SENATE BILL 578

STATE PRESCRIPTION DRUG BENEFITS - RETIREES

Senate Budget and Taxation Committee
March 2, 2022

Testimony of
William A. Kahn

Favorable

My name is William A. Kahn, 83 years old, I retired on December 31, 2003 from the Office of the Maryland Attorney General. I served for 26 years as an assistant attorney general, the last 20 years as the head of the Office's Contract Litigation Unit.

Senate Bill 578 reinstates the State's retirees prescription drug plan (the "State Plan") but only for those retirees and employees who were hired before July 1, 2011 (the "pre-2011 hires"). This is a limited population that, with the passage of time, will decrease to zero, as will the State's expenditures for them. The State's obligation to these retirees is close-ended and, as explained below, is very affordable.

Why have so many pre-2011 hires been pressing so hard to avoid being off-loaded onto Medicare Part D, even with the three State reimbursement programs enacted in 2019 but not implemented because of the federal court's 2018 preliminary injunction?[1] Each of us may have slightly different reasons but one that we have in common is that, when we were hired and during our employment, we were told and understood that the benefits we had as employees would continue into our retirement, in effect, as deferred compensation. In essence, this was a promise made to us which should be honored on both moral and legal grounds.[2]

The General Assembly took our views into account by enacting Chapter 767 (Laws of Maryland 2019) which would replace the State plan with three State reimbursement programs superimposed on Medicare Part D. This was an attempt to limit retirees' out-of-pocket costs. For one, I am appreciative of this consideration given us but it is necessary to say that, unfortunately, this is an imperfect solution that does not come nearly close enough to the benefits of the State Plan that were promised to us.

Medicare Part D - An Overview

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[1]The injunction was issued in *Fitch v. Maryland*, Civ. No. PJM-18-2817 (D. Md), in September, 2018. Previously, in May, 2018, by letter, the Department of Budget and Management had notified retirees that the State Plan would terminate at year-end. Retirees were alarmed. They also were surprised; this was the first that they had heard of the termination. The reason is that the legislation that provided for this termination had been buried in the 145-page Budget and Reconciliation Financing Act of 2011. Chapter 397 (Laws of Maryland, 2011) at 57-64.

[2]Retirees relied on this promise in many ways, from when they were hired until they retired. For example, some had an option to rely on a spouse's benefits but chose State benefits. Some had an option at retirement of a larger pension allowance that would not carry forward, with the attendant State post-employment benefits to a spouse, but instead chose a lower allowance so that a spouse would be covered by both the pension and the benefits.

While Medicare Part D may be good for Medicare-eligibles who otherwise would have no insurance for prescription drugs, it is a confusing, cumbersome, burdensome, and risky alternative to the State Plan. It is an alternative that each retiree will have to contend with, again and again, each and every year. If a picture is worth a thousand words, please look at the exhibit that is attached. This is a chart from Medicare & You 2022. Currently, there are 21 Medicare Part D plans available to Maryland residents. The chart gives a summary of those plans, including information on premiums, deductibles, co-payments and co-insurance.

You will see that the per person premiums range from a low of $7.10 per month, or $85.20 per year, for Silverscript SmartRx, to a high of $100.60 per month, or $1,207.20 per year, for AARP MedicareRx Preferred. For a retiree and spouse, the Medicare Part D annual premium ranges from $170.40 to $2,414.40. (These premiums are not out-of-pocket costs and therefore would not be reimbursable under the 2019 programs.) Under the State Plan, the premium for retiree and spouse, both Medicare-eligible, is $73 per month, or $876 per year.

Most Medicare Part D plans have a $480 deductible; three do not have any deductible. One has a deductible of "$100 some drugs; call plan;" another has "$310 some drugs; call plan." The State Plan has no deductible.

All Part D plans have variable co-payments for lower cost (lower tier, generic) drugs and variable co-insurance for higher cost (higher tier) drugs. Co-insurance for these higher cost drugs is significant, ranging from 15% to 50%. Co-payment and co-insurance are for only a 30-day supply.

