**HB 1120**

# Department of Legislative Services

Maryland General Assembly
2019 Session

## FISCAL AND POLICY NOTE
**Third Reader - Revised**

House Bill 1120 (Delegate Carey, *et al.*)
Appropriations Budget and Taxation

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

This emergency bill establishes prescription drug out-of-pocket (OOP) reimbursement or catastrophic coverage programs for specified State retirees, dependents, or surviving dependents who are enrolled in a Medicare prescription drug benefit plan. State employees hired after June 30, 2011, remain ineligible for prescription drug coverage from the State when they retire. By July 1 of each year, the Secretary of Budget and Management must send a notice to specified individuals of their eligibility to enroll in the programs that contains certain information. The Department of Budget and Management (DBM) must provide (1) specified one-on-one counseling to Medicare-eligible retirees and (2) quarterly reports on specified aspects of its implementation of the bill's requirements to the Governor and General Assembly.

## Fiscal Summary

**State Effect:** State retiree health liabilities increase by at least $2.88 billion over 30 years, which may negatively affect the State's AAA bond rating. Assuming favorable resolution of the pending federal lawsuit, State expenditures may initially decrease significantly in FY 2021, potentially by as much as $80.0 million, which reflects savings from providing full prescription drug coverage under the federal injunction. State expenditures then increase by an estimated $38.0 million in FY 2022 and are assumed to grow annually thereafter according to actuarial assumptions, reflecting the cost of providing reimbursement and catastrophic coverage to many Medicare-eligible retirees instead of terminating their prescription drug coverage altogether. Retiree health expenditures are assumed to be allocated 60% general funds, 20% special funds, and 20% federal funds. General fund expenditures increase by $2.15 million in FY 2021 to administer the programs and provide one-on-one counseling services and by $3.9 million on an annualized basis thereafter. DBM can carry out the notification and reporting requirements with existing resources. No effect on revenues.

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

**Small Business Effect:** None.

## Analysis

**Bill Summary:**

*Prescription Drug Coverage Programs*

Assuming the favorable outcome of pending legislation, by January 1, 2020, DBM must establish three new prescription drug benefit programs for specified current and future retirees who are enrolled in a Medicare prescription drug benefit plan:

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

The three programs may include a health reimbursement account (HRA) established in accordance with the Internal Revenue Code. All three programs may set different OOP limits or reimbursement amounts for retirees or beneficiaries who qualify for a partial State premium subsidy (rather than a full subsidy). Eligible participants may enroll in the three plans during the open enrollment period or any special enrollment period. For the Prescription Drug Coverage Program and the Catastrophic Prescription Drug Assistance Program, a participating retiree may elect to cover a spouse and dependent children;

surviving spouses and children of retirees are also eligible to participate in the two programs.

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

*Counseling Services*

DBM must provide one-on-one counseling to Medicare-eligible retirees that assists them in (1) selecting a Medicare Part D prescription drug plan based on the retiree's specific medical and medication needs and (2) determining eligibility and applying for specified financial assistance programs. DBM must also provide a customer service hotline and an interactive website for related purposes. DBM must contract with an experienced employee benefits administrator to provide the services and counseling, which must be provided for at least three months before the Medicare open enrollment period through the end of open enrollment. Counseling may be provided over the phone or in person and must be provided in a manner that ensures equitable geographic access. DBM is authorized to conduct specified emergency procurements to implement the bill.

*Implementation Schedule*

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

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

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

*Notification Requirements*

By May 1, 2019, DBM must provide written certified notice of the bill's provisions to specified State employees, Medicare-eligible retirees, and other Medicare-eligible dependents and surviving spouses and children.

It is the intent of the General Assembly that DBM attend at least one annual meeting of the Joint Committee on Pensions to update the committee on the implementation of the bill's provisions.

