Where Health Care
and Retirement Intersect

RETIREMENT HEALTH BENEFITS

Prepared to assist members in answering questions about health benefits during retirement.

Table of Contents

INTRODUCTION

The purpose of this Manual is to provide general education and information on legal issues surrounding retiree health benefits. This document is not a complete statement of the law or administrative rules, however. Moreover, there are numerous types of retiree health plans that have been bargained by PSEA local associations throughout the state, and thus, results may differ from those indicated herein based upon particular factual circumstances.

For this reason, PSEA and PSEA-Retired are not providing any legal, tax, or financial guidance in this Manual. Rather, any questions pertaining to specific retiree health plans and their legal, tax, or financial impact should be directed to school employers and members' financial and tax advisors. Any advice contained in this presentation is not intended or written to be used, and cannot be used, to avoid penalties under the Internal Revenue Code or to promote, market, or recommend to another party any transaction or matter addressed herein. There are no third-party beneficiaries to this presentation, and it should not be relied upon for advice or counsel in any particular or specific factual situation.

SECTION 513(b) OF THE SCHOOL CODE

OVERVIEW:

- Section 513(b) of the Public School Code, 24 P.S. § 513(b), requires school entities to maintain retirees on their group health plan, **at the employee's cost**, until the employee turns sixty-five (65) years of age, provided:

  (1) the employee has taken normal (i.e., superannuation[1]) retirement, has thirty (30) or more years of service with the Public School Employees' Retirement System (PSERS), or has taken PSERS disability retirement;

  (2) the employee is receiving a pension from PSERS; and

  (3) the employee is not eligible as an employee or dependent under any employer-provided health plan.

- The cost that a retiree pays to maintain the employer's group health plan must be equal to the cost of the health care offered to active employees, except that school employers may charge retirees an additional two percent (2%) administrative fee.

- Some local associations have bargained that employers continue to provide insurance to retirees, **at the employer's cost**. The question then becomes for how long and for what specifically the employer will pay. (*See* "Vested Retiree Health Benefit" discussion, at pp. 4-6.)

ISSUES:

Q: What happens to the health insurance that I receive by virtue of Section 513(b) once I turn age sixty-five (65)?

A: Review your collective bargaining agreement. If there is no contract language granting you the opportunity to continue receiving benefits under your employer's group health plan beyond the age of sixty-five (65) and your eligibility for Medicare, then the employer is authorized to discontinue your health coverage, since Section 513(b) only requires the offering of continued health coverage until the age of sixty-five (65).

---

[1] Superannuation under the Public School Employees' Retirement Code, 24 Pa.C.S. § 8102, is as follows:

(1) For those with Class T-C or T-D Service: (a) 62 years of age and one year of service; (b) 60 years of age and 30 years of service; or (c) 35 years of service at any age.

(2) For those with Class T-E or T-F service: (a) 65 years of age and three years of service or (b) a combination of age and service points that is equal or greater to 92, with a minimum of 35 years of service.

24 Pa.C.S. § 8102.

Q: Can my dependents continue school employer insurance after I turn age sixty-five (65)?

A: Review your collective bargaining agreement. If there is no contract language granting your dependents the opportunity to continue on your employer's plan, your dependents will then be entitled to continue the employer's insurance under COBRA for a maximum of thirty-six (36) months or until they enroll in Medicare themselves, as applicable.

Q: What happens to my employer insurance if my spouse turns sixty-five (65) before I do?

A: Review your collective bargaining agreement to see if there is language that would allow dependents (i.e., your spouse) to continue to receive your employer's group health benefits while on Medicare. If there is no contract language granting your dependent the opportunity to continue receiving health insurance on the employer's group health plan while also receiving benefits from Medicare, then the school employer will be authorized to terminate your spouse's insurance.

Q: What happens if I am eligible for health coverage under my spouse's employer health plan such that I am taken off my school employer's plan, but then, my spouse loses his/her job . . . May I be reinstated on my former school employer's group health plan?

A: Yes. Section 513(b) explicitly states that a retiree can be reinstated on the employer's group health plan if his/her alternative health coverage ceases.

Q: What happens if I retire at the end of a school year and my school employer starts charging me for my health insurance during the summer following that school year?

A: Notify your local association and then contact your PSEA UniServ Representative. Your local association may be able to file a grievance on your behalf, arguing that you worked the entire school year and thus, you are entitled to all of the regular benefits afforded active employees for that year—which generally includes health insurance paid throughout the summer. (NOTE: This issue is not specifically addressed within Section 513(b) of the School Code but is included in this section's discussion anyway for informational purposes.)

YOUR NEXT STEPS:

At least three months prior to retirement, retirees should clarify the type and the extent of health coverage that their school employers will provide under Section 513(b), both in terms of themselves and any dependents. Retirees should request that the school employer's information on retiree health benefits be provided in writing.

Retirees should seek confirmation of the information that they receive from their school employer with their local association leaders and/or their PSEA UniServ Representative.

