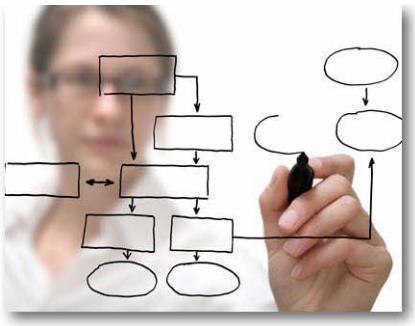
HEALTH OPTIONS PROGRAM (HOP) ELIGIBILITY REVIEW

Pennsylvania Public School Employees' Retirement System

May 20, 2013





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May 20, 2013

Mr. Mark F. Schafer
Director, Health Insurance Office
Public School Employees' Retirement System
5 North 5th Street
Harrisburg, PA 17108-0125

Re: Health Options Program Eligibility Review

Dear Mark:

We are glad to present our study report for the Health Options Program Eligibility Review.

The report includes analyses of a number of questions relating to eligibility to join the HOP, as well as supporting research on federal requirements for employers around qualifying events and illustrations of how other large state systems providing health benefits for retirees handle eligibility for their plans.

Segal is prepared to provide further details related to the comments or recommendations made in this report and to discuss any questions you may have. We look forward to working with PSERS to accomplish the recommended actions.

We again thank you, Valerie Sponseller, and the numerous managers and staff at PSERS and CoreSource who participated in the onsite interviews, for their time and cooperation in connection with this project.

Sincerely,

J. Richard Johnson
Senior Vice President

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1. Executive Summary

1.1 Background

The Public School Employees' Retirement System (PSERS) retained The Segal Company (Segal) to conduct a study of the eligibility rules, practices, and policies under the PSERS Health Options Program (HOP).

PSERS is a statewide retirement system covering over 400,000 individuals from over 700 participating school districts throughout the Commonwealth.

For over 40 years, PSERS has deducted health insurance premiums from the retirement benefits of annuitants participating in a Medicare supplement plan from an approved insurance carrier. The original plan was called the PSERS Statewide Group Health Insurance Plan and the insurance carrier was Capital Blue Cross, in conjunction with Independence Blue Cross, Blue Cross of Northeastern PA, and Blue Cross of Western PA. The Plan allowed spousal coverage and, upon the death of the retiree, that coverage could continue provided the surviving spouse paid premiums directly to Capital Blue Cross.

Act 23 of 1991 created the Premium Assistance benefit to provide a health insurance premium subsidy to eligible retirees. The Act defined "participating eligible annuitants" as all eligible annuitants who are enrolled in a health insurance program approved by the board. Since eligible annuitants included retirees under age 65, the PSERS Statewide Group Health Insurance Program was expanded to provide stand-alone health insurance coverage to individuals not eligible for Medicare. Effective January 1, 1994, the board adopted the PSERS Health Options Program (HOP) and limited the plans approved for Premium Assistance to all Commonwealth public school employer plans and HOP.

Act 88 of 1998 gave specific authority to the board to "sponsor a participant funded group health insurance program for annuitants, spouses of annuitants, survivor annuitants and their dependents."

Act 9 of 2001 expanded the description of the Group Health Insurance Program to include a definition of "eligible person" as "an individual who is an annuitant or survivor annuitant or the spouse or dependent of an annuitant or survivor annuitant."

Today, the Health Options Program (HOP) provides a self-insured Medicare supplement plan, a self-insured Medicare prescription drug plan contracted directly with the Centers for Medicare and Medicaid Services, and an array of Medicare Advantage with Medicare Prescription Drug plan options through six managed care organizations (MCOs). HOP also provides a companion pre-65 medical plan with optional prescription drug coverage and offers pre-65 managed care plans through the six MCOs. Together, these plan options cover over 85,000 retirees, spouses, and dependents.

Under Commonwealth law, public school employers must extend health care coverage availability to eligible retirees until the retiree turns age 65 and becomes eligible for Medicare.

Some public school employers also allow retirees to continue in their school plans after they reach age 65 and become eligible for Medicare, but most public school employers now end coverage for retirees who reach age 65.

Losing school health benefit coverage constitutes a "qualifying event," which opens the door for participation in the PSERS HOP. Each year, more than 7,000 PSERS retirees attain age 65, lose their coverage from their school plans, and become eligible to elect coverage under the HOP. That number is growing as the flood of retirees in the Baby Boomer generation reaches age 65. Once enrolled in the program, HOP participants are offered an opportunity annually to change their plan elections and choose among the plans offered for their location.

1.2 Purpose of Eligibility Review

As noted above, the Health Options Program along with its predecessor, the PSERS Statewide Group Health Insurance Program, has provided retirees with access to health insurance coverage for over 40 years. During that time, the definition of retirees eligible to enroll in the plan has changed, coverage for spouses and dependents was added, and eventually, the Code was modified to define broadly PSERS' authority to sponsor health insurance for retired school employees. Evolution of the plan and the increased diversity of enrollee situations have given rise to questions about the HOP's eligibility provisions and whether these provisions are consistent with the Code, the best interest of retirees and HOP participants.

This eligibility review was prompted because of a number of specific concerns and issues around eligibility determinations under the HOP. Examples of some of these issues include:

- Qualifying events as they pertain to spouses and dependents
- Comparable ("Mirror") Coverage for both retiree and spouse
- Retirees who miss their initial eligibility enrollment at age 65.

With the potential uncertainty surrounding these and other situations, and the possibility that similar eligibility concerns could be dealt with on an inconsistent basis, PSERS has determined that a full review of the HOP's eligibility requirements should be conducted.

The primary purposes of this study are to:

- Review the primary eligibility provisions relating to qualifying events
- Review specific eligibility issues that have arisen.
- Evaluate current practices against current industry standards/best practices to identify inconsistencies.
- Identify ways in which the HOP's eligibility policies and/or processes could be revised and improved for greater efficiency and alignment with PSERS' charter for the program.
- Propose next steps for PSERS to take on these issues.

1.3 Primary Findings and Recommendations

Segal identified a number of areas where the definitions of eligible persons and qualifying events can be adjusted and documented to provide more clarity on the circumstances under which retirees, spouses and dependents can enroll in the plan. We recommend development of a policy that specifies the qualifying events for each eligible person to assure consistency in administration and understanding among participants and administrators.

In addition, we found that the approach of specifying qualifying events and eligible persons is a valid way to both encourage enrollment among eligible persons and limit eligibility among those that do not, or no longer have, a financial relationship with PSERS. The approach works well to serve PSERS' mission for the program.

We explored a number of specific eligibility questions and have made recommendations to clarify each of those issues for future enrollment decisions. We specifically recommend relaxing the current "mirror coverage" requirement to allow a retiree with approved outside prescription drug coverage to choose medical only coverage in HOP while his or her spouse has both medical and prescription drug coverage in the program.

2. Project Methodology

2.1 Approach and Methodology

Our overall approach to conducting this Health Options Program Eligibility Review and addressing PSERS' eligibility issues and concerns under the HOP consisted of the following steps:

(a) Gathering and reviewing all available documentation concerning eligibility and enrollment;

(b) Conducting on-site interviews with selected PSERS and CoreSource staff who work specifically with participant eligibility;

(c) Conducting telephone interviews with staff of selected school districts participating in PSERS;

(d) Performing detailed analyses of information obtained from each of the various sources;

(e) Developing a comprehensive report, which documents our findings, observations, and recommendations; and

(f) Identifying next steps, including possible actions PSERS might take to enhance aspects of its current eligibility practices, policies, and procedures.

Details for steps (a), (b) and (c) are described in Appendix A.

We note that subsequent to the interviews with staff of selected school districts conducted in 2012, one of the districts interviewed, the School District of Philadelphia, decided to terminate its Medicare eligible retiree health coverage effective December 31, 2012, creating a qualifying event for about 2,700 retirees, spouses and dependents. PSERS, along with CoreSource and Segal worked with the School District of Philadelphia to coordinate transition and enrollment into the HOP of eligible Medicare retirees, spouses and dependents who lost their coverage.

3. Eligible Persons and Qualifying Events

In order to analyze the eligibility process and make suggestions for possible improvements, we focused on the current Code provisions regarding both eligibility (the definition of "Eligible Persons") and enrollment (the qualifying events that allow members to enroll in the HOP). As part of this review, Segal also examined specific eligibility situations that have arisen in the past and have resulted in persons being deemed eligible or ineligible for coverage under the HOP. An analysis of these specific situations appears in the tables later in this section of the report.

Chapter 87 of the Pennsylvania Retirement Code ("Code") establishes the Public School Retirees' Health Fund. Chapter 89 describes the administration of the Health Fund. In addition, Section 8509 establishes the Premium Assistance program, which provides up to $100 per month reimbursement of out of pocket health plan premium cost to Eligible Annuitants. Eligible persons (those eligible to participate in the HOP) are defined in Section 8702(a). While "eligible person" is broadly defined in the Code, there are no specific definitions of dependents or any definition of qualifying events in the Code.

There are limited references in the Code as to *which persons* are eligible for HOP coverage (which are generally referred to as defined terms) and none about *when* someone can enroll in the HOP (qualifying events). Specific qualifications about who can enroll and when they can enroll are subject to board policy. We understand from our interviews that if a term is defined in the Code, PSERS has made a point of using that term in the same manner in HOP. All other terms have been established by past practices and are subject to review and change by the board. PSERS notes that it has followed a policy of interpreting rules liberally where possible to be as inclusive as practical for the program.

We categorize below the terms that are used to identify the individuals that become eligible to participate in the HOP and the various and multiple events that occur when individuals become entitled to enroll, to understand how they compare to industry standards. In addition, we identify the major circumstances under which an eligible person gains entry into the program.

3.1 Eligible Persons

Section 8902(a) of the Code defines an "eligible person" (someone who is eligible to enroll in the HOP) as "an individual who is an annuitant or survivor annuitant or the spouse or dependent of an annuitant or survivor annuitant."

As noted in the Background Section of this report, early in the existence of the HOP, an "annuitant" was defined as someone receiving an annuity from PSERS, and a "survivor annuitant" was defined as the surviving spouse who was enrolled in the PSERS sponsored plan at the annuitant's death. In addition, dependent children were originally defined by Capital Blue Cross and not defined in the Code.

The following table crosswalks our understanding of how various "eligible persons" are defined and applied, insurance industry/regulatory standards, underwriting/administrative aspects and recommendations.

DEFINITION AND APPLICATION OF "ELIGIBLE PERSONS" UNDER HOP

Item	Current Definition/Application	Industry/Regulatory Standard	Underwriting/ Administrative Aspects	Recommendation
Annuitant	Code Definition: Annuitant- *Any Member on or after the effective date of retirement until his annuity is terminated*. Member: *Active member, inactive member, annuitant, or vestee*	Retired Employee	Enrolling Annuitants at age 65 (initial eligibility for Medicare) and having their premiums deducted from their monthly retirement benefit improves the risk pool and minimizes administrative cost.	None
Survivor Annuitant	Code Definition: Survivor Annuitant: *The person or persons last designated by a member under a joint and survivor annuity option to receive an annuity upon the death of such member*. PSERS permits a Survivor Annuitant to enroll in HOP on or after the effective date of the Member's retirement	Survivor Annuitants are typically not given the option of enrolling in the plan for retirees	Allowing Survivor Annuitants to enroll in HOP before they become an annuitant increases the risk pool but can also add to administrative expenses unless premiums are deducted from the Member's monthly retirement benefit. PSERS does not "track" the address of individuals designated as Survivor Annuitants until they begin receiving a monthly annuity payment.	Require that Premiums for Survivor Annuitant coverage be deducted from the Annuitant's monthly retirement benefit. At the time of the Annuitant's death, the Survivor Annuitant may enroll in HOP provided they have their premiums deducted from their monthly annuity payment from PSERS.
Spouse	In Pennsylvania, the term "spouse" means a legally recognized union between a man and a woman. PSERS permits spouses of deceased Annuitants to enroll in HOP. PSERS does not	Spouses of Retirees are permitted to enroll in plans for retirees and may be able to continue coverage upon the death of the retiree provided premiums	Allowing an Annuitant's spouse to enroll in HOP during the Annuitant's lifetime increases the risk pool and does not add to the administrative	Define under what circumstances a surviving spouse can continue his or her coverage in HOP. Allow spouses not enrolled in HOP at

Item	Current Definition/Application	Industry/Regulatory Standard	Underwriting/ Administrative Aspects	Recommendation
	allow a "former" spouse to continue coverage in HOP upon the effective date of divorce.	are paid by the surviving spouse. A growing number of plans allow domestic partners to enroll in the plan. Survivor Annuitants or their spouse are not permitted to enroll in retiree plans.	expenses. Allowing the spouse to continue participation in HOP after the Annuitants death increases administrative expenses unless the spouse is a Survivor Annuitants or coverts a death benefit into a lifetime annuity.	the time of the Annuitant's death to enroll in HOP only if they are eligible for a death benefit and they convert a lump sum death benefit into a monthly annuity from PSERS.
Dependent of Annuitant or Survivor Annuitant	The Code does not define *Dependent*. PSERS uses the definition from the original contract with Capital Blue Cross to include: 1. Unmarried children under age 19, including: natural children, stepchildren, legally adopted children, and children legally placed for adoption. 2. Unmarried children age 19 to 23, who are enrolled as full-time students in an accredited college or university or in a technical or specialized school and who are not regularly employed by one or more employers on a full-time basis.	The Affordable Care Act, or health care reform, extends coverage under employer plans to children under age 26. As a governmental plan covering retirees and no employees, PSERS HOP is exempted from many ACA provisions, including the requirement to cover dependents to age 26.	Allowing an Annuitant's dependent(s) to enroll in HOP during the Annuitant's lifetime increases the risk pool and does not add to the administrative expenses. Allowing the dependent(s) to continue participation in HOP after the Annuitants death increases administrative expenses unless the dependent is a Survivor Annuitant or converts a death benefit into a lifetime annuity. Allowing a Survivor Annuitant's dependent to enroll in HOP during the time the Survivor Annuitant is receiving a monthly	While the Code lists a dependent as an "eligible person," the dependent's eligibility status upon the Annuitant's or Survivor Annuitant's death is not mentioned. Define under what circumstances a dependent of an Annuitant or Survivor Annuitant can continue coverage in HOP upon the Annuitants or Survivor Annuitant's death.

Item	Current Definition/Application	Industry/Regulatory Standard	Underwriting/ Administrative Aspects	Recommendation
	3. Adopted children less than age 18 at the time of adoption. 4. Unmarried children disabled by a mental and/or physical disability, covered under the plan prior to reaching the maximum age limit, who meet all of the following conditions: a. Incapable of self-sustaining employment b. Dependent on the annuitant for support c. Lives with the annuitant		benefit from PSERS increases the risk pool and does not add to the administrative expenses. Allowing the dependent to continue participation in HOP after the Survivor Annuitant's death increases administrative expenses	

Allowing a spouse or dependent to continue HOP coverage upon the death of the annuitant is a current practice. While an individual is no longer a "spouse" or "dependent" of an annuitant upon the annuitant's death, the practice may be continued without detriment to the program. PSERS may also wish to consider allowing a spouse of a deceased annuitant who converts a lump sum death benefit to a monthly annuity from PSERS to enroll in HOP upon the annuitant's death.

The trend in the industry is to grant eligibility to domestic partners, as is the case with the State employees' system. Domestic partners are eligible to enroll in HOP if the Annuitant has selected a joint and survivor benefit and designated their domestic partner as the Survivor Annuitant.

A "dependent of an Annuitant or Survivor Annuitant" is listed as an eligible person but not defined in the Retirement Code. The current operational interpretation is consistent with industry standards except for the extension of eligibility to age 26 (currently 19 under HOP) as required for employer plans subject to the Affordable Care Act rules.

Recommendations:

1. Require that a Survivor Annuitant be subject to the same requirements as a spouse and dependents while the Annuitant is in pay status. This requires that the Survivor Annuitant select the same "coverage" as family members and that premiums are deducted from the Annuitant's monthly benefit.
2. Specifically state that a spouse or dependents already participating in HOP may continue HOP coverage upon the death of an Annuitant. Allow a spouse not participating in HOP at the time of the Annuitant's death to enroll in HOP if they become a beneficiary receiving a monthly annuity from PSERS.
3. Discontinue the practice of allowing surviving spouses to enroll in HOP when they are not receiving a monthly benefit from PSERS.

3.2 Qualifying Events

The term "qualifying event" is used by different laws and programs in slightly different contexts. We believe a first step in reviewing the nature of qualifying events under the HOP must also include analysis of the primary ways in which the term "qualifying event" is used relating to benefit plans. In the following sections and in **Appendix B**, we consider qualifying events first from the HOP perspective, then from an industry perspective as defined by COBRA, HIPAA Special Enrollment Rules, and finally the Internal Revenue Code section 125 Cafeteria Plan. We believe consideration from all these points of view helps in understanding how the HOP relates to other common employer usage of qualifying events.

3.2(a) HOP Qualifying Events

The following are **Qualifying Events** as adopted by the board in May of 2001 and currently used in all HOP communications materials:

- Retirement or loss of health care coverage under a school employer's health plan (Coverage includes any COBRA coverage available under the school district's plans).
- Involuntary loss of health care coverage under a non-school employer's health plan (coverage includes any COBRA coverage available under the plan).
- Reaching age 65 or becoming eligible for Medicare.
- A change in family status (including divorce, death of the retiree or spouse, addition of a dependent through birth, adoption, or marriage or loss of a dependent through loss of eligibility).
- Becoming eligible for Premium Assistance due to a change in legislation.
- Termination of a plan approved for Premium Assistance or moving out of a plan's service area.

The HOP uses the term "qualifying events" to describe the events that allow eligible members to enroll in or change options under the HOP. Qualifying events apply to Annuitants, Survivor Annuitants, spouses and dependents of Annuitants or Survivor Annuitants independently (e.g., if the spouse of an Annuitant reaches age 65, he or she may enroll in the HOP Medical Plan regardless of whether the retiree is enrolled). In addition, if one member of the family has a qualifying event, all members may enroll or change their coverage option if already enrolled. While the qualifying events are generally appropriate, applying them to all eligible persons independently may allow people with no financial link to PSERS the ability to participate in HOP.

That same term is used under COBRA benefit plan communication materials. A similar concept of "Change in Status Rules" was introduced with the implementation of Section 125 Change in Status rules. The primary difference between a qualifying event as applied by the HOP and the use of that term by COBRA or HIPAA is that the COBRA event is tied to both access to the coverage and a specified maximum time duration for coverage. For HOP purposes, the qualifying event serves as the key for ongoing HOP coverage eligibility in the program should the retiree or other eligible individual enroll during the stated window following the event.

See **Appendix B** for a detailed table comparing the HOP's qualifying events with COBRA Qualifying Events, the HIPAA special enrollment rules, and the Section 125 ("cafeteria plan") "change in status" rules. The table identifies a number of anomalies among the various definitions and usage, along with recommendations on areas where PSERS should consider possible modifications to its existing qualifying event policies and procedures.

As a government-sponsored, voluntary, retiree-only and retiree pay all group insurance program with no employees covered, the HOP is generally not subject to COBRA, the HIPAA special enrollment rules, the Section 125 change in status rules. However, these rules form the "industry

standards" regarding life changes that trigger enrollment opportunities and may provide insight into the current HOP qualifying event rules and outcomes.

While the Qualifying Events used by HOP are generally adequate for the administration of HOP, there have been instances where administrative interpretations have been applied. For example, the following qualifying event situations are addressed only in materials provided and used by CoreSource, the third party administrator, and not in printed material:

- If a public school employer stops contributing for a retiree's coverage, but the individual may continue to participate in the district's plan, the individual is deemed to have a "loss of health care coverage under a school employer's health plan" and has a Qualifying Event.
- If a retiree moves back to the United States from a foreign country with socialized medicine, the individual is deemed to have an "involuntary loss of health care coverage under a non-school employer's health plan" and has a Qualifying Event.
- If loss of health care coverage under a public school employer's health plan occurs due to the exhaustion of pre-paid benefits included in the retirement package, the individual is deemed to have a "loss of health care coverage under a school employer's health plan" and has a Qualifying Event.
- If a retiree fails to enroll in HOP within 180 days of retirement and PSERS determines through a re-calculation of service that the retiree's eligibility for premium assistance has changed, the individual is deemed to have "Become eligible for Premium Assistance due to a change in legislation" and has a Qualifying Event.
- If a nursing home does not accept Medicare Advantage or companion managed care plan coverage under HOP, but will accept HOP Medical Plan or Pre-65 Medical Plan coverage, the individual is deemed to have "moved out of a plan's service area" and has a Qualifying Event.
- If a member in a grandfathered plan (frozen enrollment) moves to another county and that frozen enrollment plan is not offered in the member's new county the individual is deemed to have "moved out of a plan's service area" and has a Qualifying Event.