Contrast the State Plan, which has no co-insurance and only fixed co-payments and, depending upon the participant's choice, co-payments for either a 45-day or 90-day supply. The fixed 90-day co-payments (twice the 45-day co-payments) are:

Generic	$20
Preferred brand name	$50
Non-preferred brand name	$80

If a retiree needs and orders a 90-day supply of a non-preferred brand name medication, the effective co-payment for a 30-day supply is $80 divided by 3 or $27. This is very substantially less than the co-insurance or co-payments for the highest tier drugs under Medicare Part D.

Moreover, for five classes of drugs, for specified generic medications, there are zero co-payments. See Department of Budget and Management's 2022 version of "Guide to your Health Benefits at 21.

And Medicare Part D plans have the infamous coverage gap where the norm is 25% coinsurance. There is no coverage gap in the State Plan.

The foregoing is the relatively easy part of coping with Medicare Part D. The more difficult part is dealing with the difference in plan formularies, which creates inordinate difficulty in the very personal decision to select a Part D plan each and every year.

To explain this difficulty, I would like to start with my own experience with the State Plan.

The Formulary

My wife of 24 years, who unfortunately passed away in 2017, was diagnosed with an auto-immune disease known as scleroderma and with end-stage kidney disease, as well as a number of related and unrelated medical issues. She was on many medications; some were relatively cheap and some were very expensive. As to some of these medications, she experienced serious adverse effects that necessitated substituting prescriptions for different drugs. The State Plan covered each and every one of them.

This taught me how very comprehensive the formulary is, i.e., the list of drugs covered by the State Plan. Only a few of those drugs - the anti-rejection drugs prescribed for her after a successful kidney transplant - could be considered life-sustaining. However, these other medications, while individually not "life-sustaining", collectively were life-sustaining; they controlled the nasty effects of scleroderma, allowed her to live into her 81st year, and enabled us to lead reasonable quality lives together.

I am very grateful for the State Plan, which, unlike Medicare Part D plans, covered all of my wife's medications with no hassle and no significant burden. My view, I believe, is typical of every other retiree who participates in the State Plan.

The key here is the State Plan's formulary. Since the sunset legislation in 2011, no one has opined, nor could, that Medicare Part D plans are as comprehensive as the State Plan formulary. All that any so-called expert can tell you is whether a particular Part D plan covers all or just some of the medications you take today. Whether the plan you choose will cover a drug prescribed for you after you enroll is a huge gamble. That is not the case with the State Plan.

It is this notion of formulary and its comprehensiveness that makes the State Plan very important to all of us.

Part D Plan Selection

As mentioned earlier, currently, there are 21 Medicare Part D plans available to Maryland residents, with 21 different formularies and 21 combinations of premiums, deductibles, co-payments and co-insurance.. This maze of options is what one must navigate to contend with the burdens of Medicare Part D.

Medicare does provide a web site that is time-consuming to use but can help a little. Create an account, enter the drugs you are currently taking and up to five preferred pharmacies, and the site will identify the plans that cover your current medications as well as the associated premiums and out-of-pockets costs.

However, there is no way to compare the comprehensiveness of the plans and their respective formularies, so that you can judge whether the insurance is good enough to protect you against lack of coverage for future prescriptions. (Medicare requires that plans cover at least two drugs in each category and class, which is not much of an assurance since it allows a Part D plan formulary to be very narrow and minimal.[3]) Anecdotally, however, we know that there are major differences among those plans and, again anecdotally, we know that the State Plan is superior. Despite an internet search, I found nothing that would help to differentiate plans on the basis of formulary nor is there a source that offers to do anything more than the Medicare Part D web site does.

Medicare Part D excludes from all Part D plans certain categories of drugs Among them are drugs prescribed for:

1. anorexia
2. weight gain (including for obesity)
3. weight loss
4. relief of cough or cold (even drugs available only by prescription)
5. sexual or erectile dysfunction

The State Plan provides coverage in these categories.

Part D plans are free to change their formularies every year and each of us would have to go through a plan selection process each and every year. Annually, we would be faced with the question, what do my spouse and I get in the way of insurance for an annual premium of $85.20 or $2,414.40. The answer is that there is no way to know.

Plan selection is a very worrisome aspect of Medicare Part D. This is not true of the State Plan.

