Dear Chairman Guzzone, Vice Chair Rosapepe, and Committee Members:

My name is Jane L. Wolfson. I came to Towson University in 1998 to establish and direct the interdisciplinary Environmental Science and Studies Program for graduate and undergraduate students that spanned 4 independent colleges at the University. I retired from the State on June 30, 2016.

Senate Bill 349 should receive a favorable report, reinstating the prescription drug benefit for State Medicare-eligible retirees, which, before July 1, 2011, was part of the compensation package we received at the time of hiring. Doing so would be consistent with the 2004 Government Accounting Standing Board (GASB) Statement No. 45 recommendations which focused attention on the OBEP challenge faced by state and local governments. The GASB summary states (emphasis added)

> Postemployment benefits (OPEB as well as pensions) are part of an **exchange of salaries and benefits for employee services rendered**. Of the total benefits offered by employers to attract and retain qualified employees, some benefits, including salaries and active-employee healthcare, are taken while the employees are in active service, **whereas other benefits, including post-employment healthcare and other OPEB, are taken after the employees' services have ended**. Nevertheless, **both types of benefits constitute compensation** for employee services.

This clearly states that the 2011 Maryland Legislation that retroactively cancelled the State's promised prescription benefits were effectively taking funds that no longer rightfully belonged to the State. This might be the reason that Maryland is the ONLY jurisdiction that has retroactively canceled OPEB benefits.

The 2011 change in policy was not public knowledge until implementation was attempted in 2018, at which time retirees expressed outrage and distress. Outrage, because they had honorably and dutifully remained with the State through years of low salaries and salary freezes, no merit increases, no cost-of-living increases, and furloughs because of the promised security in retirement. I and my fellow state employees accepted below-market salaries during our employment because of the assurance provided by deferred retirement benefits. Distress, because they counted on the State to live up its promises. They did their work for the State with honor and expected the State to similarly honor its obligations to them.

The widespread outrage in response to the 2018 notification of change in benefit eligibility and the realization about what this change would mean for a secure retirement, resulted in the *Fitch v. State of Maryland* lawsuit filed in 2018. It also led, in 2019 to the hastily drafted and passed SB 946, an honest attempt by legislators to ameliorate the impact of the loss of prescription drug benefits on previously covered retirees.

SB 946 was signed into law by then Governor Hogan becoming 2019 Chapter 767. SB 946 appears to have been developed in 2019 in response to two main drivers: the distress being expressed to legislators by impacted retirees and the surprise on the part of legislators that this change in policy had ever happened! The prescription drug benefits were rescinded by

some phrases in the middle of the 147-page Budget Reconciliation Act of 2011; an easy item to miss if you were in the legislature at the time and certainly if you were elected afterwards. Unfortunately, SB 946 fails in its mission to ameliorate the impact in various ways and new legislation is needed.

The drafters of SB 946 believed the claim that Medicare D was equivalent to the State Prescription plan. This equivalency is demonstrably false. Every Medicare D plan has a formulary that lists covered drugs. The State Prescription Drug plan also has a formulary. The difference lies in the extent of the formulary. The State plan has a highly inclusive listing of drugs whereas the Medicare D plan formularies are very limited. Any drug prescribed for a retiree that is not in a retiree's selected Medicare D plan is paid for in full by the retiree. In order to fully "reap" the benefits of a Medicare D plan you either need to require almost no medications or allow your Medicare D plan program administrator to serve as your prescribing physician swapping one drug formulation for another without regard to their efficacy or how well they address your ailment; no one should be asked to do that.

One provision of SB 946 was to continue to cap the so-called "out-of-pocket" prescription drug expenses at the same level as provided by the State prescription plan, i.e., $1,500 rather than the Medicare cap. Unfortunately, this provision which is "attempting" to protect retirees does not do so because of two problems. One is the definition of "out-of-pocket" (OOP) that Medicare established. To qualify as an OOP expense, a cost must be associated with a drug included in the formulary of the selected plan. If a drug is not included on that selected plan's formulary, any retiree-borne cost associated with it is not included in the calculation of OOP. The retiree is on their own to pay for these additional expenses out of their limited income.

The second problem arises from the type of plan being offered by Medicare. The State prescription coverage can include the retiree or the retiree along with a spouse and/or family. Medicare Part D plans are all individual plans. With the State plan, an individual OOP limit is $1,500 and the family OOP limit $2,000. With Medicare D, a retiree and a Medicare-eligible spouse will, in 2025, have two $2,000 OOP caps. New legislation is needed to provide the support to retirees that, legislators hoped, SB 946 would provide.

The State and members of the leadership continue to claim that "most retirees should experience little, if any, changes in out-of-pocket prescription drug costs. Many could even see lower costs," but they offer no evidence how this could happen. When I do a plan-by-plan comparison, my costs go up significantly. Part of the cost issue is the different 'types' of cost of the medication in Medicare Part D plans vs the State plan. With the State plan, costs depend on the tier of the drug and co-payments that range between $20 and $80 for a 90-day prescription. Medicare D plans are co-insurance plans for which, except for the cheapest generics, the enrollee has to pay a certain percentage of the cost of the drug, from 20% to 50% so costs increase as prescription prices rise. Most plans also have a hefty deductible.

