PSERS Premium Assistance Plan Approval Policy Analysis and Recommendations

November 26, 2008

The Segal Company was asked to study how PSERS present Premium Assistance plan approval policy should be revised to take into account the changing Medicare retiree health benefit marketplace. The following analysis presents our findings and observations and describes the methodology we used. A separate statement of the recommended plan approval policy appears as the last section of the report (beginning on page 8).

Background

The Premium Assistance program plan approval policy and the primary structure of PSERS Health Options Program (HOP) are based on the concept of group health benefit insurance utilized by employers and other plan sponsors (see Attachment 1 – *Employer Sponsored Health Plans*). This group health insurance approach is modified for Medicare eligible retirees in recognition of Medicare's individual coverage design (see Attachment 2 - *Current Retiree Medical Plan Marketplace*).

Origins of Post Employment Health Care Coverage for PSERS Retirees

Act 1988-110 and Act 1989-43 of the Pennsylvania Legislature requires Commonwealth school districts (employers) to permit qualifying retirees to purchase continuing coverage in the school's group health insurance plan if they are under age 65 and:

1) Retired under normal retirement, or
2) Retired under disability retirement, or
3) Retired with 30 or more years of service.

The Acts stipulated that the purchase of the continuation of coverage shall equal the cost of the program for active employees and dependents plus 2%. Since enactment, some school districts have agreed to pay all or some of the cost of continuation of coverage as a retirement incentive and/or as a result of contract negotiations.

Premium Assistance Program

Act 1991-23 of the Pennsylvania Legislature created the Premium Assistance benefit effective July 1, 1992. Premium Assistance of up to $55 per month became available to eligible PSERS retirees. Act 2001-9, increased the amount of the premium assistance benefit to up to $100 per month and added a new eligibility requirement, effective January 1, 2002. This benefit helps retirees pay for basic health insurance.

The eligibility requirements for Premium Assistance are as of January 1, 2002 are:

1) One of the following service/disability requirements
   (a) At least 24.5 years of service, or
   (b) At least 15 years of services provided public school employment terminated and retirement occurred on or after age 62:, or
   (c) Receiving a disability benefit from PSERS,
   and

2) Out-of-pocket premium expense for basic health insurance coverage from one of the following:
   (a) PSERS Health Options Program (HOP), or
   (b) A school district (employer) group health insurance plan providing hospital, medical and major medical coverage.

Premium Assistance is not payable for separate dental, vision or prescription drug plans. It is not payable for out-of-pocket premium expenses for the retiree's spouse or other dependents.

Approved Plans

The PSERS Board approved the HOP and school district plans effective January 1, 1994, the same year the PSERS Group Health Insurance Program became HOP. The HOP was designed primarily to provide group benefit plan options for retirees as they turn age 65 and lose coverage at their local school districts. HOP also provided pre-65 health insurance coverage to retirees and their spouse and dependents not eligible for school district coverage or Medicare.

At the time the Board's policy for Approved Plans was defined, the retiree health benefit marketplace for employers was built around extension of their regular group health insurance plans, usually the same plans provided to active employees, with reduction in benefits to take into account benefits being provided by Medicare. The carrier for the active employee and pre-Medicare retiree health care coverage provided a 65-Special policy for retirees eligible for Medicare.

Trends in School District Retiree Health Insurance Coverage

Since the Medicare Modernization Act and the creation of Medicare Part D prescription drug coverage, a number of school districts have terminated their Medicare supplement plans. Other school districts are reacting to the changing Medicare insurance market and are evaluating alternatives to traditional Medical supplements for their retirees age 65 and older.

This evolving Medicare insurance market has prompted the Retirement Board to revisit its Premium Assistance benefit plan approval policy. While the plan approval policy is limited to plans covering individuals eligible for Medicare, PSERS' evaluation includes, but is not limited to, the continuity of coverage over the member's lifetime.

Premium Assistance Program - Plan Approval Policy Review

On January 25, 2008, the PSERS Retirement Board passed resolutions regarding the Premium Assistance program, including the following excerpts:

- PSERS should review the Medicare plan and policy offerings of all Commonwealth school districts that offer health benefits to their retirees beyond age 65. The review should include surveying data on plan carriers, plan types, benefit levels, whether self-insured or fully insured, and the number of participants currently in each plan offering. The review should be conducted periodically to assure that all plans meet any guidelines established to qualify for Premium Assistance benefits.

- PSERS should establish specific guidelines and policies regarding school district sponsored plans that qualify for Premium Assistance. The guidelines should be flexible enough to allow competition among offerings, but strict enough to avoid having new types of plans introduced without PSERS' oversight. While the guidelines should be targeted primarily to address plans available for Medicare eligible retirees, they should also address school plans for retirees prior to eligibility for Medicare.

- PSERS should periodically review the guidelines established for school district plans to qualify for Premium Assistance to assure they remain current with the changing Medicare insurance market place.

Current Plans Approved for Premium Assistance

HOP and School districts offer a variety of different medical and prescription drug plans for eligible retirees.

HOP Plans

Effective January 1, 2009, PSERS HOP offers the following group sponsored health plans:

- HOP Medical Plan (for Medicare eligible retirees and spouses)
- HOP Medical Plan with Enhanced Medicare Prescription Drug Benefits
- HOP Medical Plan with Basic Medicare Prescription Drug Benefits
- HOP Pre-65 Medical Plan (with and without prescription drug benefits)
- HOP Managed Care Plan / Highmark FreedomBlue PPO (offered to Medicare eligible retirees in Pennsylvania)
- HOP Managed Care Plan / Highmark FreedomBlue PFFS (offered to Medicare eligible retirees outside Pennsylvania)
- HOP Pre-65 Managed Care Plan / Highmark PPOBlue
- Various Medicare and pre-65 frozen managed care plans provided by Aetna, AmeriHealth, Capital BlueCross BlueShield, Highmark, Humana, Independence Blue Cross and UPMC.

