HOUSE BILL 670
STATE PRESCRIPTION DRUG BENEFITS - RETIREES

Senate Budget and Taxation Committee
February 28, 2024

Testimony of William A. Kahn

Favorable

My name is William A. Kahn, 85 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.

House Bill 670 reinstates the State's retirees prescription drug plan (the "State Plan") but only for those Medicare-eligible 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. As explained in my testimony on 2022 Senate Bill 578 (Attachment 2), which discusses in detail many reasons to not off-load retirees onto Part D, this is an affordable population, both in terms of current cost and long-term liability.

House Bill 670 should receive a favorable report.

Why are retirees upset by the pending termination of the State plan for us?

While 2019 Senate Bill 946 (2019 Chapter 767) replaces the State plan with three State reimbursement programs superimposed on Medicare Part D, these programs do not fix a very significant problem of Part D. There are several reasons.

1. The State promised us that our health benefits would continue into our retirement, a promise. In 2004 Laws of Maryland Chap. 296, the General Assembly reinforced its commitment that State retirees were entitled to continue in the State Plan despite the enactment of Medicare Part D.

The State Plan prescription drug coverage is much more comprehensive than Part D plans because the State Plan “wraps around” and supplements Part D.

The State seems to view Part D as monolithic, but it is not. In 2024, there are 19 separate Part D plans in Maryland, each with its own formulary (list of covered drugs), premium, deductible, and co-insurance and co-payments.

Annual Part D premiums range from $5 to $1,361 per person ($10 to $2,722 for a two-person household). Contrast the State Plan, with its <u>much</u> better formulary, with annual premium of $639 for one retiree and $1,124 for retiree plus one. (Ask: What kind of drug coverage can you get for $10 per year?)

Any decent Part D plan is more expensive than the State Plan, just in premiums alone. In addition, 16 of the 19 Part D plans have deductibles, some as high as $545 ($590 in 2025) – doubling the cost for a two-person household - and the co-insurance and co-payments are significantly higher for all but the cheapest generics.

2. Importantly, the 2019 Senate Bill 946 programs do not fix the problem with the most significant impact on state retirees: the maximum for "out-of-pocket costs" applies ONLY to covered drugs.

If a retiree is prescribed a drug that is not covered by the retiree's prescription drug plan, the retiree must pay for it out of his or her own funds. The cost of this not-covered drug does not count toward the $1,500/$2,000 maximum or cap under the State Plan and will not count toward the 2025 Part D cap of $2,000.

This is because, under Part D, by definition, "out-of—pocket costs" *excludes* the cost of not-covered drugs. It is critical to understand that "out-of-pockets costs" applies *only* to costs paid from the participant's own funds for **covered** drugs (i.e., the full negotiated price within the deductible and co-insurance and co-payments after that).

This is explained in the Evidence of Coverage for the State's SilverScript Part D plan. (Being a wrap-around Part D plan, the State's SilverScript Part D plan must conform to Part D definitions.) SilverScript Evidence of Coverage (2024) at 98 (Attachment 1) states:

> **State of Maryland Annual Maximum Out-of-Pocket Maximum (MOOP)** - The most you will pay in a year for your share of the cost for *covered* prescription drugs. (Italics added.)

In Medicare Part D parlance:

> True out-of-pocket (TrOOP) costs are payments that count toward a person's Medicare drug plan out-of-pocket threshold . . .
>
> These payments don't count toward a person's TrOOP costs: . . .
>
> • *Drugs not covered by the plan* (Italics added.)[1]

The new State Retiree Prescription Drug Coverage Program, *§2-509.1(d)(2)(i), Md. Pers. & Pensions Ann. Code*, reimburses Medicare-eligible State retirees for "out-of-pocket costs that exceed" $1,500/$2,000. The new State Retiree Catastrophic Prescription Drug Assistance

[1] "Understanding True Out-of-Pocket (TrOOP) Costs," Partners, Department of Health and Human Services, at https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwj_lc36vqiEAxU-GFkFHWL8DL4QFnoECEcQAQ&url=https%3A%2F%2Fwww.cms.gov%2Ffiles%2Fdocument%2F11223-ppdf&usg=AOvVaw3QBCm3DfgJM6_xknBdAjkz&opi=89978449

Program, §2-509.1(e)(2)(I), reimburses Medicare-eligible retirees for "out-of-pocket costs" the retiree incurs in the Part D catastrophic phase.[2]

But, because "out-of-pocket costs" under Medicare is limited to covered drugs, the full costs of all not-covered drugs are the retiree's sole responsibility.

This is a financial exposure that is substantial for several reasons. First, Part D formularies are narrower than the State Plan's comprehensive formulary, increasing the likelihood that Part D will not cover many drugs. Second, during open enrollment, a retiree enrolls in a plan that covers the retiree's then-current prescriptions. Completely unforeseeable are those additional drugs that may be prescribed after enrollment and the likelihood that these new drugs will not be covered. Third, for these not-covered drugs, the retiree must pay the full list price without benefit of any rebates, discounts, and other reductions available to pharmacy benefit managers for these drugs.

The State Retirees Life-Sustaining Prescription Drug Assistance Program, § 2-509.1(f)(2)(i), poses a similar difficulty. That program

> reimburses a participant for "out-of-pocket" costs for a life-sustaining prescription drug that is:
>
> 1. covered by the [State Plan]; and
>
> 2. not covered by the prescription drug benefit plan under Medicare in which the participant is enrolled.
>
> (quotation marks added)

But, if a life-sustaining drug is not covered by the retiree's Part D plan, by definition, the retiree has no "out-of-pocket" cost for that drug and is not entitled to any reimbursement for it. The retiree must pay the full list price from his or her own funds.

2019 Senate Bill 946 failed to provide relief to State retirees for not-covered drugs. The statute uses the wrong words.

3. Conclusion

In 2019, through Senate Bill 946, this Committee acknowledged the unfairness of off-loading pre-2011 State employees and retirees, who had been promised and expected continuation of their prescription drug benefit, onto Medicare Part D. Its attempt to mitigate is largely inadequate.

This Committee should issue a favorable report on House Bill 670.

[2] From 2006 through 2023, the retiree cost sharing was 5% in the catastrophic phase.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill **gaps** in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare (*Traditional Medicare* or *Fee-for-Service Medicare*) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered prescription drugs to members of our plan.

Out-of-Pocket Costs – See the definition for cost sharing above. A member's cost sharing requirement to pay for a portion of prescription drugs received is also referred to as the member's out-of-pocket cost requirement.

- **State of Maryland Annual Maximum Out-of-Pocket (MOOP)** – The most you will pay in a year for your share of the cost for covered prescription drugs.
- **Medicare True Out-of-Pocket (TrOOP)** – The expenses that count toward a person's Medicare prescription drug plan out-of-pocket threshold (for example, $8,000 in 2024). This includes amounts paid by you or qualified payers on your behalf toward the cost of your covered Medicare Part D prescription drugs. Generally, payments by family and friends and charities count toward TrOOP but not payments by other health plans. TrOOP costs determine when a person's catastrophic coverage portion of their Medicare Part D prescription drug plan will begin. In other words, TrOOP defines when you exit the coverage gap (sometimes referred to as the "donut hole") and enter the Catastrophic Coverage Stage of your Medicare Part D prescription drug plan.

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.