We Are Affordable

The Fiscal and Policy Note for Senate Bill 578 is opaque as to the State's cost for retirees' prescriptions. Moreover, the note contains no information on the difference in cost between maintaining retirees on the State Plan over the State's cost for Medicare Part D with

[3]Part D plans are encouraged to use the U. S. Pharmacopeia model system for classifying drugs into therapeutic categories and classes; however, subject to federal approval, Part D plans "may define categories and classes as they wish." Huskamp and Keating, *The New Medicare Benefit: Formularies and Their Potential Effects on Access to Medications*, Journal of General Internal Medicine, July 2005, at 663, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1403290 : Center for Medicare and Medical Services, *Medicare Prescription Drug Benefit Manual*, Chap. 6 (Rev. 18, Jan. 15, 2016) § 30.2.1. "If a plan defines a class broadly (e.g., drugs that influence the angiotensin–renin system) instead of narrowly (e.g., angiotensin receptor blockers [ARBs]), the formulary could cover fewer drugs for certain conditions," Huskamp at 663, especially because the plan need not offer more than two drugs in each class.

2019's three-program overlay. Rather, the note only projects increases in retirees' prescription drug **claims** and even these are uncertain.

Nonetheless, less than 40 percent of the dollar value of retirees prescription drug claims are a cost to the State. We know this from the fiscal note to 2020 House Bill 1230, which stated that, of the $313.1 million in projected 2022 retirees' prescription claims, the State's share would be $119.4 million (because the State Plan remained in effect). Thus, the State's cost was only 38 percent of total claims.

In that same fiscal note, the Department of Legislative Services projected that the State would be paying $37 million if the three 2019 programs superimposed on Medicare Part had been implemented.[4] Therefore, if the State could have off-loaded pre-2011 hires, the State would have saved $82.4 million in 2022.

The Senate Bill 578 fiscal note contains actuarially projected claims increases of $40.5 million in calendar year 2023 and 51.0 million in calendar 2024. Using the experienced rate for the cost to the State of 38%, the State's projected cost increase would be $15.4 million and $19.4 million, respectively. So, if the State could have off-loaded pre-2011 hires, the State would expect to have saved $82.4 million in 2022, and $97.8 million in 2023 and $101.8 million in 2024. In future years, this saving would fluctuate depending upon inflation, population increases that result from retirements, and population decreases because of retiree deaths. Because of the latter, sooner or later, the State's cost will go to zero.

This cost is very small for several reasons. First is the promise made to State employees for the dedicated service that we retirees delivered. The prescription drug benefit is, in fact, deferred compensation that we earned. Second, the State has paid the cost of this benefit every year in memory and no one ever has said or even argued that the current year cost was unaffordable. Third, in the context of a General Fund budget proposed as $58.2 billion for fiscal year 2023, $82.4 million represents a mere 0.014 percent of State expenditures; $97.8 million represents a mere 0.016 percent; and $101.8 million represents a mere 0.017 percent. Thus, continuing this benefit will have a negligible impact on State budget priorities.

To say that retirees are not worth less than 0.02 percent of annual expenditures – after decades of service to the State -- is to relegate State retirees to a very low rung in the context of State budget priorities. Moreover, it would fly in the face of the federal court's December 30, 2021 ruling that the State is bound to its retirees by a unilateral contract embedded in statute.

Maryland's AAA Bond Rating

In 2011 and in subsequent years, the proponents of off-loading State retirees onto Medicare Part D have raised the specter of Maryland losing its AAA credit rating because of long term costs of the State Plan. It was said that "failure to act may endanger the State's AAA

[4]No implementation plans ever were outlined, even when the members asked Department of Budget and Management Secretary David Brinkley directly in a briefing to the Joint Committee.

bond rating . . ."[5] Initially, it was proposed to off-load retirees immediately but, in the face of strenuous opposition, the Budget and Reconciliation Financing Act of 2011 was amended to postpone the termination until 2020, subsequently moved forward to the end of 2018.

The stated impetus was a change in government accounting principles adopted by the Government Accounting Standards Board ("GASB") in 2005. The thrust of this change was that Maryland and other states (and other governments) should account for their Other Post-Employment Benefits ("OPEB") in essentially the same way as private businesses - despite the significant differences between them, including a state's revenue generating activities and capabilities. Pursuant to GASB guidelines, Maryland has included with its balance sheet the present value of expected annual costs of the State Plan and other OPEB programs over a long term; this present value is called an unfunded OPEB liability. GASB guidelines also provide that, to sustain these long term costs, a government should set up an OPEB trust and annually fund that trust to cover current year OPEB costs plus an amount to cover a portion of future OPEB costs. This latter amount is referred to as pre-funding. If implemented, pre-funding would have been a departure from Maryland's pay-as-you-go policy for OPEB costs.