School District Plans - Survey

No catalog or compendium exists of health benefit plans offered by participating school districts to their pre-65 and Medicare eligible retirees. There exists a clear need to identify plans for each participating school district to allow a determination of whether the plans meet the Board's requirements to be Approved Plans. To gain knowledge about the health benefit plans currently being offered by participating school districts to the pre-65 and Medicare eligible retiree groups, Segal conducted a data gathering survey of the more than 700 school districts and other jurisdictions participating in PSERS (see Attachment 3 - *School District Survey*).

Survey Conclusions

Based on the school districts and participating employers submitting to the survey, we offer the following conclusions:

- Most of the school districts do not offer health benefits to retirees age 65 and older, and of those that do offer such benefits, almost half reported that they offer the same benefit plans that are offered to active employees and retirees under age 65.

- Of the reporting districts that do not offer the same benefits to Medicare retirees as for actives, half did not complete the survey question. Of the half that did respond, only five noted that they offer individual Medicare supplement policies.

- For pre-65 retiree coverage, a large majority of the school districts responding indicated that they provide the same benefit plans for pre-65 retirees as for active employees. Where certain districts reported offering different plans, those plans all appear to be variations of the coverage offered with the same primary insurance carrier as the active benefits. We note that 35 of the respondents did not answer the question regarding what plans they offer to pre-65 retirees.

The Need for an Updated Definition of "Approved Plan"

The progressive change in the retiree health insurance marketplace, particularly the development and marketing of Medicare Advantage plans, and the move away from the traditional group benefit plan model for benefits provided for Medicare retirees, serve to highlight the need for an updated definition of an Approved Plan under the Premium Assistance program.

The Board's current policy considering a school district group health insurance plan as an Approved Plan is no longer sufficiently descriptive given the changed options available in the current marketplace. Where managed care and Medicare supplement coverage is now being sold that does not have the characteristics of traditional group insurance, a more detailed policy definition needs to be promulgated to participating school districts (see Attachment 4 - *Policy Considerations*).

We believe that a Board policy must have the following objectives and scope:

- Address health benefit coverage for both pre-65 retirees and Medicare eligible retirees
- Not set restrictions on the school districts' ability to comply with the law requiring coverage continuation for their retirees up to age 65
- Encourage school districts to protect spouses and dependents of any age through access to the same coverage as available to the retiree, even though Premium Assistance is only paid to the retiree
- Encourage the most cost efficient delivery of health benefits for retirees and their dependents consistent with providing benefits to active employees
- Foster the affiliation value of participating in the employer's plan and having the employer's full commitment behind the plan
- Simplify certification and compliance for school districts that extend their active employee group health benefit programs to participating retirees
- Be sufficiently flexible to allow school districts to achieve the best overall purchase in the marketplace consistent with the other objectives and with the eligible retiree group
- Help to avoid predatory practices that allow plans or carriers to exclude individuals or groups that do not meet restrictive underwriting standards

HOP As A Model "Approved Plan"

In establishing an updated definition of Approved Plan for Premium Assistance purposes, we believe PSERS should look to the strong and efficient group insurance model represented by your own Health Options Program.

The HOP program:

- Offers retirees a choice of health benefit plan types, including a group Medicare supplement plan and a group negotiated Medicare Advantage program for retirees eligible for Medicare
- Offers a companion plan for pre-65 retirees, spouses and dependents not eligible for Medicare with a choice of a fee-for-service group health benefit plan and a managed care PPO.
- Provides group benefit coverage options for all eligible retirees, spouses and dependents regardless of their age.
- Provides all plans on a guaranteed issue, guaranteed access basis, where retirees are not subjected to individual underwriting and possible rejection due to prior health experience.
- Requires any participating Managed Care Organization to offer not only Medicare plan options, but also a companion plan to cover the eligible spouse and/or dependents before they turn age 65.
- Serves as a health plan of last resort to cover any PSERS retiree who loses coverage or otherwise incurs a qualifying event (change in status such as death of spouse, addition of spouse, loss of retiree's school district benefit coverage, etc.)
- Provides benefit options using the basic principles of group insurance.

- Takes financial and contractual responsibility for the plans offered to retirees, including self-insuring some benefits to maximize financial savings and better control the expenditure of the retirees' contributions
- Administers the eligibility, enrollment, premium payment, communications, and customer servicing of its programs.

HOP represents the purest form of group benefit insurance, where the contributions to fund the plan come entirely from the participants, and the risk for the plan is spread across a large group of participants. HOP negotiates for the best available coverage within the ability of retirees to pay for the program. As an example, by providing benefits on a group basis, HOP has for many years been able to hold the overall premium increases for its participants below the prevailing increases in the retiree health individual marketplace. With a group benefit approach, HOP provides the prospect of continuation of coverage from the time the retiree becomes eligible to join the plan until that retiree dies.

HOP also serves as an example of providing Medicare Advantage managed care plan options to its participants on a group basis. As noted elsewhere in this analysis, Medicare requires carriers to operate their MA plans much in the manner of individual policies, but there are a number of group characteristics, as demonstrated in the HOP Managed Care plans. The managed care plan options are available to retirees, spouses and dependents on a guaranteed issue and guaranteed access basis, with no individual medical underwriting. The carriers bill HOP for premium payment under a consolidated billing for all participants in their plans. HOP receives reporting from the carriers on a group plan basis.

Approved Plan Definition and Tests

We propose that PSERS adopt a standard for defining an Approved Plan for Premium Assistance benefit based on five aspects of a school district's responsibility for the plan. These aspects help to define plans that follow the same criteria as used for the PSERS Health Options Program benefits, that provide continuation of coverage for the retiree and eligible dependents, and that are subject to the same selection and approval scrutiny as the health benefit plans the district provides for active employees.