VESTED RETIREE HEALTH BENEFITS

OVERVIEW:

- To bargain a vested (i.e., guaranteed) retiree health benefit in collective bargaining agreements, locals must do so through explicit contract language. *International Union v. Skinner Engine Co.*, 188 F.3d 130 (3d Cir. 1999).

- Many local associations have bargained a vested right for retirees to continue to receive employer-provided (i.e., employer-paid) health benefits beyond the collective bargaining agreement under which the employee retires. In so doing, locals have bargained explicit *durational language* within their contract.

  For example (durational language in italics):

  > "Retirees will receive employer-provided health benefits at the employer's cost *until they are eligible for other government-provided or employer-provided health benefits*."
  >
  > "Retirees will receive employer-provided health benefits at the employer's cost for *ten years*."

- It is very difficult to bargain a vested benefit to a particular plan (e.g., HMO plan or indemnity plan) or level of retiree benefits (e.g., no co-pays, no deductibles, no premium-sharing). In fact, courts have been loath to find that locals have bargained a vested right for retirees to a particular type or level of health benefits. *See, e.g.*, *Mars Area Educ. Ass'n v. Mars Area Sch. Dist.*, 987 A.2d 231 (Pa. Commw. Ct. 2008), *allocatur denied* 997 A.2d 1180 (Pa. 2010); *Boyd v. Rockwood Area. Sch. Dist*., 907 A.2d 1157 (Pa. Commw. Ct. 2006); *Sharpsville Area Educ. Ass'n v. Sharpsville Area Sch. Dist*. (Arb. Newman 2006).

- Moreover, PSEA recommends that locals bargain language that retirees receive the same health care benefits that active employees receive. With such language, retirees would receive any future increase in co-pays, deductibles, or premium-sharing that active employees may sustain.

ISSUES:

Q: Do local associations have a duty to bargain retiree health benefits?

A: No. Local associations owe no duty to bargain on behalf of retirees since retirees are no longer part of the bargaining unit.
Allied Chemical and Alkali Workers of America Local Union No. 1 v. Pittsburgh Plate Glass, 404 U.S. 157 (1971). As such, employers have no mandatory obligation to bargain over retiree benefits. Thus, the subject of retiree health benefits is only a

permissive subject of bargaining. *Allied Chemical; Fraternal Order of Police v. City of Reading,* 30 PPER ¶ 30062 (F.O. 1999).

Caveat: If local associations undertake the effort to bargain on behalf of retirees and, in so doing, bargain vested health benefits, locals then owe the duty of fair representation to retirees to refrain from bargaining to eliminate or alter those vested benefits. *Nedd v. United Mine Workers of America*, 556 F.2d 190 (3d Cir. 1977), *cert. denied* 434 U.S. 1011 (1978); *Toensing v. Brown*, 528 F.2d 69 (9th Cir. 1975); *Hendricks v. Airline Pilots Ass'n Int'l*, 696 F.2d 673 (9th Cir. 1983).

Q: Why does PSEA advise its locals to only bargain vested rights as to the duration of retiree health benefits, but not as to the type or level of retiree health benefits?

A: Once a local association bargains a vested right of a retiree to health insurance, it must enforce those vested rights or risk a duty of fair representation claim. As such, there are significant liability, policy, and political concerns for locals that bargain vested rights to retiree health benefits.

Thus far, there have not been liability, policy, or political concerns that have arisen when local associations have bargained a vested right to a particular duration of employer-provided (i.e., employer-paid) retiree health benefits. Examples would be bargaining language creating vested rights to employer-paid health insurance until retirees become eligible for other government-provided coverage (e.g., Medicare) or for a particular period of time (e.g., ten years). It is for this reason that PSEA **does not** oppose local associations bargaining vested rights to the duration of retiree health benefits.

By contrast, there have proven to be legal and organizational conflicts if local associations bargain a vested right of retirees to a particular type of benefits (e.g., an indemnity plan) or a particular level of benefits (e.g., no co-pays, no co-premiums, no-deductibles), but then are unable—due to poor economic circumstances—to bargain salary increases for active employees or even health insurance that is similar to what prior retirees are getting because of the local association and employer's prior contractual obligation creating vested rights to a particular plan or level of benefits for retirees. This is especially true given the rapidly changing health insurance marketplace and the cost of maintaining special coverage for a small group of retirees, which, in turn, would inhibit the employer from bargaining salary increases and/or benefits for current employees.

If a local association would attempt to alter these vested benefits, the local could be subject to a lawsuit alleging that it breached its duty of fair representation.

For this reason, PSEA has consistently recommended that retiree health insurance may be bargained to vest for a particular duration of time, but that vested rights to a particular type or level of coverage **should not** be bargained.

Q: What is PSEA's advice on bargaining health care benefits for retirees as compared to active employees?

A: PSEA advises that local associations should bargain that retirees receive the same health care coverage—as that coverage may change—as active employees. Thus, if active employees receive increased co-pays or deductibles, so will retirees.

Q: How do I plan for retirement if PSEA will not bargain vested rights to a particular plan (e.g., indemnity plan) or level of retiree health benefits (e.g., no co-pays, no premium-sharing)?

