Where Health Care and Retirement Intersect

RETIREMENT HEALTH BENEFITS

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

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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 specific 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 by individual members for advice or counsel in any particular or specific factual situation.

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SECTION 513(b) OF THE SCHOOL CODE

THE LAW:

- o Section 513(b) of the Public School Code, 24 P.S. § 513(b), requires school entities to maintain retirees and their dependents 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.

- o 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 and their dependents, except that school employers may charge to retirees an additional two percent (2%) administrative fee.

- o Some local associations have bargained that employers continue to provide insurance to retirees and their dependents, **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

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[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.

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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).

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.

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 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.

ADVICE:

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 placed in writing.

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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.

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VESTED RETIREE HEALTH BENEFITS

THE LAW:

- 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., indemnity) or level of retiree benefits (e.g., no co-pays, no deductibles, no premium-sharing). In fact, courts have been loathe 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).

- 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 enhancement in benefits, as well as 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 they 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

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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 the 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—out of desperation—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.

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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) 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 benefits may increase—especially in terms of co-pays, deductibles, or possibly 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.

ADVICE:

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 placed 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 yet 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 allow for their financial ability to pay increased health care costs in the future.

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CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

THE LAW:

- 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] Specifically, COBRA guarantees employees and their families who lose health benefits due to certain qualifying events the right to choose to continue qualified group health benefits provided by qualified employers for limited periods of time.

- Employees have the obligation to pay the full cost of health coverage, including a two percent (2%) administrative charge, 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 for reasons other than gross misconduct (which, obviously, includes an employee's retirement); and

  (2) Reduction in the Hours of Employment.

  Qualifying Events for Spouses:

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

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

  (3) Covered employee becoming eligible for Medicare;

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

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[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.

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(5) Death of the employee.

Qualifying Events for Dependent Children:

(1) Loss of dependent child status under the health plan rules;

(2) Voluntary or involuntary termination of the employee's employment 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

(6) Death of the employee.

- The maximum COBRA continuation coverage, as it may impact retiree health coverage, is as follows:

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

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

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

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

  NOTE: In certain circumstances, the above coverage periods may be extended. Examples are (i) eligibility for social security disability (which qualifies one 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 one to an additional eighteen (18) months of coverage, for a total of thirty-six (36) months.

  NOTE FURTHER: For those receiving an additional eleven (11) months of COBRA coverage due to disability, the amount of administrative cost for the health benefits may be increased from 2 to 50 percent.

- Those entitled to COBRA continuation coverage must receive a notice from their employer advising them of their opportunity for COBRA coverage within thirty (30) days of the employee's death, termination, reduced hours of employment, or entitlement to

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Medicare. This notice should include all of the information necessary to understand the applicable COBRA premiums (e.g., the amount of premiums; when the premiums are due; and the consequences of late or non-payment).

- Qualified beneficiaries of COBRA continuation coverage must be given sixty (60) days to make an election to take advantage of the COBRA benefits. The sixty (60) days is measured from the date the COBRA election notice is provided.

- Qualified beneficiaries of COBRA continuation coverage must notify their employer plan administrator of a qualifying event within sixty (60) days after divorce or legal separation or a child's ceasing to be covered as a dependent under the plan rules. Once such notification is provided to the employer, the employer has fourteen (14) days to send a COBRA election notice, and the qualified beneficiary then has sixty (60) days to elect COBRA continuation coverage.

ADVICE:

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: The Consolidated Omnibus Budget Reconciliation Act*" (2012).

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MEDICARE

THE LAW:

- 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 Medicare Advantage (known as Medicare Part C, which generally combines Parts A and B, and usually Part D).

- 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 skilled nursing services); and

  (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 one may pay co-pays, co-insurance, and deductibles for Part A-covered services.

- Medicare Part B

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

  (2) Has a monthly premium which will be deducted from one's social security or disability retirement checks if such are being received (NOTE: For those not yet on either social security or disability retirement, they will receive a bill for their Part B premiums.); and

  (3) Enrollment in Part B is voluntary. However, enrollment in Part A is required unless one wishes to forfeit one's entitlement to social security.

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- 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, Specialized Needs Plans (SNP), HMO Point-of-Service (HMOPOS) plans, and Medical Savings Account (MSA) plans. Essentially, for those opting for Medicare Part C (i.e., Medicare Advantage plans), Medicare pays a fixed amount for care to private companies offering Medicare Advantage plans. These companies 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 one needs a referral; whether one 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 also include Medicare Part D (i.e., prescription drug coverage);

  (3) Offers all of the *services* that Original Medicare covers, except hospice care. (NOTE: Those not receiving Medicare under Part C, known as the Medicare Advantage Plan, receive what is known as Original Medicare – i.e., Parts A and B).

  (4) Charges a monthly premium, in addition to the monthly premium that one will receive for Medicare Part B; and

  (5) Includes services that would, otherwise, be covered by Medicare Supplement (i.e., Medigap) plans for those on Original Medicare. Thus, those on Medicare Advantage Plans need not 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: (1) 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 Plans (MSA); and (2) Medicare Advantage Plans;

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

  (4) Charges a monthly fee that varies by plan. For those on Original Medicare, the cost is in addition to the Part B premium. For those on Medicare Advantage Plans that

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includes Medicare prescription drug coverage, the monthly premium may include an amount for prescription drug coverage; and

(5) Monthly premiums for Medicare Part D Prescription Drug Coverage may be higher based upon income levels.