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

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

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

Chapter 397 established new eligibility requirements for retirees to enroll in the State plan and qualify for the premium subsidy if they are hired on or after July 1, 2011. Therefore, the eligibility requirements to enroll in the State plan are different for those who began employment with the State before July 1, 2011, and those who began employment with the State on or after that date. Employees hired *before* July 1, 2011, are eligible to enroll and participate in the group coverage when they retire if they have:

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

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

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

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

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

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

As noted earlier, Chapter 397 made changes to OPEB coverage provided to State retirees, particularly in the area of prescription drug coverage. First, it authorized the State to establish health insurance benefit options for retirees that differ from those for active State employees. In addition, Chapter 397 increased the share of the premium for prescription drug coverage paid by retirees from 20% to 25% (it remained 20% for active State employees) and raised OOP limits for retirees to $1,500 for a single retiree and $2,000 for family drug coverage (previously, the limit had been $750 for single or family coverage for both active employees and retirees). Finally, it eliminated State prescription drug coverage for Medicare-eligible retirees in fiscal 2020. Fiscal 2020 was the year that improvements to Medicare Part D prescription coverage enacted by the federal Patient Protection and Affordable Care Act (ACA) were to be fully phased in, allowing Medicare-eligible retirees to get comparable prescription coverage through Medicare instead of from the State.

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

In accordance with Chapter 397, State prescription drug coverage for Medicare-eligible retirees was to end July 2019. However, because the improvements to Medicare Part D coverage under the ACA were accelerated, and because the State plan year begins on January 1 of each year, Chapter 10 of 2018 (the Budget Reconciliation and Financing Act) accelerated the date coverage would end to January 1, 2019. Chapter 10 also clarified that

a non-Medicare-eligible spouse, surviving spouse, dependent child, or surviving dependent child of a Medicare-eligible retiree may remain enrolled in the State prescription drug plan even if the retiree is no longer eligible. Finally, it required the Secretary of Budget and Management to provide written notice to individuals affected by the change in the State prescription drug plan.

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

State and federal courts have not consistently recognized a contractual obligation that protects retiree health benefits from diminution or infringement when they are established in statute. In the absence of relevant case law in Maryland, a 2005 opinion of the Maryland Attorney General concluded that "the statute does not create a contractual obligation and the General Assembly remains free to amend the law that provides such benefits." It also found that cases in other states had reached various conclusions, including, in some cases, recognizing a vested right to health benefits for retirees. But the Attorney General advised that such cases had limited application in Maryland because they were based on particular state constitutions, collective bargaining agreements, or circumstances in other states. In 2014, a federal district court in California ruled against retired employees of Orange County, finding that county ordinances, resolutions, and other documents did not create an implied vested right to a specific health benefit.

*Medicare Part D Coverage Model*

The standard Medicare Part D coverage model includes a $415 deductible that must be paid before coverage begins. The plan then requires a participant to pay a 25% coinsurance on all prescription drugs until OOP costs reach the catastrophic coverage threshold of $5,100 in a calendar year (including the deductible). However, because participants get credit for prescription drug rebates negotiated by Medicare, *actual* OOP costs are about $2,500 before reaching the catastrophic coverage threshold. Under catastrophic coverage, participants pay a 5% coinsurance indefinitely.

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

changes to Medicare-eligible retirees as a result of the transition to Medicare Part D coverage.

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

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

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

*Prescription Drug Coverage Under Medicare Part B*

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

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

Under current State plan requirements, Medicare-eligible State retirees must participate in Medicare Part B as a condition of maintaining their medical coverage under the State plan because the State plan serves as a supplement to Medicare Parts A and B. DBM advises that many drugs not covered by Part D that likely qualify as "life-sustaining drugs" under the bill are covered by Part B. Moreover, retirees enrolled in the State PPO plans are

reimbursed for half of their OOP costs for those medications (*i.e.*, half of their 20% coinsurance payment), and those enrolled in the EPO plans are reimbursed for all of their OOP costs for those medications.

**State Fiscal Effect:**

*Other Postemployment Benefits Liabilities*

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

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

DBM's consulting actuary projects that the provision of prescription drug reimbursement coverage and catastrophic coverage under the bill increases the State's net OPEB liability by at least $2.88 billion; this estimate does not reflect any additional liabilities created by the Life-Sustaining Prescription Drug Assistance Program (discussed below). Under the new GASB accounting rules, the full liability is reflected on the State's balance sheet so an increase of that magnitude has the potential to negatively affect the State's AAA bond rating. Any such effect is not reflected in this analysis but could be meaningful.