A: PSEA advises that, when individuals contemplate retirement and make plans with their financial counselors toward that goal, they should assume that their health care costs may increase—especially in terms of co-pays, deductibles, or premium-sharing—and allow for enough "cushion" in their finances to account for these potential contingencies.

Q: What happens if my local association has bargained a vested right to a duration of retiree health benefits and my school employer breaches my vested right? Can my local association assist me by filing a grievance on my behalf?

A: Yes, provided that there is language within the collective bargaining agreement that refers to retirees and/or retiree benefits. *United Steelworkers v. Canron*, 580 F.2d 77 (3d Cir. 1978); *Greene County*, 20 PPER ¶ 20137 (Prop. Dec. & Order 1989). If the benefit is not enforceable through the collective bargaining agreement, it may be enforced through litigation in county court.

YOUR NEXT STEPS:

Retirees should clarify the type and the extent of health coverage that their school employers will provide, both in terms of themselves and any dependents. Retirees should request that the school employer's information on retiree health benefits be provided in writing.

Retirees should seek confirmation of the information that they receive from their school employer with their local association leaders and/or their PSEA UniServ Representative.

Unless retirees are told otherwise by both their school employers and their local associations and/or PSEA, **they should assume that they do not have vested rights to a particular type of insurance plan or a particular level of benefits**. Put another way, they should assume that their health care coverage will change in the future in the same manner that health coverage for active employees may change. Retirees should base their retirement and financial determinations on that presumption and plan for their financial ability to pay increased health care costs in the future.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

You can learn more about COBRA on the Department of Labor's website at https://www.dol.gov/general/topic/health-plans/cobra.

OVERVIEW:

- COBRA amended the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code, and the Public Health Service Act to provide continuation of group health coverage that otherwise would be terminated.[2] COBRA generally guarantees employees and their families who lose health benefits due to certain qualifying events the right to choose to continue group health benefits provided by employers for limited periods of time.

- Employees have the obligation to pay the full cost of health coverage, including a two percent (2%) administrative fee, during the applicable time period.

- COBRA applies to all group health plans maintained by private-sector employers (with at least 20 employees) or by state and local governments.

- Qualifying events allowing for qualified beneficiaries (i.e., employees, spouses, or dependent children) to be eligible for COBRA include the following:

  Qualifying Events for Employees:

  (1) Voluntary or involuntary termination of employment, including retirement, for reasons other than gross misconduct; and

  (2) Reduction in the hours of work that causes a loss of health coverage.

  Qualifying Events for Spouses:

  (1) Voluntary or involuntary termination of the employee's employment, including retirement, for any reasons other than gross misconduct;

  (2) Reduction in the hours worked by the employee;

  (3) Covered employee becoming eligible for Medicare;

[2] The amendments to the Public Health Services Act apply to government employees. The amendments under ERISA (29 U.S.C. §§ 1161-1169) and the Public Health Services Act (42 U.S.C. §§ 300bb-1-300bb-8) parallel each other and provide the same benefits.

(4) Divorce or legal separation from the employee; and

(5) Death of the employee.

Qualifying Events for Dependent Children:

(1) Loss of dependent child status under the health plan rules, including aging out of eligibility;

(2) Voluntary or involuntary termination of the employee's employment, including retirement, for any reason other than gross misconduct;

(3) Reduction in the hours worked by the employee;

(4) Covered employee becoming entitled to Medicare;

(5) Divorce or legal separation of the employee and spouse that causes a loss of coverage (e.g., coverage for stepchildren); and

(6) Death of the employee.

- The maximum COBRA continuation coverage periods, as they may impact retiree health coverage, are as follows:

(1) **Initial Retirement** – Retiring Employee/Spouse/Dependent Child – Eighteen (18) months of COBRA

(2) **Retiree Enrollment in Medicare** – Spouse/Dependent Child – Thirty-six (36) months of COBRA

(3) **Death of Retiree** – Spouse/Dependent Child – Thirty-six (36) months of COBRA

(4) **Loss of "Dependent Child" Status under Plan** – Dependent Child – Thirty-six (36) months of COBRA

NOTE: The above coverage periods may be extended in certain circumstances including (i) becoming eligible for Social Security disability (this qualifies a qualified beneficiary for an additional eleven (11) months of coverage, which, with the original eighteen (18) months, results in a total of twenty-nine (29) months of coverage); and (ii) the occurrence of a second qualifying event, which would entitle a qualified beneficiary to an additional eighteen (18) months of coverage, for a total of thirty-six (36) months. It is important to provide timely notice of the disability in order to receive the COBRA coverage period extension for disability.

For qualified beneficiaries receiving an additional eleven (11) months of COBRA coverage due to disability, the amount of the administrative fee for the health benefits may be increased from 2 to 50 percent.

- If an individual becomes eligible for COBRA continuation coverage because of the following qualifying events: the employee's death; termination of employment; reduction of hours worked; or entitlement to Medicare, the employer must notify the plan of the qualifying event within thirty (30) days. After the plan receives the notice of the qualifying event, it must give qualified beneficiaries an election notice, which describes the right to continue coverage and how to make an election.

