s):** Department of Budget and Management; Kaiser Family Foundation; Department of Legislative Services

**Fiscal Note History:** First Reader - February 25, 2019  
sb/vlg Third Reader - March 18, 2019  
Revised - Amendment(s) - March 18, 2019  
Revised - Updated Information - March 19, 2019  
Enrolled - May 8, 2019  
Revised - Amendment(s) - May 8, 2019  
Revised - Updated Information - May 8, 2019

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