To be considered an Approved Plan for Premium Assistance, a school district's health benefit plan(s) offered to retirees must meet the following five tests relating to the school district's responsibility for the plan:

1. Contractual responsibility:

- The school district operates the retiree plan and has responsibility for the plan, either through a direct, procured contract between the school district and the health plan carrier or third party administrator, or through an informal agreement or extension of a contract in place for active employees. Individually placed policies contracted between the carrier and the individual retiree where the school district is not a party to the contract do not qualify.
- The plan is approved by the school board in the same manner as the health plans offered to active employees.

- The plan covers only retirees of the school district sponsoring the plan and not of other jurisdictions.

2. Operational responsibility

- The specific retiree plan option is reflected in the school district's communication materials to employees and retirees, including a specific description of the benefits available under the plan.
- The school district publishes rate charts for the plan showing the retiree's share and the district's share.
- The school district maintains its role as the primary contact with the retiree regarding the plan. For example, retiree communications about plan eligibility, benefit coverage, and premium payments are directed first through the school district, then to the carrier.
- The plan is marketed through and as a part of the school district's regular employee enrollment processes (e.g., annual open enrollment).
- The school district maintains contact with the carrier through a group service representative. If carrier representatives or agents are used to assist in enrollment, any compensation or commission to such representatives or agents must be on a standard basis regardless of the retiree's plan selection.
- The school district maintains a consolidated and up-to-date retiree participant eligibility and plan participation listing and provides that listing to PSERS on a regular and timely basis.

3. Financial responsibility

- The school district pays the retiree health plan premiums directly to the carrier and collects the retiree's share of the premium as a reimbursement to the employer.
- If the retiree is subject to direct premium billing from the carrier, the carrier provides to the school district a full reconciliation of all amounts collected from retirees.

4. Design responsibility

- The retiree health plan design is approved by the school district and that plan design applies to all retirees in the category eligible for coverage in that plan.
- The retiree does not have the opportunity to select individual policy features that differ from all other similarly eligible retiree participants in that category.
- Plan benefits are offered on a "guaranteed issue" basis and are not subject to individual medical underwriting for coverage and premium setting.
- Plan participation is guaranteed access, with no groups excluded from eligibility due to insurability.
- Plan design changes apply to all current and future retirees of that school district participating in that plan.
- Plans must meet all federal and state pre-existing condition exclusion limits
- Only plans that include a primary medical benefit component will be considered. Stand alone plans that do not include medical benefits (e.g., stand alone Medicare Part D prescription drug benefits, dental benefit plan, vision benefit plan, etc.) do not qualify for Premium Assistance.

- If the district offers coverage for the retiree, it must also offer a companion health benefit plan option for any eligible spouse or dependents, whether Medicare eligible or not yet eligible for Medicare.

5. Reporting responsibility

- The school district assumes responsibility for any reporting and disclosure required for the retiree plan, whether to the carrier, to PSERS, to another government entity or to the participant.

Segal recommends that these five tests serve as the basis for developing the Board's new Premium Assistance Plan Approval Policy.

Administration of the Policy

Once a new Policy is adopted, a mechanism to determine if a school district is in compliance will be necessary (see Attachment 5 - *Policy Administration*).

It is envisioned that school districts will be responsible for certifying to PSERS, initially and periodically thereafter as requested by PSERS, that each of their Medicare retiree health plans meets the five criteria. In addition, school districts will be responsible for certifying to PSERS any new retiree health benefit plan established after the initial effective date of this policy or any significant changes in the benefit coverage, type of benefit plan, eligibility, plan carrier, or premium structure. School districts will also be responsible for submitting to PSERS data necessary to verify Premium Assistance payments made on behalf of retirees participating in their plans.

PREMIUM ASSISTANCE BENEFIT POLICY

As a result of this study and analysis, Segal recommends the following outline for Board's new Premium Assistance Plan Approval Policy.

1. Premium assistance benefits shall be available for eligible retirees for Approved Plans offered by the following entities:

    a. PSERS Health Options Program
    b. Commonwealth school district (PSERS reporting unit)

2. To be considered an Approved Plan, a health benefit plan must meet the following criteria relating to the school district's responsibility for the plan:

    a. Contractual Responsibility

- The school district operates the retiree plan and has responsibility for the plan, either through a direct, procured contract between the school district and the health plan carrier or third party administrator, or through an informal agreement or extension of a contract in place for active employees. Individually placed policies contracted between the the carrier and the individual retiree where the school district is not a party to the contract do not qualify.
- The plan is approved by the school board in the same manner as the health plans offered to active employees.
- The plan covers only retirees of the school district sponsoring the plan and not of other jurisdictions.

b. Operational Responsibility

- The specific plan option is reflected in the school district's communication materials to employees and retirees, including a detailed description of the benefits available under the plan.
- The school district publishes rate charts for the plan showing the retiree's share and the district's share.
- The school district maintains its role as the primary contact with the retiree regarding the plan. For example, retiree communications about plan eligibility, benefit coverage, and premium payments are directed first through the school district, then to the carrier.
- The plan is marketed through and as a part of the school district's regular employee enrollment processes (e.g., annual open enrollment).
- The school district maintains contact with the carrier through a group service representative. If carrier representatives or agents are used to assist in enrollment, any compensation or commission to such representatives or agents must be on a standard basis regardless of the retiree's plan selection.
- The school district maintains a consolidated and up-to-date participant eligibility listing and provides that listing to PSERS on a regular and timely basis.

c. Financial Responsibility

- The school district pays the retiree health plan premiums directly to the carrier and collects the retiree's share of the premium as a reimbursement to the employer.
- If the retiree is subject to direct premium billing from the carrier, the carrier provides to the school district a full reconciliation of all amounts collected from retirees.

d. Design Responsibility

- The retiree health plan design is approved by the school district and that plan design applies to all retirees in the category eligible for coverage in that plan.
- The retiree does not have the opportunity to select individual policy features that differ from all other similarly eligible retiree participants in that category.
- Plan benefits are "guaranteed issue" and not subject to individual medical underwriting for coverage and premium setting.