- Qualified beneficiaries must be given sixty (60) days to elect COBRA continuation coverage. The sixty (60) days is measured from the date the COBRA election notice is provided.

- You and your dependents are responsible for notifying the employer, or plan administrator, of two COBRA qualifying events – (1) divorce or legal separation, and (2) a dependent ceasing to be an eligible dependent (e.g., by aging out of eligibility). The notice must be provided within sixty (60) days after the qualifying event. Failure to provide the notice timely may mean that you or your dependent will not be able to elect COBRA coverage. After timely notification is provided to the employer, the employer has fourteen (14) days to send you a COBRA election notice, and you then have sixty (60) days to elect COBRA continuation coverage.

- Qualified beneficiaries who are disabled must give timely notice of the disability to receive extended COBRA coverage (for disability). The plan administrator will be able to provide more information about this deadline.

- COBRA premiums must be paid on time, and failure to pay COBRA premiums will result in the loss of COBRA coverage. The first COBRA premium payment is due no later than 45 days after the COBRA election date, which generally is the date that the election notice is received by the plan administrator. After that, generally payments are due monthly.

YOUR NEXT STEPS:

You should monitor the COBRA-related deadlines, including, for example, the deadline to elect coverage and the deadlines to pay COBRA premiums, very carefully. Missing COBRA-related deadlines may result in you losing your right to elect or continue COBRA coverage.

Notify your local association and then contact your PSEA UniServ Representative if you do not receive a COBRA notice to which you or your dependents are otherwise entitled. Contact your PSEA UniServ Representative with any other questions pertaining to COBRA.

Source: U.S. Department of Labor, "*An Employee's Guide to Health Benefits Under COBRA"* (2016).

HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs) and HEALTH SAVINGS ACCOUNTS (HSAs)

You can learn more about Health Reimbursement Arrangements and Health Savings Accounts in IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans, which may be found on the IRS's website at https://www.irs.gov/pub.

OVERVIEW:

Health Reimbursement Arrangement (HRA)

- A Health Reimbursement Arrangement (HRA) is an arrangement funded by an employer that reimburses an employee for qualified medical expenses incurred by the employee and the employee's eligible dependents, as applicable. The benefit provided under an HRA is limited to the dollar amount available under the HRA. An employer may design the HRA in a variety of ways, including, for example, permitting unused amounts in an HRA to be carried over to subsequent years or into retirement, or not. These terms will be described in the HRA document.

- An HRA is paid for solely by contributions from the employer. Generally, an employee may not contribute to an HRA. There are certain limited exceptions to this rule, including, for example, mandatory contributions of a retiring employee's unused vacation and sick leave.

- Generally, there are no limits imposed by the Internal Revenue Code on amounts that may be contributed to an HRA on an annual basis or amounts accumulated in an HRA. Contributions to an HRA may be made by employer when an employee is an active employee or when an employee is a retiree.

- An HRA for a current employee generally is coupled with a group health plan that provides major medical coverage. Retirees and former employees may be covered by an HRA providing only HRA benefits (i.e., not coupled with a group health plan that provides major medical coverage).

- An HRA may reimburse qualified medical expenses incurred by an employee or the employee's dependents after the date that the individual becomes covered by the HRA.

- Qualified medical expenses include medical expenses as described in Internal Revenue Code section 213(d) that are not otherwise paid or reimbursed. Qualified medical expenses may include out-of-pockets expenses such as copayments, coinsurance, and deductibles, certain health insurance premiums. The HRA documents will describe the expenses that the HRA will reimburse. An HRA may never be cashed out; it may only reimburse an individual for a qualified medical expense. Reimbursements paid by an HRA are not taxed.

Health Savings Account (HSA)

- A Health Savings Account (HSA) is tax-favored account under Internal Revenue Code section 223 that is funded by an employer or an employee or both that may pay for certain qualified medical expenses. To be eligible for HSA contributions, an individual must be covered by a qualified high deductible health plan (HDHP). The contributions in an HSA belong to the individual holding the account and are available for use following termination of employment. Unused amounts in an HSA carry over from year-to-year.

- An HSA is set up with an HSA trustee, which is often a bank or insurance company.

- The Internal Revenue Code limits the amount of money that may be contributed to an HSA on an annual basis. In 2020, the limit for an individual with single HDHP coverage is $3,550, and the annual limit for an individual with family HDHP coverage is $7,100. Individuals aged 55 or older may make an additional contribution of $1,000 per year. The contribution limit is $0 beginning with the month that an individual first enrolls in Medicare. Note that the contribution rules for HSAs are complex and there are tax consequences related to such contributions, so it is important to comply with the contribution rules.

- An employer may make contributions to an employee's HSA. Contributions made to an HSA by an employer are nonforfeitable. An employee also may make contributions to the employee's HSA, including on a pre-tax basis through salary reduction as permitted by the employer.

- An individual may only make or receive contributions to an HSA if the individual is covered by a qualified high deductible health plan (HDHP). A qualified HDHP must have certain minimum deductibles (as set by the Internal Revenue Code). To be eligible to receive or make contributions to an HSA, an individual must not be covered by any impermissible non-HDHP coverage, which generally means that an individual may not have other health coverage that pays benefits before the HDHP deductible has been satisfied (with certain exceptions).