Maryland set up an OPEB trust in 2005 but, except for pre-funding in fiscal years 2007, 2008, and 2009, it has not departed from its pay-as-you-go policy. So, the fiscal notes continue to include reference to an unfunded OPEB liability and adds that this "may negatively affect the State's AAA bond rating."[6] But maybe not.

In truth, that has not happened yet. The size of the State Plan liability, or indeed of all OPEB liability, is not going to be solely responsible for a change in credit rating. This is because the rating agencies view those liabilities in the overall context of Maryland's balance sheet and its economic environment and, as has been cogently explained to this Committee in 2019, GASB never intended that its change in financial reporting requirements should be used to justify diminishing of OPEB benefits. See Exhibit 2, the March 3, 2019 written testimony of Edward R. Kemery, PhD, in the file of Senate Bill 193 (2019 session).

Notably, four states, Georgia, North Carolina, Texas, and Delaware, each having a significantly larger unfunded OPEB liability than Maryland, have continued to maintain their AAA bond ratings from each of the three major rating agencies.

So, it is worth repeating that the size of the State Plan liability alone is not sufficient to affect credit agency ratings. These agencies do not view unfunded liability in isolation. They look at it in the overall context of Maryland's balance sheet, its financial management record, and its economic environment. Surely, these agencies might prefer that all states pre-fund their OPEB liabilities and they may quibble if a state does not. However, that Maryland continues its pay-as-you-go policy in spite of this preference has not affected the agencies' judgment that Maryland is worthy of a AAA rating.

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[5]Public Employees' and Retirees' Benefit Sustainability Commission Interim Report at 25 (January 2011).

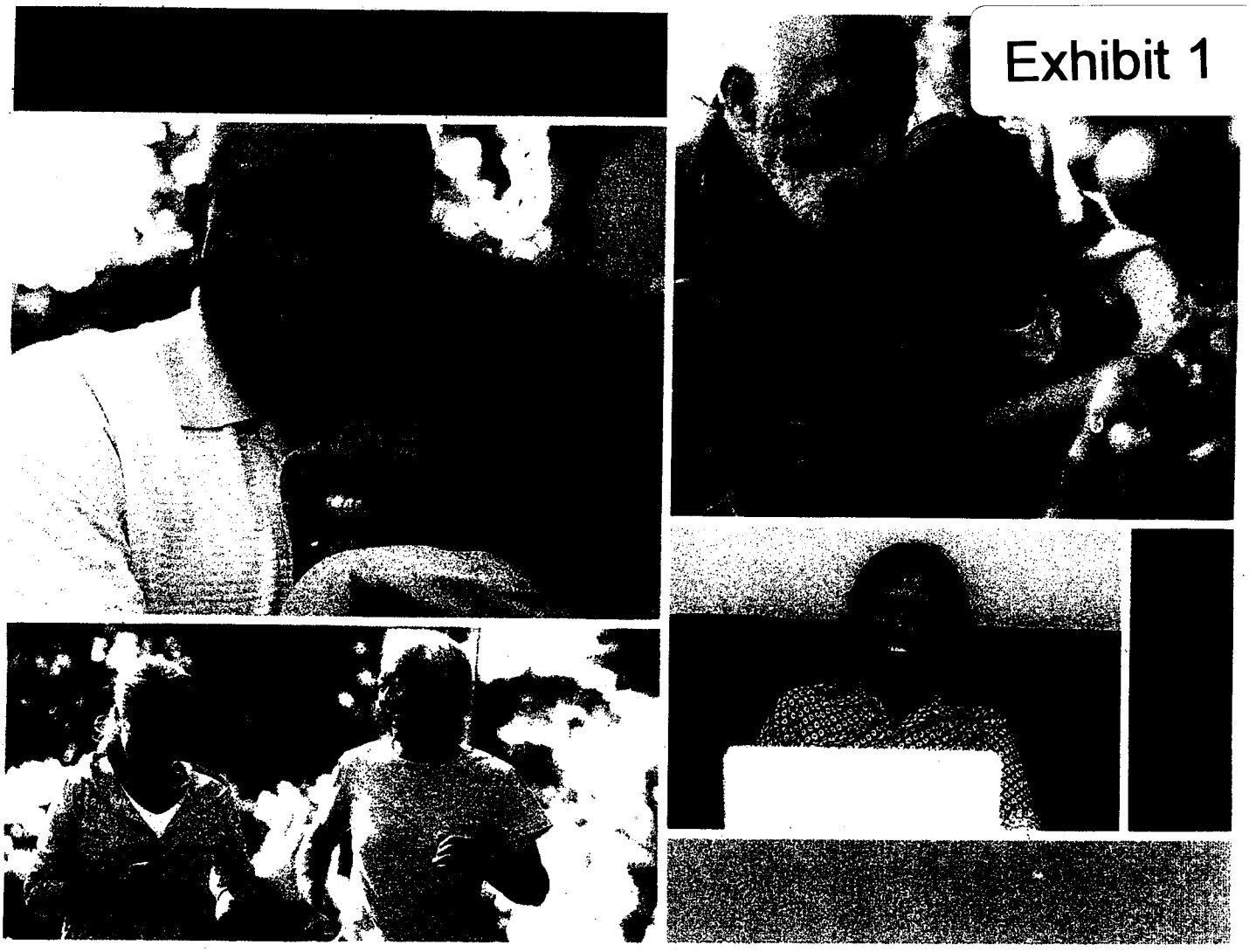
[6]Fiscal and Policy Notes, Senate Bill 946 and House Bill 1120 (2019 session) at 1; see also these Notes at 6.