The HOP has a broader definition of who is eligible for benefits than that generally found in most group health plans, whether public or private, active or retiree plans. Because the Code includes "Survivor Annuitants" as a class of eligible individuals and does not define "surviving spouses" as a class, the HOP is required to cover non-spousal individuals who are included in that category. This is much broader than most plans, where only a retiree, the retiree's spouse and/or dependent children are eligible. In fact, many retiree health plans define a spouse and dependent children as those who are such at the time the member retires. Those plans will not allow a retiree to add a new dependent after the member's retirement (except in very special circumstances), nor do they allow a surviving spouse to add a new dependent following the member's death. The retiree health plan in those cases is considered as an adjunct to the primary retirement benefit and specifically limits any perpetuation of families beyond the one in place at the time of retirement.

When HOP was established in 1994, PSERS conducted annual open enrollments allowing any annuitant, their spouse and dependents to enroll. Mid-year enrollments were generally limited to retirement (loss of public school employer coverage) or becoming eligible for Medicare. The open enrollment for 2003 was the last annual event. The board decided that while HOP participants could change their plans annually, during an option selection period, annual

opportunities for "new" enrollments would end. The board did, however, reserve the right to conduct ad hoc open enrollments. Since 2003, PSERS has conducted two open enrollments:

- 2006 in conjunction with Medicare adding Part D prescription drug coverage, and
- 2011, five years after the 2006 open enrollment.

When annual open enrollments were eliminated, the list of Qualifying Events was expanded, creating multiple opportunities for other individuals to enroll in HOP. Since the opportunity to add a spouse or dependent to HOP coverage during an annual open enrollment ceased, Qualifying Events were applied beyond the retiree (generally family members, but there is actually no requirement to be related to the retiree).

In its current state, there are numerous opportunities for individuals to become enrolled in the HOP following a retiree's initial eligibility, or initial opportunity to enroll. Some of these opportunities, such as allowing enrollment by a spouse of a deceased active member who has never had a qualifying event, are almost independent of the retired member's circumstances. In the current form of definition, it would be possible to have a retiree who dies, leaving a surviving spouse who joins HOP, then has a qualifying event by getting married again and brings his or her new spouse onto the plan. They adopt a child and bring that child onto the plan, the original spouse of the retiree dies and the plan still has the spouse's new spouse and adopted child enrolled, neither of which had any tie to the original retiree's pension. While this situation is somewhat far-fetched, it is possible and results in maintenance of enrollees that do not show up at all on the PSERS retirement system data files.

One of the economic efficiencies of HOP is the deduction of premiums from an Annuitant's monthly retirement benefit. This eliminates the need to produce premium payment coupons, receive and process individual payments, track address changes and collect delinquent premiums. While some "self-payments" are necessary to accommodate Annuitants whose monthly retirement benefit is insufficient to cover premium expenses and also to allow surviving spouses to continue their coverage upon the death of the annuitant, PSERS should maintain control over when those eligible to enroll can enroll in the HOP.

We believe PSERS could control enrollment by the specifying when and how Qualifying Events apply to individual eligible persons. For example, a spouse may be eligible to continue his or her participation in HOP, but not enroll for the first time upon the Annuitant's death.

We believe PSERS should identify more specifically the criteria for which persons will be allowed to enroll beyond the original retiree, spouse and dependents at the time of retirement. We believe there should be a direct correlation of these criteria with payment of retirement benefits from PSERS to limit the perpetuation of enrollment eligibility beyond those directly referenced as potential recipients of retirement benefits from the system.

The following table presents a Qualifying Event crosswalk identifying the current definitions/applications, the broad insurance industry/regulatory standard, underwriting/administrative Aspects for HOP, and recommendations:

HOP QUALIFYING EVENT CROSSWALK AND RECOMMENDATIONS

1. Retirement or loss of health care coverage under a school employer's health plan (Coverage includes any COBRA coverage available under the school district's plans).				
Item	**Current HOP Definition/Application**	**Industry/ Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
a. Annuitant	As of the date of retirement or loss of health insurance coverage provided by the school (in whole or part) or the termination of COBRA coverage (voluntary or not)	Individuals must enroll in the retiree plan at retirement or the exhaustion of COBRA coverage (involuntary termination)	Allowing Annuitants to enroll in HOP before exhausting COBRA benefits is cost neutral	No change
b. Survivor Annuitant	A Survivor Annuitant may enroll in HOP at the time of the Member's retirement. The Survivor Annuitant is deemed to "retire" upon the Annuitant's death and may enroll in HOP. The Survivor Annuitant may convert the annuity to a lump sum without affecting their eligibility to enroll in HOP	Survivor Annuitants are not usually eligible to enroll in plans at any time	Allowing Survivor Annuitants to enroll in HOP before they become an annuitant increases the number of insured without adverse selection. If the Survivor Annuitant is treated as a "member of the family" and must select the same benefit plan and have premiums deducted from the Member's monthly benefit, administrative expenses are minimized. If premiums are not deducted, administrative expenses are increased. Allowing Survivor Annuitants to enroll in HOP when the Member dies increases the number of	Before the Survivor Annuitant is receiving a monthly benefit from PSERS, the Survivor Annuitant must select the same plan as the Annuitant and have premiums deducted from the Annuitant's monthly benefit. A Survivor Annuitant may enroll in HOP upon the death of the Annuitant provided the Survivor Annuitant is

1. Retirement or loss of health care coverage under a school employer's health plan (Coverage includes any COBRA coverage available under the school district's plans).				
Item	**Current HOP Definition/Application**	**Industry/ Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
			insured, but may add to adverse selection depending on the age of the Survivor Annuitant. If the Survivor Annuitant receives a monthly benefit from PSERS and premiums are deducted from the monthly benefit, administrative expenses are minimized. If the Survivor Annuitant takes the value of the benefit in a lump sum, administrative expenses are increased.	receiving a monthly benefit and premiums are deducted.
c. Spouse	A spouse of an Annuitant may enroll in HOP at the time of the Member's retirement or loss of COBRA coverage. The spouse may enroll in HOP even though the Annuitant does not.	A spouse must enroll in the retiree plan at the Annuitant's retirement or the exhaustion of COBRA coverage (involuntary termination) A spouse cannot enroll in the plan without the retiree.	Allowing spouses to enroll in HOP at the time the Annuitant retires increases the number of insured without adverse selection. If premiums are deducted from the Member's monthly benefit, administrative expenses are minimized.	No Change
d. Dependent of Annuitant	A dependent of an Annuitant may enroll in HOP upon the Member's retirement or loss of COBRA coverage. The	Dependents must enroll in the retiree plan at the Annuitant's retirement or the exhaustion of	Allowing dependents to enroll in HOP at the time the Annuitant retires increases the number of insured but may have a negative	No change.

1. Retirement or loss of health care coverage under a school employer's health plan (Coverage includes any COBRA coverage available under the school district's plans).				
Item	**Current HOP Definition/Application**	**Industry/ Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
	dependent may enroll in HOP even though the Annuitant does not.	COBRA coverage (involuntary termination) Dependents cannot enroll in the plan without the retiree.	underwriting impact as dependents enroll in subsidized benefit programs. If premiums are deducted from the Member's monthly benefit, administrative expenses are minimized.	
e. Dependent of Survivor Annuitant	A dependent of a Survivor Annuitant may enroll in HOP upon the Member's retirement or loss of COBRA coverage. A dependent of a Survivor Annuitant may enroll in HOP upon the Annuitant's death and at the time the Survivor Annuitant receives a benefit from PSERS. The dependent may enroll in HOP even though the Annuitant or Survivor Annuitant does not.	Survivor Annuitants, their spouse and dependents are not usually eligible to enroll in plans at any time	Allowing dependents of a Survivor Annuitant to enroll in HOP at the time the Member retires increases number of insured but may have a negative underwriting impact as dependents enroll in subsidized benefit programs. Administrative expenses are increased tracking and billing the Survivor Annuitant's dependents. If dependents of the Survivor Annuitant are eligible to enroll when the Survivor Annuitant begins to receive a monthly benefit from PSERS, the number of insured is increased but may have a negative underwriting impact as dependents enroll in subsidized benefit programs. If	Allow dependents of a Survivor Annuitant enroll in HOP at the time the Survivor Annuitant enrolls in HOP.

1. Retirement or loss of health care coverage under a school employer's health plan (Coverage includes any COBRA coverage available under the school district's plans).				
Item	**Current HOP Definition/Application**	**Industry/ Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
			premiums are deducted from the Survivor Annuitant's monthly benefit, administrative expenses are minimized	

2. You involuntarily lose health care coverage under a non-school employer's health plan (which includes any COBRA continuation coverage you may elect under that non-school employer's health plan).				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
a. Annuitant	As of the date of loss of health insurance coverage provided by a non-school employer or the termination of COBRA coverage (voluntary or not)	Individuals must enroll in the retiree plan at retirement.	Allowing Annuitants to delay their enrollment in HOP until they lose coverage under a spouse's employer plan or coverage resulting in the retiree's employment may cause adverse selection depending upon the age of the Annuitant at the time of enrollment.	No change
b. Survivor Annuitant	A Survivor Annuitant may enroll in HOP at the time the Annuitant or Survivor Annuitant involuntarily loses health care coverage under a non-school employer's health plan	Survivor Annuitants are not usually eligible to enroll in plans at any time	Allowing Survivor Annuitants to enroll in HOP before they become an annuitant increases the number of insured without adverse selection. If the Survivor Annuitant is treated as a "member	A Survivor Annuitant may enroll in HOP if the Survivor Annuitant loses coverage and premiums are

2. You involuntarily lose health care coverage under a non-school employer's health plan (which includes any COBRA continuation coverage you may elect under that non-school employer's health plan).				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
	retirement. The Survivor Annuitant is deemed to "retire" upon the Annuitant's death, and if he or she involuntarily loses health care coverage under a non-school employer's health plan may enroll in HOP.		of the family" and must select the same benefit plan and have premiums deducted from the Member's monthly benefit, administrative expenses are minimized. If premiums are not deducted, administrative expenses are increased. Allowing Survivor Annuitants to enroll in HOP when the Member dies and involuntarily lose health care coverage under a non-school employer's health plan increases the number of insured, but may add to adverse selection depending on the age of the Survivor Annuitant. If the Survivor Annuitant receives a monthly benefit from PSERS and premiums are deducted from the monthly benefit, administrative expenses are minimized. If the Survivor Annuitant takes the value of the benefit in a lump sum, administrative expenses are increased.	deducted from the Annuitant's monthly benefit. Once a Survivor Annuitant is in pay status, they may enroll in HOP upon the loss of coverage.

2. You involuntarily lose health care coverage under a non-school employer's health plan (which includes any COBRA continuation coverage you may elect under that non-school employer's health plan).				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
c. Spouse	A spouse of an Annuitant may enroll in HOP at the time the spouse, Annuitant, Survivor Annuitant or dependent of an Annuitant or Survivor Annuitant loses coverage under an employer plan.	A spouse must enroll in the retiree plan at the Annuitant's retirement A spouse cannot enroll in the plan without the retiree.	Allowing a spouse to enroll in HOP at the time the spouse loses coverage under an employer plan increases the number of insured without adverse selection. If premiums are deducted from the Member's monthly benefit, administrative expenses are minimized.	A spouse of an Annuitant may enroll in HOP at the time the spouse loses coverage under an employer plan.
d. Dependent of Annuitant	A dependent of an Annuitant may enroll in HOP at the time the dependent, Annuitant, Survivor Annuitant or spouse loses coverage under an employer's plan.	A dependent's loss of coverage under another plan is not a Qualifying Event and does not allow enrollment in the retiree plan.	Allowing dependents to enroll in HOP after the Member retires and loss of coverage under an employer's plan increases the number of insured but may have a negative underwriting impact as dependents enroll in subsidized benefit programs. If premiums are deducted from the Member's monthly benefit, administrative expenses are minimized.	A dependent of an Annuitant may enroll in HOP at the time the dependent loses coverage under an employer plan.
e. Dependent of Survivor Annuitant	A dependent of a Survivor Annuitant may enroll in HOP at the time the dependent, Annuitant, Survivor Annuitant, or spouse loses coverage under an employer's plan.	Survivor Annuitants, their spouse and dependents are not usually eligible to enroll in plans at any time	Allowing dependents of a Survivor Annuitant to enroll in HOP after the Member retires and the dependent loses coverage under an employer's plan increases number of insured but may have a negative underwriting	A dependent of a Survivor Annuitant may enroll in HOP at the time the dependent loses coverage under an employer's plan.

2. You involuntarily lose health care coverage under a non-school employer's health plan (which includes any COBRA continuation coverage you may elect under that non-school employer's health plan).				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
	The dependent may enroll in HOP even though the Survivor Annuitant does not.		impact as dependents enroll in subsidized benefit programs. Administrative expenses are increased tracking and billing the Survivor Annuitant's dependents. If dependents of the Survivor Annuitant are eligible to enroll after the Survivor Annuitant begins to receive a monthly benefit from PSERS and the dependent loses coverage under an employer's plan, the number of insured is increased but may have a negative underwriting impact as dependents enroll in subsidized benefit programs. If premiums are deducted from the Survivor Annuitant's monthly benefit, administrative expenses are minimized.	

3. You or your spouse reach age 65 or become eligible for Medicare.				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
a. Annuitant	An Annuitant may enroll as of the date the Annuitant, Survivor Annuitant, spouse or a dependent of an Annuitant or Survivor Annuitant becomes eligible for Medicare	Individuals must enroll in the retiree plan at retirement.	Allowing Annuitants to enroll at age 65 or eligibility for Medicare increases the number of insured and has a positive underwriting impact. Deducting premiums from the Annuitant's monthly benefit minimizes administrative expenses.	An Annuitant may enroll as of the date the Annuitant or Annuitant's spouse becomes eligible for Medicare.
b. Survivor Annuitant	A Survivor Annuitant may enroll in HOP as of the date the Annuitant, Survivor Annuitant, spouse, or dependent of an Annuitant or Survivor Annuitant becomes eligible for Medicare.	Survivor Annuitants are not usually eligible to enroll in plans at any time.	Allowing Survivor Annuitants to enroll in as of the date the Member, Survivor Annuitant or Survivor Annuitant's spouse becomes eligible for Medicare increases the number of insured without adverse selection. If the Survivor Annuitant is treated as a "member of the family" and must select the same benefit plan and have premiums deducted from the Member's monthly benefit, administrative expenses are minimized. If premiums are not deducted, administrative expenses are increased. Allowing Survivor Annuitants to enroll in HOP after the Member dies and the Survivor Annuitant or Survivor Annuitant's spouse	A Survivor Annuitant may enroll in HOP as of the date the Annuitant or Survivor Annuitant becomes eligible for Medicare..

3. You or your spouse reach age 65 or become eligible for Medicare.				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
			becomes eligible for Medicare increases the number of insured. If the Survivor Annuitant receives a monthly benefit from PSERS and premiums are deducted from the monthly benefit, administrative expenses are minimized. If the Survivor Annuitant takes the value of the benefit in a lump sum, administrative expenses are increased.	
c. Spouse	As of the date the spouse of an Annuitant, Annuitant, Survivor Annuitant, or dependent of an Annuitant or Survivor Annuitant becomes eligible for Medicare.	Spouses must enroll in the retiree plan at the Annuitant's retirement. Spouses cannot enroll in the plan without the retiree.	Allowing spouses of Annuitants to enroll at age 65 or eligibility for Medicare increases the number of insured and has a positive underwriting impact. If premiums are deducted from the Annuitant's monthly benefit, administrative expenses are minimized.	A spouse may enroll as of the date the spouse of an Annuitant or Annuitant, becomes eligible for Medicare.
d. Dependent of Annuitant	A dependent of an Annuitant may enroll in HOP when the dependent of an Annuitant, Annuitant, Survivor Annuitant, spouse, or dependent of a Survivor Annuitant becomes eligible for Medicare.	Dependent coverage status is established at the time of retirement and dependents cannot be added as a result of a change in Medicare eligibility of the	Allowing dependents to enroll in HOP if the dependent, Annuitant or Annuitants spouse becomes eligible for Medicare increases the number of insured but may have a negative underwriting impact if the dependents enrolls	A dependent of an Annuitant may enroll in HOP when the dependent of an Annuitant or Annuitant becomes eligible for Medicare.

3. You or your spouse reach age 65 or become eligible for Medicare.				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
		Annuitant of Annuitant's spouse.	in a subsidized benefit program. If premiums are deducted from the Member's monthly benefit, administrative expenses are minimized.	
e. Dependent of Survivor Annuitant	A dependent of a Survivor Annuitant may enroll in HOP at the time the dependent of Survivor Annuitant, Annuitant, Survivor Annuitant, or spouse becomes eligible for Medicare. The dependent may enroll in HOP even though the Survivor Annuitant does not.	Survivor Annuitants, their spouse and dependents are not usually eligible to enroll in plans at any time	Allowing a dependent of a Survivor Annuitant to enroll in HOP at the time after the Member's retirement that the Annuitant (Member), dependent, Survivor Annuitant or Survivor Annuitant's spouse becomes eligible for Medicare, increases the number of insured but may have a negative underwriting impact if the dependent enrolls in subsidized benefit programs. Administrative expenses are increased for tracking and billing the Survivor Annuitant's dependents. If dependents of the Survivor Annuitant are eligible to enroll after the Survivor Annuitant begins to receive a monthly benefit from PSERS and the dependent, Survivor Annuitant, or Survivor Annuitant's spouse	A dependent of a Survivor Annuitant may enroll in HOP at the time the dependent of Survivor Annuitant becomes eligible for Medicare.

3. You or your spouse reach age 65 or become eligible for Medicare.				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
			becomes eligible for Medicare, the number of insured is increased but may have a negative underwriting impact as dependents enroll in subsidized benefit programs. If premiums are deducted from the Survivor Annuitant's monthly benefit, administrative expenses are minimized	

4. A change in family status (including divorce, death of the retiree or spouse, addition of a dependent through birth, adoption, or marriage or loss of a dependent through loss of eligibility)				
(i) divorce				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
a. Annuitant	As of the date the Annuitant's divorce	As of the date the Annuitant has a change in family status (including: divorce; death of the spouse; addition of a dependent through birth, adoption, or marriage; or loss of a dependent through loss of eligibility).	Allowing Annuitants to enroll as of the date the Annuitant has a change in family status increases the number of insured but may create adverse selection depending upon the age of the annuitant, spouse or dependents. Deducting premiums from the Annuitant's monthly benefit minimizes administrative expenses.	No change
b. Survivor Annuitant	As of the date the Survivor Annuitant or Annuitant has a divorce	Survivor Annuitants are not usually eligible to enroll in plans at any time		Not a Qualifying Event
c. Spouse	An Ex-spouse of an Annuitant cannot enroll or continue enrollment in HOP	Spouses must enroll in the retiree plan at the Annuitant's retirement Spouses cannot enroll in the plan without the retiree.	Allowing spouses of Annuitants to enroll in HOP if the spouse of an Annuitant has a change in family status increases the number of insured but may cause adverse selection depending upon the age of the spouse. Administrative expenses are increased for tracking and billing the Survivor Annuitant's dependents.	No change

4. A change in family status (including divorce, death of the retiree or spouse, addition of a dependent through birth, adoption, or marriage or loss of a dependent through loss of eligibility)				
(i) divorce				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
d. Dependent of Annuitant	As of the date the Annuitant's divorce	As of the date the Annuitant has a change in family status (including: divorce; death of the spouse; addition of a dependent through birth, adoption, or marriage; or loss of a dependent through loss of eligibility).	Allowing a dependent of an Annuitant to enroll as of the date the Annuitant has a change in family status increases the number of insured but may create adverse selection depending upon the age of the annuitant, spouse or dependents. Deducting premiums from the Annuitant's monthly benefit minimizes administrative expenses.	No change
e. Dependent of Survivor Annuitant	As of the date the Survivor Annuitant or Annuitant has a divorce	Survivor Annuitants are not usually eligible to enroll in plans at any time		Not a Qualifying Event

4. A change in family status (including divorce, death of the retiree or spouse, addition of a dependent through birth, adoption, or marriage or loss of a dependent through loss of eligibility)				
(ii) death				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
a. Annuitant	As of the death of the Annuitant's spouse or dependent or the death of the Survivor Annuitant or dependent of a Survivor Annuitant	As of the date the Annuitant has a change in family status (including: divorce; death of the spouse; addition of a dependent through birth, adoption, or marriage; or loss of a dependent through loss of eligibility).	Allowing Annuitants to enroll as of the date the Annuitant has a change in family status increases the number of insured but may create adverse selection depending upon the age of the annuitant, spouse or dependents. Deducting premiums from the Annuitant's monthly benefit minimizes administrative expenses.	As of the death of the Annuitant's spouse or Survivor Annuitant
b. Survivor Annuitant	As of the death of the Annuitant, Annuitant's spouse or dependent or the death of the dependent of a Survivor Annuitant	Survivor Annuitants are not usually eligible to enroll in plans at any time		Upon the death of the Annuitant the Survivor Annuitant provided may continue HOP coverage or enroll if the Survivor Annuitant receives a monthly benefit from PSERS.
c. Spouse	As of the death of the Annuitant the spouse can continue coverage or enroll for the first time.	Spouses must enroll in the retiree plan at the Annuitant's retirement Spouses cannot enroll in the plan without the	Allowing spouses of Annuitants to enroll in HOP if the spouse of an Annuitant has a change in family status increases the number of insured but may cause adverse selection depending upon	Upon the death of the Annuitant, the spouse of an Annuitant can continue his or her participation in HOP. If a spouse is eligible

4. A change in family status (including divorce, death of the retiree or spouse, addition of a dependent through birth, adoption, or marriage or loss of a dependent through loss of eligibility) (ii) death				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
		retiree.	the age of the spouse. Administrative expenses are increased for tracking and billing the Survivor Annuitant's dependents.	for a death benefit and converts the lump sum to a monthly annuity with PSERS, the spouse may enroll in HOP at the time of the Annuitant's death.
d. Dependent of Annuitant	As of the death of the Annuitant the dependent can continue coverage or enroll for the 1st time.	Dependents must enroll in the retiree plan at the Annuitant's retirement Dependents cannot enroll in the plan without the retiree.	Allowing dependents of Annuitants to enroll in HOP if the dependent of an Annuitant has a change in family status increases the number of insured but may cause adverse selection depending upon the age of the spouse. Administrative expenses are increased for tracking and billing the Annuitant's dependents upon the death of the retiree.	Upon the death of the Annuitant, dependents of an Annuitant can continue their participation in HOP.
e. Dependent of a Survivor Annuitant	As of the death of the Survivor Annuitant the dependent can continue coverage or enroll for the first time.	Survivor Annuitants are not usually eligible to enroll in plans at any time	Allowing dependents of Survivor Annuitants to enroll in HOP if the dependent of a Survivor Annuitant has a change in family status increases the number of insured but may cause adverse selection depending upon the age of the dependent. Administrative	Upon the death of the Annuitant the Dependents of a Survivor Annuitant can enroll in HOP if the Survivor Annuitant is receiving a monthly payment

4. A change in family status (including divorce, death of the retiree or spouse, addition of a dependent through birth, adoption, or marriage or loss of a dependent through loss of eligibility)				
(ii) death				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
			expenses are increased tracking and billing the Survivor Annuitant's dependents.	from PSERS. Upon the death of the Survivor Annuitant a Dependent of a Survivor Annuitant is no longer eligible to participate in HOP.