- Plan participation is guaranteed access, with no groups excluded from eligibility due to insurability.
- Plan design changes apply to all current and future retirees of that school district participating in that plan.
- Plans must meet all federal and state pre-existing condition exclusion limits.
- Only plans that include a primary medical benefit component will be considered. Stand alone plans that do not include medical benefits (e.g., stand alone Medicare Part D prescription drug benefits, dental benefit plan, vision benefit plan, etc.) do not qualify for Premium Assistance.
- If the district offers coverage for the retiree, it must also offer a companion health benefit plan option for any eligible spouse or dependents, whether Medicare eligible or not yet eligible for Medicare

e. Reporting Responsibility

- The school district assumes responsibility for any reporting and disclosure required for the retiree plan, whether to the carrier, to PSERS, to another governmental entity, or to the participant.

3. Plans offered by PSERS Health Options Program must meet the same five requirements, with PSERS being considered as the sponsoring district for this purpose.

4. If a school district offers the same group health benefit plans to its retirees that it offers to active employees, then the district can be considered to be in compliance with the Approved Plan criteria with regard to those plans.

5. School districts are responsible for certifying to PSERS initially and periodically thereafter as requested by PSERS that each of their retiree health plans meets the five criteria. In addition, school districts are responsible for certifying to PSERS any new retiree health benefit plan established after the initial effective date of this policy or any significant changes in the benefit coverage, type of benefit plan, eligibility, plan carrier, or premium structure. School districts are also responsible for submitting to PSERS data requested about the plans offered.

6. PSERS will develop and promulgate operational guidelines and regulations to administer this policy.

7. PSERS will administer this policy. A delegate or contractor may be named to assist with the administration.

8. The PSERS Retirement Board will review this policy at least every fifth year to identify and take into account market changes for retiree health benefits that have a bearing on this policy.

Attachment 1

Employer Sponsored Health Plans

Employers have long determined that if they offer health benefits to employees and retirees, the most cost efficient way to offer that coverage is through a group health insurance plan. By combining the risk for all their employees and retirees, an employer can provide a better level of coverage than the individual can purchase on his or her own. In addition, the cost for the coverage can be spread across the entire eligible population, resulting in greater stability of premiums and greater overall cost efficiency. The group insurance approach also allows the employer to assure that all of its employees and retirees who participate in the plan will have guaranteed access to the benefits and not be subject to individual underwriting that may exclude pre-existing conditions or may provide the coverage, but at an increased cost.

When an employer offers multiple group health plan options to its employees and retirees, there is a need to manage the plan design, eligibility and premium levels to encourage selection of plans that make the most sense for the participant and that help to contain ever-increasing health benefit costs. By negotiating and maintaining a basic level of health benefit coverage in each plan option, the employer can allow employees to select the type of plan or carrier that meets their individual needs, without creating an uninsured or underinsured condition. In a group insurance environment, the employer also seeks to balance multiple plan options so that the premiums charged for each option fairly reflect the value of the plan in defraying the medical costs for the participant. Thus, a plan with a higher level of benefits would need to reflect a higher premium than a plan with a more basic level of coverage.

To provide a valuable medical cost safety net, an employer also needs to take into account the coverage needs for the spouse and other dependents. Often, an employee's or retiree's decision to participate in health benefit coverage is conditioned on the ability for the participant to cover his or her eligible spouse and/or dependents at a reasonable cost. Employers routinely provide the ability to cover a spouse and/or dependents in the group health benefit plan at similar group rates as provided for the employee or retiree. The spouse and dependents are subject to the same guaranteed issue and access requirements as the employee or retiree, even if the cost must be paid fully by the employee or retiree. This continuity of access to health benefits helps to provide stability to the plan, and normally results in lower overall claims costs per participant.

In recent years, some employers have looked into providing a voucher for the employee or retiree to purchase individual medical insurance coverage. In the typical voucher situation, the employer will pay up to a certain flat dollar amount per month toward coverage that the employee or retiree proves they are purchasing. The employer assumes no liability for providing health benefits beyond the flat dollar contribution and does not sponsor, negotiate, design or maintain the insurance program. In reality, the employee or retiree is on his or her own for health insurance. While this approach has a certain appeal to employers for capping their health benefit costs at a fixed amount and for reducing their administrative role, it also promotes inconsistency of health benefits among an employee group. Because the premiums for individual coverage are age-rated and take into account the individual's particular health history, there is no cost efficiency that comes from pooling the risks for a group of plan participants. Older participants

pay more for the same coverage than do younger participants. A flat dollar voucher subsidy from the employer thus creates a built-in distinction in the affordability of benefits against older employees and retirees. By contrast, a group health insurance plan spreads the risk for all participants across the entire group so all participants have a reasonable premium.

Attachment 2

Current Retiree Medical Plan Marketplace

Medicare eligible retirees now have more health insurance plan choices than ever. The following summarizes the primary options available to retirees age 65 and older.

Group Medicare Supplement Health Plans

These plans are maintained through the retiree's employer or through an association and provide the same benefit levels for all participants in the plan. Such plans are designed to fill the gaps in coverage from Medicare Part A and Part B. These plans activate after Medicare has already considered a claim and then pay all or a portion of the amounts not paid by Medicare, hence the "supplement" concept. By operating on a group basis, the sponsor and the retiree both have the opportunity to enjoy lower group rates and guaranteed access to coverage without individual rates based on age or health status.

Individual Medigap Policies

Medigap plans are sanctioned by Medicare to be offered on an individual policy basis, in accordance with one of 12 pre-approved plan designs. These policies are rated and sold by commissioned insurance agents on an individual basis and may include age-rated premiums. In addition, these policies may be marketed by a carrier through an association such as AARP or AAA.