Conclusion

Senate Bill 578 is a good solution to the retiree prescription drug benefits issue. It is good for the State and for its pre-2011 hires. If enacted, it also will represent a settlement of the Fitch litigation that is reasonable and fair for all.

Please issue a favorable report on Senate Bill 578.

Exhibit 1



Medicare & You 2022

The official U.S. government Medicare handbook

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Medicare PRESCRIPTION DRUG PLANS in Maryland

This chart provides basic information about what your costs will be for each plan. See page 128 for information on how to read this chart. Contact the plan for specific details. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to compare plans or look for a plan that isn't listed. TTY users can call 1-877-486-2048. See page 9 to find out how to get personalized help when choosing a plan.

Plan Name	Monthly Premium*	Annual Deductible	Amount You Pay for Each Prescription (1-month supply)*	Coverage During the Gap
Aetna Medicare (S5601) **Members' Rating of Plan: 83%**				**www.aetnamedicare.com**
SilverScript Choice (PDP) (010) Phone: 833-526-2445	$30.50	$480 some drugs; call plan	$0 - $20 Copay and/or 17% - 37% Coinsurance	Standard cost-sharing applies: 25% Coinsurance
SilverScript Plus (PDP) (011) Phone: 833-526-2445	$66.50	$0	$0 - $47 Copay and/or 33% - 50% Coinsurance	$0 - $10 Copay and/or 25% Coinsurance
SilverScript SmartRx (PDP) (180) Phone: 833-526-2445	$7.10	$480 some drugs; call plan	$1 - $47 Copay and/or 25% - 50% Coinsurance	Standard cost-sharing applies: 25% Coinsurance
Cigna (S5617) **Members' Rating of Plan: 84%**				**www.cignamedicare.com**
Cigna Essential Rx (PDP) (284) Phone: 800-735-1459	$31.20	$480 some drugs; call plan	$0 - $20 Copay and/or 18% - 43% Coinsurance	Standard cost-sharing applies: 25% Coinsurance
Cigna Extra Rx (PDP) (250) Phone: 800-735-1459	$58	$100 some drugs; call plan	$0 - $47 Copay and/or 31% - 50% Coinsurance	$4 - $20 Copay and/or 25% Coinsurance
Cigna Secure Rx (PDP) (214) Phone: 800-735-1459	$33.30	$480 some drugs; call plan	$0 - $45 Copay and/or 25% - 50% Coinsurance	Standard cost-sharing applies: 25% Coinsurance

* If you qualify for Extra Help, your monthly premium and the amount you pay for each prescription may be less than the amounts listed in these columns. Contact the plan for specific formulary (list of covered drugs) and cost information. If you qualify for the full Extra Help and the premium amount is BLUE, your premium for that plan will be $0.

