Testimony to GA for SB 578.pdf
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Position: FAV

TESTIMONY IN SUPPORT OF SB 578

My name is Ann Heslin and I started work for the State of Maryland in 1970 when I was a recent college graduate. I worked for low wages with frequent furloughs and suffered through pay freezes for as much as five years straight. The only good reason to remain working for the State was the good benefits. The Health Benefits handbooks stated that retirees would have the same benefits as active employees. This was also stated in pre-retirement seminars. I always understood that this was part of our compensation and I wanted to make certain that my retirement years were as risk-free as possible without unaffordable medical expenses. Of course, the low State wages, led to lower average lifetime earnings when it was time for my Social Security benefits to be calculated.

I am testifying in support of SB 578. This is a Bill that would reverse the effects of the 2011 Budget Reconciliation legislation that eliminated the option for Medicare-eligible state retirees to participate in the State's Prescription Benefits program effective Fiscal 2020 and force them onto Medicare Part D for prescription coverage. SB 578 would be a fair settlement of the Fitch, el al lawsuit against the State for eliminating those Prescription Benefits. The Federal District Court Judge in that case, Judge Peter Messitte ruled in late December 2021 that Medicare-eligible retirees who retired from the State prior to January 1, 2019 DID have a contractual guarantee of State Prescription Benefits throughout their retirement and should continue to receive such benefits. The State has appealed that ruling, as have Parties, Fitch, et al and AFSCME. Fitch, el and AFSCME are fighting for these benefits to be based on when someone started work with the State, not when they retired from the State. There are many people who could have retired years ago and be eligible, according to Messitte's decision, but are unfairly penalized for continuing to work 40 or more years for the State.

My husband and I cannot go back and sign up for prescription coverage through his work with the federal government because he was not using those benefits when he retired. I worked for decades for the State of Maryland as a social worker, primarily doing CPS, Foster Care and Family Preservation, including After-Hours Coverage for nights, weekends and many major holidays.

A major factor in deciding to permanently reduce my pension by selecting a double annuity was so that my husband could continue to enjoy the good State health benefits, including prescription insurance coverage, if I predeceased him. The fact that I gave up something in order to get something certainly sounds as though it is a contract to me.

Medicare Part D does not provide anything close to the prescription insurance coverage that has been provided to retired State employees. It does not cover as many medications, including a medication that I take. It does not cover prescription medications used for anorexia, weight gain, weight loss, relief from cough or cold drugs, or sexual or erectile dysfunction. Different Part D plans provide vastly different price supports for medications. If the State were to provide a prescription benefit that caps out-of-pocket costs for Medicare-eligible retirees, as under the previously passed Maryland State Retiree Prescription Drug Coverage Program and the Catastrophic Prescription Drug Assistance Program, retirees are able to select a Part D plan that costs less per month, but charges a high amount for prescriptions. Under the Retiree Prescription Drug Assistance Program with a cap of $1500 per year for out of pocket prescription costs, the State would reimburse costs over that amount no matter how high the costs are, so there is no incentive to choose a plan that provides better coverage for costs. The Medicare Part D Plan Finder offered me a choice of plans with a total annual cost for my covered ongoing medications of over $5,000 per year to over $26,000 per year. That does not include medications that are used for brief periods because there is no way to calculate such costs using the Plan Finder.

If the State finds that the health benefits provided to employees and retirees are too expensive for the State, I feel it is only fair to change policies for new or not yet vested employees, rather than forcing retirees to choose between bankruptcy or not taking life-saving medications. If medical conditions are untreated, health insurance usage will increase and raise those costs for the State. The State has a huge surplus and the full funding of SB 578 would only cost the State less than 0.02% of the State Budget. Eventually, the State's cost for this program would become zero, as retirees and their dependents die.

Previous objections to providing prescription benefits to retirees included that such costs might affect the State's AAA Bond rating, but the GASB, which provides such credit ratings, stated that retirees should not be cut off from such benefits, instead, there should be prefunding of those benefits by the State making deposits into the Other Post Employment Benefits (OPEB) account. The accumulated interest in that account, if consistently funded, would further reduce costs for the State, but the State has not made any deposits in that account since 2009. Georgia, Texas, North Carolina and Delaware all have unfunded OPEB liabilities that are significantly larger than Maryland's, but they have all maintained their AAA Bond ratings.