*Annual Costs of Prescription Drug Coverage Programs*

Calculation of the bill's effect on the State's expenditures for retiree prescription drug coverage is complicated by two factors. First, the federal injunction requires the State to maintain coverage despite current State law, and the injunction remains in effect for an

indeterminate amount of time (until the lawsuit is resolved). Second, the State plan year begins on January 1, but the State fiscal year begins on July 1. In accordance with the implementation schedule in the bill, this analysis assumes that changes in coverage are made only at the beginning of each plan year, so any change in coverage levels and expenditures affects only half of the first fiscal year.

The bill requires the State to establish the new programs effective January 1, 2020; until then, the injunction is likely to remain in effect, so the bill has no immediate fiscal effect. If the lawsuit is resolved in the State's favor after April 1 and before April 2020 (*i.e.*, either less than nine months before the 2020 plan year or more than nine months before the 2021 plan year), the new programs will take effect for the second half of fiscal 2021 (January 1, 2021, through June 30, 2021) at a prorated (half-year) cost of at least $18.0 million, as this estimate does not include the cost of the Life-Sustaining Prescription Drug Assistance Program. The current coverage maintained by the injunction is projected to cost approximately $98.0 million for a half year of coverage in fiscal 2021, so the bill would represent a considerable savings in fiscal 2021.

In fiscal 2022, the coverage programs in the bill are expected to cost at least $38.0 million on an annualized basis (not including the Life-Sustaining Prescription Drug Assistance Program, discussed below). As current law in the absence of the injunction anticipates no State costs for Medicare-eligible retirees, State expenditures increase by $38.0 million in fiscal 2022 and are assumed to increase annually according to actuarial assumptions. If the lawsuit is resolved in the plaintiff's favor, the bill has no effect because the State must maintain existing coverage. If the lawsuit is not resolved prior to April 2020, any potential fiscal effect is delayed and contingent on a favorable ruling for the State. In general, State retiree medical costs are assumed to be allocated 60% general funds, 20% special funds, and 20% federal funds.

*Life-Sustaining Prescription Drug Assistance Program*

Many of the drugs likely to qualify as life-sustaining drugs under the bill are quite expensive, sometimes costing more than $5,000 for a one-month supply. However, as noted above, DBM advises that many of the life-sustaining drugs not covered by Medicare Part D are covered by Part B. Together, Part B and the State plan cover either 90% or 100% of the cost of these drugs. A precise estimate of the program's cost could not be developed in time for this analysis, but the reimbursement provided by Part B and the State plan suggests that total reimbursements by the Life-Sustaining Prescription Drug Assistance Program may be only a small fraction of the cost of those drugs, and in some cases the program will not have to reimburse any of the cost.

*Program Administration and Counseling Services*

DBM advises that the annual cost of contracting for the administration of HRAs for approximately 50,000 plan participants is estimated to be $3.5 million. In fiscal 2021, the HRAs are needed only for half the year at a cost of $1.75 million; beginning in fiscal 2022, the annualized cost is $3.5 million.

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

**Additional Comments:** The May 31, 2019 deadline for coverage under the Prescription Drug Coverage Program may prompt State employees who are currently eligible to retire to do so on or before that date, in some cases, earlier than they had planned to do so. A preliminary assessment by the Department of Legislative Services indicates that as many as 7,000 employees are currently eligible to retire. This creates two potential additional costs for the State that are not factored into this analysis.

First, to the extent that the bill causes State employees to retire sooner than they otherwise would, State pension liabilities and corresponding employer contributions increase due to benefits being paid out for a longer period of time. A reliable estimate of any such increase is not feasible because it is not known how many employees will choose to retire who would not otherwise have done so for the purpose of qualifying for participation in the coverage program. However, the potential effect may be significant.

Second, to the extent that the bill prompts a significant number of employees to retire at once, the State may incur significant costs for recruitment, training, and overtime to fill and compensate for resulting vacancies. Again, a reliable estimate is not feasible because it is not known how many eligible State employees will retire to qualify for participation in the coverage program who would not otherwise have retired at that time.

## Additional Information

**Prior Introductions:** None.

**Cross File:** SB 946 (Senator Griffith, *et al.*) - Budget and Taxation.

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

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