HB 979

Department of Legislative Services

Maryland General Assembly
2019 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 979 (Delegate Parrott, *et al.*)
Appropriations

State Employee and Retiree Health and Welfare Benefits Program - Retiree Participation in the State Prescription Drug Benefit Plan

This emergency bill restores prescription drug coverage for retirees of the State under the State Employee and Retiree Health and Welfare Benefits Program (State plan) and allows retirees to cover their spouses and dependent children under the State plan. Specified surviving spouses and surviving dependent children of eligible retirees may also enroll in the State plan.

Fiscal Summary

State Effect: State retiree health liabilities increase by an estimated $10.7 billion, which may negatively affect the State's AAA bond rating. Assuming favorable resolution of the pending federal lawsuit, there is no fiscal effect in FY 2019. However, as discussed below, State expenditures increase significantly – potentially by $89.5 million in FY 2020 and $187.5 million in FY 2021. Expenditures grow annually thereafter according to actuarial assumptions and are assumed to be allocated 60% general funds, 20% special funds, and 20% federal funds. No effect on revenues.

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

Small Business Effect: None.

Analysis

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 premiums, 83% of point of service premiums, and 85% of premiums for exclusive provider organizations 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 out-of-pocket (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, the Department of Budget and Management (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.

Based on Medicare-eligible retirees' claims cost in calendar 2017, DBM estimates that 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

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 (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 restoration of full prescription drug benefits under the bill increases the State's net OPEB liability by $10.7 billion, or double the current liability level. 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

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. 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 maintain coverage, which is also required by the federal injunction, so the bill has no immediate fiscal effect. If the lawsuit is resolved in the State's favor prior to January 2020, the bill requires State expenditures to be maintained for the second half of fiscal 2020 (January 1, 2020, through June 30, 2020) at a prorated (half-year) cost of $89.5 million. State expenditures are then annualized beginning in fiscal 2021 and assumed to increase annually according to actuarial assumptions, resulting in a fiscal 2021 cost of $187.5 million. If the lawsuit is resolved in the plaintiff's favor, the bill has no effect because the State must maintain coverage anyway. If the lawsuit is not resolved prior to January 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.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Department of Budget and Management; Department of Legislative Services

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