4. A change in family status (including divorce, death of the retiree or spouse, addition of a dependent through birth, adoption, or marriage or loss of a dependent through loss of eligibility)				
(iii) addition of a dependent through birth, adoption, or marriage.				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
a. Annuitant	As of the date the Annuitant has a dependent through birth, adoption, or marriage, an Annuitant may enroll for the first time with the dependent or add dependent coverage and change plans.	As of the date the Annuitant has a change in family status (including: divorce; death of the spouse; addition of a dependent through birth, adoption, or marriage; or loss of a dependent through loss of eligibility).	Allowing Annuitants to enroll as of the date the Annuitant has a change in family status increases the number of insured but may create adverse selection depending upon the age of the annuitant, spouse or dependents. Deducting premiums from the Annuitant's monthly benefit minimizes administrative expenses.	The Annuitant may add dependent coverage and change plans

4. A change in family status (including divorce, death of the retiree or spouse, addition of a dependent through birth, adoption, or marriage or loss of a dependent through loss of eligibility) (iii) addition of a dependent through birth, adoption, or marriage.				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
b. Survivor Annuitant	As of the date the Survivor Annuitant has a dependent through birth, adoption, or marriage, a Survivor Annuitant may enroll for the first time with the dependent or add dependent coverage and change plans.	Survivor Annuitants are not usually eligible to enroll in plans at any time	Allowing Survivor Annuitants to enroll in HOP as of the date the Survivor Annuitant has a change in family status but before the Survivor Annuitant begins receiving a monthly benefit from PSERS increases the number of insured but may create adverse selection depending upon the age of the Survivor Annuitant, spouse or dependents. Administrative expenses are increased for tracking and billing the Survivor Annuitant. Deducting premiums from the Survivor Annuitant's monthly benefit minimizes administrative expenses.	Not a Qualifying Event
c. Spouse	As of the date the Spouse has a dependent through birth, adoption, or marriage, an Annuitant may enroll for the first time with the dependent or add dependent coverage and change plans.	See Annuitant	See Annuitant	Not a Qualifying Event

4. A change in family status (including divorce, death of the retiree or spouse, addition of a dependent through birth, adoption, or marriage or loss of a dependent through loss of eligibility) (iii) addition of a dependent through birth, adoption, or marriage.				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
d. Dependent of Annuitant	As of the date the Annuitant has a dependent through birth, adoption, or marriage, a dependent of an Annuitant may enroll for the first time and change plans.	Dependents must enroll in the retiree plan at the Annuitant's retirement Dependents cannot enroll in the plan without the retiree.	Allowing dependents of Annuitants to enroll in HOP if the dependent of an Annuitant has a change in family status increases the number of insured but may cause adverse selection depending upon the age of the spouse. Administrative expenses are increased for tracking and billing the Annuitant's dependents upon the death of the retiree.	The Annuitant may add dependent coverage and change plans
e. Dependent of a Survivor Annuitant	As of the date the Survivor Annuitant has a dependent through birth, adoption, or marriage, a dependent of a Survivor Annuitant may enroll for the 1st time and change plans.	Survivor Annuitants are not usually eligible to enroll in plans at any time	Allowing dependents of Survivor Annuitants to enroll in HOP if the dependent of a Survivor Annuitant has a change in family status increases the number of insured but may cause adverse selection depending upon the age of the dependent. Administrative expenses are increased tracking and billing the Survivor Annuitant's dependents.	Not a Qualifying Event.

4. A change in family status (including divorce, death of the retiree or spouse, addition of a dependent through birth, adoption, or marriage or loss of a dependent through loss of eligibility)				
(iv) loss of a dependent through loss of eligibility.				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
a. Annuitant	As of the date the Annuitant's dependent loses eligibility due to age requirements the Annuitant may enroll in HOP.	As of the date the Annuitant has a change in family status (including: divorce; death of the spouse; addition of a dependent through birth, adoption, or marriage; or loss of a dependent through loss of eligibility).	Allowing Annuitants to enroll as of the date the Annuitant's dependent loses eligibility increases the number of insured but may create adverse selection depending upon the age of the annuitant.	Not a Qualifying Event for enrollment, but Annuitant may change Options.
b. Survivor Annuitant	As of the date the Survivor Annuitant's dependent loses eligibility due to age requirements.	As of the date the Annuitant has a change in family status (including: divorce; death of the spouse; addition of a dependent through birth, adoption, or marriage; or loss of a dependent through loss of eligibility).	Allowing Survivor Annuitants to enroll as of the date the Survivor Annuitant's dependent loses eligibility increases the number of insured but may create adverse selection depending upon the age of the annuitant.	Not a Qualifying Event for enrollment, but Survivor Annuitant may change Options.
c. Spouse	As of the date the Annuitant's dependent loses eligibility due to age requirements.	As of the date the Annuitant has a change in family status (including: divorce; death of the spouse; addition of a	Allowing the spouse to enroll as of the date the Annuitant's dependent loses eligibility increases the number of insured but may create adverse selection depending upon the age of the	Not a Qualifying Event for enrollment, but Spouse may change Options.

4. A change in family status (including divorce, death of the retiree or spouse, addition of a dependent through birth, adoption, or marriage or loss of a dependent through loss of eligibility) (iv) loss of a dependent through loss of eligibility.				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
		dependent through birth, adoption, or marriage; or loss of a dependent through loss of eligibility).	spouse.	
d. Dependent of Annuitant	As of the date the Annuitant's dependent loses eligibility due to age requirements.	As of the date the Annuitant has a change in family status (including: divorce; death of the spouse; addition of a dependent through birth, adoption, or marriage; or loss of a dependent through loss of eligibility).	Allowing dependents to enroll as of the date the Annuitant's dependent loses eligibility increases the number of insured but may create adverse selection.	Not a Qualifying Event for enrollment, but remaining dependents may change Options.
e. Dependent of Survivor Annuitant	As of the date the Survivor Annuitant's dependent loses eligibility due to age requirements.	As of the date the Survivor Annuitant has a change in family status (including: divorce; death of the spouse; addition of a dependent through birth, adoption, or marriage; or loss of a dependent through loss of eligibility).	Allowing dependents to enroll as of the date the Survivor Annuitant's dependent loses eligibility increases the number of insured but may create adverse selection.	Not a Qualifying Event for enrollment, but remaining dependents may change Options.

5. Becoming eligible for Premium Assistance due to a change in legislation				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
a. Annuitant	As of the date the Annuitant becomes eligible for Premium Assistance due to a change in legislation.	No industry equivalent.	Allowing Annuitants to enroll in HOP if they become eligible for Premium Assistance increases the number of insured. Deducting premiums from the Annuitant's monthly benefit minimizes administrative expenses.	No change
b. Survivor Annuitant	A Survivor Annuitant may enroll in HOP if the Annuitant becomes eligible for Premium Assistance due to a change in legislation. A Survivor Annuitant is not affected by a change in Premium Assistance once the Survivor Annuitant begins receiving a monthly benefit from PSERS.	Survivor Annuitants are not usually eligible to enroll in plans at any time.	Allowing Survivor Annuitants to enroll in HOP when the Annuitant (Member) becomes eligible for Premium Assistance before they become an annuitant increases the number of insured without adverse selection. If the Survivor Annuitant selects the same benefit plan as the Annuitant and has his or her premiums deducted from the Member's monthly benefit, administrative expenses are minimized. If premiums are not deducted, administrative expenses are increased.	Survivor Annuitant can enroll in HOP if the Annuitant enrolls in HOP.
c. Spouse	A spouse of an Annuitant may enroll in HOP as of the date the Annuitant becomes eligible for Premium Assistance due to a	Spouses must enroll in the retiree plan at the Annuitant's retirement or the exhaustion of	Allowing spouses to enroll in HOP at the time the Annuitant becomes eligible for Premium Assistance due to a change in	Spouse can enroll in HOP if the Annuitant enrolls in HOP

5. Becoming eligible for Premium Assistance due to a change in legislation				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
	change in legislation. The spouse may enroll in HOP even though the retiree does not.	COBRA coverage (involuntary termination) Spouses cannot enroll in the plan without the retiree.	legislation increases the number of insured without adverse selection. If premiums are deducted from the Member's monthly benefit, administrative expenses are minimized.	
d. Dependent of Annuitant	A dependent of an Annuitant may enroll in HOP at the time the Annuitant becomes eligible for Premium Assistance due to a change in legislation. The dependent may enroll in HOP even though the Annuitant does not.	Dependents must enroll in the retiree plan at the Annuitant's retirement or the exhaustion of COBRA coverage (involuntary termination) Dependents cannot enroll in the plan without the retiree.	Allowing dependents to enroll in HOP at the time the Annuitant becomes eligible for Premium Assistance increases the number of insured but may have a negative underwriting impact as dependents enroll in subsidized benefit programs. If premiums are deducted from the Member's monthly benefit, administrative expenses are minimized.	Dependent of Annuitant may enroll in HOP if the Annuitant enrolls in HOP.
e. Dependent of Survivor Annuitant	A dependent of a Survivor Annuitant may enroll in HOP at the time the Annuitant (Member) becomes eligible for premium assistance due to a change in legislation. A dependent of a Survivor Annuitant may not enroll in HOP due to a change in Premium	Survivor Annuitants, their spouse and dependents are not usually eligible to enroll in plans at any time.	Allowing dependents of a Survivor Annuitant to enroll in HOP at the time the Annuitant (Member) becomes eligible for Premium Assistance due to a change in legislation increases number of insured but may have a negative underwriting impact as dependents enroll in subsidized benefit programs. Administrative	Dependents of a Survivor Annuitant may enroll in HOP if the Survivor Annuitant enrolls in HOP at the time of the Annuitant (Member) becomes eligible for Premium Assistance due to a

5. Becoming eligible for Premium Assistance due to a change in legislation				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
	Assistance legislation as it does not affect the Survivor Annuitant once he or she receives a benefit from PSERS.		expenses are increased for tracking and billing the Survivor Annuitant's dependents.	change in legislation and enrolls in HOP.

6. Termination of a plan approved for Premium Assistance or moving out of a plan's service area				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
a. Annuitant	An Annuitant participating in a school plan that is terminated or an Annuitant enrolled in a HOP plan with limited service area moves out of the service area.	No industry equivalent regarding terminating school plans. Retiree plans with multiple options will allow a retiree to change options if moving out of a plan's service area.	Allowing Annuitants to enroll in HOP if their school employer's plan terminates increases the number of insured but may have a negative underwriting impact depending upon the age of the Annuitant. Deducting premiums from the Annuitant's monthly benefit minimizes administrative expenses.	No change
b. Survivor Annuitant	A Survivor Annuitant participating in a school plan that is terminated or a Survivor Annuitant enrolled in a HOP plan with limited service area moves out of the service area.	Survivor Annuitants are not usually eligible to enroll in plans at any time	Allowing Survivor Annuitants to enroll in HOP if the school employer's plan in which they are enrolled terminates increases the number of insured but may have a negative underwriting impact depending upon the age of the	No change

6. Termination of a plan approved for Premium Assistance or moving out of a plan's service area				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
	A Survivor Annuitant receiving a monthly benefit from PSERS participating in a school plan that is terminated or a Survivor Annuitant enrolled in a HOP plan with limited service area moves out of the service area.		Annuitant. Deducting premiums from the Annuitant's monthly benefit minimizes administrative expenses.	
c. Spouse	A spouse of an Annuitant participating in a school plan that is terminated or a spouse of an Annuitant enrolled in a HOP plan with limited service area moves out of the service area may enroll in HOP as of the date the Annuitant or the spouse of an Annuitant loses coverage because of that termination or moving out of the plan's service area.	No Industry equivalent regarding terminating school plans. Spouses of retirees where their plans have multiple options will allow a retiree and spouse to change options if moving out of a plan's service area. Spouses cannot enroll in the plan without the retiree.	Allowing spouses to enroll in HOP at the time their coverage terminates under a school plan increases the number of insured but may have a negative underwriting impact depending upon the age of the spouse. If premiums are deducted from the Member's monthly benefit, administrative expenses are minimized.	No Change
d. Dependent of Annuitant	A dependent of an Annuitant participating in a school plan that is terminated or a dependent of an Annuitant enrolled in a HOP plan with limited service area moves out of the service area may enroll in HOP as of the date the	No Industry equivalent regarding terminating school plans. Dependents of retirees where their plans have multiple options will allow a retiree and	Allowing dependents to enroll in HOP at the time their coverage terminates under a school plan increases the number of insured but may have a negative underwriting impact if they enroll in a subsidized plan. If premiums	No change

6. Termination of a plan approved for Premium Assistance or moving out of a plan's service area				
Item	**Current HOP Definition/Application**	**Industry/Regulatory Standard**	**Underwriting/Administrative Aspects**	**Recommendation**
	Annuitant or the dependent of an Annuitant loses coverage because of that termination or moving out of the plans service area.	dependent to change options if moving out of a plan's service area. Dependents cannot enroll in the plan without the retiree.	are deducted from the Member's monthly benefit, administrative expenses are minimized.	
e. Dependent of a Survivor Annuitant	A dependent of a Survivor Annuitant participating in a school plan that is terminated or a Survivor Annuitant enrolled in a HOP plan with limited service area moves out of the service area. A dependent of a Survivor Annuitant receiving a monthly benefit from PSERS participating in a school plan that is terminated or a Survivor Annuitant enrolled in a HOP plan with limited service area moves out of the service area.	Survivor Annuitants, their spouse and dependents are not usually eligible to enroll in plans at any time.	Allowing a dependent of a Survivor Annuitants to enroll in HOP if the school employer's plan in which they are enrolled terminates increases the number of insured but may have a negative underwriting impact if they enroll in a subsidized plan. Deducting premiums from the Annuitant's monthly benefit minimizes administrative expenses.	No change

We recommend the following regarding application of Qualifying Events:

1. Have the foundation of enrollment in HOP be the ongoing financial relationship between PSERS and the individual enrolled in HOP.

2. Provide continuity of coverage to spouses, Survivor Annuitants and dependents enrolled in HOP upon the death of the Annuitant (Member).

3. Modify the application of Qualifying Events and specify when they apply to the Annuitant, Survivor Annuitant, spouse and dependents of Annuitants, or Survivor Annuitants.

The table beginning on the following page summarizes which persons could be affected by a Qualifying Event given implementation of these recommendations:

These recommendations are intended as a starting point and can be modified to add and/or limit opportunities to enroll. The policy should specify which persons can be covered through a subsequent qualifying event and tie that eligibility back to the specific persons named in the statute. The policy should also indicate where a qualifying event is a one-time occurrence with regard to a person. We also recommend creating a process for addressing and documenting new types of circumstances as they are presented, so the definition of eligible persons remains reasonably congruent with the actual practice in the HOP.

The special qualifying event and eligibility circumstances that were reviewed as a part of this project are summarized in later sections.

SUMMARY OF PERSONS AFFECTED BY QUALIFYING EVENTS (Recommended)						
	Qualifying Event	**Annuitant**	**Spouse (of Annuitant)**	**Dependent (Child) of Annuitant**	**Survivor Annuitant**	**Dependent (Child) of Survivor Annuitant**
KEY: QE=Qualifying Event; Continuation=Individual enrolled in HOP may continue coverage; CO=Change Option within HOP						
1.	**Retirement (receiving a monthly annuity payment from PSERS) or loss of health care coverage under a school employer's health plan (Coverage includes any COBRA coverage available under the school district's plans).**					
a	Annuitant's Retirement	QE	QE	QE	QE	QE
b	Annuitant's loss of school coverage	QE	QE	QE	QE	QE
2.	**Involuntary loss of health care coverage under a non-school employer's health plan (coverage includes any COBRA coverage available under the plan).**					
a	Annuitant's loss of non-school employer's coverage	QE	Not a QE	Not a QE	Not a QE	Not a QE
b	Spouse's loss of non-school employer's coverage	QE	QE	Not a QE	Not a QE	Not a QE
c	Dependent Child's loss of non-school employer's coverage	QE	Not a QE	QE	Not a QE	Not a QE
d	Survivor Annuitant's loss of non-school employer's coverage	QE	Not a QE	Not a QE	QE	Not a QE
e	Dependent Child's loss of non-school employer's coverage	QE	Not a QE	Not a QE	Not a QE	QE
3.	**Reaching age 65 or becoming eligible for Medicare.**					
a	Annuitant age 65 or becoming eligible for Medicare	QE	QE	QE	QE	QE
b	Spouse of Annuitant age 65 or becoming eligible for Medicare	QE	QE	QE	Not a QE	Not a QE
c	Dependent Child becoming eligible for Medicare	QE	Not a QE	QE	Not a QE	Not a QE
b	Survivor Annuitant age 65 or becoming eligible for Medicare	QE	Not a QE	Not a QE	QE	QE
e	Dependent Child becoming eligible for Medicare	QE	Not a QE	Not a QE	Not a QE	QE

SUMMARY OF PERSONS AFFECTED BY QUALIFYING EVENTS (Recommended)						
	Qualifying Event	**Annuitant**	**Spouse (of Annuitant)**	**Dependent (Child) of Annuitant**	**Survivor Annuitant**	**Dependent (Child) of Survivor Annuitant**
KEY: QE=Qualifying Event; Continuation=Individual enrolled in HOP may continue coverage; CO=Change Option within HOP						
4.	**A change in family status (including divorce, death of the retiree or spouse, addition of a dependent through birth, adoption, or marriage or loss of a dependent through loss of eligibility).**					
(i)a	Annuitant's divorce	QE	Not a QE	QE	Not a QE	Not a QE
(i)d	Survivor Annuitant's divorce	Not a QE	Not a QE	Not a QE	Not a QE	Not a QE
(ii)a	Annuitant's death	N/A	Continuation[1]	Continuation	QE	Limited QE[2]
(ii)b	Spouse's death	QE	N/A	QE	Not a QE	Not a QE
(ii)c	Annuitant's Dependent Child's death	QE	CO	Not a QE	Not a QE	Not a QE
(ii)d	Survivor Annuitant's death	QE	Not a QE	Not a QE	N/A	Termination
(ii)e	Survivor Annuitant's Dependent Child's death	QE	Not a QE	Not a QE	CO	CO
(iii)a	Annuitant's addition of dependent through birth, adoption or marriage	QE	Not a QE	Limited QE[3]	Not a QE	Not a QE
(iv)a	Annuitant's loss of a dependent through loss of eligibility	CO	CO	CO	Not a QE	Not a QE
(iv)d	Survivor Annuitant's loss of a dependent through loss of eligibility	CO	CO	CO	CO	CO
5.	**Becoming eligible for Premium Assistance due to a change in legislation**					
a	Annuitant becomes eligible for PA	QE	QE if Annuitant enrolls	QE if Annuitant enrolls	QE if Annuitant enrolls	QE if Annuitant enrolls

[1] A spouse converting a death benefit to a PSERS annuity may enroll in HOP upon the Annuitant's death
[2] Dependent may enroll in Survivor Annuitant enrolls
[3] Dependent can be added to Annuitant's coverage

SUMMARY OF PERSONS AFFECTED BY QUALIFYING EVENTS (Recommended)						
	Qualifying Event	**Annuitant**	**Spouse (of Annuitant)**	**Dependent (Child) of Annuitant**	**Survivor Annuitant**	**Dependent (Child) of Survivor Annuitant**
KEY: QE=Qualifying Event; Continuation=Individual enrolled in HOP may continue coverage; CO=Change Option within HOP						
6.	**Termination of a plan approved for Premium Assistance or moving out of a plan's service area**					
(i)a	Annuitant's PA approved plan is terminated	QE	QE if Annuitant enrolls	QE if Annuitant enrolls	QE if Annuitant enrolls	QE if Annuitant enrolls
(ii)a	Annuitant moves outside HOP plan's service area	CO	CO	CO	CO	CO

4. Specific Eligibility Issues

This section looks at more specific eligibility issues related to the HOP. These issues have arisen from actual situations with retirees and school district plans.