The State's current prescription insurance for Medicare-eligible retirees and their dependents is an EGWP (Employer Group Waiver Program) which incorporates Medicare Part D, but provides more coverage with lesser costs for the retiree. By using a EGWP the State receives a significant amount of reimbursement for costs from the Federal Government. Combining the Federal Government reimbursement and the insurance premiums paid by retirees for their EGWP coverage, the State is only paying 38% of the cost of the program. It is not clear from the Fiscal Note whether those Federal Government reimbursements and retiree insurance premiums, revenue for the State, are counted in the estimated $5.7 billion long-term liabilities for the State. During previous testimony in Annapolis, It was unclear whether the State was just happily counting those contributions from the Federal Government and from the retirees' premiums as revenue and then, counting the full cost of the EGWP program in calculating liabilities.

The costs to Medicare-eligible State retirees under individual Medicare Part D plans would be vastly more than under the current group EGWP program. State retirees earned these benefits as part of their overall contractually promised compensation. State employees would never have accepted the comparatively low wages, contrasted with federal, county and private industry salaries for similar work, if it were not for the promise of good health benefits. State employees wanted assurance that when retired, they could afford to pay for needed health benefits even if they developed a high cost medical condition.

The State faces a difficult situation hiring and keeping employees in the current economic climate. That fact should reinforce to the State that you can't run State services with competent staff and not provide adequate compensation to those staff. The State's action in stabbing their former employees in the back by sneakily stealing employee hard-earned compensation during those workers' weakest, most vulnerable years will send a strong message to prospective new employees. Who wants to go to work for an organization that promises compensation and then takes that away in order to spend funds that would have gone to them elsewhere in the State Budget?

The State passed the legislation that eliminated prescription benefits for Medicare-eligible state retirees in 2011 but didn't inform the 90,000 retirees and their dependents until 2018. Employees who sustained an employment-connected disability forcing early retirement were especially aggrieved, including some who had court ordered settlements that included having all health benefits for life. Not many employees and retirees who would be impacted by the 2011 change and not even many lawmakers who voted for the legislation noticed the language that made that change because it was buried in the overall Budget legislation. Not many legislators back in 2011 were made aware of how severely this legislation would impact retirees' financial security. They were told that Medicare Part D would offer comparable prescription coverage, but that is untrue.

Now is the time to right this wrong that was done to the elderly and the disabled former state workers, including those who worked as police officers, correctional officers, university staff, state hospital staff, parole and probation staff, judicial staff and many more who gave the best years of their lives working hard in comparatively low paying jobs for the State. They deserve your vote for SB 578.

Ann L. Heslin, LCSW-C
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SUPPORT SB 578.pdf
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Position: FAV

MARYLAND PROFESSIONAL EMPLOYEES COUNCIL
AFT, AFL-CIO Local 6197

A union of professionals in service to the people of Maryland.

Written Testimony to the Budget & Taxation Committee
SB 578 - State Prescription Drug Benefits – Retirees
March 2, 2022

SUPPORT

Good morning Mr. Chair and members of the Senate Budget and Taxation Committee. On behalf of the Maryland Professional Employees Council, AFT- Local 6197, representing over 5,000 professional employees for the state of Maryland, we ask for a favorable report on SB578. This bill makes sure the state follows through on the promise it made to state employees when it came time for those employees to retire by reinstating that State Retiree Prescription Drug benefit to state employees who began work before July 2011.

No one who decides to spend their careers in the service of our state does so with the idea that they will become rich. We love our state and we do feel a sense of community when we are able to bring important services to the residents of Maryland in order to make our state the best it can be. We do hope that we as state workers will be compensated fairly, and at an appropriate level based on our expertise, experience, and level of training. When the time comes for us to retire, we expect that our employer, who has benefitted so greatly by the many years of service we have given Maryland, will in turn follow-through on its commitment to do right by its retirees in the form of a stable, steady, defined income, coupled with helping us handle the costs of our health care and prescription drugs.

SB 578 reaffirms the commitment the state made to its workers when it came time for those workers to retire. It is patently unfair to change what amounts to deferred compensation to state workers once those workers have already completed their work for the state. Many of these state employees live on fixed incomes and cannot go back to work in order to afford the prescriptions they need for survival. For far too many state employees, the move to discontinue the retiree prescription drug plan was seen as a slap in the face; that Maryland employees are expendable, and the compensation they get for their service to Maryland is too often used as a piggy bank to fund other state budget deficiencies.