Medicare PRESCRIPTION DRUG PLANS in Maryland

Plan Name	Monthly Premium*	Annual Deductible	Amount You Pay for Each Prescription (1-month supply)*	Coverage During the Gap
Clear Spring Health (S6946) **Members' Rating of Plan: 82%**				**www.clearspringhealthcare.com**
Clear Spring Health Premier Rx (PDP) (031) Phone: 877-317-6082	$17.20	$480 some drugs; call plan	$1 - $47 Copay and/or 25% - 50% Coinsurance	Standard cost-sharing applies: 25% Coinsurance
Clear Spring Health Value Rx (PDP) (002) Phone: 877-317-6082	$29.40	$480 for all drugs	$1 - $47 Copay and/or 25% - 37% Coinsurance	Standard cost-sharing applies: 25% Coinsurance
Elixir Insurance (S7694) **Members' Rating of Plan: 80%**				**www.elixirinsurance.com**
Elixir RxPlus (PDP) (122) Phone: 888-377-1439	$37	$480 some drugs; call plan	$1 - $47 Copay and/or 25% - 49% Coinsurance	Standard cost-sharing applies: 25% Coinsurance
Elixir RxSecure (PDP) (005) Phone: 888-377-1439	$34.90	$480 for all drugs	$1 - $12 Copay and/or 15% - 37% Coinsurance	Standard cost-sharing applies: 25% Coinsurance
Humana (S5884) **Members' Rating of Plan: 84%**				**www.humana.com/medicare**
Humana Basic Rx Plan (PDP) (103) Phone: 800-706-0872	$35	$480 for all drugs	$0 - $2 Copay and/or 19% - 41% Coinsurance	Standard cost-sharing applies: 25% Coinsurance
Humana Premier Rx Plan (PDP) (151) Phone: 800-706-0872	$78.90	$480 some drugs; call plan	$1 - $47 Copay and/or 25% - 49% Coinsurance	Standard cost-sharing applies: 25% Coinsurance
Humana Walmart Value Rx Plan (PDP) (184) Phone: 800-706-0872	$22.70	$480 some drugs; call plan	$1 - $20 Copay and/or 15% - 47% Coinsurance	Standard cost-sharing applies: 25% Coinsurance
Mutual of Omaha Rx (S7126) **Members' Rating of Plan: 80%**				**www.mutualofomaharx.com**
Mutual of Omaha Rx Plus (PDP) (004) Phone: 800-961-9006	$92.10	$480 for all drugs	$1 - $10 Copay and/or 18% - 47% Coinsurance	Standard cost-sharing applies: 25% Coinsurance
Mutual of Omaha Rx Premier (PDP) (074) Phone: 800-961-9006	$35.50	$480 some drugs; call plan	$0 - $20 Copay and/or 23% - 44% Coinsurance	Standard cost-sharing applies: 25% Coinsurance

* If you qualify for Extra Help, your monthly premium and the amount you pay for each prescription may be less than the amounts listed in these columns. Contact the plan for specific formulary (list of covered drugs) and cost information. If you qualify for the full Extra Help and the premium amount is BLUE, your premium for that plan will be $0.