4.1 Comparable "Mirror" Coverage

Background

In addition to eligibility for the HOP, some PSERS retirees and/or their spouses are eligible for other retiree coverage provided through their school district, their union or a federal program, such as the Veterans Affairs Department (the VA) or the military. For example, a retiree might be eligible for prescription drug benefits through the VA or a union-based plan that does not provide coverage for the spouse.

PSERS' current eligibility and enrollment policies require that a retiree who enrolls his or her spouse, survivor annuitant or other dependents must select the exact same ("mirror") coverage for all persons covered under the HOP program. For example, if the retiree selects the HOP Medical Plan with Basic Medicare Rx option, then the spouse added to the plan must be covered under those same plan choices. HOP currently does not allow the retiree to select only the medical plan without the Rx option while the spouse enrolls in both plans. This has proved somewhat problematic and confusing for retirees who have other coverage for a portion of their overall benefits package.

While the "mirror coverage" requirement is commonplace in the insurance industry, it was critical in the days when PSERS' retirement annuity system could recognize only limited variations in premium deductions from the retiree's annuity check. Currently the annuity and third party administration systems allow the possibility for more individual flexibility in plan selection.

Analysis

The extent of the potential population affected by the mirror coverage requirement is unknown. Upon termination of its Medicare eligible retiree health plans, the School District of Philadelphia (the largest school district that was still maintaining its own post-65 retiree health programs) had about 2,700 participating retirees and spouses. Almost all of the retirees of that district qualify for and are enrolled in prescription drug coverage through their union. Only about 300 persons were enrolled in prescription drug plans through one of the district's authorized carriers. Most of those 300 persons were spouses, because most retirees already have the prescription drug coverage through their union as noted above. It is our belief that more than 300 spouses exist for this large population of retirees and that most of those spouses have enrolled in Medicare supplement, Medicare Advantage and/or Medicare Prescription Drug Plan coverage outside of the School District of Philadelphia programs.

We do not know how many PSERS retirees and/or their spouses would be enrolled if HOP coverage were expanded to allow the spouse to have different coverage than the retiree. HOP

attracts more than 50% of the newly eligible retirees turning age 65 and losing local school district coverage each year. That leaves a large number of retirees and spouses who elect not to participate in the HOP. Segal is conducting ongoing surveys of retirees that choose not to enroll in the HOP, but the results do not indicate a clear connection between those who do not enroll and the mirror coverage rules. Likewise, PSERS and CoreSource periodically learn of a retiree or spouse with VA prescription drug benefits or Tri-Care for Life military benefits where the retiree and spouse would want to select different benefit options; however, there are no statistics on how many of these situations exist across the current or emerging PSERS eligible population.

This mirror coverage issue does not arise when there is only a retiree with no spouse, or a surviving spouse only with the outside prescription drug benefits, since that person may already select coverage in the HOP Medical Plan only (no prescription drug coverage), or the HOP Medical Plan plus either the HOP Basic or Enhanced Medicare Rx option, or just the HOP Basic or Enhanced Medicare Rx option with no medical coverage (this last option subject to loss of premium assistance benefits for the retiree, if eligible). The issue only occurs with multiple person contracts where one has the outside drug coverage.

Comparability to Other Retiree Health Programs. The HOP mirror coverage rules are already in line with the coverage rules for other large public sector retiree health benefit programs, where all covered persons under the contract must have the same coverage. Retiree health plans typically do allow one exception to their mirror coverage rules, where one spouse is over age 65 and Medicare eligible and the other is not yet age 65 and must be in a commercial coverage plan. This is the same split contract coverage situation PSERS already allows.

Administration of Individual Coverage Selections. System capabilities have changed since the HOP mirror coverage rules were adopted. Previously, enrollment needed to be consistent for all covered parties in a contract to keep track of the contract electronically. Now, it is now fully possible and cost feasible to allow completely separate coverage options and decisions and still track all members of a covered family into one contract relationship for purposes of the payroll deduction and reporting. PSERS' third-party administrator, CoreSource, has indicated that they now have this capability to track different coverage for spouses/dependents and do so for some third party administration clients.

In addition, the state health insurance exchanges now being constructed in accordance with the Patient Protection and Affordable Care Act (ACA) for implementation effective January 1, 2014 will be based on separate elections and coverage for the individual insurance exchange. For the small business exchanges also being implemented, the electronic systems being built will track individual coverage selections and roll them up into contracts and groups for employer reporting. Also, major insurance carriers and other companies are developing private insurance exchanges that allow individual enrollment and choice of plan. We believe it is possible that the new standard for employer sponsored health benefit plans will soon become full individual election and tracking.

PSERS' Mirror Coverage Policy. Even though this new capability for individual election of benefit options exists in today's marketplace, we do not believe that PSERS can or should move wholesale to that individual tracking standard at the present time, particularly as the availability of HOP benefits is focused on a limited group of qualified retirees their dependents, not on a general population. However, a change to ease the current mirror coverage policy slightly would

be one step in that direction, and one we believe could help PSERS better serve its retirees and participants.

We understand through our interview with Chuck Serine at PSERS that changing the policy on mirror coverage is within the board's purview and would not require a change to the Code provisions establishing the program.

If PSERS decides to modify the mirror coverage requirement, there should be clear definition of how far the ability to have different coverage should extend. We believe that PSERS should make any change in the current requirements incrementally to address the immediate problem and not immediately relax all rules relating to mirror coverage. For example, the policy could be adjusted initially only to allow one spouse to participate in the HOP Medicare Rx benefit and the other spouse not to participate in the HOP Medicare Rx benefit option, provided both spouses are enrolled in the HOP Medical Plan and the spouse not electing the Medicare Rx benefit option proves comparable prescription drug coverage in another officially recognized plan. Spouses would not be able to elect have different medical plan options (e.g., one have a Medicare Advantage plan that includes prescription drug benefits and the other have only the HOP Medical Plan). Also, PSERS should require medical plan participation by both spouses to be eligible for the difference in prescription drug coverage. For example, a spouse would not be able to elect only coverage in one of the HOP Medicare Rx options without the retiree having that same prescription drug coverage.

In relaxing the mirror coverage rules for coverage by another prescription drug plan for spouses, PSERS would also need to consider how such a policy would apply in the event that an eligible dependent could demonstrate qualified prescription drug coverage elsewhere. We believe the same concepts would apply – only the person(s) in the covered family demonstrating prescription drug coverage in one of the recognized plans would be able to elect not to have prescription drug coverage. If the dependent is not able to demonstrate such other coverage and the retiree and/or spouse has selected one of the HOP Medicare Rx options, then the dependent must mirror the person with the highest level coverage, namely the one with HOP Medical Plan and one of the HOP Medicare Rx options. We do not believe there are many cases where a dependent could demonstrate such coverage, but PSERS should take the possibility into account when operating policies are being prepared.

There would be some additional administrative complexity created by allowing different coverage for spouses or dependents. More rate permutations would need to be calculated; more rate tiers and variations would need to be administered by CoreSource; more options would need to be described in the printed and online materials and SPDs; and additional verifications would be required up front and on a periodic basis for retirees with split Rx coverage to prove their coverage elsewhere. Implementation of this policy will also complicate the annual personalized statement process, because there would be new rate categories (e.g., retiree and spouse with HOP Medical Plan, spouse with HOP Medicare Rx) to be accommodated into the logic. Determination would need to be made about what rate permutations and information should be reflected on participant statements.

The retiree, spouse or dependent would need to prove his or her participation in the other outside prescription drug benefit to qualify for the relaxed mirror coverage requirement. This would need to be proved for the initial enrollment into the plan, or change of enrollment to add the prescription drug for the spouse, and also re-verified on a periodic basis, preferably each year. A

suitable process for verifying ongoing coverage will need to be developed. PSERS' third party administrator (CoreSource) could be assigned to perform the verification of retiree coverage. If the retiree cannot prove continued participation in the indicated prescription drug program, the ability to have different coverage will end and the retiree and spouse must again have mirror coverage.

Timing. We believe a change as structurally complex as this should be made in conjunction with other annual changes to the program, rather than midyear. Also, we suggest that the best time to implement the change to mirror coverage would be at the next board-authorized open enrollment period, rather than at a regular Option Selection Period. We do not recommend starting this process by providing the option to incoming retirees as they first turn 65. While there would be some advantages of starting with the smaller groups already becoming eligible, we believe the existing retiree participants would soon hear of this change of policy and demand that they be allowed to make the same elections. In addition, the operational changes required to accommodate split coverage between medical and prescription drug for some participants would best be accomplished when the third party administrator is already adjusting for the new year's benefit program. Verification of retiree external prescription drug coverage could be accomplished as part of an application for change of coverage during the enrollment period.

We believe introducing the new policy as part of an open enrollment will help to reduce the volume of retiree calls relating to the change. There is likely some pent up demand among PSERS retirees for this change, particularly among those who would like to enroll in the HOP but could not match their particular needs to the products offered through the program. By handling the change at one open enrollment, PSERS can satisfy itself that you have given all PSERS retirees the opportunity to make this choice. Future activity would then be limited to newly eligible retirees, except in the unlikely cases where the other prescription drug coverage is no longer available to the retiree.

The policy change should be strictly limited to apply only to election of the HOP Medical Plan (or HOP Pre-65 Medical Plan) and the HOP Basic and Enhanced Medicare Prescription Drug options. Managed Care Organizations contracting with PSERS to offer Medicare Advantage and managed care options should not be eligible for this treatment, as those programs automatically include both Medicare Advantage and Prescription Drug benefits with no separate selection by the retiree.

> **Recommendation:** Segal recommends that PSERS modify the current "mirror coverage" policy slightly to allow a retiree, spouse or dependent who can prove prescription drug coverage in an approved union plan resulting from employment at a participating school district, or in a recognized federal plan such as the VA, or in a military program such as Tri-Care for Life, where the coverage cannot be extended to a spouse, to have different prescription drug coverage under the HOP. Retirees, spouses and dependents in this situation must continue to have the same medical plan election. Only the person(s) with the proven outside prescription drug coverage may be opted out of prescription drug coverage through HOP.
>
> No change would be made that would allow separate elections by the retiree, spouse or dependent, merely modification of the options available to the retiree for his or her election for a two-person or three-person contract.

PSERS should define approved or recognized prescription drug plans that will be considered for this purpose. The list should only include the known federal or military plans and any known union sponsored Rx plans currently in existence.

We recommend that PSERS implement the change to its mirror coverage policy for the entire HOP population effective for the first of a plan year (calendar year). We believe making the change in conjunction with a limited open enrollment is the best way to implement the policy without having considerable confusion among existing participants and concern among those who did not enroll in HOP because the mirror coverage policy was in effect. The earliest date for that open enrollment to allow full implementation in all systems would be the fall of 2013 for calendar year 2014. By opening the doors to allow anyone who is in this situation a one-time opportunity to come into the plan and make the Rx split selection, PSERS would remove the potential backlog of people complaining that they can't get in. After that open enrollment, entry would continue through the established enrollment rules where a retiree with a qualifying event may enroll in the HOP and may also prove prescription drug coverage in another approved plan to trigger the ability for the retiree and spouse to elect different prescription drug coverage. If an open enrollment is scheduled, persons coming in with the prescription drug split election would be paying the penalty rates for the HOP Medical Plan, which would reduce the impact of any adverse selection.

We do not recommend allowing the retiree and spouse (and dependent) to select different medical plan options. With PSERS' structure of the self-insured Medicare supplement plan and Medicare Prescription Drug plans, augmented by Medicare Advantage plans that all include prescription drug coverage with no option, there are currently by design no comparable medical only options to the HOP Medical Plan. We do not believe there is a compelling argument to extend the choice of plans beyond what is needed to address the specific situation. Further choice would only add significant complexity and cost to the program as well as significant additional confusion to participants trying to understand their options in the HOP.

Additional Analysis for Policy Implementation. To help PSERS frame the changes to the mirror coverage policy and identify the impact of the change, we offer the following additional analysis. The following table describes the range of coverage permutations that could result from allowing different prescription drug coverage for spouses:

HOP Plan Election Permutations with Split Rx Coverage		
Situation	**Retiree**	**Spouse/Dependent**
Retiree has prescription drug coverage through a union plan from school district employment, VA benefits, or military Tri-Care for Life. Spouse has no outside Rx coverage. **Both are Medicare eligible.**	HOP Medical Plan only	HOP Medical Plan with Basic Medicare Rx option, or HOP Medical Plan with Enhanced Medicare Rx option Dependent must have both medical and Rx coverage

HOP Plan Election Permutations with Split Rx Coverage		
Situation	**Retiree**	**Spouse/Dependent**
Retiree has prescription drug coverage through a union plan from school district employment, VA benefits, or military Tri-Care for Life. Spouse has no outside Rx coverage. **Retiree is Medicare eligible. Spouse is pre-65.**	HOP Medical Plan only	HOP Pre-65 Medical Plan with Rx Dependent must have both medical and Rx coverage
Retiree has prescription drug coverage through a union plan from school district employment, VA benefits, or military Tri-Care for Life. Spouse has no outside Rx coverage. **Retiree is pre-65. Spouse is Medicare eligible.**	HOP Pre-65 Medical Plan only (no Rx)	HOP Medical Plan with Basic Medicare Rx option, or HOP Medical Plan with Enhanced Medicare Rx option Dependent must have both medical and Rx coverage
Retiree has prescription drug coverage through a union plan from school district employment, VA benefits, or military Tri-Care for Life. Spouse has no outside Rx coverage. **Both retiree and spouse are pre-65.**	HOP Pre-65 Medical Plan only (no Rx)	HOP Pre-65 Medical Plan with Rx Dependent must have both medical and Rx coverage
Spouse has other prescription drug coverage through VA benefits or military Tri-Care for Life. Retiree has no outside Rx coverage. **Both are Medicare eligible.**	HOP Medical Plan with Basic Medicare Rx option, or HOP Medical Plan with Enhanced Medicare Rx option	HOP Medical Plan only Dependent must have both medical and Rx coverage
Spouse has other prescription drug coverage through VA benefits or military Tri-Care for Life. Retiree has no outside Rx coverage. **Retiree is Medicare eligible. Spouse is pre-65.**	HOP Medical Plan with Basic Medicare Rx option, or HOP Medical Plan with Enhanced Medicare Rx option	HOP Pre-65 Medical Plan only (no Rx) Dependent must have both medical and Rx coverage
Spouse has other prescription drug coverage through VA benefits or military Tri-Care for Life. Retiree has no outside Rx coverage. **Retiree is pre-65. Spouse is Medicare eligible.**	HOP Pre-65 Medical Plan with Rx	HOP Medical Plan only Dependent must have both medical and Rx coverage

HOP Plan Election Permutations with Split Rx Coverage		
Situation	**Retiree**	**Spouse/Dependent**
Spouse has other prescription drug coverage through VA benefits or military Tri-Care for Life. Retiree has no outside Rx coverage. **Both are pre-65.**	HOP Pre-65 Medical Plan with Rx	HOP Pre-65 Medical Plan only (no Rx) Dependent must have both medical and Rx coverage
Dependent has other prescription drug coverage through VA benefits or military Tri-Care for Life. Retiree and spouse have no outside Rx coverage. **Both are Medicare eligible.**	HOP Medical Plan with Basic Medicare Rx option, or HOP Medical Plan with Enhanced Medicare Rx option	HOP Medical Plan with Basic Medicare Rx option, or HOP Medical Plan with Enhanced Medicare Rx option Dependent has medical coverage only.

We have also described the likely impacts this policy will have in a number of areas. The following table summarizes those findings.

PROPOSED ELIGIBILITY CHANGE: MODIFICATION OF "MIRROR COVERAGE" REQUIREMENT	
PROPOSED POLICY: ***Allow a retiree with covered spouse to elect medical coverage for both spouses (HOP Medical Plan and/or HOP Pre-65 Medical Plan) and elect prescription drug coverage through the HOP Basic or Enhanced Medicare Rx option for only one spouse, with proof of coverage in a recognized union, military or federal prescription drug program for the person not selecting the HOP prescription drug coverage.***	
Consistency with PSERS Mission	
• Does the proposed eligibility change accommodate the needs of the population PSERS is trying to serve?	Yes. The change addresses a specific identified need for some members and their spouses and offers the program an ability to attract these retirees into the HOP where the previous choices have not aligned with the retiree needs.
• Does the proposed eligibility change address the needs of a few members or the needs of the membership as a whole?	While PSERS is aware of at least one school district where retirees have a union-sponsored prescription drug benefit that does not benefit spouses, the eligibility change would also address a broader population with federal or military benefit eligibility that is not currently well defined or known
• Does the proposed eligibility change encourage members to enroll in the HOP as	Yes. The change would remove one additional hurdle that some retirees face when they have a

PROPOSED ELIGIBILITY CHANGE: MODIFICATION OF "MIRROR COVERAGE" REQUIREMENT	
early as possible?	qualifying event and are eligible to enroll in HOP.
Premium Cost	
• What is the premium cost of the proposed eligibility change?	While the health profile and cost of each individual is not known exactly, Segal's actuaries believe that reducing the mirror coverage requirement would not cause a major shift in the premium cost for the medical or prescription drug programs.
• If there is a premium cost increase as a result of this policy change, does the increase affect the membership as a whole while benefitting few?	The initial loosening of the mirror policy to allow limited differences in prescription drug coverage will likely attract an inflow of current retirees at a range of ages. On an ongoing basis, by enrolling retirees and spouses at their earliest possible eligibility (typically age 65), the plan will benefit by gaining membership that has a healthier profile and likely lower cost than the average for the entire Medicare retiree group (average age 79+). In addition, HOP already has a mechanism in place to protect against adverse selection after the initial eligibility period. Whenever a retiree joins the plan as a result of an open enrollment or other situation that is not a Qualifying Event, the retiree pays a penalty rate for the HOP Medical Plan of 10% above the standard rate if he or she can prove they are coming in from prior Medicare supplement or Medicare Advantage coverage, or 20% above the standard rate if prior Medicare supplement or Medicare Advantage coverage cannot be proved. Since the HOP Medical Plan does not charge rates adjusted by participant age, these penalty rates for latecomers help balance the cost more appropriately across the participating population and avoid penalizing HOP Medical Plan participants who enrolled when they first had the opportunity. Unlike the HOP Medical Plan, PSERS must charge the same premium for all participants in the Medicare Rx plan options regardless of when they enroll, as CMS rules will not allow penalty rates based on entry date or other factors.
Administrative Cost/Efficiency	
• Does the proposed eligibility change increase administrative costs?	Yes. Currently, CoreSource sets up a single "contract" for the retiree and spouse since the retiree and spouse must have mirror coverage. If retiree and spouse do <u>not</u> have mirror coverage, CoreSource would need to set up the retiree as a single "contract" and set up the spouse as a single "contract," thereby increasing the number of

PROPOSED ELIGIBILITY CHANGE: MODIFICATION OF "MIRROR COVERAGE" REQUIREMENT	
	contracts. As PSERS pays administrative fees based on the number of contracts, this policy change could increase the administrative costs. Even if CoreSource can fully track separate spouse contracts into a super-contract for the retiree for purposes of the payroll deduction from the retiree pension check, there would be increased complexity in the overall administrative account structure. Where CoreSource now tracks primary rate buckets that are based on plan, region and number of persons covered assuming the same coverage for all, with this proposed change, CoreSource would need to add another degree of account complexity to track allowed variations of the basic pattern. For example, CoreSource would need to add a complete set of rate accounts for all regions to reflect retiree and spouse both in the HOP Medical Plan and only the spouse in HOP Basic Medicare Rx option, another set for both in HOP Medical Plan and only the spouse in HOP Enhanced Medicare Rx option, and possibly two more similar to the above where the retiree has the HOP prescription drug additional coverage and the spouse does not (the reverse of the first situation). The number of rate bucket sets that must be added to the current structure increases with the number of variations allowed from the mirror coverage. While not a final deciding factor, PSERS should be aware of the potential additional administrative cost and complexity in making its decision on this issue.
• What other administrative and cost impacts would be expected?	The proposed change would also increase the complexity and cost of generating personalized statements for the annual Option Selection Period. Additional rate permutations would need to be calculated and provided for each region and rate variation (HOP Medical plus Basic or Enhanced Rx) and tier (e.g, standard rates, 15% discount rates, 12% discount rates, 10% and 20% penalty rates, etc.). The statement program logic will need to be updated to identify contacts that include differing drug plan enrollment and test those against the other logical tests and accuracy reviews. The checking sequences for the statements would be marginally more complex, requiring additional testing of the split Rx coverage contracts.