Group Medicare Advantage Plans

An employer or sponsor may offer a group Medicare Advantage plan to Medicare eligible retirees, where all of the retiree's health benefits are provided by the managed care organization (MCO) and that MCO receives direct reimbursement from Medicare for the portion of the benefits that would have been provided through Original Medicare Parts A and B. Medicare Advantage plans may be offered on a number of different managed care platforms, including Preferred Provider Organization (MA-PPO), Health Management Organization (MA-HMO), and the most recent addition - Private Fee-for-Service (MA-PFFS). These plans take advantage of the MCO's negotiated provider network and allow a Medicare eligible retiree to receive all benefits through the managed care provider, without having claims separately submitted to Medicare, then to a supplement plan. When offered on a group basis, these plans may offer the opportunity for lower rates for the sponsor and for the retiree comfortable with participating in a managed care program.

As Medicare Advantage plans have developed, the Centers for Medicare and Medicaid Services (CMS) has allowed and encouraged the growth of MA plans in both employer sponsored group format and as individual policies. Many of the CMS rules governing Medicare Advantage plans actually operate from an individual placement basis, even when an employer sponsors a group plan. For example, most MA plans are fully insured and rates for coverage levels must be

approved through CMS on an individual policy model. In addition, marketing expenses (often including commissions) are usually built into the product when it is filed with CMS.

Employers offering MA plans to their retirees usually do so as an extension of the group health benefit plans they maintain for their active employees and pre-65 retirees. While the Medicare Advantage model may be structured on an individual policy basis, there are some key differences when these policies are offered in an employer environment:

1. The retiree coverage is provided as an extension of an existing procured group health benefit contract. The same carrier provides both active employee and retiree plans. The employer contracts directly with the carrier and provides the benefits to the retiree. There is no contract directly between the individual retiree and the carrier.

2. The MA plans are offered on a guaranteed issue basis with no individual medical underwriting. Retirees may join the program regardless of their current health status.

3. The MA plans feature a single premium level for all eligible retirees electing the program and do not require different premium levels based on the retiree's age.

4. The Medicare Advantage group plans are designed with one benefit design applicable to all retirees who elect participation in that plan. Individual retirees do not have the ability to change the benefits specifically to their specification. An employer may offer two or more MA plan designs, and those plans designs are available to all retirees eligible for the particular plans. For example, the employer may offer one plan design for retirees subject to collectively bargaining and another for retirees who are administrators and non-bargained office personnel

5. The employer receives and pays a consolidated billing for all retirees enrolled in the program, and the employer collects any required premiums from the retirees.

6. The employer receives regular management reports on the enrollment and progress of the plan, and negotiates annual premium adjustments with the carrier for all retirees.

7. The MA plan is an integral component of the employer's overall health benefit program. Retirees participate in the employer's annual enrollment process and the employer maintains all records of retiree plan selection and premium costs.

Individual Medicare Advantage Policies

Managed care organizations (MCOs) are sanctioned by Medicare to sell individual Medicare Advantage policies in their approved market areas. These policies are typically based on either the MA-HMO or MA-PFFS platforms described above, but represent individual policies with age-rated premiums. The plans may also be subject to some individual underwriting based on the applicant's health status. Individual MA policies are typically sold by insurance agents, who receive finder's fees and commissions for the sale. Billing for the policies is usually through monthly debit against the retiree's checking account or by quarterly pre-payment of premiums by check.

Medicare Part D Prescription Drug Plans

With the implementation of Medicare Part D prescription drug benefits in 2006, employers, plan sponsors and individual Medicare eligible retirees have many options for receiving the government subsidized drug benefits. Employers may continue to provide group prescription drug coverage for Medicare eligible retirees through their regular group health benefit programs and apply for reimbursement of a part of the premiums they subsidize. In addition, employers may contract with a Medicare Prescription Drug Plan (PDP) to provide the Medicare Part D benefits on a group basis, along with additional benefit features not covered under the standard Part D design. Finally, approved Medicare PDPs may offer individual PDP policies to Medicare eligible retirees. These individual policies are usually sold on a commission basis.

There is considerable pressure in the retiree marketplace for placement of individual Medicare Advantage, Medigap and Prescription Drug Plan policies. Carriers with approved MA, Medigap and PDP policies pay larger than average commissions to agents producing those policies as they seek to gain market share in this newly opened market.

Attachment 3

School District Survey

To gain knowledge about the health benefit plans currently being offered by participating school districts to the pre-65 and Medicare eligible retiree groups, Segal conducted a data gathering survey of the more than 700 school districts and other jurisdictions participating in PSERS. The online survey requested specific plan and employer information in the following major areas:

- School district identifying data and contact information
- Eligibility for retiree plans
- Information on premium cost sharing for retirees
- Plan coverage statistics, numbers of active employees, retirees under age 65, retirees age 65 and over, surviving spouses, other.
- Identification of carriers and types of plans offered to active employees, to retirees under age 65, and to retirees age 65 and older
- For Medicare eligible retirees (generally age 65 and older) where a Medicare Advantage (MA) Plan is offered, the type of MA and whether the plan is a group plan or individual policy
- Information about retirees living outside Pennsylvania and the plans offered to those retirees
- Prescription drug benefits provided to retirees
- Current premium rates for retiree health coverage
- Information on what administrative and operational functions for the retiree health plans are handled by the school district, the insurance company, or another party (such as a broker or agent representative)

Segal published the electronic survey questionnaire to the official PSERS reporting contacts listed for each participating school district and requested that the contact person notify us if a different person would be responsible for submitting the benefit survey information. We followed up with all known contacts to encourage submission of information and to remind those who had not started or not completed the survey.

We also asked that jurisdictions mail us a copy of the enrollment materials and premium rate charts they provide to their pre-65 and Medicare eligible retirees regarding the health benefit coverage available.

Contact information for the persons noted on the survey responses as the proper benefits plan contact was compiled and provided to PSERS for inclusion in the retirement system's database.

Survey Results

Segal received 418 complete and partial responses to the survey.