This bill sends a clear message to our state workers and retirees—that we value their work, that their contribution to the state should be honored, and that the state follows through on the promises it makes. It is for these reasons we call for a favorable report to SB 578. Thank you.

Jerry Smith
President

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SB 578_Fav_Jeff Myers.pdf
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March 1, 2022

Senator Guy Guzzone, Chair
Budget and Taxation Committee
3 West
Miller Senate Office Building
Annapolis, Maryland 21401

Re: Senate Bill 578 State Prescription Drug Benefits--Retirees

Dear Committee Members:

Please provide a favorable vote and report on SB 578.

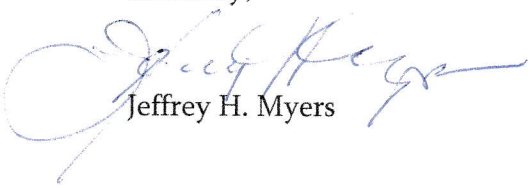
In April of 1985 I started work as an assistant attorney general for the State. Based on the experience of many friends and relatives who had retired from the State from the late 1960s up to and including 2017, it was my understanding (as well as that of a great many other people) that part of the State's retirement benefits was the State's medical insurance coverage for retirees, including pharmaceutical benefits.

As you are aware, a great number of people felt cheated when the General Assembly decided in 2018 that it did not need to honor this common understood commitment. Granted the ground shifted somewhat when the federal government adopted Medicare Part D. Yet however one views this matter, employees who had vested by 2011, should not be excluded from the State's pharmaceutical benefit program. Perhaps an even more apparent and obvious touchstone is that no State employee who was qualified for a full 30-year retirement by 2018, which is when the General Assembly decided to change the rules, should be precluded from participating in the State's long time pharmaceutical program for retirees. Note that I specify "who was qualified," not who retired. The General Assembly's actions in 2018 resulted in the State losing many capable employees who retired before the end of 2019 in order to avoid the removal of their long-understood benefit. Employees who had the 30 years to retire, but chose to stay and continue to work for the good of the citizens of Maryland should not be penalized.

Vote in favor of Senate Bill 578 to honor the work of many dedicated State employees

who put in long years of service to our citizens.

Sincerely,



Jeffrey H. Myers

AFSCME_FAV_SB578.pdf
Uploaded by: Lance Kilpatrick
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Patrick Moran - President

Testimony
SB 578 – State Prescription Drug Benefits – Retirees
Budget & Taxation
March 2, 2022
Support

AFSCME Council 3 supports the passage of SB 578. We represent approximately 30,000 *active* state and higher education employees within the state of Maryland.

Traditionally, considering employment with state or local government implied an acceptance of a trade off of marginally lower salaries in return for the promise of greater retirement benefits. That tradeoff has been significantly eroded: lower salaries have only gotten lower, while retirement benefits have been diminished. There is no doubt that part of the reason vacancies within state government have risen to over 6000 during the Hogan Administration is a result of this toxic pairing of lower salaries and retirement benefit erosion. And with the District Court's December opinion that retirement benefits are not guaranteed until a person *actually* retires, we now have the threat of retirement benefits not being *real* for active state and local government employees. HR directors would now have to honestly say that retirement benefits are projected, but not guaranteed, for a new hire.

SB 578 honors existing retirees by maintaining the original State plan, but the committee should take into account the changes that have taken place to the prescription drug landscape since the passage of SB 946. We have enacted a prescription drug affordability board; we have enacted a reverse prescription drug purchase auction, a process with which to choose a pharmacy benefit manager to supply active and retired employees with their prescription drug needs. Both these laws have the potential to generate hundreds of millions of dollars in savings to the State. With the resolution of the "Fitch" case not expected to impact beneficiaries until January 2024, it is a prime opportunity for a new administration and new General Assembly to revisit other post employment benefits in a comprehensive manner that would restore the promise and gratitude to those who would choose public service for our great State. We urge a favorable report of SB 578, and further urge seizing the opportunity to reimagine and enrich the benefits available to those who work on behalf of their fellow Marylander's.