PROPOSED ELIGIBILITY CHANGE: MODIFICATION OF "MIRROR COVERAGE" REQUIREMENT	
• Does the proposed eligibility change create administrative inefficiencies for PSERS?	Possibly. The number of different rate permutations that would apply to retirees and need to be entered into the PSERS V3 administration system for the retiree's payroll deduction to reflect the split of coverage for prescription drug would increase.
• What proof would the retiree need to provide to make this selection?	Proof of current coverage by a recognized union prescription drug program resulting from the retiree's employment with a school district participating in PSERS, or by a military or federal retiree benefit program (such as the VA or Tri-Care for Life) that provides drug benefits only for the person eligible for that coverage and not for that person's spouse. Proof should be required upon enrollment, and audited by the third party administrator periodically thereafter (recommended annually) to assure the retiree or spouse is continuing their participation in the program that triggered the need for different Rx coverage.
Adverse Selection	
• Does the proposed eligibility change potentially expose HOP to adverse selection?	Marginally. By requiring both spouses to have HOP Medical Plan coverage and allowing only one to participate in the Medicare Rx option, even if one were a high utilizer and the other were not, the overall cost impact should be marginal, particularly with PSERS' existing policy of requiring a penalty rate for entries without a qualifying event. If PSERS eventually were to adopt an additional low option Medicare supplement plan, the requirement to have both spouses in the same medical plan if one is electing a different drug benefit would need to be reviewed based on the administrator's ability to handle the additional complexity of selection.
Policy Change	
• Is there already an informal or formal policy addressing the proposed eligibility change that may have to be revised?	Yes, formal policy currently requires mirror coverage.
Code Change	
• Can the proposed eligibility change be justified under current law?	Yes. According to Chuck Serine of the PSERS Office of Chief Counsel, requiring/not requiring mirror coverage is within the board's purview; the law would accommodate requiring or not requiring mirror coverage
• Would changes be required to the Code?	No.

PROPOSED ELIGIBILITY CHANGE: MODIFICATION OF "MIRROR COVERAGE" REQUIREMENT	
SPD and Communications Materials Changes	
• Does the proposed eligibility change require changes to the SPD, website and printed materials and brochures?	Yes. The best time to make a transition would be when materials are being updated anyway for the beginning of a calendar year.
Ease of Understanding	
• Is the proposed eligibility change expected to be fairly well understood by the typical retiree?	Yes. It will require careful explanation to assure that the communications materials do not overstep the degree of policy change.
Industry Standards	
• Is the proposed eligibility change consistent with industry standards?	No. In general, mirror coverage is an industry standard. For example, typically a member selects health plan options and enrolls the spouse/dependent children under the selected health plan options. Typically the only variation from the mirror coverage standard is "split coverage" when the retiree is over age 65 and eligible for Medicare benefits and the spouse is not yet 65 and must be enrolled in a non-Medicare pre-65 benefit plan. PSERS already recognizes split coverage between the retiree and spouse.
Enrollment Numbers	
• How many retirees/covered individuals are affected by this change?	Not clear. While PSERS is aware that most School District of Philadelphia (SDP) retirees are eligible for a prescription drug plan provided by their union, there are currently no reliable numbers on the exact number that have spouses and would enroll in the HOP to get the split prescription drug coverage if given an opportunity. Only a few hundred SDP retirees or spouses transitioned to PSERS at the end of 2012 subscribed to prescription drug benefits through the sponsored plans. Upwards of 1,000 SDP early retirees turn 65 each year and become eligible for HOP. Presumably, most of those retirees qualify for the union Rx benefit and some would have spouses. In addition, PSERS has only anecdotal knowledge of the number of retirees or spouses that may be eligible for VA or Tri-Care benefits. Some surveying has been done among current retiree participants, but that research does not reach those retirees who did not enroll in the HOP years ago because of the mirror coverage policy. Segal's actuaries estimate there may be as many as 1,000 retirees in this situation who might be enticed to enroll should the policy be changed and an open enrollment held. On an ongoing basis, there could

PROPOSED ELIGIBILITY CHANGE: MODIFICATION OF "MIRROR COVERAGE" REQUIREMENT	
	be a few hundred early retirees turning 65 each year who are in this outside coverage situation.
Premium Assistance Impact	
• Would this policy change have an impact on the Premium Assistance program for qualified PSERS retirees?	Yes. Any eligible retirees who are not currently receiving Premium Assistance benefits who enroll in HOP during an open enrollment triggered by this change in policy would increase the amount of Premium Assistance benefits being paid by the Commonwealth. The incremental increase would be $100 per month per additional retiree enrolled.

Next Steps

Upon review and discussion of the recommendations contained in this report a policy should be drafted for the board's consideration. The following are suggested as preliminary decision points before a policy is drafted and confirmed with the Office of Chief Counsel that changes to the Code are not required for the proposed changes:

- Determine if enrollment in HOP should be contingent upon an ongoing financial relationship between PSERS and the individual while allowing enrolled spouses and dependents to continue their HOP coverage upon the death of the Annuitant (Member).
- Modify the application of Qualifying Events and specify when they apply to the Annuitant, Survivor Annuitant, spouse and dependents of Annuitants, or Survivor Annuitants.
- Determine whether PSERS will adjust the mirror coverage requirement in the limited manned as described and recommended above.
- Decide whether to offer a special enrollment opportunity to retirees and their dependents affected by this change.

4.2 Medicare Participation Requirement

The Health Options Program requires that a Medicare eligible retiree or spouse be enrolled in the appropriate Medicare programs to maintain eligibility for enrollment in the HOP.

For enrollment in the HOP Medical Plan (Medicare supplement), the retiree (and covered spouse) must be enrolled in Medicare Part A and Part B. For enrollment in a HOP sponsored Medicare Advantage Plan, the retiree (and covered spouse) must be enrolled in Medicare Part B and must pay the Part B premium in addition to the Medicare Advantage plan premium.

We understand that from time to time questions arise from retirees about this requirement and that PSERS does not make exceptions to this basic requirement. Indeed, in past years when there were still retirees in the program who had never contributed toward Medicare benefits during their active employment, PSERS actively reached out to these retiree participants to encourage them to enroll in Medicare Parts A and B, because the cost of that enrollment with the required penalties for late enrollment, plus the premium for the HOP Medical Plan (Medicare supplement) was still less than those retirees were paying for participation in the more limited non-Medicare plan under the HOP. PSERS was successful in this effort and Medicare Part A and Part B enrollment is no longer an issue.

The plans HOP offers to supplement Medicare benefits (HOP Medical Plan) or to replace them (Medicare Advantage) are designed specifically to coordinate with Medicare benefits. The requirement for Medicare Part A and Part B enrollment is reasonable and the standard practice among systems offering retiree health benefits.

Enrollment in Medicare Part B is a requirement for participation in Medicare Advantage plans. The individual is not required to enroll in original Medicare Part A because the Medicare Advantage plan (Part C) provides both the Part A and Part B benefits instead of original Medicare and is reimbursed by the Centers for Medicare and Medicaid Services (CMS) for providing those benefits.

> **Recommendation:** We recommend no change in the current policy. PSERS should continue to enforce rigidly enrollment of Medicare eligible individuals in Medicare Parts A and B for continued participation in the HOP Medical Plan.

4.3 Retirees Who Miss Initial Enrollment Window

Background

Questions have arisen relating to eligibility of PSERS retirees who miss enrolling in the HOP during their initial enrollment window when they turn 65 and lose local school district coverage. Primarily, these questions relate to whether and under what circumstances these retirees should be allowed to enter the plan after missing that eligibility window. The board has periodically authorized a full or limited open enrollment period where those who missed their original enrollment period, but have not experienced a Qualifying Event, can enroll in the program and pay a penalty premium rate for the HOP Medical Plan.

The most recent open enrollment authorized by the board was in 2010 for the 2011 calendar year. The next previous authorized open enrollment was in 2005 for the 2006 calendar year, when Medicare Part D went into effect and the HOP Medicare Prescription Drug Plan options were implemented. While a full open enrollment requires outreach to many thousands of PSERS retirees who have not enrolled in the HOP, the number of actual enrollments that result from the open enrollment is typically small.

Analysis

The main reason for limiting when someone can enroll in the HOP to specific events is to avoid adverse selection.

Limiting ability to enroll in a group health plan is typical among employers and plan sponsors. Employer group health plans accomplish this by allowing a person to enroll in the plan only during a certain period following employment or attainment of eligibility, and then during a specified open enrollment period each year. Prior to the passage of the Affordable Care Act (ACA), plans could impose pre-existing conditions on late enrollees and this was done frequently for individual health insurance policies and group association plans. A delayed starting date for coverage might also be imposed.

In addition, many employers do not allow active employees to waive coverage or to dis-enroll unless the employee can prove coverage through another source. This policy was typically implemented to assure that the group plan gets the fullest possible participation to avoid adverse selection.

For retirees, Medicare holds a general enrollment period each January through March for Part B but imposes a late enrollment penalty for both Part B and D (the two components of Medicare that require that the beneficiary pay a premium). The Part B penalty is 10% of the current Part B premium for each 12-month period the person could have had Part B coverage but did not. The Part D penalty is 1% per month the retiree is late in enrolling.

Segal has assisted PSERS with determining premium levels and establishing penalty premium rates for several years. We continue to believe that making latecomer participants pay a reasonable penalty premium rate to make up for their failure to enroll when first eligible is a sound and efficient way to accommodate such late enrollments. The premiums can be set high enough to discourage idle enrollments, but not so high as to be clearly punitive to the retiree who is on a fixed income.

Given the low number of new enrollments each time PSERS' board declares an open enrollment, we recommend that retirees who do not enroll during their initial eligibility period not be allowed to enter the plan without a qualifying event except when there is an open enrollment in which they can be included. We do not see a backlog of retirees who are disadvantaged by this policy. CoreSource does not report any major number of calls and concerns to the PSERS HOP Administration Unit from retirees who are upset about missing the enrollment window. In addition, during our interviews with PSERS staff, we found no major concerns that those who miss their initial enrollment should have any more opportunities to join the plan than are already afforded.

However, there may be situations where it could be appropriate to allow a special enrollment, such as for a retiree who was hospitalized during open enrollment period, or where the retiree had granted someone the power of attorney during their enrollment period and that person failed to enroll the retiree. Such situations should be heard as appeals and granted where appropriate based on the specific circumstances, without having to hold a global open enrollment.

> **Recommendation:** We recommend no change to the current policy of limiting enrollment if a retiree fails to enroll during his or her initial eligibility window. Retirees who fail to enroll during their initial enrollment period may be included in a subsequent

board-declared open enrollment and enter the plan at that time, paying penalty rate premiums based on their time of entry.

4.4 School District Coverage

Some questions about PSERS HOP eligibility have related to the coordination of eligibility between school district plans and the HOP. In particular, retirees are often confused about when and under what circumstances their changing eligibility with their local school district plan will trigger eligibility for entry into the HOP. This section addresses those questions and presents information gained from interviews with two large school systems that maintain retiree health benefits after age 65.

Background

Under Commonwealth law, Act 110 (1988) requires school districts to extend health care coverage in the plan to which the retiree belonged as an active to eligible retirees and their dependents until the retiree is eligible for Medicare or becomes eligible for other group health coverage. Act 43 (1989) amended Act 110 by defining which retirees are eligible for continuation of group coverage as: superannuitants aged 62 or older; those who retired with 30 years of service; or those receiving a PSERS disability benefit. Most school districts allow these non-Medicare retirees to continue participation in the same plans they had as active employees. Some districts also allow these retirees to continue in their school district plans after they reach age 65 and become eligible for Medicare, but most districts now end coverage for retirees who reach age 65. The Districts are allowed to charge the COBRA rate for this coverage. Collective bargaining agreements may require that there are benefits provided that exceed Act 110/43. Both the Pittsburgh School District and School District of Philadelphia supplement Act 110/43 for some retirees. Employees categorized as non-professionals generally receive only the Act 110/43 benefits.

To round out our understanding of how eligibility coordination occurs or does not occur between local school districts and the HOP, we looked into how school districts treat eligibility. The prime focus of this study is not to determine how all Commonwealth school districts handle their eligibility, so the review is by definition not exhaustive. We did focus on a few systems that can serve as illustrations of the range of eligibility practices.

Retiree Turns Age 65 and Loses Coverage

A majority of the Commonwealth school districts have already terminated any health benefit coverage for retirees over age 65. About 200 of the 700+ school districts still have some over-65 retirees covered with health benefits, although in most circumstances these are small numbers and are often former administrators of the district who have negotiated a special employment contract where the district agreed to pay for the administrator's health care benefits after age 65.

In most districts, when the retiree turns age 65, he or she loses local school district coverage and has a qualifying event, thereby opening the eligibility window with PSERS HOP. If the retiree has a spouse covered by the local school district plan, that spouse typically also loses coverage,

regardless of age. Through that qualifying event, the retiree then has the option to enroll in the Health Options Program, for the retiree, spouse and any eligible dependents. The retiree may elect coverage for himself or herself alone, or also including the spouse and eligible dependents in the same plan options.

The retiree's decision in this situation is guided by whether the retiree is eligible for Premium Assistance. Once the retiree is no longer eligible for an approved plan with the school district, the only plan options to maintain the Premium Assistance subsidy are in the Health Options Program. If the retiree is not eligible for Premium Assistance, the decision is somewhat broader and based more on whether the HOP offers competitive pricing and benefits against commercial individual Medicare Advantage or Medigap plans.

We understand from our school district interviews for this project as well as for earlier reviews of Premium Assistance, that school districts do not typically allow a spouse of a retiree turning age 65, who is not yet 65 himself or herself, to remain in the school district plan. Thus, when the retiree ages out of the school district plan, the entire covered family group is disrupted.

Spouse Turns Age 65 and Loses Coverage, Retiree is Not Yet Age 65

Similar to the situation described above, when the retiree is under age 65 and covered by a local school district plan, and the spouse turns age 65, typically the spouse will lose eligibility for coverage in the school district plan. Some school districts that allow continued coverage after age 65 will allow the spouse over age 65 to continue on the plan. They note that Act 110/43 is tied to retiree's Medicare eligibility. The retiree may or may not be allowed to continue as a single person contract in the school district's pre-65 plan, and usually continues with whatever retiree premium subsidy applies, but is prohibited from covering the Medicare eligible spouse.

This triggers a HOP qualifying event for the spouse and allows the retiree to make a decision about covering the spouse only both himself or herself and the spouse in the Health Options Program. The decision is guided by whether the retiree is receiving any health plan coverage subsidy from the school district for the district's pre-65 retiree plan and the relative premium cost of that plan to the HOP Pre-65 Medical Plan.

PSERS' position of allowing the retiree to enroll his or her spouse in the HOP when that spouse turns age 65 is reasonable. It does not extend eligibility beyond the persons who would ultimately be eligible for the program, merely allows those persons to enroll in the program at their first required decision point for coverage. This policy also can be a positive for the program because it helps the retiree avoid significant disruption of coverage for the spouse and positions the HOP as a perceived safety net into which the retiree can enroll when he or she also turns age 65.

Over 65 and Still Working, But Not at School District

Continued work after retirement does not directly affect eligibility for the HOP. Retirees who subsequently go back to work for the school district would return to active employee status and be eligible for the district's employee plans. If over age 65, the school's health plan benefits would be primary and Medicare would become secondary coverage. When the retiree retires again, he or she would again lose school district health benefit coverage and would again have a qualifying event that would allow enrollment in the Health Options Program.

Retirees and spouses who are over age 65 and still working, but not at the school district, are subject first to the age requirements for enrollment in the school district plan. If over age 65 and the district does not continue coverage, then they are not eligible for participation in the school district plan, regardless of their work status. If over age 65 and the district does extend coverage, then the retiree would retain eligibility for school district benefits but those benefits would coordinate with the retiree's other coverage as an active employee. Medicare would be secondary to the other employer coverage; the school district plan would be secondary to Medicare, since the retiree is not employed by the school district. This situation would be unlikely since the retiree would be paying premiums simultaneously for the employer plan, Medicare and the school district plan.

Active School District Employee Dies

If a school district employee dies while employed and covered by the school district's health benefits, the spouse's continued participation in that plan would be dependent upon the district's rules and any collective bargaining agreements. Typically, the spouse would be offered COBRA coverage and then lose coverage at the end of the COBRA period. Some school districts do not have fixed rules on this situation; they will look at the person's length of service and may offer the spouse Act 110/43 coverage.

PSERS has had an appeal from the spouse of a deceased active member who claims she has a right to enroll in the HOP, even though the member was not a retiree and had never had the opportunity to enroll in the program. Among other things, the claim was based on the provision in the pension rules whereby when a member dies, the benefit is calculated "as if" the member had retired on the day before the death. PSERS has ruled in favor of allowing the spouse the opportunity to enroll in this circumstance.

While a definitional connection of a spouse of an active member to the spouse of a retiree is supported by the "as if" clause of the death benefit, we believe that the widowed spouse should only be eligible to enroll in HOP if the lump sum benefit is converted to a monthly annuity. This position is predicated upon our recommendation in Section 3.1 "Eligible Persons" to allow spouses converting a lump sum death benefit to a monthly annuity payment from PSERS to enroll in HOP at the time of the Annuitant's death. A widowed spouse that elects a lump sum payment does not have an ongoing financial relationship with PSERS and that person's participation in HOP adds to administrative expenses. If the board decides to allow the spouse the opportunity to enroll in HOP upon the death of an active member, PSERS should limit the opportunity to this event only. This limitation will help to prevent perpetuation of coverage into different generations that were never related to the decedent's coverage at the time of death.

Retiree Does Not Lose Coverage, But School District Plan is Non-Competitive

Some Medicare retirees in their school district plans do not lose coverage, but do want to join the HOP to get better benefits or a better price than they are currently paying. In some cases the school plan provides a non-Medicare prescription drug benefit whereby the participants pay the full cost of prescription drug coverage and receive no Medicare subsidy. The cost of these prescription drug plans can be many times more expensive than Medicare prescription drug plans. Retirees see the premium for their health plans at the school district going up significantly each year and are anxious to have another plan option. They approach PSERS to ask if they can

enroll in the HOP. PSERS does not allow retirees who still have retiree health benefit access at their school district to be eligible for enrollment in the HOP. The school district must terminate the program and cause a loss of coverage for Medicare retirees to trigger a qualifying event.

Termination of the Medicare retiree coverage is a school district decision. When the school district makes PSERS or CoreSource aware that they are considering a plan termination, PSERS works closely with the district to describe and facilitate the process, including informational meetings for retirees, HOP information packets and applications and access to the HOP Administration Unit call center. The school district is counseled regarding the eligibility and qualifying event rules for the HOP, to help make sure they are terminating all available Medicare retiree coverage within a class. Should the district only terminate one plan offering but continue to offer other plans, the retiree will not lose coverage access and therefore will not have a qualifying event.

We believe this policy requirement for an involuntary termination of coverage by the school district is consistent with the established program objectives of being a safety net for eligible PSERS retirees and does not need to be modified.

PSERS should continue to educate school district that still maintain Medicare retiree health coverage as to the importance of working with PSERS to assure that the district's retirees will have a clear qualifying event to trigger the opportunity to enroll in the HOP.

We do not recommend changing PSERS' policy regarding qualifying events to allow a retiree who has Medicare coverage through his or her school district to simply opt out of the local district plan and into the HOP at will.