Medicare Retiree Results

Of the 418 school districts responding:

- 306 reported that they do not provide coverage to Medicare eligible retirees
- 45 reported that they offer the same benefit plans for retirees age 65 and over that are offered to active employees and retirees under age 65.
- 67 districts reported that they do not offer the same benefit plans for retirees age 65 and over that are offered to active employees and retirees under age 65. Of these 67 districts:
  - 16 reported that they offer a Group Medicare Supplement Plan
  - 5 reported that they offer Individual Medicare Supplement Policies
  - 7 report that they offer Medicare Advantage plans. (Note that all school districts reporting Medicare Advantage plans stated that they are group plans. No districts reported that they offer individual MA policies.)
  - 4 reported that they offer other types of plans to retirees, usually restating the other type to be a Medicare benefit level of their primary group medical plan.
  - 35 did not name a separate plan or did not complete the questions.

We followed up on the five districts that reported offering individual Medicare Supplement policies and requested that they provide us copies of the enrollment and informational materials they provide to their retirees. We have not received that information as yet.

Pre-65 Retiree Results

Of the 418 school districts responding to the survey:

- 365 indicated that they provide the same health benefit plans to pre-65 retirees as they provide to active employees.
- 18 respondents stated that they provide different plans to pre-65 retirees than they provide to active employees. In most cases, these 18 indicated that they provide the same carrier but a different plan platform (e.g., Indemnity, PPO, etc.) than the primary platform offered to active employees. Note that this online survey was not geared to gather all reasons why the school district would have its pre-65 retirees on a separate platform from active employees.
- 35 of the respondents did not complete the question regarding what plans they provide for pre-65 retirees.

We received hard copy enrollment information from only 37 school districts, despite telephone and email follow up requests.

General Observations

- We believe that the response rate for the survey was adequate for gaining insight on the general situation regarding retiree health coverage, but did not approach the level of data necessary for PSERS to assure that all school districts are complying with the Board's policy

regarding Premium Assistance. As evidenced by our unsuccessful efforts to encourage participants to respond fully to the survey, this gathering and maintenance of data about the districts' plans will require concerted effort from PSERS.

- To administer the policy on a full data basis, PSERS will need to develop and maintain a database of the Approved Plans being offered to retirees. The database would be composed of information provided by the participating school districts, along with a determination by PSERS or its delegate whether the submitted plan complies with the detailed requirements of the policy. Approved Plans would be issued a "carrier code" to assist in identifying them going forward. While we recommend that an ongoing submission requirement be placed on school districts to provide information to PSERS about their plans or risk losing the Premium Assistance benefits for all their retirees, we are aware that the implementation of such a requirement would also necessitate a level of ongoing administration that does not exist today. A less labor intensive approach might be preferable.

- We suggest that PSERS will have better success for initial and ongoing certification of plans as Approved Plans by requesting the least amount of data absolutely required to make the determination. By drawing the parameters such that any district providing the same group benefit plans to retirees that are provided to active employees would meet the Approved Plan definition by simply certifying to the parameters, PSERS would have a much smaller number of plans on which to gather data and make a determination. For those that do not provide the same group benefit plans to retirees as to active employees, we would recommend obtaining a progression of information that allows the plan sponsor to stop providing data at the first point the plan meets the requirements as an Approved Plan. A suggested progression of questions and data is provided later in this analysis.

- We also recommend that school district's signoff on the Premium Assistance Election Form used by individual retirees to claim the Premium Assistance benefit could be modified to become a certification that the retiree participates in their plan and that the school district's plan meets the Approved Plan criteria. This would give another opportunity for updating the certifications as individual members retire.

Attachment 4

Policy Considerations

The following questions were considered with regard to the application and administration of the Premium Assistance policy. Segal looks forward to the opportunity to discuss these open questions.

1. Should PSERS take a hard line or a softer line on administration and enforcement of the policy?

   - See hard line / soft line discussion points below
   - To what extent does a hard line approach cause more concern for the participants than for the school districts?

2. To what extent do we hold the participant harmless if the school district installs plans that don't qualify?

   - This situation could result in retirees losing coverage as a direct result of actions taken by the district.
   - If a school district plan is found not to be an Approved Plan, then notification to employer would need to have instructions for unwinding the situation – immediate transfer of the affected retirees to an Approved Plan, if offered by the district.

3. If the district certifies a retiree plan but that plan is determined not to be an Approved Plan and the employer does not offer another Approved Plan for retirees, does that trigger a Qualifying Event?

   - For the retirees over age 65?
   - What would happen to the pre-65 retirees who are caught in this situation, where the district is required to continue coverage under Commonwealth law?

4. What level of certification will PSERS require of the school districts?
   - On-line submission and certification only
   - On-line submission and submission of hard copies of plan booklets for pre-65 and Medicare plans offered
   - Above, plus an official certification from the school board
   - Other?

5. At what point(s) does PSERS determine that a district does not have an Approved Plan?

   - Time driven – e.g., submit plan and carrier changes by October 1 for the next calendar year approval
   - Cycle driven – submit 60 days in advance of effective date of the plan (to take into account districts that may change benefit plans on fiscal year instead of calendar year)
   - Other factors to determine Approved Plan decision timing?

6. Should PSERS require annual certification of plan compliance or submission of plans for approval?

   - Most school districts do not offer coverage to Medicare eligible participants, so no details to submit for that population
   - Districts that provide coverage to Medicare eligible retirees typically do not change plans often, based on past history.
   - All districts are required to provide coverage for pre-65 retirees. Most have indicated they provide the same plans as for active employees.
   - Less frequent than annual certification would require more data to be submitted and more administrative review

7. Should there be a requirement that carriers have secure financial strength ratings, defined as S&P rating of B+ or higher?

8. Should we require that all plan designs meet all federal "actuarial equivalence testing" requirements? Apply to medical plans or just PDPs?

9. Should we require that any dividends, rebates or subsidies earned on the Medicare eligible population must be used to offset plan costs of retirees and not used for other populations?

