City of Cincinnati Retirement System
Benefits Committee

City Hall Council Chambers and via Zoom
October 6, 2022 – 12:00 PM

AGENDA

Members
Tom Gamel
Mark Menkhaus, Jr.
Bill Moller
John Juech

CRS Staff
Mike Barnhill

Law
Ann Schooley

Call to Order

Approval of Minutes
- September 22, 2022

Unfinished Business
- Disabled Adult Children Insurance Coverage
- Executive Session
- Amendments to CMC ch 203 re Healthcare Administration Issues

Adjournment

Next Meeting: TBD

City of Cincinnati Retirement System
Benefits Committee Meeting
Minutes
September 22, 2022/ 12:00 P.M.
City Hall – Council Chambers and remote

Board Members Present
Tom Gamel, Chair
Mark Menkhaus, Jr.
John Juech

Administration
Mike Barnhill
Ann Schooley

Call to Order
The meeting was called to order at 12:01 p.m. by Chair Gamel and a roll call of attendance was taken. Committee members Gamel, Menkhaus, and Juech were present. Committee member Moller was absent. Trustee Rahtz was present.

Approval of Minutes
Trustee Menkhaus moved, and Trustee Juech seconded, to approve the minutes of the meeting of July 14, 2022. The motion was approved by unanimous roll call vote.

Unfinished Business
Disabled Adult Children Insurance Coverage
Cary Woodruff from Horan Consulting made a presentation of slides related to Disabled Adult Dependent Coverage. The slides were circulated in the committee's meeting packet. Highlights:

- Coverage for disabled adult children is the same as for other covered members.
- Costs vary widely, from $0 up to $97k/year.
- Residential treatment facility costs are excluded by both the active and the retiree plans.
- SS provides benefits only for total disability (5 part test); 3-5 months to get decision.
- SS disability definition: can't work and earn $1,350/mo. + condition expected to last 12 mos. or result in death. Trustee Gamel asked whether trust income counts as earnings; only employment earnings count.
- Comparison of two programs: Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). SSI is means-tested; SSDI is not. SSDI requires Social Security work credits. SSI leads to Medicaid coverage; SSDI leads to Medicare coverage after 24 mo. waiting period.

DRAFT

- Coordination between retiree plan and Medicaid, Medicare and Federal Marketplace. There is no coordination with Medicaid—the retiree plan would always be primary.
- Alternative insurance options: Federal Marketplace (est. cost: $15,400/yr); Medicaid is standard insurance option for disabled adults.
- Differences between active and retiree plans; in active plan physician certifies disability; in retiree plan, SSA determines disability. Retiree plan requires disability to be before age 19.
- Child eligible for Medicare would be enrolled in retiree Medicare Advantage plan.
- Standard approach: disabled adult children covered like any other covered person.
- Impact of trust funds: SSDI—no impact; SSI—considered unless special needs trust (with clawback provision)

At a couple points during the Horan presentation, an attorney for a retiree with a disabled adult child (Dan Spraul) sought to ask questions of Horan. Chair Gamel requested that Mr. Spraul stop asking questions during the presentation. Ultimately, following an at ease, the Law Department (Ann Schooley) advised Mr. Spraul that this was a Benefits Committee meeting, not an opportunity to conduct a cross-examination while the Benefits Committee was seeking to get answers to its questions.

Trustee Rahtz asked how the CRS plan compares to other plans in terms of eligibility requirements for disabled adult children. Director Barnhill explained that in 2009 when the Benefits Committee took this issue up, they looked at the OPERS eligibility requirements, which did not have enhanced eligibility requirements that are now in the CRS plan.

Public Comment

Attorney Dan Spraul was given an opportunity to provide public comment. Mr. Spraul then read a letter into the record. The letter is attached to these minutes.

Trustee Gamel and Mr. Spraul discussed whether there was a change in the plan in 2009 or 2022. Mr. Spraul asked what notice was given to active employees of the 2009 changes. Director Barnhill responded that the notice was only sent to retirees.

Trustee Gamel advised Mr. Spraul the CRS does not have a role in extending his client's COBRA healthcare, and that they would need to contact the City's Risk Management division to discuss this matter. Mr. McCarthy provided comment that his COBRA extension was for 27 months.

Mr. Spraul's final comment was that he is seeking CRS to help, otherwise they will be seeking relief through an action in court.

Committee Action

Trustee Menkhaus asked if the issue was being driven by an internal policy and how it could be changed. Ms. Schooley responded that the issue was not a Board policy, but rather an issue with the City's Municipal Code. Ms. Schooley advised that the Board could seek a change to the CMC, and propose that to the Administration and City Council.

Mr. Spraul then sought to engage Ms. Schooley and Trustee Gamel in a colloquy regarding interpretation of CMC 203-48, with both declining to engage.