- An HSA may reimburse qualified medical expenses incurred by an employee or the employee's eligible dependents after the date that the HSA is established. The individual determines when to seek reimbursement from the HSA for a qualified medical expense; there is no time limit on when an HSA distribution must occur.

- Qualified medical expenses include medical expenses as described in Internal Revenue Code section 213(d) that are not otherwise paid or reimbursed. Qualified medical expenses may include out-of-pockets expenses such as copayments, coinsurance, and deductibles. Generally, an HSA may not reimburse health insurance premiums with exceptions for COBRA coverage, long-term care insurance, and retiree medical coverage for an individual age 65 or older, but not a Medicare Supplement policy. Distributions from an HSA for a qualified medical expense are not taxed.

- Distributions may be taken from an HSA for expenses that are not qualified medical expenses, but such distributions are taxable and may be subject to additional tax. If an individual takes such a distribution after the date that the individual becomes disabled or reaches age 65, the additional tax may not apply. IRS Publication 969 describes the tax rules for these types of HSA distributions.

- An individual should designate a beneficiary to receive the HSA account balance following the individual's death. Different tax rules apply depending on whether the designated beneficiary is the individual's spouse or another person. IRS Publication 969 describes the tax rules applicable to HSAs and beneficiaries.

YOUR NEXT STEPS:

Ask whether you have an HRA available to you as a retiree. If you do, determine how much money in available in the HRA and whether contributions are made on an on-going basis, and if yes, for how long. Determine whether the HRA account balance rolls over from year-to-year. If it does not, you will want to ensure that you submit claims for reimbursements so that you do not lose funds.

If you have an HSA, determine whether you can continue to make contributions to the HSA following retirement. Update your HSA beneficiary designate, as needed. Determine when you want to take distributions from your HSA.

Contact your PSEA UniServ Representative with questions pertaining to whether you are covered by a retiree HRA.

MEDICARE

You can learn more about Medicare and download the "Medicare and You" booklet at www.medicare.gov.

OVERVIEW:

- Medicare is health insurance for the following individuals:

  (1) People age sixty-five (65) or older;
  (2) People under age sixty-five (65) with certain disabilities; and
  (3) People of any age with End-Stage Renal Disease (ESRD) (i.e., permanent kidney failure requiring dialysis or a kidney transplant).

- Medicare has four parts:

  (1) Part A: Hospital Insurance
  (2) Part B: Medical Insurance
  (3) Part C: Medicare Advantage
  (4) Part D: Prescription Drug Coverage

- There are two main ways to obtain Medicare coverage: (1) Original Medicare (i.e., Parts A and B) or (2) Medicare Advantage (known as Medicare Part C, which generally combines Parts A and B, and usually Part D). You may supplement coverage under Medicare Parts A and B with a Medicare Supplemental policy, which also is sometimes called a Medigap policy.

- Medicare Part A

  (1) Covers inpatient care in hospitals, as well as skilled nursing facilities, hospice, and home health care services (NOTE: Part A does not cover custodial or long-term care);

  (2) Generally has no monthly premium (i.e., most people have paid for Part A through payroll taxes that they or their spouse paid while working), although you may pay co-pays, co-insurance, and deductibles for Part A-covered services; and

  (3) Enrollment in Part A is required (unless you wish to forfeit your entitlement to Social Security benefits).

- Medicare Part B

  (1) Covers doctors' and other health care providers' services, outpatient care, durable medical equipment, and home health care, as well as many preventive care services;

(2) Has a standard monthly premium that generally will be deducted from your Social Security or disability retirement checks if you are receiving such a payment (NOTE: If you are not yet receiving either Social Security or disability retirement benefits, you will receive a bill for your Part B premiums.);

(3) If your income is above a certain limit, you will pay the standard Medicare Part B premium PLUS an additional amount called the Income Related Monthly Adjustment Amount; and

(4) Enrollment in Part B is voluntary, but it is important to enroll in Part B when you are first eligible or during your applicable Special Enrollment Period. Failure to enroll at the correct time may result in a permanent late enrollment penalty.

Generally, the Special Enrollment Period applies during the first eight (8) months following the month that the employer or group health coverage ends or when the employment ends, whichever comes first.

If a person retires and is covered by the insurance of his or her spouse's active employment, the retiree can delay signing up for Medicare Part B without penalty. The Special Enrollment Period begins to run when the retiree loses coverage through the spouse's group health plan or the spouse leaves employment, whichever is first. If a person retires and is covered by the insurance of a retired spouse, he or she must sign up for Medicare Part B or incur a penalty.

If a person enjoys employer-provided health insurance coverage beyond age 65, he or she should still sign up for Medicare at age 65.