Hard Line / Soft Line Characteristics

The following are noted as characteristics that would exist under a hard line approach to administration of the Premium Assistance policy:

- PSERS board publishes policy and guide to Approved Plans
- Annually, the school district must submit detailed plan information, retiree premiums and current participation lists for pre-65 and Medicare plans offered.
- PSERS or its delegate reviews the submitted materials and entertains a recommendation whether the submitted plan is an Approved Plan.
- If the school district does not submit information proving that its plans are Approved Plans, or if only some of the required information is provided, then PSERS would notify the school district that it does not have an Approved Plan.
- Unless the school district remedies the situation by implementing a complying plan for retirees within the designated time frames, all retirees 65 and older in the plan would automatically lose Premium Assistance at the end of that year.
- Non-compliance or termination of a plan for Medicare retirees would not trigger a qualifying event (allowing those retirees to select into the HOP program) unless specifically approved by the PSERS Board. In considering whether to allow a qualifying event window for these retirees, the PSERS Board will also consider the characteristics of the group and determine whether the premiums for the existing HOP participants will be adversely affected. The the extent that the premiums would be affected, the Board may determine to charge at a different rate from the standard HOP rates.

The following characteristics would be indicative of a soft-line approach to administration of the Premium Assistance policy:

- PSERS board publishes policy and guide to Approved Plans
- Communication to school districts includes a description and examples of the types of plans that are expected to qualify and those that would not be Approved Plans.
- The school district is asked to confirm and provide proof that its offered plans meet all the required characteristics, including that the retiree is paying $100 or more for the coverage.
- The school district is also asked to provide a list of current retiree participants, with identifying number so they can be cross-referenced to the HOP retirement plan records.
- For those districts that submit their information, the retirees who are listed as participants in their Approved Plans are considered to be qualified for Premium Assistance without having to submit individual proof of coverage. This provides a clear advantage for those retiree participants.
- For districts that do not submit plan information, the individual premium assistance retirees are required to submit proof of coverage. The retiree's proof of coverage must include a description of the plan as well as proof of premium payment. The form must be endorsed by the school district verifying that the retiree is a participant in the plan.
- PSERS would monitor the individual submissions and look for plans that obviously are not group benefit plans (e.g., individual Medicare supplement policies). When such plans are discovered, PSERS would write to the school system requesting a full disclosure of the plan in question. If the district does not submit information on the plan, then PSERS would notify the district that the premium assistance for its retirees is in jeopardy and that if information is not submitted within a stated time limit a full audit of all retirees of that school district will be conducted requiring proof of coverage from each retiree.

Illustrative Operational Approach

We suggest that PSERS can have success in obtaining school district compliance with a new Approved Plan policy by using a certification that progresses from the most basic criteria to more detailed information regarding whether the plan meets the requirements.

The following question sequence is illustrative of the progression we recommend. Specific question sets would need to be developed in accordance with the final policy approved by the Board.

For Plans Offered to Age 65 and Older Retirees:

1. Do you make retiree health benefits available to your retirees age 65 and over?

   <If "No", then certification is complete for Medicare eligible and over 65 retirees>
   <If "Yes", then answer the following question>

2. Are the plan(s) you offer to retirees age 65 and over the SAME plans that are offered to your active employees (with appropriate benefit changes for Medicare primary coverage)?

   <If "Yes", then certification is complete for Medicare eligible and over 65 retirees>
   <If "No", then answer the following question>

3. Is the retiree health benefit plan you offer for retirees age 65 and over a "group" benefit plan or an "individual policy"?

   <If "Group Benefit Plan", answer question 4.>
   <If "Individual Policy", answer question 5>

4. Is the group benefit plan sponsored by the school district:
   a. Contracted between the school district and the carrier or third party administrator and approved by the School Board in the same manner as the group health benefit plans for active employees?
   b. Reflected in the school district's regular communications with active employees and retirees on health plan designs and premium rates?
   c. Etc. <<must meet all five criteria for plan approval>>

5. Is the individual policy being offered by the school district:
   a. Provided under a contract between the school district and the carrier or third party administrator and approved by the School Board in the same manner as the group health benefit plans for active employees?
   b. Reflected in the school district's regular communications with active employees and retirees on health benefit plan designs and premium rates?
   c. Etc. <<must meet all five criteria for plan approval>>

6. How much do retirees pay per month for single coverage under the plan?

   <If "$100 or greater", meets Premium Assistance dollar requirement to receive full $100 payment>
   <If "Less than $100", requires further information and reduced reimbursement to retiree.>

A similar question progression would apply for pre-65 retiree benefit plans.

Attachment 5

Policy Administration

Certification of Plans

All school districts offering health benefits to retirees should be required to certify to PSERS that each plan offered for school district retirees meets the Approved Plan criteria to assure that retirees may continue to remain eligible for the Premium Assistance credit to their annuity checks.

To determine accurately whether a retiree plan meets the Approved Plan criteria, the school district should be required to provide at least the following items:

- Plan name
- Plan structure (group plan or individual policy)
- Type of plan (e.g., Medicare Advantage, Medicare supplement, etc.)
- Eligible group (pre-65 retirees, Medicare eligible retirees, etc.)
- Eligibility provisions to join the plan (including employee category)
- Carrier name
- Description of benefit provisions and features
- Monthly premium rates charged to retirees for single coverage
- Census of current participants
- Certification from the employer that the plan meets the five responsibility requirements described in the Premium Assistance policy.

With over 700 participating districts in PSERS, an annual submission, review and approval of all plans covering school district retirees would be a significant administrative process requiring deliberate assignment of PSERS resources. From our survey, even though not a complete representation of all participating districts, we note that most school districts do not provide coverage for Medicare eligible retirees. Of those that do provide Medicare coverage, most reported that they provide the same plans for retirees as for their active employees and pre-65 retirees.

To reduce the administrative burden for this policy, we recommend that PSERS consider the following alternative approach that focuses on certification by the school district that the health benefit plans it offers to its retirees comply with the requirements for an Approved Plan under the policy. The proposed approach would involve a check-off certification:

1. Whether the district provides health benefits for pre-65 retirees and for retirees age 65 and older.
2. Whether the district continues the same group health benefit plans for pre-65 retirees as provided for active employees and that the monthly premium charged to those retirees is $100 or greater.