Medicare PRESCRIPTION DRUG PLANS in Maryland

Plan Name	Monthly Premium*	Annual Deductible	Amount You Pay for Each Prescription (1-month supply)*	Coverage During the Gap
UnitedHealthcare (S5820) **Members' Rating of Plan: 84%**				**www.AARPMedicareRx.com**
AARP MedicareRx Preferred (PDP) (004) Phone: 888-867-5564	$100.60	$0	$5 - $47 Copay and/or 33% - 45% Coinsurance	$10 - $20 Copay and/or 25% Coinsurance
UnitedHealthcare (S5921) **Members' Rating of Plan: 78%**				**www.AARPMedicareRx.com**
AARP MedicareRx Saver Plus (PDP) (350) Phone: 888-867-5564	$40.70	$480 for all drugs	$1 - $47 Copay and/or 25% - 40% Coinsurance	Standard cost-sharing applies: 25% Coinsurance
AARP MedicareRx Walgreens (PDP) (387) Phone: 800-753-8004	$29.30	$310 some drugs; call plan	$0 - $45 Copay and/or 27% - 45% Coinsurance	$10 - $20 Copay and/or 25% Coinsurance
Wellcare (S4802) **Members' Rating of Plan: 81%**				**www.wellcare.com/PDP**
Wellcare Classic (PDP) (079) Phone: 888-293-5151	$31.50	$480 for all drugs	$0 - $44 Copay and/or 25% - 39% Coinsurance	Standard cost-sharing applies: 25% Coinsurance
Wellcare Medicare Rx Value Plus (PDP) (208) Phone: 888-293-5151	$68.90	$0	$0 - $47 Copay and/or 33% - 50% Coinsurance	Standard cost-sharing applies: 25% Coinsurance
Wellcare Value Script (PDP) (140) Phone: 888-293-5151	$12.90	$480 some drugs; call plan	$0 - $47 Copay and/or 25% - 50% Coinsurance	Standard cost-sharing applies: 25% Coinsurance

* If you qualify for Extra Help, your monthly premium and the amount you pay for each prescription may be less than the amounts listed in these columns. Contact the plan for specific formulary (list of covered drugs) and cost information. If you qualify for the full Extra Help and the premium amount is BLUE, your premium for that plan will be $0.

Exhibit 2

SENATE BILL 193

STATE PRESCRIPTION DRUG BENEFITS – RETIREE BENEFITS

Senate Budget and Appropriations Committee

March 5, 2019

Written Testimony of
Edward R. Kemery, PhD

In Favor with Amendment

I am Edward R. Kemery. I hold a doctorate in industrial and organizational psychology and a master's degree in forensic studies. I was employed as Professor of Management by the University of Baltimore (UB) for approximately 30 years, retiring in 2017. During my tenure at UB, I taught courses in human resource management. Additionally, I was a Certified Fraud Examiner and, with this background, I taught courses in fraud investigation to accounting students.

I am in favor of Senate Bill 193. It restores State retirees' prescription benefits as they were prior them being eliminated by 2011 legislation. I believe that an amendment to the bill will insure future funding of this post-employment benefit so that retirees will continue to receive it per the State's promise to them – a promise that was made and then broken by the State.

I have read repeatedly that a major driver of the decision to remove retirees' prescription benefits is because the liability they create is not sustainable. The Fiscal Note attached to this bill, estimates the liability of retaining current prescription benefits to be $10.7 billion, and thus argues that it could impact the State's AAA bond rating. The annual cost of the bill estimated as $89.5 million and $187 million in FY 2020 and FY 2021, respectively.

The bond rating impact fear was prompted by a change in the Government Accounting Standards Board (GASB) reporting requirements for Other Post-Employment Benefits (OPEB) liability in 2005. Historically, government financial sheets reported actual (pay-as-you-go) liability. The change in reporting now requires financial disclosure of all (present and future) liability. The effect of this is that OPEB liability, at least on paper, increased dramatically. In "Chicken Little" fashion, legislators used this to get on the bandwagon to reduce the State's OPEB liability. And, the first thing targeted for removal was retiree prescription benefits.

But, is the sky really falling when it comes to OPEB liability and bond ratings?

To answer this question, I conducted research. I reviewed GASB's website, searched online for "OPEB and bond ratings," and reached out to several experts on the matter. From what I learned, I have concluded, and you should as well, that the GASB-OPEB bond rating issue is nothing but a red herring. It follows directly that using this "problem" to eliminate a benefit that retirees were promised, and that they paid for by working their entire careers to earn, simply cannot be justified.

On GASB's website there is a section on OPEBs. Contained within that section is an area titled, *Core Principles and Key Issues*, which contains GASB's position on funding OPEB liabilities, including:

> "...the GASB believes that a government has an obligation to pay OPEB based on the level of retirement benefits promised to an employee in exchange for his or her services.
>
> Even though the obligation is constructive and not legal, a reduction in OPEB could result in adverse consequences for the government or increases in other compensation costs." (Reference 1)

GASB's Statement #75 provides further clarification on a government's obligation to fund OPEBs.