- Medicare Part C

(1) Is also called "Medicare Advantage" and includes different options of medical plans, including HMOs, PPOs, Private-Fee-For-Service (PFFS) plans, and Specialized Needs Plans (SNP). If you enroll in a Medicare Advantage Plan, Medicare pays a fixed amount for care to the private company offering your Medicare Advantage Plan. The companies offering Medicare Advantage Plans must follow Medicare rules, although each Medicare Advantage Plan may charge different out-of-pocket costs and have different rules for how one receives services (e.g., whether you need a referral; whether you may only go to service providers within the plan);

(2) Offers extra health coverage, such as vision, hearing, dental and/or health and wellness programs. Most Medicare Advantage Plans also include Medicare Part D (i.e., prescription drug coverage);

(3) Offers all of the *services* that Original Medicare covers, except hospice care. (NOTE: If you don't receive Medicare under Part C, known as a Medicare Advantage Plan, you will receive what is known as Original Medicare – i.e., Parts A and B).

(4) Charges a monthly premium, in addition to the monthly premium for Medicare Part B (sometimes the Medicare Part B premium is included in the Medicare Advantage Plan premium); and

(5) Includes services that would, otherwise, be covered by Medicare Supplement (i.e., Medigap) plans for those on Original Medicare. Thus, if you enroll in a Medicare Advantage Plan, you will not need to, or be allowed to, purchase Medicare Supplemental insurance.

- Medicare Part D

(1) Offers prescription drug coverage to everyone with Medicare;

(2) Provides two ways to obtain Medicare prescription drug coverage: (a) through Medicare Prescription Drug Plans (PDPs), which add drug coverage to Original Medicare, some Medicare Cost plans, some Medicare Fee-for-Service plans (PFFS) and some Medicare Medical Savings Account Plans (MSA); and (b) Medicare Advantage Plans;

(3) Requires enrollment in a plan for the calendar year. However, there are certain events that can give rise to the ability to switch prescription drug coverage, including (a) moving from a plan's service area; (b) losing other creditable prescription drug coverage; or (c) starting to reside in an institution (e.g., a nursing home);

(4) Charges a monthly fee that varies by plan. If you elect Original Medicare, the cost is in addition to the Part B premium. If you elect a Medicare Advantage Plan that includes Medicare prescription drug coverage, the monthly premium may include an amount for prescription drug coverage; and

(5) You will pay monthly premiums for Medicare Part D Prescription Drug Coverage. If your income is above a certain limit, you will pay the monthly premium PLUS an additional amount called the Income Related Monthly Adjustment Amount (Part D-IRMAA).

- Medicare Supplemental Insurance (i.e., a Medigap Policy) is provided through private insurance companies to assist in the payment of health care costs that are not covered by Medicare.

- Deciding What Medicare Path to Take

Step #1: How do you wish to obtain your coverage?

Original Medicare	OR	Medicare Advantage Plan
(Parts A and B)		(Part C, combining Parts A, B, and usually Part D)

Step #2: Decide if you need to add prescription drug coverage.

Original Medicare	OR	Medicare Advantage Plan
(would add Part D)		(Most Medicare Advantage Plans cover prescription drugs. You may be able to add some drug coverage in some plans if not already included.)

Step #3: Decide if you need to add supplemental coverage

Original Medicare	OR	Medicare Advantage Plan
(recommended to add Medicare Supplemental coverage, i.e., Medigap policies)		(You do not need and cannot be sold Medicare Supplemental coverage, i.e., Medigap policies)

- Enrollment in Medicare Parts A and B

(1) **Initial Enrollment Period** – This period begins three (3) months before the month you turn age sixty-five (65) and ends three (3) months after the month you turn age sixty-five (65). If you are under age sixty-five (65) and are receiving Social Security disability benefits, the Initial Enrollment Period begins following your twenty-fourth (24^{th}) monthly Social security disability payment.

(2) **General Enrollment Period** – If you don't sign up for Parts A and B during the Initial Enrollment Period, and you fail to qualify for a Special Enrollment Period, you may enroll between January 1 and March 31 each year. Medicare coverage would then begin as of July 1. Premiums may be increased, however, as a penalty for late enrollment ("the late enrollment penalty").

(3) **Special Enrollment Period** – If you don't sign up for Parts A and B when first eligible (i.e., during the Initial Enrollment Period) because you are covered under a group health plan based on your **current employment** (or your spouse's current employment), you may enroll during a Special Enrollment Period without having to pay the late enrollment penalty. The Special Enrollment Period applies during the first eight (8) months following the month that your group health coverage ends, or when your employment ends, whichever happens first. The Special Enrollment Period also applies if you are covered under a group health plan through your spouse's employment. NOTE: COBRA coverage, retiree health plans, and individual coverage (like coverage through the Marketplace) are **not** considered coverage through current employment for you or your spouse. Thus, to avoid having to pay the late enrollment penalty, you should enroll for Medicare during your Initial Enrollment Period or your Special Enrollment Period, as applicable, notwithstanding the continuation of benefits with your former employer due to COBRA or a contracted retiree health benefit.

- Enrollment in a Medicare Advantage Plan may take place during the Initial Enrollment Period for Parts A and B or during the period between October 15 and December 7 of each year. NOTE: You also can make changes to your Medicare Advantage Plan enrollment each year between January 1 and March 31. During this Medicare Advantage Open Enrollment Period, you may (1) switch to another Medicare Advantage Plan, or (2) disenroll from the Medicare Advantage Plan and return to Original Medicare.