SB 578.Richkus_testimony.pdf
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Position: FAV

SENATE BILL 578

STATE PRESCRIPTION DRUG BENEFITS - RETIREES

Senate Budget and Taxation Committee
March 2, 2022

Testimony of
Peta N. Richkus,
retired State employee
MD Secretary of General Services, Jan 1999 – Jan 2003
Commissioner, Port of Baltimore, MD Port Administration, Jul 2008 – Jan 2014

Recommended: Favorable

Senate Bill 578 should receive a favorable report, reinstating the prescription drug benefit earned by State Medicare-eligible retirees hired before July 1, 2011. Doing so would be consistent with the most recent ruling (12/30/2021) in the *Fitch v. State of Maryland* case: Judge Peter Messitte has found the contract between the State and those retirees hired before July 1, 2011 to be "unilateral" and that those retirees "have a contractual right to prescription drug benefits."

State retirees have been pressing hard over the last three years to have their prescription drug benefit (the State Plan) reinstated. When hired, and throughout their employment by the State, employees were told and left to believe that the benefits provided to employees would continue into retirement as, in effect, deferred compensation exacted by the State. And in compensation for lower salaries, numerous rounds of furloughs and other dilatory impacts to employee compensation. This contractual obligation to retired state employees should be honored on both moral and legal grounds.

What about the legislation that provided for this termination? The one that was buried in the 145-page Budget and Reconciliation Financing Act (BRFA) of 2011? Chapter 397 (Laws of Maryland, 2011) at 57-64? ***UNLESS*** *they were closely following that year's legislation and* ***UNLESS*** *they read that year's BRFA – and most State employees were not/did not/do not – they would not have known about the decision to strip away the prescription drug benefit for all Medicare-eligible retirees. Significantly, until they received a May 2018 letter from the Department of Budget and Management, affected retirees had not been advised that this termination of the prescription drug benefit was planned.*

While the three state reimbursement programs to be overlaid on Medicare Part D by Senate Bill 946 (Chapter 767, Laws of Maryland 2019) would provide some relief to retirees, these programs hardly come close to the level of benefits that had been promised.

The Formulary

A key component of the value of the State Plan to retirees relates to its comprehensive formulary, the extensive catalogue of covered drugs made available to State employees and to retirees before they tun 65. Since the legislature changed the law in 2011, no one has opined, nor could they, 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 an enrollee takes today. Whether any selected plan will cover a drug needed and prescribed after enrollment is unknowable. The cost and cash flow implications can be catastrophic. Especially for retirees on fixed incomes who have budgeted their retirement lives based upon the promise that their prescription drug coverage would continue, along with the other OPEB benefits of health, vision and dental care promised to them. And the retirees who would suffer the most are among the oldest since the change specified "Medicare-eligible," i.e. those retirees 65 and older. In 2019, DLS calculated that 40% of Medicare-eligible retirees could face **additional** out-of-pocket costs of up to $10,000. Chapter 397 would offer some buffer, at considerable cost of time and energy. But it is not the benefit that was promised. For Medicare-eligible retirees, most 70 and older and long-past their earning years, there is no way to "make up" these unplanned, unbudgeted costs.

Part D Plan Selection

Currently, there are 21 Medicare Part D plans available to Maryland residents, with 21 different formularies and 21 different combinations and permutations of premiums, deductibles, co-payments and co-insurance.

This maze of options is what one must navigate to enroll and re-enroll in Medicare Part D every year. Medicare provides a website that is very cumbersome and time-consuming to use but can provide a little help. 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, at the selected pharmacies, as well as the associated premiums and out-of-pockets costs for those particular plans. In recognition of the complexities of Part D plan selection, the Department of Legislative Services (DLS) estimated the price tag to administer the three 2019 supplemental "overlay" programs and provide the acknowledged-as-necessary, one-on-one counseling services was $2.15 million, just for FY 2021.

There is no way to compare the comprehensiveness of the Part D plans and their formularies so that one can judge whether a particular Part D plan is good enough to protect against lack of coverage for future prescriptions. Over the last three years, retirees have provided numerous examples of the anticipated negative health and financial impacts from the loss of the benefit in comparison with the superiority of the State Plan, notwithstanding the 2019 overlay.

Affordability

The 30-year cost of the State Plan, calculated as the present value of estimated future costs of the

State Plan, has been the primary argument made against legislative fixes over the last three years. This estimated future value appears on the State's balance sheet as an unfunded liability. However, this liability discloses nothing about the State's annual cost.

Posted yesterday around 11am, the Fiscal and Policy Note for SB 578 does not clearly address the State's cost for retirees' prescriptions. Nor does the Note contain any information on the difference in cost between maintaining retirees on the State Plan versus the State's cost for Medicare Part D with 2019's three-program overlay. The Note only projects increases in retirees' prescription drug claims and even these are uncertain.