3. Whether the health benefits offered to retirees age 65 and older meet the specific requirements as an Approved Plan and that the monthly premium charged to those Medicare eligible retirees is $100 or greater.

Failure to certify these items would require a more detailed submission and approval process, with direct involvement by PSERS and termination of Premium Assistance for all Medicare eligible retirees participating in the district's plans unless the retiree obtains the school district's certification of participation and premium payments on an individual form to be submitted to PSERS. We believe the number of non-complying school district plans that would need to be submitted and reviewed would be small and that most districts will desire to reduce their own administrative burden by submitting the required certifications.

The following describes the proposed certification process:

Initial Plan Certification

For the implementation of the new policy, we recommend an initial certification process that will require school districts to determine and certify whether their existing plans meet the Approved Plan criteria. To the extent that a school district does not certify its plans, the transition process allows the retirees to become eligible for the Health Options Program. Following the initial certification, any new plans or carriers added or changes to existing certified plans would trigger a new certification requirement.

A school district will be allowed 120 days following the approval of the Premium Assistance policy by the PSERS Board to provide a written certification that each health benefit plan it provides for pre-65 retirees and Medicare eligible retirees is in compliance with the requirements to be designated an Approved Plan.

Failure of a school district to certify during the initial certification period that its plan meets the Approved Plan criteria will cause that plan to be terminated for Premium Assistance the first of the following calendar year and current school plan retiree participants will be given the opportunity to enroll in the Health Options Program as of that termination date.

School districts that fail to certify their retiree health plans will be notified in advance if their plan is to be terminated, and before retirees receiving Premium Assistance who are participating in the plan are notified. PSERS will work with non-certifying school districts to encourage them to adopt a plan that complies with the Approved Plan criteria.

We recommend that PSERS allow this one-time window for enrollment in HOP for participating retirees whose school districts fail to certify their retiree health plans as Approved Plans. In this way, the HOP can serve as a safety net for retirees who otherwise might be left with no options to continue receiving Premium Assistance payments as a direct result of their district's failure to comply.

We also recommend that, following the initial certification and transition period, any school district terminating coverage for its retirees age 65 and older would trigger a qualifying event opening eligibility for those retirees to enter the HOP only upon acceptance of the action by the PSERS Board. At the time of the plan termination, the PSERS Board would determine whether to allow the retirees the option to enter the HOP program as well as whether the group would

adversely affect the existing participants in the HOP and would therefore require a different premium level.

Ongoing Plan Certification

After the initial certification process, a school district must submit a written certification of compliance with the Approved Plan criteria for a health benefit plan offered to retirees age 65 and older in the following instances:

1. Change of eligibility requirements
2. Change of health benefit provisions that depart significantly from coverage provided to the eligible group previously, including change in the benefits provided for eligible spouses and dependents
3. Addition of or conversion to a new plan or plan type for existing and new retiree participants
4. Addition or substitution of a new plan carrier
5. Change in premium structure or subsidies provided by the school district toward the cost of the coverage.

At the occurrence of any of the above events, or upon request from PSERS, the school district would be required to submit a written certification that the plan in its new form complies with the Approved Plan criteria. The certification must be submitted within 60 days of the change.

Maintenance and Reporting of Participant/Eligibility Data

A school district offering health benefits to retirees must maintain a current and up-to-date participant and eligibility listing. The listing must provide data elements as specified by PSERS, including participant identification, plan selection and coverage level data and premium amounts being paid by the retiree for the school district's retiree health plan coverage.

PSERS should provide an NPAS web function to allow easy school district maintenance and update of their participation listings. In the event an NPAS web function is not available, PSERS should provide a suitable data transmission format and process to school districts for submission of their plan listings.

Failure of a school district to maintain a data listing with PSERS for its participating retirees will result in a review of the plan and notification of participating retirees that they must submit an individual Premium Assistance application. In that event, each retiree will be notified that to continue to receive Premium Assistance credits the retiree must obtain a signature from the school district on the individual form certifying that the retiree is a participant and is paying at least $100 in premium per month.

Timing

We recommend the following regarding the timing for plan certification and approval:

- A school district's retiree health benefit plans would be subject to an initial certification process following approval of the Premium Assistance policy by the PSERS Board.
- PSERS will provide a certification checklist to the participating school districts.
- Districts will have 120 days to certify that their retiree plans comply with the requirements as Approved Plans.
- Once the district provides the initial certification to PSERS, the plan will be subject to review and periodic re-certification on a schedule to be determined by PSERS.
- If the district changes the certified plan by altering the benefits provided, by adding or removing a carrier, or by adding a new plan, the district must certify to PSERS that the changed or new plan meets the Approved Plan criteria within 60 days of the change.
- A school district that determines not to meet the approval criteria and does not certify that it meets the approval criteria, will be instructed to discontinue new enrollments in the non-qualifying plan and implement a qualifying plan within six (6) months.

Operational Implications for PSERS

Implementation of the Premium Assistance policy will impose additional administrative responsibility on PSERS. The following functions are among those that will need to be initiated, staffed and maintained:

- Expansion of direct communications and reporting channels with each participating school district to include certification of plans for retirees age 65 and older.
- Development of communications materials to participating school districts to effect the policy
- Development of notification materials to participating retirees affected by their school district's failure to certify its retiree health plans as Approved Plans.
- Development of internal review procedures and policies providing specific administrative guidance on plan approval
- Development of an NCAS web function for submission and maintenance of retiree health plan participant census, plan selection and premium information
- Review of data and materials submitted from school districts
- Development of school district notification processes regarding certification or non-certification of retiree health plans
- Development of an exception and appeals review process
- Integration of the new policy with existing procedures for collection of overpayments of Premium Assistance credits to individual retirees who cannot prove they are in an Approved Plan
- Development of reporting vehicles to the PSERS Board regarding plan certification results and issues.