- Enrollment in Medicare Part D can be accomplished at the following times: (1) during the Initial Enrollment Period for Parts A and B; or (2) during the period between October 15 and December 7 of each year. (Prescription drug plans also may be switched or dropped during this October 15 through December 7 period.)

Coordination of Benefits	Who Pays First
(1) If you have retiree insurance (i.e., insurance from former employment) . . .	Medicare pays first.
(2) If you are age sixty-five (65) or older and have group health care coverage based upon your or your spouse's current employment, and the employer has more than 20 employees . . .	Your group health care pays first.
(3) If you are age sixty-five (65) or older and have group health care coverage based upon your or your spouse's current employment, and the employer has less than 20 employees . . .	Medicare pays first.

ISSUES:

Q: I am sixty-seven (67) years old, but I am still employed as a custodian with my school employer. How will my school employer's insurance coordinate with Medicare?

A: Your school employer's insurance will be primary (provided that your school employer has 20 or more employees), and Medicare will be secondary.

Q: I am a sixty-six-year-old (66-year-old) retired school employee, but I am still listed as a dependent on my wife's school employer's group health plan. My wife is sixty-six (66) years old and is still working. How will my wife's school insurance coordinate with Medicare?

A: Your wife's school employer's insurance will be primary for both you and she (provided that her school employer has 20 or more employees), and Medicare will be secondary.

Q: I am sixty-eight (68) years old and am still eligible for retiree health insurance from my school employer because the employer bargained with my union to provide five (5) years of retiree health insurance upon retirement. I retired at age sixty-five (65) and thus, I am eligible for retiree health insurance until the age of seventy (70). How will my retiree health insurance coordinate with Medicare?

A: Medicare will be primary, and your school employer's health insurance will be secondary. Note, however, that your school employer's group health plan may not allow those eligible for Medicare to be included in the group health plan. In such cases, the school employer will have to secure a Medicare-supplement-type policy for those Medicare-eligible retirees for whom the employer is contractually obligated to provide retiree health insurance under the collective bargaining agreement.

Q: I am a fifty-two-year-old (52-year-old) and suffered a permanent disability as a result of a car accident when I was fifty (50). Two (2) years ago, I qualified for both Social Security disability and disability through the Public School Employees' Retirement System (PSERS). Since two (2) years have passed since I qualified for Social Security disability, I am now eligible for Medicare. I also am eligible to contribute to my former employer's group health plan by virtue of Section 503(b) of the School Code, as well as a provision in the collective bargaining agreement that mirrors the School Code. How does my retiree health insurance coordinate with Medicare?

A: Individuals are eligible for Medicare two (2) years after beginning to receive Social Security disability benefits. Since you are now eligible for Medicare, Medicare will be primary, and the school group health plan will be secondary.

YOUR NEXT STEPS:

Review the *Medicare and You* publication several months before you will turn sixty-five (65).

For questions concerning Medicare or Medicare and Medicare Supplemental (i.e., Medigap), call 1-800-MEDICARE (1-800-633-4227) or go to www.medicare.gov.

State Health Insurance Assistance Programs (SHIPS) answer questions about choosing a health plan, buying a Medicare Supplement policy, and other Medicare-related matters.

Pennsylvania's state health insurance assistance program is APPRISE. The APPRISE program offers free Medicare counseling to older Pennsylvanians. APPRISE counselors are specially trained to answer your questions and provide you with objective, easy-to-understand information about Medicare, Medicare Supplemental Insurance, Medicaid, and Long-Term Care Insurance. You may reach the APPRISE program at 1-800-783-7067 and http://www.aging.pa.gov.

Source: Centers for Medicare & Medicaid Services (CMS), "*Medicare & You*" (2019). NOTE: Information about Medicare changes on an annual basis. The information contained above is based only upon 2019 information. CMS prints its "*Medicare & You*" publication on an annual basis and thus, any information pertaining to Medicare for years other than 2019 should be verified with the publication pertinent to the year in question. The "*Medicare & You*" publication may be obtained by calling 1-800-MEDICARE (1-800-633-4227) or by accessing www.medicare.gov.

PREMIUM ASSISTANCE FROM THE PUBLIC SCHOOL EMPLOYEES RETIREMENT SYSTEM (PSERS)

OVERVIEW:

- Section 8509 of the Public School Employees' Retirement Code, 24 Pa.C.S. § 8509, offers eligible public-school retirees who participate in medical plans of Pennsylvania public-school employers or of the PSERS Health Options Program (HOP) monthly premium assistance in the amount of $100 per month. Public-school retirees eligible for premium assistance include the following:

  (1) Public-school retirees with at least 24 ½ years of credited service regardless of age;

  (2) Public-school retirees with Class T-C or T-D service who terminate school employment at or after reaching age sixty-two (62) with at least 15 years of credited service;

  (3) Public-school retirees with Class T-E or T-F service who terminate school employment at or after reaching age sixty-five (65) with at least 15 years of credited service; or

  (4) Any individuals receiving PSERS disability retirement.