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

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

Original Medicare (would add Part D)	OR	Medicare Advantage Plan (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 (recommended to add Medicare Supplemental coverage, i.e., Medigap policies)	OR	Medicare Advantage Plan (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 one turns sixty-five (65) and ends three (3) months after the month one turns sixty-five (65). If on social security disability, the initial enrollment period begins following the twenty-fourth (24th) monthly social security disability payment.

(2) **General Enrollment Period** – Those who fail to enroll for Parts A and B during the Initial Enrollment Period and fail to qualify for the Special Enrollment Period may enroll between January 1 and March 31 each year. Medicare coverage would then begin as of July 1. Premiums will be increased, however, as a penalty due to late

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enrollment.[3]

(3) **Special Enrollment Period** – Those who fail to enroll for Parts A and B when first eligible (i.e., during the Initial Enrollment Period) because they are covered under a group health plan from an employer or union based upon their **current employment** may enroll during the Special Enrollment Period without having to pay the increased premium penalties. The Special Enrollment Period applies during the first eight (8) months following the month that the employer or union group health coverage ends, or when the employment ends, whichever comes first. The Special Enrollment Period also applies to individuals who receive health coverage through an employer or union group health plan due to their spouses' employment. NOTE: COBRA and retiree health plans are **not** considered current employment for individuals and/or their spouses. Thus, to avoid having to pay the increased premium penalties, individuals should enroll for Medicare during the Special Enrollment Period, notwithstanding their continuation of benefits with their former employer due to COBRA or a contracted retiree health benefit.

- Enrollment in Medicare Part C 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: Between January 1 and February 14, those on Medicare Advantage Plans may switch 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 may also be switched or dropped during this October 15 through December 7 period.)

- Coordination of Benefits

  (1) If you have retiree insurance (i.e., insurance from former employment) . . . Medicare pays first.

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[3] These penalties are as follows:

- For Part A, the penalty premium is 10 percent of the current Part A premium charged to those who do not have a long enough work history to qualify for free Part A coverage. This 10 percent premium will last for twice the number of twelve-month periods that one was eligible for Part A coverage but did not enroll for it.

- For Part B, the penalty is a monthly penalty added to the monthly premium that one pays for Part B coverage. The penalty is 10 percent of the monthly Part B premium, for each twelve-month period that one could have enrolled in Medicare Part B, but did not do so. This penalty will last for as long as one has Medicare Part B coverage.

- For Part D (prescription drug coverage), there is a penalty of 1 percent of the average monthly prescription drug premium for every month that one is late. This penalty will also last for as long as one has Medicare Part D coverage. One is late in enrolling for Part D coverage if one did not enroll for Part D coverage within three months after enrolling for Medicare Part A or B coverage.

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(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.

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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, while your school employer's health insurance will be secondary. Even then, 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 have suffered a permanent disability as a result of a car accident that I was involved in when I was fifty (50). Two (2) years ago, I qualified for both social security disability as well as 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 in two (2) years following eligibility for social security disability. Since you are now eligible for Medicare, Medicare will be primary, and the school group health plan will be secondary.

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ADVICE:

Questions concerning Medicare in general or regarding various Medicare and Medicare Supplemental (i.e., Medigap) plans may be answered by calling 1-800-MEDICARE (1-800-633-4227) or by accessing www.medicare.gov.

Source: Centers for Medicare & Medicaid Services (CMS), "*Medicare & You*" (2012). NOTE: Information about Medicare changes on an annual basis. The information contained above is based only upon 2012 information. CMS prints its "*Medicare & You*" publication on an annual basis and thus, any information pertaining to Medicare for years other than 2012 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.

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

THE LAW:

- o 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.

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

- o Premium assistance is not taxable income.

- o Premium assistance for eligible public school retirees will only be paid if they incur 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 the retiree has an out-of-pocket premium expense from HOP or a Pennsylvania school employer health plan.

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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).

Q: *I am being continued as a dependant on my spouse's plan since he is still actively employed by the district. The additional cost for my dependant coverage exceeds $100 a month. Can I submit it for reimbursement to my spouse's Section 125 Plan?*

A: The rules governing what constitutes a legitimate out-of-pocket expense are determined by the IRS. They do not consider any payment from a pre-tax income source such as a Section 125 Plan or a Health Savings Account funded by an employer as a qualifying expense. To get around this rule, an individual will need to make sure that $100 of their total payment comes from after tax income. Any additional amount over the $100 can then be covered by another source.

ADVICE:

- When seeking retirement estimates from PSERS in planning for retirement, ensure 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, ensure 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, http://www.hopbenefits.com/index.cfrm?fa=premiumAssistance.

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PSERS HEALTH OPTIONS PROGRAM (HOP)

THE LAW:

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

- o 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.

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

- o 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)). (NOTE: Coverage under a school employer's health plan includes COBRA continuation of the school employer's health plan. Thus, within one hundred eighty (180) days of the completion of the COBRA coverage, one may enroll in the HOP medical 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.

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THE LAW:

- o 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.

ADVICE:

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.

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