> "Obligations for postemployment benefits (including OPEB and pensions) arise from an exchange between an employer and its employees of salaries and benefits...***The most prominent implication of that conclusion is that an employer incurs an obligation to its employees for OPEB as a result of the employment-exchange transactions.*** (Emphasis mine) The Board's perspective that those transactions should be viewed in the context of an ongoing, career-long employment relationship has implications related to the measurement of the employer's OPEB liability and recognition of OPEB expense." (Reference 2, p. 134)

The State claims that it does not have an obligation to fund OPEBs because of an absence of a contract. GASB's Statement #75 indicates that an obligation to fund OPEBs exist, despite the absence of a contract.

> "The Board believes that reducing OPEB potentially results in adverse consequences for the employer or increases other compensation costs even if the benefits are constructive obligations. Therefore, the Board determined that it would be inappropriate to limit an employer's liability to the legal obligation." (Reference 2, p.140)

Two things become clear when considering GASB's position on funding OPEBs. First, ***GASB believes that a state has an obligation to fund OPEB liabilities.*** In other words, the change in financial reporting prompted by GASB was never intended as a justification for a state to terminate OPEBs. In addition, GASB suggests that there may be adverse consequences subsequent to a decrease in OPEB liability.

I found several pertinent articles online. One article, from *Pensions & Investments* is illustrative, and suggests that the GASB reporting standard has had virtually no impact on credit ratings.

> "It is our view that much of the hand-wringing over the issue is overblown, and that the new GASB reporting scheme will not materially affect the credit ratings of most public plan sponsors. This is because the rating agencies themselves have signaled their understanding that the new GASB reporting rules might be mere window dressing that,

ultimately, does not change the already apparent realities of the marketplace." (Reference 3)

This article was published in April, 2014, some ten years after the GASB standard was implemented. In order to learn what, if anything has changed in the ensuing five years, I conducted an Internet search in order to identify instances in which a state's bond rating was reduced because of OPEB liabilities. I could find none.

Then, I reached out to two financial organizations, Moody Analytics (one of the bond rating organizations) and Odyssey Advisors. In my email to each, I asked if they are able to identify an instance in which a state bond rating was lowered because of OPEB liability. I received replies from each organization. Both email replies did indicate that bond raters take into account OPEBs when determining bond ratings. However, significantly, they were in agreement that they are unable to cite any examples of a state's bond rating being downgraded owing to OPEB liabilities.

It has been 15 years since the GASB standard went into place and the State of Maryland has been consistently underfunding the OPEBs during this time period. In fact, the State has failed to provide any funding to reduce its OPEB liability since 2011. It stands to reason that if unfunded liability were to truly affect the State's bond rating, it would have happened by now.

I encourage every State of Maryland legislator to do his or her own homework on this matter. You owe it to your constituents, not only State retirees, but also current State employees and the citizens of the State who depend upon them daily. If legislators do their homework, I am confident that they will understand that OPEB liability indeed is a red herring when it comes to a negative impact on State bond ratings. Consequently, your only fair and just response is to reinstate the State retirees' prescription benefit plan.

It is noteworthy that the Blue Ribbon Commission to Study Retiree Health Care Funding Options established in 2006, had a legislative mandate to "Recommend a multi-year implementation plan to address fully funding the obligations of the State as set forth in the Governmental Accounting Standards Board's (GASB) Statement 45 as soon as practicable." (Reference 4) For unknown reasons, this mandate did not receive any traction because this Commission did not meet again after submitting its 2008 interim report. Subsequently, the Public Employees' and Retirees' Benefits Sustainability Commission (PERBSC), established in 2010, did not have a similar mandate. Rather than to make recommendations for maintaining retiree benefits, it seems as though PERBSC's mandate was to identify ways to cut existing benefits (Reference 5).

One reason why I am in favor of SB193 is that it does not contain new programs and out-of-pocket caps, the true costs of which are unknown. The costs of maintaining our prescription benefits are well-understood. This means that current and future costs can be budgeted for and funded accordingly. What follows from this is that legislation must be enacted to require the Governor to include pay-as-you-go costs and a portion of OPEB liability in the annual budget. Doing so will insure that the State will be in the position to maintain the level of prescription benefits promised to, and earned by, its retirees.

Senate Bill 193 should receive a favorable report with the amendment I suggested.

References

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