Active Employee Becomes Disabled

If an active school district employee participating in PSERS becomes disabled and eligible for a disability retirement, if the retiree is not yet age 65 (Medicare eligible), he or she will be entitled to remain on the school district retiree health plan. At age 65, the disabled retiree would lose local school district coverage (assuming the district does not offer coverage beyond age 65) and have a qualifying event, just as any other PSERS retiree turning age 65.

Should the retiree be disabled and eligible for Medicare prior to age 65, there would only be a qualifying event if the school district does not allow the retiree to remain on the plan.

These situations appear to be straightforward and already addressed by PSERS' qualifying event rules. As such, we do not believe any change to the existing policy is warranted at this time.

Participation in State Health Insurance Exchange

With the implementation for January 1, 2014 of the state health insurance exchanges under the Patient Protection and Affordable Care Act (PPACA or ACA), PSERS will face another set of eligibility situations and possible requests for exceptions to existing eligibility rules. In general, an individual may apply for health insurance through the exchange and possibly be eligible to receive various Medicaid and/or federal subsidies. If that individual is an employee, enrollment through the exchange may trigger both loss of the subsidies and an employer penalty. If that

individual is a retiree not yet eligible for Medicare, withdrawal from the school district's plans would trigger loss of Premium Assistance payments.

The plans available on the state health insurance exchanges will be primarily commercial individual policies and options for smaller employers starting in 2014. Large groups will not be able to participate in the exchanges for their employees until at least 2017. The coverage available initially on the exchanges will be commercial health insurance and not Medicare products. Therefore, we believe the large majority of PSERS retirees, spouses and dependents currently participating in the HOP will have no initial immediate attraction to the health insurance exchanges.

The exchanges will be holding their initial open enrollment period during the fall and winter months of 2013-2014. There will be considerable advertising and direct marketing traffic regarding the open enrollment and PSERS retirees are likely to be confused by the external messaging from the exchanges. We do anticipate that PSERS and the HOP Administration Unit will receive many retiree questions about participation in the exchanges and should be prepared to answer those questions. In most cases, the answer will be that Medicare eligible retirees will not have options on the exchange, and that for non-Medicare eligible retirees, moving to the exchange will trigger loss of premium assistance benefits.

State health exchange participation will become a more prominent part of the eligibility administration for the HOP in future years. We believe that as the exchanges pick up momentum and come fully on line, private and public sector employers alike will be increasingly pressured to offer exchange participation in an array of plans as an option to their existing group insurance coverage for their eligible employees and retirees.

We believe the implementation of the exchanges will have a greater impact on participating school districts, where there is a decided possibility that retirees under age 65 will have coverage through the exchange as an option or the sole source for their health insurance. In the not too distant future, with the continuation and expansion of the state health insurance exchanges, it will not be unusual for a PSERS retiree or spouse becoming eligible for the HOP to be moving in from participation on an exchange, not from a traditional employer group plan. Commercial pre-65 insurance plans through the exchange may also make a strong push to keep active employees in their individual retiree policy options when they retire. PSERS will need to prepare to handle these situations, which might require further refinement of the eligibility rules for the program.

It is likely that PSERS will also face questions from school districts who are considering adding one or more health plans through the exchange as an available program option, or eventually even shutting down their traditional group insurance plans in favor of employer participation on the exchange. The school districts may request that PSERS consider a health exchange plan as an "approved plan" for premium assistance purposes. When this begins to happen, there could be eligibility definition concerns to take the new coverage types into account when verifying creditable coverage.

In addition, because PSERS has retirees in many states across the country, it is likely that eligibility will be affected by slightly different but still compliant requirements in each state jurisdiction. Those different requirements may create issues in determining eligibility for the HOP and also will require PSERS to be aware of the differences in exchanges when answering retiree questions.

Recommendation: We recommend that PSERS continue to review the federal requirements relating to state health insurance exchanges under the Patient Protection and Accordable Care Act of 2010. As the exchanges are implemented for 2014, PSERS should be prepared to answer retiree questions and likely scenarios as persons eligible to enroll in the HOP make decisions about where they will enroll. PSERS should also be prepared to answer school district questions regarding use of state health insurance exchanges as "approved plans" for premium assistance purposes. Going forward, PSERS should analyze and determine how it will react to retirees coming into HOP eligibility directly from participation on a state exchange, either as an individual or as an employee or retiree of a school district.

4.5 Domestic Partner Eligibility

Coverage for the domestic partner of an Annuitant is not currently allowed under the Health Options Program. This policy is based on the current definition of spouse in Pennsylvania and that a domestic partner is not specifically noted or defined among the eligible persons listed in the statute governing the Health Options Program. If, however, the domestic partner of an Annuitant is the Survivor Annuitant for purposes of the retiree's pension benefit under PSERS, both may participate in HOP upon the Member's retirement and the Survivor Annuitant may continue his or her participation in HOP upon the death of the Annuitant by virtue of being a Survivor Annuitant.

The practice of including or excluding domestic partners varies across benefit programs in the Commonwealth. For example, the Retired Employee Health Program (REHP) for retired Commonwealth employees recognizes domestic partners for coverage under the program. School districts across the Commonwealth also have varying policies on coverage of domestic partners. Under PSERS, a domestic partner is not recognized as a spouse for purposes of the retirement benefit, but the retiree is allowed to name a non-spouse Survivor Annuitant as noted above.

At some future point, should Pennsylvania legally recognize a domestic partner as a spouse, PSERS will need to revisit the definitions of eligible persons in the Retirement Code as well as its policies regarding eligibility for HOP. A domestic partner recognized as a spouse would then be subject to the eligibility rules of HOP just as any other spouse.

If domestic partner coverage were allowed without recognition as a spouse, PSERS should require proof of domestic partner status, similar to the process of proving a spousal relationship, evidenced by official documents and/or by affidavits of the parties involved. As a basis for its own policy requirements, PSERS could look to the policies regarding proof of domestic partner status already in place with other state agencies such as the REHP, as guided by legal counsel.

If the board determines, with the advice from the Office of Chief Counsel, that domestic partners may enroll in HOP, rules would be needed regarding eligibility and application of qualifying events to the domestic partner. As noted above, we have recommended above that PSERS consider tightening the rules on all subsequent qualifying events to limit the participation primarily to the retiree and his or her spouse or Survivor Annuitant and any dependents directly related to those primary parties at the time of the retiree's retirement. The Survivor Annuitant could be allowed to continue coverage in HOP after the retiree's death, but prohibited from

extending or expanding that coverage through future qualifying events. We suggest that the existing policy for qualifying events with regard to a Survivor Annuitant could be applied as well to a domestic partner.

Rules would also be needed regarding the coverage of dependents of the domestic partner. The treatment of dependents of Survivor Annuitants could be used as a model for such a policy. If the Survivor Annuitant has dependents at the time of his or her entry into HOP that are proved as dependents for the retiree at that time and therefore eligible for coverage by the retiree, then that Survivor Annuitant and those dependents may continue coverage in HOP following the retiree's death. We have recommended in this study that the application of a qualifying event not extend to changes for a Survivor Annuitant subsequent to the retiree's death, such as remarriage, additional dependents, etc. Should that policy be adopted and if the Survivor Annuitant of a deceased retiree joins in a subsequent marriage or civil union, that action would not be considered a qualifying event that would allow additional dependents to be enrolled in the HOP.

We offer the following operational analysis regarding the potential impact of allowing domestic partners to be covered in the HOP:

- Coverage of domestic partners would require some additional verification and dependent tracking functions for the third party administrator's systems. While CoreSource can already track multiple persons under the retiree's social security number identifier, the verification and affidavit processes typically associated with domestic partner coverage in an employer health benefit plan are not currently implemented for the HOP.

- Since retirees already pay 100% of the cost of coverage for themselves and their covered spouse and/or dependents (including a Surviving Annuitant) outside of any federal Medicare subsidies, there would be no additional direct program or State subsidy involved.

- Premium assistance is only available to eligible retirees, not to spouses or dependents. There would be no additional funding of premium assistance required.

- From a program underwriting perspective, coverage of a domestic partner by a retiree would increase the size of the risk pool, and not be expected to increase administrative significantly if premiums are deducted from the member's monthly benefit.

4.6 Policies, Business Rules and Regulations

Background

PSERS has been granted authority by the Pennsylvania Legislature to sponsor a participant-funded group health insurance program. Specifically, Retirement Code §8502.2, "Health insurance," states the following:

- Authority. The board may sponsor a participant-funded group health insurance program for annuitants, spouses of annuitants, survivor annuitants and their dependents. The

board may promulgate regulations regarding the prudent and efficient operation of the program, including but not limited to:

a) Establishment of an annual budget and disbursements in accordance with the budget.
b) Determination of the benefits structure.
c) Determination of enrollment procedures.
d) Establishment of premium rates sufficient to fully fund the program, including administrative expenses.
e) Contracting for goods, equipment, services, consultants and other professional personnel as needed to operate the program.

In addition to the statutes implementing the Health Options Program, the following documents are used in the administration of the program:

- Plan documentation including the determination of Eligibility and the official definition of Qualifying Event currently in force for the program which includes:
  - ✓ SPD for all options
  - ✓ Website postings
  - ✓ Enrollment materials
  - ✓ Announcement letters
- Legal opinions (internal and external) relating to Health Options Program eligibility.
- Informal policy decisions from PSERS (usually email correspondence between the HOP and CoreSource).

In addition, CoreSource maintains the following internal documents:

- Qualifying Events Summary
- CoreSource, Incl. 9/22/2010 Summary of provisions
- 4/28/09 document on Eligible dependents
- Qualifying Event (QE) Module

PSERS currently uses the appeal process developed for the pension system for review of eligibility determinations. This procedure is summarized as follows:

- The HOP Administration Unit (CoreSource) receives a question that pertains to eligibility.
- If the question cannot be resolved in accordance with existing definitions of eligibility or past decisions, the question is escalated to the Director of the Health Insurance Office of PSERS (Mark Schafer).
- If the Director cannot answer and resolve the question, it is escalated to the Executive Staff Review Committee (ESRC).
- If the issue is not resolved to the satisfaction of the claimant, they may request an Administrative Hearing.
- The result of the Administrative Hearing, is then brought before the board.
- If the board denies the appeal, a lawsuit can be brought in Commonwealth Court.

Analysis

Currently, there is no comprehensive policies and procedures document detailing the administration of the HOP. CoreSource has developed, and provided to Segal for review for this project, a number of internal documents that they use in administration of the Program. Many of these documents are carried forward from policies and procedures of Capital Blue Cross upon the termination of those earlier contracts.

Without a formal policy/procedure regarding eligibility for the HOP, ad hoc interpretations and decisions on specific eligibility situations are often liberal in favor of the member. A liberal eligibility interpretation may not be in the best interest of the HOP and its participating retirees if it leads to greater complexity of rules to join the plan and to increased adverse selection into the plan by retirees with much higher than average medical claims costs. Since the entire cost of the program (outside of federal subsidies for the Medicare prescription drug plans) is paid by the retiree and/or spouse, a liberal administration of eligibility rules can increase cost for all current members.

Conversely, the HOP provides a safety net of health insurance for PSERS retirees and their eligible spouses and dependents. It is in the best interest of the program to do all it can to extend coverage to every eligible person, as defined in the law and interpreted in policy by the board. PSERS should be active in identifying and acting upon new eligibility situations that arise over time, while still seeking to maintain consistency in its interpretation of eligibility. To accomplish that objective, PSERS could develop a well-defined eligibility policy that identifies as many likely exceptions as possible and places parameters around those situations up front, so they are not turned into potentially inconsistent administrative exceptions later.

If too many exceptions to stated eligibility rules are allowed over time, those exceptions tend to be become the new rules. PSERS would be well served to make periodic reviews of eligibility rules. We believe it is important to develop and promulgate eligibility rules that are clearly defined and that reduce the number of exceptions put before executive leadership of the program.

Typical group health plan policy calls for eligibility situations to be handled first by the designated third party administrator in accordance with the specific first level determination rules and guidelines established by the plan sponsor. Appeals of eligibility decisions by the third party administrator are usually subject initially to a second level review process within the administrator before moving to the plan sponsor. Should the matter not be resolved by the third party administrator, the question then moves on to the manager of the health benefit plan, then to a staff committee of the plan. Often, the staff committee is composed of one or more senior managers with specific knowledge about the health plan, along with other appointed staff members, sometimes including employees and retirees on the committee. If the staff committee cannot resolve the eligibility issue, it may be moved along through a formal appeal procedure and ultimately decided by the sponsor's board.

PSERS' current process follows this general pattern, but does not require the staff committee (the ESRC) to report directly to the Health Care Committee of the board on its resolution of issues or interpretation of eligibility policy. If the ESRC does not resolve the issue, the member can request a formal appeal. However, that appeal currently goes to the Appeals Committee of the board. We believe it would be more appropriate for eligibility appeals to come before the

Health Care Committee, where there is arguably a greater understanding of the issues in play for the group health plan.

We believe PSERS would be well served by linking the entire eligibility review and appeal process directly from the third party administrator to the Director of the Insurance Programs, to the ESRC and finally to the Health Care Committee. Rather than establish another staff review committee specifically for eligibility issues, we suggest that PSERS could modify its current approach to utilize the ESRC as a mid-level step after the third party administrator and Director of Health Insurance Programs have ruled. The ESRC would continue to review specific member eligibility issues, but also would submit its reviews and resolutions to the Health Care Committee for ratification, particularly if the resolution had the possibility of changing current eligibility policy for the program. This would be a similar policy to that followed for pension eligibility and premium assistance appeals, but utilizing the board members specifically versed in health benefit oversight. The Health Care Committee of the board could then handle eligibility appeals and make any needed policy changes overtly.

> **Recommendations:** We recommend that PSERS develop and maintain a policy detailing the eligibility rules and regulations of the Health Options Program. The policy would be promulgated among all parties involved with assessing and determining member eligibility for HOP.
>
> We also recommend that the current eligibility review and appeal process be modified to place the existing Executive Staff Review Committee (ESRC) directly in the approval path between the initial eligibility review by the third party administrator and Director of Health Insurance Programs, and the formal appeal process with the board. We also recommend that eligibility appeals for HOP be reviewed by the Health Care Committee of the board, rather than the Appeals Committee. The ESRC would report its decisions to the Health Care Committee and would justify any eligibility interpretations that extend eligibility to more groups than described in the board's established eligibility policy. These changes would help to create consistency in outcomes and assure a clear process for any such appeals.

5. Comparison of HOP to Other State Systems

PSERS Health Options Program appears to be among only a few retiree programs that base eligibility to enroll on a "qualifying event". While other statewide programs for school employees and other state employees recognize a qualifying event as an opportunity for a person to join or make changes to coverage, most base their primary eligibility on a person's retirement from active service.

In addition, we noted that some states make provision for a retiree who has health benefits continuing with the local district for a period after retirement to have an enrollment opportunity in the statewide plan when local coverage terminates. This appears to be the exception rather than the norm, as most come in upon retirement whether pre-65 or Medicare eligible.

Some statewide retirement systems that provide health benefits for retirees of public schools also provide significant subsidies of those benefits, in some circumstances even full payment of the premium cost. Those systems are able to base their eligibility on the retirement action of the retiree, since they pick up coverage immediately upon retirement, with local school district funding to the retirement system subsidizing the cost. That contrasts with Pennsylvania, where school districts must offer health benefit coverage to retirees until they become eligible for Medicare at age 65 and the Health Options Program is purely a voluntary, retiree-pay-all option.

Not all states have statewide retirement agencies that provide retiree health benefits for local government or educational system retirees. The following four examples are illustrative of the range of eligibility policies and entry triggers in place currently among statewide systems for school district employees and state employees.

5.1 Pennsylvania Retired Employee Health Plan (PA-REHP)

The Pennsylvania Retired Employee Health Plan (PA-REHP) covers retired employees of the Commonwealth. The following general rules apply to the retiree's eligibility for and access to the benefit program:

- If the retiring employee signs retirement papers within 90 days of the termination of employment and is eligible for REHP benefits, health coverage will begin the day after coverage as a Commonwealth employee ends.
- A retiree may enroll in the REHP at any time, but the effective date of coverage cannot be more than 60 days prior to filing the forms for non-Medicare coverage. Medicare employees are enrolled on the first of the month on a prospective basis.
- If the retiree cancels coverage, it can be reinstated one time only, unless canceled because of re-employment by the Commonwealth and subsequent coverage under the Active Employees Health Program.

- Coverage will be available to retirees who do not enroll at retirement or who cancel their coverage because they are receiving health coverage as a dependent on their spouse's/domestic partner's coverage with the commonwealth or other employer.

- Non-Medicare eligible retirees may elect medical and prescription drug coverage, medical only or prescription drug only. Medicare eligible retirees may elect medical and prescription drug coverage, prescription drug only or medical only if the retiree qualifies for a government or employer sponsored prescription drug program that does not qualify as a Medicare Part D prescription drug plan, such as TRICARE.

- Coverage for eligible dependents begins when the retiree's coverage begins.

- Upon the death of the retiree, the surviving spouse/domestic partner may apply for REHP coverage on a self-pay basis. COBRA coverage may be available for other dependents.

The REHP recognizes domestic partners as eligible for coverage. REHP also allows separate election of medical and prescription drug benefits if the retiree qualifies for another prescription drug program that is not a Medicare PDP. The system allows a one-time only reinstatement of canceled coverage.

5.2 Michigan Public School Employees' Retirement System (MPSERS)

The Michigan Public School Employees Retirement System (MPSERS) covers over 140,000 school district retirees out of a total of more than 187,000 eligible retirees. More than half of the participating retirees are not yet eligible for Medicare. The System subsidizes between 30 percent and 90 percent of the health benefit cost for retirees based on service accruals between 10 years and 25 years, without regard for whether the retiree is Medicare eligible. Funding is provided through retirement system charges to participating employers.

The following are key features of eligibility for the MPSERS program:

- Eligibility for the retiree health program is primarily as a result of retirement. Retirees become eligible for the program regardless of eligibility for Medicare benefits.

- Coverage can begin:

    1. On the retirement effective date, provided the retiree completes the application at least three months prior to retirement. If applications are received after the end of the retirement month, the retiree is subject to a six-month delay in coverage. In addition, the system must receive dependent documentation by the end of the retirement month or coverage is denied for the dependents. A retiree may then re-enroll dependents subject to a six-month delay in coverage.

    2. In the month following date of application and required proofs, if applying for retroactive effective date, subject to the same requirements as #1 above.

    3. On a deferred basis up to 90 days past retirement effective date, but the retiree must apply as for normal coverage, or wait six months for coverage to begin.

4. After the retirement effective date, if enrolling for the first time. Enrollment is subject to a six-month delay unless a qualifying event due to involuntary loss of other coverage. There will be no gap in coverage if the application and documents are provided within 30 days of the qualifying event.

- The system states that it can waive the six-month requirement if the participant enrolls online. No public details are provided about the circumstances under which the waiver will be applied.

- In addition, the system defines qualifying events for dependents to be added, including: adoption, birth, death, divorce, marriage, involuntary loss of coverage in another group plan.

MPSERS uses a coverage delay policy to handle late enrollments beyond the rather limited window available around the member's retirement. They are also encouraging online enrollment through selective waiver of the six-month delay in coverage.

5.3 State Teachers Retirement System of Ohio (STRS Ohio)

The State Teachers Retirement System of Ohio (STRS Ohio) is one of the five statewide retirement system covering public employees of various jurisdictions and types. Retiree health benefits are provided through the retirement system. Another of the five systems provides retirement and retiree health benefits for non-teacher school employees.

The following are key eligibility components for STRS Ohio:

- Eligibility for STRS Ohio retiree health benefits requires 15 or more years of credited service under the pension system.

- The System provides a 2.4 percent of plan cost subsidy for each year of service. For 30 years' service, the maximum subsidy is 72 percent of the cost.

- Eligibility is tied to retirement, so retirees not yet eligible for Medicare also participate in this program.

- Some participating employers in the System offer their own retiree health care coverage for several months after retirement, usually as the result of collective bargaining. The retiree has 31 days after loss of coverage at the local school district to contact STRS Ohio or faces a 90-day waiting period. A retiree cannot change his or her STRS Ohio health care effective date after premium deduction and coverage have begun, regardless of employer plan termination of coverage.

- STRS holds an open enrollment each year, during which the participant may enroll himself or herself or a dependent. Coverage for enrollment during the open enrollment period becomes effective on January 1 following the enrollment.

STRS imposes a 31-day window for the retiree to notify the system after losing school district coverage or a 90-day waiting period applies.

5.4 Virginia Local Choice Program

The Commonwealth of Virginia offers a statewide health benefits pool for local government employers that choose to participate. The program caters to smaller local government entities (including school districts, which are separate by city and county in Virginia, but do not have separate taxing authority and must participate as part of the governmental budget for that locality). It currently covers more than 48,000 persons in 285 jurisdictions, an average of just over 160 covered persons per jurisdiction. Note that larger jurisdictions and school districts do not find the Local Choice program to be advantageous for them and those larger entities maintain their own health benefit programs for active employees and retirees.