Below is a table of total medication cost comparisons developed by a colleague using the current prescription needs of an actual Maryland State retiree. Those making the 'same or lower cost' statement have never done the comparison. Please note that the least expensive plan is about $4,000 more than this retiree's current costs on the State plan. New legislation is

needed, legislation to restore benefits, even if just in the short term, while new, more equitable and financially viable legislation is developed.

Comparison of the Nineteen 2024 Medicare Part D Plans Available in Montgomery County Maryland

The following comparisons of Medicare Part D plans were made using the Medicare.gov comparison tool. The comparisons are based on the actual information of a 70 year old man with Type II Diabetes and Psoriatic Arthritis. The costs are based on the drugs actually taken by the test subject.. The take home pay is his actual income derived from his State of Maryland Pension and Social Security benfits. The estimates for the Maryland SilverScript Employer plan were derived from actual costs of drugs and benefits from the plan as stated in the Evidence of Coverage.

Annual Take Home Pay: $82,644

					Covered Drugs															
Medicare Part D Plans	**Monthly Premium**	**Annual Cost Drugs + Premium**	**Deductible**	**Star Rating**	**Carvedilol**	**Farxiga**	**Fenofibric Acid**	**Folic Acid**	**Valsartan**	**Tresiba**	**Metformin**	**Methotrexate**	**Mounjaro**	**Novolog**	**Crestor**	**Spironolactone**	**# Drugs Covered**	**Enter Coverage Gap**	**Leave Coverage Gap**	**Months in Gap**	**Costs as % of Take Home**
AARP Medicare Rx Preferred From UHC	**$103.00**	**$6,429**	**$0**	**3.5**		**x**	**x**		**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**10**	**March**	**July**	4	**7.8%**
Humana Walmart Value Rx	$43.50	$8,154	$545	3.0		x			x	x	x	x	x	x	x	x	9	March	June	3	9.9%
Humana Basic Rx Plan	$44.40	$8,235	$545	3.0		x			x	x	x	x	x	x	x	x	9	March	June	3	10.0%
Humana Premier Rx Plan	$104.60	$8,467	$0	3.0		x			x	x	x	x	x	x	x	x	9	March	July	4	10.2%
Mutual of Omaha Rx Essential	$26.30	$14,784	$545	1.5		x	x		x		x	x	x	x	x	x	9	March	June	3	17.9%
SilverScript SmartSaver	**$12.40**	**$16,802**	**$280**	**3.0**	**x**	**x**	**x**		**x**	**x**	**x**	**x**		**x**	**x**	**x**	**10**	**March**	**August**	5	**20.3%**
SilverScript Plus	$113.40	$17,823	$200	3.0	x	x	x	x	x	x	x	x		x	x	x	11	March	September	6	21.6%
Wellcare Value Script	$0.40	$18,293	$545	3.5	x	x	x		x	x	x	x	x		x	x	10	April	September	5	22.1%
Wellcare Medicare Rx Value Plus	$78.90	$18,885	$0	3.5	x	x	x		x	x	x	x	x		x	x	10	April	October	6	22.9%
Clear Spring Health Value Rx	$25.80	$22,013	$545	0.0		x	x		x	x	x	x	x		x	x	9	April	August	4	26.6%
AARP Medicare Rx Walgreens from UHC	$54.20	$22,448	$410	3.0		x			x	x	x	x		x	x	x	8	March	September	6	27.2%
Wellcare Classic	$37.40	$24,122	$545	3.5		x			x	x	x	x	x		x	x	8	April	September	5	29.2%
Cigna Extra Rx	$69.10	$27,688	$145	2.5	x		x		x	x	x	x	x		x	x	9	May	November	6	33.5%
Cigna Saver Rx	$20.00	$29,914	$545	2.5			x		x	x	x	x	x		x	x	8	May	November	6	36.2%
Cigna Secure Rx	$41.40	$30,097	$545	2.5			x		x	x	x	x	x		x	x	8	May	December	7	36.4%
Mutual of Omaha Rx Premier	$84.60	$31,314	$349	1.5		x			x		x	x		x	x	x	7	April	September	5	37.9%
AAUP Medicare Rx Saver from UHC	$62.40	$31,530	$545	3.0		x			x	x	x	x		x	x	x	8	March	September	6	38.2%
SilverScript Choice	$42.50	$33,799	$545	3.0	x	x	x		x	x	x	x			x	x	9	April	November	7	40.9%
Mutual of Omaha Rx Plus	$89.10	$52,306	$545	1.5			x		x		x	x			x	x	6	Never	Never	0	63.3%
Maryland SilverScript Employer Plan	**$53.28**	**$2,709**	**$0**	**n/a**	**x**	**x**	**x**		**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**11**	**No Coverage Gap**			3.3%

When evaluating and selecting plans using the Medicare.gov website, one only sees the results of queries for specific drugs one is currently taking. There is no way to evaluate the comprehensiveness of a particular plan's formulary so one can judge whether a particular Part D plan might protect against future, currently unknown, prescription needs.