Previously, in 2021 when House Bill 1230 was filed, the fiscal impact of continuing to include pre-2011 hires in the State Plan was included.

We do know that 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 that 2020 House Bill 1230, which stated, of the $313.1 million in projected 2022 retirees' prescription claims, the State's share would be $119.4 million (the State Plan remaining in effect). According to that Note's analysis, **the State's cost would be only 38 percent of total claims**. (Also noted: approximately 40% of the cost of retirees' prescription drug plan is **paid for by the retirees themselves** plus federal funds paid to the State.) At the time, DLS projected that the State would be paying $37 million if the three 2019 programs superimposed on Medicare Part had been implemented.

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 dropped its pre-2011 hires, the State would expect to have saved $82.4 million in 2022, $97.8 million in 2023, and $101.8 million in 2024. In future years, this saving would fluctuate depending upon inflation and the cost of prescription drugs, population increases that result from retirements, and population decreases because of retiree deaths. **Due to the latter, the State's cost will ultimately go to zero.** The annual cost for the State is, in fact, quite small. In the context of a General Fund budget proposed at $58.2 billion, $82.4 million represents **0.014 percent of State expenditures.** Thus, continuing this benefit by passing SB 578 would have a negligible and decreasing impact on State budget priorities.

Maryland's Bond Rating

The other argument made against continuing the prescription drug benefit for Medicare-eligible retirees has been the claim that doing so would create such an increase to the state's Other Post-Employment Benefits (OPEB) burden as to threaten the state's valuable AAA bond rating. There are a number of problems with this "red herring" argument:

1. The rating agencies have never downgraded a state's bonds based solely on an unfunded OPEB liability. (And prescription drugs are only one part of OPEB costs.)

2. States with greater OPEB liabilities than Maryland have continued to maintain their triple-A bond ratings.
3. The State has disproved its own claim over the last three years: it has covered the State Plan benefit for the last three years (and for seven years before that), has **not** contributed to the Trust Fund, but has **not** had its bond rating downgraded. In fact, **in the most recent Standard & Poor's rating summary, there is no mention of OPEB costs at all**.[1]

Despite much expressed concern about the OPEB burden, the State has failed to do anything about it, This is not the retirees' fault. The State has failed to fund the OPEB Trust Fund for over a decade, even though the State created the Fund to manage the problem in the first place, and even though pre-funding of the Trust Fund is what Government Accounting Standards Board (GASB) guidelines require. The problem of OPEB liability, as it exists, has been substantially caused and exacerbated by the State's own choices.

*****

Finally, the preliminary injunction in the ongoing federal case (*Fitch v. State of Maryland*) does **not** preclude the General Assembly from remedying the State's breach of its promise of prescription drug benefits to its Medicare-eligible retirees. Enacting Senate Bill 578 would constitute a fair and appropriate settlement of the case.

Therefore, I respectfully urge the Committee to give SB 578 a favorable report.

[1] August 2, 2021, Standard & Poor's Global Ratings: Maryland - AAA
https://www.treasurer.state.md.us/media/152396/s&p_2021_2nd.pdf

testimony for SB 578 March 2 2022.pdf
Uploaded by: Rose Wertz
Position: FAV

Written Testimony Submitted for the Record to the Maryland State Senate
Before the Senate Budget and Taxation Committee
Submitted by Rosemary Wertz, Field Coordinator with AFT Healthcare-Maryland
March 2, 2022
Senate Bill 578 – State Prescription Drug Benefits – Retirees
Position - Support

Good afternoon Chairman and members of the Senate Budget and Taxation Committee

I am Rosemary Wertz, Field Coordinator for AFT Healthcare-Maryland, the exclusive bargaining representative for Healthcare Professionals in Maryland State government. Thank you for the opportunity to submit written testimony in support of SB 578. Our bargaining unit includes Registered Nurses, Physicians, Therapists and Counselors. Our healthcare professionals know when they accept employment with Maryland State Government that they will not make a competitive salary. They accept much lower wages in exchange for other benefits. Prescription benefits in retirement were part of the deal. Our members have made much less money while working, thinking they would need less in retirement due to the continuation of benefits. For some, it is too late for them to adjust their retirement plans to offset the reduction in benefits.