The Local Choice program offers six health plans, including four self-insured statewide medical plans, a high-deductible health plan and one fully-insured regional HMO (Kaiser Permanente in Northern Virginia). In addition, the program offers a Medicare Advantage plan with or without dental and vision benefits for Medicare eligible retirees. Non-Medicare eligible retirees participate in the regular active employee plans. Except for the HMO, all the other plans are provided through Anthem BlueCross Blue Shield.

In this program, the employer applies for acceptance into the Local Choice pool and makes the full array of benefits available to its active employees and retirees. The employer may choose whether it will cover its retirees in the program, but cannot choose to cover the Medicare retirees without also covering the non-Medicare retirees. No prescription drug coverage is available through Local Choice for Medicare eligible retirees – they are encouraged to purchase their own Medicare Part D policy.

The program requires that the employer pay a minimum portion of the cost for active employees. Unless otherwise specified, the employer must pay 80 percent of the cost of single employee coverage and 20 percent of the cost of dependent coverage. Employer contributions for retiree coverage are permitted, but not required.

The following eligibility rules are specific to Local Choice:

- Membership in the Local Choice program may be extended to a deceased employee's spouse or dependents provided they are covered in the active employee group at the time of the employee's death.

- A Medicare eligible retiree age 65 or older must apply within 31 days of separation from active service for retirement. A non-Medicare eligible retiree must apply within 31 days of separate from active service and must meet the retirement requirements of the employer and receive an immediate annuity. These provisions appear to effectively limit retiree participation only to those actually retired and separated from service.

- Dependents can be covered under the program to age 26.

- Adult incapacitated children can be covered if the enrollment is submitted within 31 days of the employee's hire date, the child has been covered continuously by group employer coverage since the disability first occurred, and the disability commenced prior to the child attaining the limiting age of the plan. In addition no siblings, grandchildren, nieces, nephews, parents, grandparents, aunts or uncles of the employee or retiree can be covered by the plan.

- The employer enrolls eligible active and retired employees and dependents online. The employer also must certify the retiree's status as a retiree. In addition, the employer collects all premiums and forwards total funding to the Local Choice program.

The Local Choice program is employer participation based and requires each participating employer to manage eligibility, enrollment in the program and premium collection for both active employees and retirees. Some teachers may also be covered for a retiree health premium subsidy through the Virginia Retirement System.

6. Findings

This section summarizes our primary findings from the study. Additional important specific findings are included and described in each analytical section. We encourage a detailed reading of each analysis.

6.1 Qualifying Events as an Enrollment Window Trigger

We find that the current approach of defining eligible persons and making enrollment in the HOP subject to a qualifying event is a sound way to manage eligibility for a voluntary, retiree-only, retiree-pay-all health benefit program. The approach also makes sense given the ability for an active school district employee to retire prior to Medicare eligibility and be covered by local school district benefit plans until age 65.

The qualifying event approach is a valid way to open the enrollment window at age 65 and encourage enrollment in the HOP at the time most retirees incur their first qualifying event. The requirement for a subsequent qualifying event if the retiree misses the first window, helps the plan avoid adverse selection from high claims cost retirees who try to shop their coverage to the lowest cost plan. The qualifying event policy has been in place long enough at this point that most school districts have adjusted their own eligibility to support the PSERS requirement.

6.2 Defining Eligible Persons

We identified a number of areas in which the naming and definition of eligible persons in HOP participant materials and operational manuals do not tie directly back to the enacting statute. For example:

1. PSERS may need to add a definition of "Survivor Annuitant" to the HOP Website and Summary Plan Descriptions (SPDs) for each plan. The Survivor Annuitant is defined in the Pennsylvania Retirement Code sections establishing the health benefit trust, but that term is not used to define an eligible person elsewhere.

2. There is some confusion between the Code and the HOP Website and SPD regarding exactly when a Survivor Annuitant becomes eligible to enroll in HOP (when "named" or when the Annuitant dies and the Survivor Annuitant becomes a survivor?).

3. "Surviving Spouse" is not listed in Code as an "Eligible Person" (Surviving Spouse is only listed in the Code under the retirement QDRO section and in election of certain retirement options), but is listed on HOP website and "HOP for Medicare-Eligible Participants 2012" as eligible to enroll. PSERS should define Surviving Spouse when the eligibility requirements are adopted by the board.

4. With the open-ended addition of dependents who can then become eligible for HOP on a subsequent qualifying event, there is the possibility that coverage can be extended beyond the persons originally related to the retiree and his or her spouse (for example, if a surviving spouse remarries and gains dependents of the new spouse). PSERS should

specify when and how qualifying events apply to Annuitants, Survivor Annuitants, spouses and dependents of Annuitants or Survivor Annuitants.

6.3 Defining Qualifying Events

PSERS' general definition of qualifying events is reasonable and the list of typical qualifying event conditions appears to include the primary conditions under which a status change would logically trigger eligibility for enrollment or change of coverage. As with any defined system in full operation, over time the HOP's qualifying event definition has become more complex, with nuances being added through staff and board decisions made in response to appeals.

PSERS operates the HOP consistently using the qualifying event eligibility rule, but does not have a clearly defined policy statement regarding the situations under which an Annuitant, Survivor Annuitant, spouse and dependent of Annuitants or Survivor Annuitants would have an enrollment opportunity in the plan. The program's third party administrator maintains a working list of qualifying event and eligibility business rules. In addition, some definitions of qualifying events and eligible persons appears in the various plan communications to participants (e.g., Summary Plan Descriptions, printed and online benefit booklets, etc.).

A number of qualifying event situations are in process but not reflected on the HOP website or SPDs. These should be included where appropriate for full disclosure.

1. School district stops paying for a retiree's coverage
2. Relocation from a foreign country
3. School employer stops offering medical benefits under its plan
4. Loss of health care coverage under a school employer's health plan due to exhaustion of pre-paid benefits included in the retirement package
5. Receipt of school district approval of disability
6. New eligibility for Premium Assistance due to recalculation of service years, adding in "buy back years"
7. Nursing home does not accept current HOP coverage
8. Members in a Grandfathered Plan moves to another county and exact same plan is not offered in that county.

We believe PSERS has contained the in-practice application of eligibility requirements reasonably closely to the defined terms and status conditions, but would benefit from a reassessment of the definitions. In addition, to further help contain inadvertent expansion of qualifying events, PSERS should consider specifying when and how qualifying events apply to each eligible person.

6.4 Qualifying Event Comparison

We offer the following general observations regarding the comparison of HOP qualifying events to similar provisions under COBRA, HIPAA and IRC Section 125 Cafeteria Benefit Plans. That analysis appears in **Appendix B**.

In most cases, the HOP qualifying event rules are similar to or broader than the corresponding rules under COBRA, HIPAA and IRC Section 125. In some situations, the HOP qualifying event rules could be interpreted to allow multiple generations of persons the opportunity to enroll in the HOP beyond the retiree, spouse and any dependents included in the original qualifying event.

Should the board desire to maintain a financial link between those enrolled in HOP and PSERS and restrain additional expansion of eligibility, the following limitations could be considered:

- Apply each qualifying event separately to Annuitants, Survivor Annuitants, spouses and dependents of Annuitants or Survivor Annuitants so that premiums can be deducted from a monthly annuity payment from PSERS. Limit the enrollment of individuals no longer associated with a PSERS annuitant to surviving spouses and dependents continuing HOP coverage as opposed to enrolling for the first time.

- Limit the qualifying event only to spouse and/or dependents who would lose (or lost) coverage as a result of the employee's retirement or the retiree's loss of coverage under the school employers' health plan.

7. Recommendations

This section summarizes our primary recommendations. Recommendations on specific issues reviewed appear throughout the report. We encourage a thorough reading of this report to identify our recommendations in context of the analysis. We have grouped these summary recommendations by the primary areas of review.

7.1 Eligibility Definitions

We recommend that PSERS review its statutory and operational definitions of persons eligible for the HOP to clarify specific relationships and to coordinate how those definitions are presented. The statutory definitions are broad enough already to allow the primary related parties to enroll, but do not address a number of situations that now occur routinely. Any further expansion of eligible persons would extend coverage to parties not directly related to the retiree. The operational definitions in use by PSERS' third party administrator have been developed responsibly to complement the statute but do not always track each person directly back to the statute. In addition, member communications often state definitions of eligible persons in broader terms that could be misconstrued by a person desiring eligibility for the program.

We recommend that PSERS develop an official compendium of both the statutory and operational definitions of persons eligible for the HOP, including definition of the situations under which each type of person would become eligible. That official compendium could then serve as the official yardstick against which new definitions would be tested. It would also be the model for any participant communications of eligible persons.

7.2 Qualifying Events

Overall, we believe the current qualifying event policies and business rules are well considered and operating properly in opening program enrollment to the correct group of Annuitants, Survivor Annuitants, spouses and dependents of Annuitants or Survivor Annuitants. Within the current policies, we do believe PSERS could consider specifying when and how the qualifying event applies to each of the eligible persons.

1. We recommend that PSERS review how its qualifying events are stated and make adjustments as needed to clarify the definition of each event. Statements of each qualifying event should be developed and approved by the board to provide a firm basis for most enrollments in the HOP.

2. We recommend reviewing the extent to which some qualifying events can be applied, particularly where they might allow persons who are not defined as eligible or related to the original retiree and spouse to enroll in the program. PSERS should balance the stringency of its qualifying events between restriction to only those persons in the retiree's immediate family at the time of the initial qualifying event and extension to similar persons related only through marriage in subsequent qualifying events. This will

involve discussion and resolution of the general accessibility of the plan, but will also help to keep the program aligned with the groups it is intended to serve.

3. We recommend that PSERS consider limiting some qualifying events to allow only those persons directly affected by the qualifying event to make changes to their elections regarding the HOP. This change might limit some dependents from entering the plan after the initial qualifying event, but would also align PSERS' policies more closely with standard COBRA, HIPAA and IRC Section 125 rules that govern most employers and plan participants.

7.3 Mirror Coverage

Segal recommends that PSERS modify the current "mirror coverage" policy slightly to allow a retiree or spouse who can prove prescription drug coverage in:

(1) a union plan resulting from employment at a participating school district; or
(2) a recognized federal plan such as the VA; or
(3) a military program such as Tri-Care for Life, where the coverage cannot be extended to a spouse, to have different prescription drug coverage under the HOP.

PSERS would continue to require that retirees and spouses in this situation have the same medical plan election, but the coverage could differ only by the person with the proven outside coverage not having prescription drug coverage through HOP. This revised policy would apply only to retirees who elect the HOP Medical Plan for themselves, their spouse and dependents.

No policy change would be made that would allow separate elections by the retiree and the spouse, merely modification of the options available to the retiree for his or her election for a two-person contract. In addition, no change would be made to the requirement that a covered dependent have the same coverage as the person who has the most comprehensive coverage (that is, the one covered with medical and prescription drug, unless the dependent could also prove coverage in a recognized plan that provides governmental or union retiree prescription drug benefits.

1. We recommend that PSERS implement the change to its mirror coverage policy for the entire HOP population effective for the first of a plan year (calendar year). We believe the best way to implement the policy without having considerable confusion among existing participants and concern among those who did not enroll in HOP because the mirror coverage policy was in effect, is to make the change in conjunction with a limited open enrollment. The earliest date for that open enrollment to allow full implementation in all systems would be the fall of 2013 for calendar year 2014. By opening the doors to allow anyone who is in this situation a one-time opportunity to come into the plan and make the Rx split selection, you would remove the potential backlog of people complaining that they can't get in. After that open enrollment, entry would continue to be through qualifying event and enrollment situations where this condition would occur would be handled as usual and regular enrollments. If an open enrollment is scheduled, persons coming in with the Rx split election would be paying the penalty rates for the HOP Medical Plan, which would reduce the impact of any adverse selection.

2. We do not recommend allowing the retiree and spouse to select different medical plan options. With PSERS' structure of the self-insured Medicare supplement plan and Medicare Prescription Drug plans, augmented by Medicare Advantage plans that all include prescription drug coverage with no option, there are currently by design no comparable medical only options to the HOP Medical Plan. We do not believe there is a compelling argument to extend the choice of plans beyond what is needed to address the specific situation. Further choice would only add significant complexity and cost to the program and would likely be confusing to participants trying to understand their options in the HOP.

3. We recommend careful planning and implementation of this policy change, since it would potentially affect many areas of PSERS participant outreach and operation.

7.4 Impact of State Health Exchanges

We recommend that PSERS continue to review the federal requirements relating to state health insurance exchanges under the Patient Protection and Accordable Care Act of 2010. As the exchanges are implemented for 2014 and future years, PSERS should be prepared to answer retiree questions and likely scenarios as persons eligible to enroll in the HOP make decisions about where they will enroll. PSERS should also be prepared to answer school district questions regarding use of state health insurance exchanges as "approved plans" for premium assistance purposes.

Going forward, PSERS should analyze and determine how it will react to retirees coming into HOP eligibility directly from participation on a state exchange, either as an individual or as an employee or retiree of a school district.

7.5 Policies, Business Rules and Regulations

We recommend that PSERS develop and maintain a set of policies and procedures that detail the eligibility administration of the Plan and document any eligibility determinations made in the past, along with specific situations in which eligibility would be honored. Such a set of policies would allow the HOP to maintain a central base of eligibility rules and exceptions granted and to establish a mechanism for making future determinations in a consistent manner.

We also recommend that the PSERS modify its current eligibility review and appeal process to have the Executive Staff Review Committee (ESRC) report its determinations to the Health Care Committee of the board. The ESRC would then become an integral link in the administration of policy and identification of eligibility issues for potential change in policy.

8. Next Steps

Segal's project team will be available to discuss and present our findings and to assist PSERS in constructing and drafting any policy changes and resolutions for board action. We will also be available to assist in developing operational rules to assist PSERS' third party administrator in managing the day-to-day eligibility review process.

We believe the major next steps include:

- Creating official documentation of eligible persons to tie operational determinations to statutory definitions;
- Creating official documentation of qualifying events to identify and record all events recognized in operation and to assure that those events meet the program's requirements; and
- Planning and implementing a limited relaxation of the current mirror coverage rules to allow a retiree or spouse who demonstrates other prescription drug coverage from an approved school district union plan or governmental plan elect the HOP Medical Plan only, while the spouse is covered by the HOP Medical Plan and one of the HOP Medicare Prescription Drug Plans. The implementation would be scheduled to occur as part of a limited open enrollment, as declared by the board.

Appendix A – Methodology Details

Gathering and Review of Documentation

This phase of the project consisted of gathering and reviewing available documentation necessary to assist us in understanding the current eligibility provisions of the HOP.

Initially, we gathered and reviewed readily available documentation concerning eligibility and enrollment, including information from the PSERS and HOP websites, HOP Summary Plan Descriptions and other Plan materials. We then reviewed policy statements, procedures, and other materials and data to which Segal already had access. In addition to these materials, we obtained copies of various other written materials and documentation related to the Plan's eligibility rules. Our review of the eligibility and enrollment documentation included the following documentation relating to the HOP:

- Statutes implementing the Health Options Program.
- Plan documentation (e.g., SPDs for all options).
- Guidance from PSERS and other agencies relating to eligibility and enrollment under the Health Options Program.
- Internal legal opinions relating to eligibility questions under the Health Options Program, including:
  - PSERS Legal opinion entitled "Domestic Partner Benefits Under HOP Program" (dated 11/5/1998);
  - PSERS Legal opinion entitled "Discrimination Based on Sexual Orientation – HOP Program (dated 8/28/2002).
  - PSERS Legal opinion entitled "Survivor Annuitants – Eligibility for HOP Program" (dated 8/31/2006);
- Policy statements from PSERS.
- Materials related to recent eligibility inquiries and determinations, including:
  - PSERS emails from 2010 regarding Survivor Annuitant Eligibility;
  - PSERS emails from 2009 regarding Surviving Spouses;
  - PSERS emails from 2008 regarding Domestic Partners.
- Other relevant materials identified in discussions with PSERS and CoreSource staff, including:
  - CoreSource Qualifying Events document (dated 9/22/2010);

- CoreSource Qualifying Events Quicksearch Module (undated);
- CoreSource Eligible Dependents document (dated 4/28/2009);
- CoreSource Frequently Asked Questions document (undated).

On-Site Interviews with PSERS and CoreSource Staff

This phase of the project consisted of conducting on-site interviews with (i) PSERS staff members with responsibility and functions relating to eligibility and enrollment, and (ii) CoreSource staff engaged in administration of eligibility and enrollment processes.

Upon completion of our review of the various enrollment and eligibility documentation, we arranged a two-day meeting with key PSERS management and staff, including the Office of Chief Counsel staff, and staff from CoreSource. The primary purpose of these meetings was to gain a more comprehensive understanding of the Plan's eligibility guidelines and each entity's role in determining eligibility. In addition, the purpose of these on-site interviews was to discuss and understand how eligibility decisions are made, identify concerns with the existing provisions and processes, and understand the resolution processes currently in place when a clear determination of eligibility is not possible. We also attempted to identify situations that do not fit neatly into established eligibility guidance, so that these situations could be documented, addressed and/or clarified for future administration of the program.

Joel Stouffer and Karen Johnson from Segal met with the following key PSERS management and staff members on February 13, 2012:

Jeff Clay
Gene Robison
Terri Savidge
Mark Schafer
Chuck Serine
William Snyder
John Tucker
Joe Wasiak

On February 14, 2012, Segal met with Kurt Henry and Wanda Wiley of CoreSource.

Telephone Interviews with Key School District Staff

This phase of the project consisted of conducting telephone interviews with staff of school districts that still provide group Medicare health benefit coverage to their retirees past age 65. We worked with PSERS staff to identify a selected group of school districts to be reviewed. After discussion, we decided to interview staff from the two largest Pennsylvania school districts.

On March 8, 2012, we interviewed Susan Hancock of the School District of Philadelphia and Nancy Kusko of the Pittsburgh School District.

We reviewed the coordination of PSERS' eligibility provisions for HOP with the retiree health benefit eligibility requirements for these school districts. This effort allowed us to more fully understand the extent to which PSERS' eligibility rules complement (or contradict) school district policies and how potential differences in rules may reduce the attractiveness or availability of HOP for those retirees. We also attempted to understand how the district's collective bargaining agreements and subsidy policies for Medicare eligible retirees compare to the PSERS eligibility rules for HOP.

In our contacts with the selected districts, we posed a number of eligibility scenarios to understand their program operation. Such scenarios included:

- A covered retiree's spouse turns age 65 and becomes eligible for Medicare. What happens to the spouse in the district's health plan? When does any change occur? How are the retiree and the spouse notified of the coverage change and their options?

- Some Medicare retirees in their school district plans want to join PSERS to get a better price on Medicare supplement coverage. However, the district has certain retiree groups for which it is contractually obligated to provide Medicare supplement benefits and the district is not willing to terminate coverage for all retirees over age 65. What are the district's options?

- An active school district employee participating in the PSERS retirement system becomes disabled and is eligible for a disability retirement. Does the disabled retiree or his/her spouse retain school district health benefit coverage as a disabled retiree?

Appendix B – HOP Qualifying Event Comparison

To understand the current rules relating to qualifying events, it will be helpful to consider how the HOP qualifying event requirements are stated and defined in various operating instruments of the program.

This Appendix compares the various components of the defined HOP qualifying events to three other sets of rules governing changes in participant status in a health insurance plan:

- the definitions for COBRA Qualifying Events,
- the HIPAA Special Enrollment Rules, and
- the Change in Status Rules for Cafeteria Plans under IRC Section 125.

Each of these other rules apply primarily to employer-sponsored health plans, where the covered participants are either active employees or retirees of that employer. While the COBRA, HIPAA and Cafeteria Plan rules do not apply fully and specifically to PSERS HOP, they are common requirements for school-based retiree and active employee health plans and they offer reasonably similar comparators for the qualifying event definitions under HOP.

We offer comments on the various definitions as well as findings and recommendations regarding a number of the definitions. Please note in the first item below that the HOP's definition of Qualifying Event is generally more liberal in allowing all members of the family to change even if the event happens to only one member of the family. By contrast, the COBRA, HIPAA and Section 125 rules generally only allow a change for those persons whose status actually changes.

The HOP qualifying event descriptions are shown in the left column and the comparable provisions from COBRA, HIPAA and IRC Section 125 appear in the right column, along with observations.