- Those who receive $100 in monthly premium assistance will receive the premium assistance as an added amount to their monthly retirement benefit.

- Premium assistance is not taxable income.

- Premium assistance for eligible public-school retirees will only be paid if the retiree incurs an out-of-pocket expense. (NOTE: If the out-of-pocket expense is less than $100, the eligible retiree will only receive the actual out-of-pocket expense.)

ISSUES:

Q: Are retirees who live outside of Pennsylvania eligible for premium assistance?

A: Yes, provided that the retiree has an out-of-pocket premium expense from HOP or a Pennsylvania school employer health plan.

Q: What if I retire under an early retirement incentive that requires my school employer to provide paid health insurance to me until I qualify for Medicare? Would I have an out-of-pocket cost that would qualify me for premium assistance?

A: Ask this question of your school employer, as it will be the entity that verifies an out-of-pocket cost to PSERS. Note, however, that there has been at least one case that has held that an individual who received employer-paid health coverage did, indeed, have an out-of-pocket expense when she opted for the employer-paid health insurance over the lump sum payment that she could have received if she did not opt for the paid health insurance. PSERS held that the lump sum payment that the retiree forfeited in favor of the health insurance was the "out-of-pocket" expense. *In re McCleary, Swanson & Wood*, Nos. 1996-17, 1996-18, 1996-19 (PSERS Bd. Op., March 5, 1999).

YOUR NEXT STEPS:

- When seeking retirement estimates from PSERS in planning for retirement, confirm that you are an eligible public-school retiree that qualifies for premium assistance (e.g., ensure that PSERS has recorded sufficient years of service). Also, confirm that there is an out-of-pocket expense that the school employer will confirm with PSERS when PSERS sends an annual verification of the out-of-pocket expense. Attempt to obtain clarification from the school employer of the out-of-pocket expense and eligibility for premium assistance in writing.

- If a Health Retirement Account (HRA) is established for you with employer funds at the time of retirement, and you use the HRA to pay for your full health insurance costs, you will not qualify for premium assistance because the employer is deemed to be paying for the coverage. If, however, you personally pay $100 for the coverage and use funds from the HRA to cover the remaining cost, you will be deemed as having an out-of-pocket cost qualifying you for premium assistance.

- Notify your local association and then contact your PSEA UniServ Representative if you believe that you are eligible for premium assistance payments and your school employer advises that you are not.

Source: "Premium Assistance," PSERS-HOP, https://www.hopbenefits.com/?fa=premiumAssistance.

PSERS HEALTH OPTIONS PROGRAM (HOP)

OVERVIEW:

- The Public School Employees Retirement Insurance Act, 24 Pa.C.S. § 8701 *et seq*., provides for the PSERS HOP Medical Plan.

- Enrollment in the HOP Medical Plan is available for Pennsylvania public-school retirees and their surviving spouses, as well as spouses or dependent children of retirees or survivor annuitants.

- The HOP Medical Plan contains two types of coverage: (a) a plan for those under age 65 and (b) a Medicare Supplement plan.

- Enrollment in the HOP Medical Plan may take place within one hundred eighty days (180) days of a qualifying event, as listed below:

  (1) A public-school employee's retirement;

  (2) A public-school retiree loses health care coverage under the school employer's health plan (as provided for under Section 513(b)), including any COBRA continuation of the school employer's health plan;

  (3) A public-school retiree loses health care coverage under a non-school employer's health plan, including any COBRA continuation coverage elected under that non-school employer's health plan;

  (4) A public-school retiree or his/her spouse reaches age 65 and becomes eligible for Medicare;

  (5) A public-school retiree has a change in family status (e.g., divorce; death of the retiree or the retiree's spouse; addition of a dependent through birth, adoption, or marriage; dependent loses eligibility);

  (6) A public-school retiree becomes eligible for premium assistance due to a change in legislation; and

  (7) A health plan approved for premium assistance terminates or a public-school retiree moves out of the plan's service area.

THE LAW:

- If one member of a public-school retiree's family has one of the above qualifying events, all members may enroll in the HOP Medical Plan or change their option if already enrolled. For example, if a public-school retiree's spouse turns age sixty-five (65) and becomes eligible for Medicare, that is a qualifying event for all eligible family members.

ISSUES:

Q: If I elect Original Medicare, may I still enroll in the HOP Medical Plan?

A: Yes. The HOP Medical Plan can be your Medicare Supplemental Plan (i.e., Medigap). The HOP Medical Plan covers many of the deductibles, co-premiums, and other expenses that you are required to pay under Original Medicare.

Q: Does the HOP Medical Plan have prescription drug plans?

A: Yes. The HOP Medical Plan has Medicare Part D plans that are specifically designed for HOP participants and their dependents.

YOUR NEXT STEPS:

Contact the HOP Medical Plan Unit at PSERS for assistance with any questions. The customer service number is 1-800-773-7725.

Source: "*Frequently-Asked Questions,*" PSERS-HOP, http://www.hopbenefits.com/cms/?fa=viewfaq.