For instance, I spoke with a member this week who retired July 1, 2021 because she was undergoing treatment for cancer. She worked for the state for over 16 years, which she thought qualified her for full benefits in retirement. The state did not notify her of the change in the law in 2011. She continued working for the state thinking she had full benefits in retirement for many years. When she called me, she was very concerned because the cost of her medicine was more than her retirement allowance for the month. She does not know if she will need additional treatment in the future. If you pass this bill, she will not have to worry about paying for her treatment in the future.

Other employees hired prior to 2011 that are still working may need to take a job in the private sector with a higher salary prior to retirement to offset the additional prescription cost. We urge the committee to consider the nursing shortage that has existed for decades and has now expanded to include all healthcare professionals. Nationwide job statistics show an alarming number of people opting to leave the workforce over the last couple of years. The recruitment and retention of healthcare professionals has become more difficult since the start of the pandemic. During a Labor Management Committee meeting this week, management at Western Maryland Hospital Center reported having successfully hired RN's at their recent job fair. They said they came for the benefits. Erosion of any benefits for state employees will negatively impact recruitment and retention. AFT Healthcare-Maryland supports SB 578 and urges a favorable vote from this committee.

Respectfully submitted,

Rosemary L. Wertz
Field Coordinator

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Oral Testimony SENATE BILL 578.pdf
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Position: FAV

SENATE BILL 578

ORAL TESTIMONY BY SHEILA TOLLIVER ON BEHALF OF SHEILA AND LARRY TOLLIVER
Hearing March 2, 2022 in the Senate Budget and Taxation Committee

I am Sheila Tolliver, and I am testifying in support of Senate Bill 578 on behalf of my husband, Larry Tolliver, and myself. We reside at 1526 Catbriar Way, Odenton, MD.

We both are State retirees, together having 58 years of creditable service in the retirement system. Larry, who served in the Maryland State Police for 28 years, retired as Superintendent in 1995. He has carried our health insurance benefits throughout his employment and retirement.

In written testimony and in a letter sent to each of you, I have provided details explaining our support. Today, with limited time, I provide just two compelling reasons for your support:

First, the State has a moral and contractual obligation to its retirees to provide the benefits, equal to those of active State employees. They were promised in law until 2011, when they were abridged. This not only is our opinion, but also that of the federal judge who has given careful consideration to the issue since 2018, as he spelled out in his Opinion Memorandum of December 30, 2021.

Second, the appropriate time to correct the error is now. The State's fiscal health is strong. The benefit has been funded without harm to the State's priorities or credit worthiness since its inception. Expecting retirees on modest fixed incomes to fight in court for a benefit they so clearly have earned is life-threatening to some and insensitive to all.

Eliminating the benefit was an error, both in its expectation that Federal benefit changes would negate the need for it and in its assumption that Maryland's laws granting the benefit were not, in fact, a contractual obligation. Passing SB 578, which restores the benefit for those hired before 2011, will correct those errors.

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Position: FAV

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).