HOP Qualifying Events	COBRA Qualifying Events, HIPAA Special Enrollment Rules, and Section 125 Change in Status Rules
General Qualifying Events apply to you, your spouse, and/or your dependents. If one member of your family has a Qualifying Event, all members may enroll in HOP or change their option if already enrolled. *(Underline added)*	In general, the COBRA Qualifying Events, HIPAA Special Enrollment Rules and Section 125 Change in Status Rules apply only to those retirees and beneficiaries whose status has been altered by the change. *(Underline added)* See the following examples:
QE #1 You retire or lose health care coverage under your school	COBRA Rules. Under COBRA, termination of employment is a qualifying event. Employees and other qualified beneficiaries are entitled to elect COBRA upon a loss of coverage resulting from an

HOP Qualifying Events	COBRA Qualifying Events, HIPAA Special Enrollment Rules, and Section 125 Change in Status Rules
employer's health plan. Coverage under your school employer's health plan includes any COBRA continuation coverage you may elect under that school employer's plan.	employee's termination of employment. ***Observation: This HOP qualifying event is generally consistent with the COBRA qualifying event rules. However, only dependents who lose their coverage as a result of the employee retiring or losing health care coverage under a school employer's health plan might be entitled to elect COBRA coverage under that employer's plan. The early retiree's continuation of coverage in the school district plan is handled similarly to a COBRA continuation, but coverage must be extended until the retiree reaches age 65.*** HIPAA Special Enrollment Rules. The HIPAA special enrollment rules allow eligible individuals who lose other coverage to special enroll under certain circumstances. If the other coverage is COBRA coverage, the individual must exhaust such COBRA coverage in order to take advantage of this special enrollment period. Thus, the special enrollment rules would only apply to an individual who exhausts COBRA, not to an individual who voluntarily terminates COBRA. ***Observation: According to CoreSource documentation, voluntary termination of COBRA coverage through a school employer plan (e.g., for non-payment of premiums or for voluntary early termination of COBRA coverage) is considered a qualifying event. However, this HOP qualifying event is not consistent with the HIPAA special enrollment requirements, which require an individual to exhaust COBRA coverage in order to special enroll. We note that PSERS is not generally subject to HIPAA requirements because it is a retiree only plan.*** Section 125 Change in Status Rules. Under the Section 125 rules, termination or commencement of employment by the employee, spouse, or dependent is a change in status that may allow cafeteria plan participants to alter their benefits elections mid-year, provided that any election change is on account of and corresponds with a change that affects eligibility for coverage under an employer's plan. ***Observation: This HOP qualifying event is generally consistent with the Section 125 change in status rules, which would allow cafeteria plan participants to make mid-year benefit changes. However, Section 125 applies to employers sponsoring a pre-tax health benefit plan for employees. As there are no employees in the HOP, the 125 rules do not apply.***
QE #2 You involuntarily lose health care coverage under a non-school employer's health plan (which includes any COBRA	COBRA Rules. As noted above, under COBRA, termination of employment is a qualifying event. Employees and other qualified beneficiaries are entitled to elect COBRA upon a loss of coverage resulting from an employee's termination of employment (including retirement).

HOP Qualifying Events	COBRA Qualifying Events, HIPAA Special Enrollment Rules, and Section 125 Change in Status Rules
continuation coverage you may elect under that non-school employer's health plan).	**Observation:** ***This HOP qualifying event is broader in potential scope than the COBRA qualifying event rules because it allows a qualifying event for involuntary loss of coverage that may not be the result of a termination of employment. Only dependents who would lose their coverage as a result of the retiree losing health care coverage under a school employer's health plan are entitled to elect COBRA coverage.*** HIPAA Special Enrollment Rules. As noted above, the HIPAA special enrollment rules would only apply to an individual who exhausts COBRA, not to an individual who voluntarily terminates COBRA. It follows that an involuntary loss of COBRA coverage under a non-school employer's health plan coverage is a qualifying event, but voluntary loss of COBRA coverage is not a qualifying event. **Observation:** ***This HOP qualifying event is consistent with the HIPAA special enrollment requirements, which require the individual to exhaust COBRA coverage in order to special enroll.*** Section 125 Change in Status Rules. Under the Section 125 rules, termination or commencement of employment by the employee, spouse, or dependent is a change in status that may allow cafeteria plan participants to alter their benefits elections mid-year, provided that any election change is on account of and corresponds with a change that impacts eligibility for coverage under an employer's plan. **Observation:** ***This HOP qualifying event is generally consistent with the Section 125 change in status rules, but is limited to events in which the person involuntarily loses health care coverage.***
QE #3 You or your spouse reach age 65 or become eligible for Medicare.	COBRA Rules. Under COBRA, the spouse and dependents of a former employee are eligible to elect COBRA coverage if they lose coverage as a result of the employee becoming entitled to Medicare. **Observation:** ***This HOP qualifying event is generally consistent with the COBRA rules with respect to a retiree becoming eligible for Medicare. The qualifying event is broader than the COBRA rules with respect to the retiree's spouse becoming Medicare eligible. Perhaps more importantly, under COBRA, it is only dependents who would lose their coverage as a result of the retiree becoming entitled to Medicare that are entitled to elect COBRA coverage.*** HIPAA Special Enrollment Rules. **Observation:** **T*his HOP qualifying event is not addressed in***

HOP Qualifying Events	COBRA Qualifying Events, HIPAA Special Enrollment Rules, and Section 125 Change in Status Rules
	the HIPAA special enrollment rules. Section 125 Changes in Status Rules. **Observation:** ***This HOP qualifying event is not addressed in the Section 125 rules.***
QE #4(a) There is a change in your family status (including **divorce, your death or death of a spouse**…)	COBRA Rules. When an employee dies, his or her spouse and dependents who would lose their coverage as a result of the employee's death are entitled to elect COBRA coverage. The spouse and dependent children of an employee who would lose coverage as a result of divorce also have the right to elect COBRA. **Observation:** ***This HOP qualifying event is somewhat consistent with the COBRA rules with respect to a retiree's death or divorce. However, this qualifying event is not consistent with the COBRA rules with respect to the death of a spouse. That is, the COBRA rules pertain specifically to the death of an employee or retiree, not to the death of a spouse. Perhaps more importantly, under COBRA, it is only the dependents who would lose their coverage as a result of the employee or retiree's death or divorce that would be entitled to elect COBRA coverage.*** HIPAA Special Enrollment Rules. Under the HIPAA special enrollment rules, employees and dependents who lose other coverage may enroll under the plan if coverage was terminated because of a loss of eligibility, including divorce or death. **Observation:** ***This HOP qualifying event is generally consistent with the HIPAA special enrollment rules, but only in the event the change in family status results in the loss of other coverage.*** Section 125 Change in Status Rules. Under the Section 125 rules, a change in the employee's marital status due to marriage, divorce, death of spouse, legal separation, and annulment is a change in status that may allow cafeteria plan participants to alter their benefits elections mid-year, provided that any election change is on account and corresponds with a change that impacts eligibility for coverage under an employer's plan. In addition, a change in the number of dependents resulting from death is a change in status that may allow cafeteria plan participants to alter their benefits elections mid-year, provided that any election change is on account and corresponds with a change that impacts eligibility for coverage under an employer's plan. **Observation:** ***This HOP qualifying event is generally consistent with the Section 125 rules (see note above)***

HOP Qualifying Events	COBRA Qualifying Events, HIPAA Special Enrollment Rules, and Section 125 Change in Status Rules
QE #4(a) (continued) There is a change in your family status (including **divorce, your death or death of a spouse**…) **Specific Scenario 1.** According to CoreSource documentation, if a surviving spouse dies, the spouse of the surviving spouse would be able to remain on the plan. If the surviving spouse of a surviving spouse were not enrolled at the time of death, this would be a qualifying event.	**Observation:** ***As noted above, this HOP qualifying event is not consistent with the COBRA rules with respect to the death of a spouse or death of a surviving spouse (i.e., the COBRA rules pertain to the death of an employee, not to the death of a spouse or surviving spouse).***
QE #4(a) (continued) There is a change in your family status (including **divorce, your death or death of a spouse**…) **Specific Scenario 2.** Under current HOP procedures, if the surviving spouse of a deceased retiree was not enrolled in the HOP at the time of the retiree's death, the surviving spouse (who is not a Survivor Annuitant) is eligible to enroll in the HOP at subsequent qualifying events.	**Observation:** ***This qualifying event is not consistent with the COBRA rules with respect to the death of a spouse. That is, the COBRA rules pertain specifically to the death of an employee, not to the death of a spouse. Perhaps more importantly, under COBRA, it is only those dependents who would lose their coverage as a result of the employee's death or divorce that would be entitled to elect COBRA coverage.*** ***The concept of "subsequent qualifying events" under the HOP is similar to the concept of "second qualifying events" under COBRA. Under COBRA, qualified beneficiaries entitled to COBRA coverage due to a covered employee's termination or reduction in hours can extend their coverage period if a second qualifying event occurs during the initial 18-month period. The extension generally cannot exceed 36 months from the date of the first qualifying event and applies to individuals who were qualified beneficiaries under the plan as of the first qualifying event and who were covered under the plan at the time of the second qualifying event.*** ***Although the concept of "second qualifying events" under COBRA does not directly apply to this scenario (i.e., second qualifying events under COBRA only apply in the case of the employee's termination or reduction in hours), it should be noted that the second qualifying event rules only apply to individuals who were qualified beneficiaries under the plan as of the first qualifying event and who were covered under the plan at the time of the second qualifying event. Thus, allowing a surviving spouse who was not enrolled in the HOP at the time of the retiree's death to enroll in the HOP at subsequent***

HOP Qualifying Events	COBRA Qualifying Events, HIPAA Special Enrollment Rules, and Section 125 Change in Status Rules
	qualifying events is not consistent with the COBRA rules.
QE #4(a) (continued) There is a change in your family status (including **divorce, your death or death of a spouse**…) **Specific Scenario 3.** If an active school district employee dies while in service, but was eligible to retire at the time of death, the surviving spouse is eligible to enroll in the HOP, even though the deceased active employee who was deemed to be a "retiree" for pension calculation purposes was never eligible for the HOP during his or her lifetime. PSERS calls for the retirement benefit of an in-service death to be calculated as if the participant had retired on the day before his or her death.	**Observation:** ***Under the COBRA rules, when an employee dies, his or her spouse and dependents who would lose their coverage as a result of the employee's death are entitled to elect COBRA coverage. Similarly, under the HIPAA Special Enrollment Rules, dependents who lose other coverage may enroll under the plan if coverage was terminated because of a loss of eligibility, including death. Both the COBRA rules and the HIPAA Special Enrollment Rules apply to the spouse dependents who would lose coverage as a result of death. Thus, allowing the surviving spouse to enroll in the HOP, when there is no loss of coverage, would not be consistent with the COBRA rules or the HIPAA Special Enrollment Rules.***
QE #4(b) There is a change in your family status (including … **addition of a dependent through birth, adoption, or marriage**…)	COBRA Rules. Dependents acquired by a qualified beneficiary during a period of COBRA coverage (e.g., a spouse who marries a qualified beneficiary after he or she has already started to receive continuation coverage) generally must be permitted to elect coverage for the remaining period of the qualified beneficiary's COBRA period. However, such dependent would not gain status as a "qualified beneficiary." For example, if a qualified beneficiary acquires a spouse who signs up for COBRA coverage, the spouse would not have COBRA rights if the employee were to die during the COBRA coverage period. This would not include a child who is born or adopted during the period of continuation coverage. A child who is born to or placed for adoption with the employee during the period of COBRA coverage is considered a "qualified beneficiary." **Observation:** ***This HOP qualifying event is generally consistent with the COBRA rules pertaining to dependents acquired by a qualified beneficiary during a period of COBRA coverage. However, it is important to note that, under COBRA, a dependent added through marriage would not gain status as a qualified beneficiary. Thus, the new spouse/dependent generally would have no further COBRA rights.***

HOP Qualifying Events	COBRA Qualifying Events, HIPAA Special Enrollment Rules, and Section 125 Change in Status Rules
	HIPAA Special Enrollment Rules. HIPAA requires plans to offer a dependent a special enrollment period for an individual becoming a dependent through marriage, birth, or adoption or placement for adoption. The dependent may be enrolled as a dependent of the individual. If the individual is eligible for enrollment, but not enrolled, the individual also may enroll at that time. Following the birth or adoption of a child, the spouse of the individual also may be enrolled as a dependent if the spouse is otherwise eligible for coverage but not already enrolled. **Observation:** ***This HOP qualifying event is generally consistent with the HIPAA special enrollment rules, provided the individual becoming a dependent through marriage, birth, or adoption is given a special enrollment opportunity.*** Section 125 Changes in Status Rules. Under the Section 125 rules, a change in the employee's marital status due to marriage is a change in status that may allow cafeteria plan participants to alter their benefits elections mid-year. In addition, a change in the number of dependents resulting from birth or adoption is a change in status that may allow cafeteria plan participants to alter their benefits elections mid-year. In all cases, any election change must be on account of and correspond with a change that impacts eligibility for coverage under an employer's plan. **Observation:** ***This HOP qualifying event is generally consistent with the Section 125 rules. However, in order to meet the Section 125 consistency rules, any election change is on account of and corresponds with a change that impacts eligibility for coverage under an employer's plan.*** ***Action Allowed: Add spouse, newly acquired children to existing coverage. May drop own plan if electing coverage under spouse's plan. §1.125-4 consistency rules apply (must gain or lose eligibility; election change corresponds to gain or loss of eligibility; if gain eligibility for other coverage, consistency rule satisfied only if electing coverage under other plan).***
QE #4(c) There is a change in your family status (including…**a dependent loses eligibility**).	COBRA Rules. The COBRA rules allow dependents to elect continuation coverage upon loss of eligibility. **Observation:** ***This HOP qualifying event is generally consistent with the COBRA rules pertaining to loss of eligibility. However, it is important to note that only dependents who would lose their coverage as a result of the dependent's loss of eligibility that would be entitled to elect COBRA coverage under that plan.*** HIPAA Special Enrollment Rules. Under the HIPAA special enrollment rules, employees and dependents who lose other coverage may enroll

HOP Qualifying Events	COBRA Qualifying Events, HIPAA Special Enrollment Rules, and Section 125 Change in Status Rules
	under the plan if coverage was terminated because of a loss of eligibility. **Observation:** ***This HOP qualifying event is generally consistent with the HIPAA special enrollment rules.*** Section 125 Changes in Status Rules. Under the Section 125 rules, an event that causes an employee's dependent to satisfy or cease to satisfy the requirements for coverage due to age, student status, marriage, or any similar circumstances is a change in status that may allow cafeteria plan participants to alter their benefits elections mid-year, provided that any election change is on account and corresponds with a change that impacts eligibility for coverage under an employer's plan. **Observation:** ***This HOP qualifying event is generally consistent with the Section 125 rules. However, in order to meet the Section 125 consistency rules, any election change is on account and corresponds with a change that impacts eligibility for coverage under an employer's plan.***
QE #5 You become eligible for Premium Assistance due to a change in legislation.	**Observation:** ***This qualifying event is specific to the HOP and is not addressed in the COBRA, HIPAA or Section 125 rules.***
QE #6 A plan approved for Premium Assistance terminates or you move out of a plan's service area.	**Observation:** ***This qualifying event is specific to the HOP and is not addressed in the COBRA, HIPAA or Section 125 rules.***

Appendix C – Qualifying Event Crosswalk Chart

The following table tracks a number of potential HOP qualifying events and identifies which persons would have the opportunity to be enrolled in the HOP with regard to that event. The table does not purport to list every possible situation that could be considered a qualifying event. We believe this crosswalk table will be of use in identifying the extent to which PSERS will allow qualifying events to perpetuate participation in the HOP across generations and families removed from the original retiree's eligibility. It also provides a framework for ongoing identification of which persons would be eligible when interpretations must be made of the qualifying event rules.

Event	Persons Gaining/Retaining Eligibility	Persons Losing Eligibility
Initial Qualifying Events		
Retiree turns age 65 and loses coverage through school district *(or)* Retiree involuntarily loses coverage through a non-school employer *(or)* Retiree loses coverage through school district termination of approved plan *(or)* Retiree moves to a geographic area not covered by approved school district plan *(or)* Legislation changes and Retiree becomes eligible for Premium Assistance	✓ Retiree ✓ Spouse ✓ Qualified Dependents of Retiree and Spouse	
Spouse loses coverage through school district while Retiree is still covered *(or)* Spouse involuntarily loses coverage from a non-school employer	✓ Spouse ✓ Qualified Dependents of Retiree and Spouse	
Active School District Employee dies in-service	✓ Surviving Spouse ✓ Qualified Dependents with PSERS Member who died	

Event	Persons Gaining/Retaining Eligibility	Persons Losing Eligibility
Subsequent Qualifying Events		
Spouse loses coverage through other employer or school district	✓ Retiree ✓ Spouse ✓ Qualified Dependents of Retiree and Spouse	
Retiree dies	✓ Surviving Spouse/Surviving Subsequent Retiree Spouse ✓ Qualified Dependents of Retiree and Spouse ✓ Qualified Dependents of Retiree and Subsequent Retiree Spouse	× Retiree
Retiree divorces	✓ Retiree ✓ Qualified Dependents of Retiree and Former Spouse	× Former Spouse × Former Spouse's Dependents
Retiree remarries	✓ Retiree ✓ Subsequent Retiree Spouse ✓ Retiree's Qualified Dependents with originally covered Spouse ✓ Qualified Dependents with Subsequent Retiree Spouse	
Surviving Spouse dies	✓ Qualified Dependents with Retiree	× Surviving Spouse
Surviving Spouse remarries	✓ Surviving Spouse ✓ Surviving Spouse's Subsequent Spouse ✓ Qualified Dependents with Retiree ✓ Qualified Dependents with Surviving Spouse's Subsequent Spouse	
Surviving Subsequent Retiree Spouse Remarries	✓ Surviving Subsequent Retiree Spouse ✓ Qualified Dependents of Retiree ✓ Qualified Dependents with Surviving Spouse	

Event	Persons Gaining/Retaining Eligibility	Persons Losing Eligibility
Surviving Subsequent Retiree Spouse dies	✓ Subsequent Spouse of Surviving Subsequent Retiree Spouse ✓ Qualified Dependents with Retiree ✓ Qualified Dependents of Subsequent Retiree Spouse	× Surviving Subsequent Retiree Spouse
Addition of Qualified Dependent (for Retiree, Spouse, Surviving Spouse, Subsequent Retiree Spouse, or Surviving Subsequent Retiree Spouse)	Family at time of qualifying event, including: ✓ Retiree ✓ Spouse/Surviving Spouse ✓ Subsequent Retiree Spouse/Surviving Subsequent Retiree Spouse ✓ Subsequent Spouse of Surviving Spouse ✓ Qualified Dependents of Retiree and/or Spouse ✓ Qualified Dependents of Retiree and/or Subsequent Spouse ✓ Qualified Dependents of Surviving Spouse and Spouse's Spouse	
Qualified Dependent dies or loses eligibility	Family at time of qualifying event, including: ✓ Retiree ✓ Spouse/Surviving Spouse ✓ Subsequent Spouse of Retiree ✓ Subsequent Spouse of Surviving Spouse ✓ Qualified Dependents of Retiree and/or Spouse ✓ Qualified Dependents of Retiree and/or Subsequent Spouse ✓ Qualified Dependents of Surviving Spouse and Spouse's Spouse	× Dependent that died or lost eligibility

Appendix D – Evaluating Eligibility Changes

In our discussions with PSERS staff regarding the HOP's eligibility provisions and the possibility of making changes to those eligibility rules in response to certain recommendations, it became obvious to us that any changes would be made only after due diligence and consideration of the pros and cons. To assist in reviewing possible changes to eligibility rules, we suggest in the following table examples of the various factors that PSERS should consider whenever making decisions affecting eligibility.

ELIGIBILITY RULE CRITERIA	
Consistency with PSERS Mission	
• Does the proposed eligibility change accommodate the needs of the population PSERS is trying to serve?	
• Does the proposed eligibility change address the needs of a few members or the needs of the membership as a whole?	
• Does the proposed eligibility change encourage members to enroll in the HOP as early as possible?	
Premium Cost	
• What is the premium cost of the proposed eligibility change?	
• If there is a premium cost increase, how does the increase affect the membership as a whole while benefitting a smaller number?	
Administrative Cost/Efficiency	
• Does the proposed eligibility change increase administrative costs?	
• Does the proposed eligibility change create administrative inefficiencies?	
Adverse Selection	
• Does the proposed eligibility change or potentially expose HOP to adverse selection?	

ELIGIBILITY RULE CRITERIA	
Policy Change	
• Is there already an informal or formal policy addressing the proposed eligibility change that may need to be revised?	
Code Change	
• Can the proposed eligibility change be justified under current law?	
• Are changes required to Code or state law?	
SPD Change	
• Does the proposed eligibility change require changes to the Summary Plan Description?	
Ease of Understanding	
• Is the proposed eligibility change expected to be fairly well understood by the typical retiree?	
Industry Standards	
• Is the proposed eligibility change consistent with industry standards?	
Enrollment Numbers	
• If the proposed eligibility change applies to a specific benefit package, what percentage of retirees/covered individuals are affected?	
Other Considerations	
•	
•	
•	

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