The 2019 SB 946 legislation promised "life-sustaining drugs" to retirees hired before July 2011 but does not define what life-sustaining means. Who gets to define life-sustaining? Medicare? The Legislature? My medical team? How can retirees appreciate this offer if they have no idea what it means and how can DBM administer a benefit that is undefined? But there are other complications. Yes, Medicare-eligible retirees are concerned about sustaining life, but they are also very concerned about medications that can preserve their quality of life while they are alive. The current debate about SB 443, End-of-life Option Act, often focuses on a patient ending their life prematurely. As an older member of the community who has witnessed friends and family die, I can say with confidence, that there is more to living than just being alive and medications that maintain quality of life are often key. SB 946 and the law arising from it offers nothing in this arena. New legislation is needed, legislation to restore benefits, even if just in the short term, while new, more equitable and financially viable legislation is developed.

Not only is the definition of "life-sustaining" missing from the legislation, just what drugs might be covered is also very confusing. A document shared by the Dept of Legislative

Services in the fall of 2023 regarding the change in prescription drug coverage, reads "The Maryland State Retiree Life-Sustaining Prescription Drug Assistance Program will reimburse a Part D recipient for OOP costs for a life-sustaining medication that is covered by the State plan but is not covered under the individual's Medicare prescription drug plan" (DLS Talking Points, prepared October 2023, pg. 2). Please note that according to this document, the declared intent of this program is to provide medications that are NOT on an individual's Medicare prescription plan, but the phrase OOP is defined by Medicare as only costs sustained for drugs that are on one's selected Part D plan formulary. This is an internal contradiction in a program that is supposed to make retirees feel as if the State is being supportive. New legislation is needed, legislation to restore benefits, even if just in the short term, while new, more equitable and financially viable legislation is developed.

For reasons I cannot understand, SB 946 also declared that only those pre-July 2011 hired individuals who were retired or retiring during the year it was passed, 2019, would be covered by the provisions of the bill. What possible logic could explain that a retiree who served for 55 years but who didn't retire until 2021 should be excluded from the benefit being offered to ameliorate the crisis? This is unconscionable. New legislation is needed, legislation to restore benefits, even if just in the short term, while new, more equitable and financially viable legislation is developed.

Conversations with legislators and their staffs over the past 5 years strongly suggest that many of them were very unaware of the change that was passed in 2011 and are equally unaware of the original promise. Those who know something about the change seem to think that Medicare Part D is equivalent to the State prescription coverage which, as I explained earlier, is not the case. People who do not understand the ramifications of their votes need to be educated about the financial impact of this change in benefits and the additional costs to a state retiree whose average pension is $1,541 a month. We have given many of our productive years to the State and would like to remain in the state, but Maryland is an expensive state to live in and this loss of prescription benefits represents a real dollar cost to retirees. New legislation is needed, legislation to restore benefits, even if just in the short term, while new, more equitable and financially viable legislation is developed.

When I was offered a position with the State, I considered what I could offer it and what it offered to me. I was impressed by the retirement package realizing that it offered me a 'safe landing' as I aged. I worked to uphold my end of our employment agreement and fully expected, when I retired in 2016, that the State would similarly uphold its commitment. This change has upended my safe landing and that of all other State retirees.

I urge you to support SB 349. Passing this bill could solve the immediate problem by restoring the original promised State prescription benefits. Passing it could also provide time to develop a more equitable, financially viable and just plan for retirees while reducing the financial burden on the State. New legislation could cover all those hired before July 2011 and remove the penalty for service to the state, past Jan 1, 2020, that currently exists. The population that is being impacted by the loss of promised prescription benefits is an older population and our demands on the State for benefits will diminish as mortality reduces our numbers and our costs to the State drop to zero.

In summary, the current law, 2019 Chapter 767, attempts to ameliorate the retroactive revocation of promised prescription benefits for Medicare-eligible retirees, but it fails to do so in several ways. It sidesteps the guidance of GASB 45 as to what population of employees should be targeted by policy changes addressing OPEB. The law presumes that the replacement coverage by Medicare D plans is equivalent to the State Prescription Drug plan: it is not. It arbitrarily excluded retirees who retired after January 1, 2020 regardless of when they were hired or how many years they worked. It attempts to create an Out-Of-Pocket cap to alleviate an excessive fiscal burden on Medicare-eligible retirees, but by adopting the language of Medicare, fails to do so. It created a program to cover "life-sustaining drugs" but fails to define them or identify who would define such a category at a later time. What is needed now is legislation that restores benefits while exploring options that will focus on date of hire rather than date of retirement, provide financial support for prescription drug purchases to Medicare-eligible retirees, thereby acknowledging their loyalty to the State during its earlier financial hard times.

I respectfully request that this Committee issue a favorable report on Senate Bill 349.

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