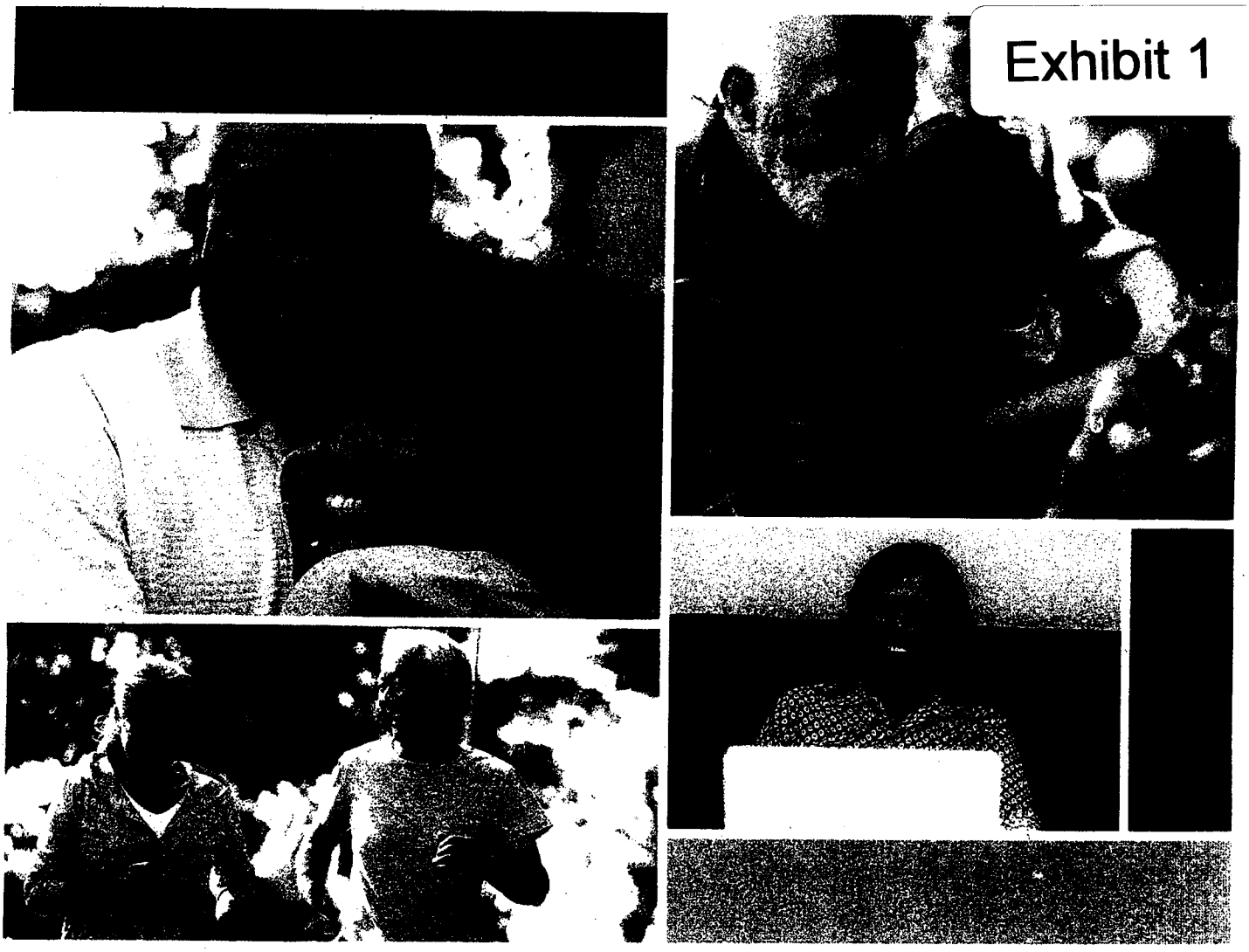
[6]Fiscal and Policy Notes, Senate Bill 946 and House Bill 1120 (2019 session) at 1; see also these Notes at 6.

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.

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Written Response.pdf
Uploaded by: Michael Bridgett
Position: INFO

Good afternoon, I am Michael Bridgett and my career with the State of Maryland lasted 31 years. This does not include time credited for Military service.

- State Employment began in 1988
- 1992 I completed a Nurse Practitioner Program that I was selected by the State of Maryland to attend. At completion I had a 3-year contract to continue employment with the State of Maryland. This was an important program because the State had a difficult time recruiting Nurse Practitioners because the pay was not competitive.
- Just prior to being Vested with the State of Maryland the Pension system changed. I had to move into the "New System" which provides less money at the end of my service. The State of Maryland Notified all State Employees and we were able to make an informed decision. This is unlike the situation with our prescription Health Plan that was hidden away for seven plus years. No informed decision making there.
- 12/2019 I rushed to retire to try to salvage some form of the Health Care Prescription coverage which I was promised for years of working at a lesser salary.
- I could go into how much this rushed retirement cost me and the hardship it caused, however I want to discuss how financially irresponsible it is to take these earned benefits away.
- Medicare D does not come close to our current Plan. I work with this every day.
- For every state employee that ends up in a Long-term care facility due to lack of access to proper medications it will cost the Tax Payer $93,000
- I am not even asking for a handout like the Medicaid Program. I am asking that you continue a program that I earn and contribute to. This is pennies spent for dollars saved.
- Benjamin Franklin saw the importance of investing in a Health Care System and believed in Public Health. An Ounce of Prevention is Worth a pound of cure. I am sure he would not understand why a preventative program that an employee earned and is still contributing money to would be eliminated at a time when the retiree needs it most.
- I completed my contract and held all ends of my deal with the State of Maryland. Please keep your end of the bargain.
- My two older children are profoundly deaf. My daughter Graduates with her Doctorial degree at the end of this semester. My son was the first deaf student to graduate from Full Sail University and he was the Valedictorian. I taught them that hard work and perseverance pays off. Please don't prove me wrong.

Thank You.