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Trustee Menkhaus moved, and Trustee Juech seconded, a motion to amend CMC 203-48 to remove the requirement that only the Social Security Administration can make the determination of disability for purposes of healthcare eligibility for disabled adult children. The motion passed unanimously on roll call vote.

Trustee Menkhaus moved, and Trustee Juech seconded, a motion to amend CMC 203-48 to remove the residence requirement from the eligibility requirements for disabled adult children. The motion passed unanimously on roll call vote.

Draft language implementing these motions is attached.

Mr. Spraul asked about how to find out about COBRA. Trustee Gamel again directed Mr. Spraul to the Risk Management division. Mr. Spraul asked about an appeal process. Director Barnhill advised that the Board had requested Law advice and assistance with drafting an eligibility appeal process. Mr. Spraul requested notice of the appeal process when it is completed.

Adjournment

Following a motion to adjourn by Trustee Moller and seconded, the Benefits Committee approved the motion by unanimous roll call vote. The meeting adjourned at 1:07 P.M.

Meeting video link: https://archive.org/details/crs-benefits-comm-9-22-22

Next Meeting: TBD

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Secretary

DRAFT

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—ATTORNEYS AT LAW—
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Cincinnati, Ohio 45202
Reception: 513-721-8210
Fax: 513-621-8703

September 22, 2022

(Hand Delivered)

City of Cincinnati Retirement System Benefits Committee
801 Plum Street, Suite 328
Cincinnati, Ohio 45202

Re: MacKenzie McCarthy's Healthcare Benefits

Dear Board Members and Staff:

Attached is a transcript of the comments I intend to deliver at today's meeting. I am providing it for your further review, or in case I am not given the opportunity to speak.

I look forward to hearing from you by Friday of next week.

Sincerely,
Spraul & Doan, LLC

Daniel G. Spraul, Attorney
Voice/text: 513-520-8059
danspraul@aol.com

encls

Comments of Daniel G. Spraul
City of Cincinnati Retirement System Benefits Committee Meeting
September 22, 2022

As you know I'm Dan Spraul an attorney with Spraul & Doan, representing the McCarthy family. We hope to resolve the coverage issues for MacKenzie, your Retiree Christopher McCarthy's permanently disabled adult daughter, short of litigation.

Because your body's decisions are so important to Mackenzie's wellbeing, her parents are both here today, Chris you know, and Geri McCarthy, and most importantly MacKenzie is here so that you have the opportunity to meet the person whose coverage you are debating.

We understand that you now require a Social Security Administration determination of disability to continue MacKenzie's coverage. While we disagree with your interpretation and the propriety of that requirement, we would like to have the opportunity to meet it before filing suit.

And we would like to have the opportunity to go through the City benefits appeal process before filing suit. However, we are unclear whether an appeal process even exists---so please let us know.

As your own expert Horan explained to you, Social Security determinations take approximately 5 months AFTER application. You may not realize that in an extensive lifelong disability case like MacKenzie's it will take months to assemble the records and experts for that application, to say nothing of the expense to the family involved with that.

Accordingly, we would request a continuation of MacKenzie's benefits until we have had the opportunity to make Social Security application and go through the City's appeals process. We would request a minimum of 9 months to pursue the Social Security Administration process, and then if need be, additional time to pursue the City's appeal process.

MacKenzie's 27 months of COBRA coverage, which was granted pending resolution of her coverage under the Plan, is set to expire this October. Notably, she was given 9 months less than the full COBRA timeframe of 36 months. We are asking for a commitment to extend coverage under the Plan, or the COBRA coverage, until at least July 2023 in order to complete the Social Security Administration process. If you are unwilling to continue MacKenzie's benefits for these purposes, then we obviously will request injunctive relief from the court.

I would like to point out here, the McCarthys have exhibited extreme patience through the moving targets the City has presented during the 2 year this process has taken so far, and they are willing to continue what feels unnecessary and unreasonable in pursuing the Social Security Administration process you have prescribed. It feels this way especially because it really is unnecessary busy-work in MacKenzie's case, and it is an unnecessary burden of time and expense for her family to engage me and pay for the voluminous medical records and time of medical experts. She very obviously is permanently disabled as the City's CRS Administrator,

Mike Barnhill, stated at your meeting in July. She also lives with her parents and is unable to work, and therefore meets the City's threshold for benefits. Further as you know, she clearly will not qualify for SSDI and Medicare because her father has worked essentially his whole career for the City and did not pay in the requisite 40 quarters for Social Security. And most frustrating, as your expert Horan explained to you, even if MacKenzie on her own qualifies for SSI/Medicaid benefits, the City STILL would be the primary healthcare payor, so that the Social Security Administration determination you require would in practice have NO ULTIMATE EFFECT on your financial obligations. Rather the only practical effect of this requirement is to wear down this family with bureaucratic hoop-jumping and expense.

Please know that this family and MacKenzie have been champions of healthcare rights and coverage for children since her injury in 1993. Ironically, her injury was caused in large part by the City's insurance Plan with Anthem (then Community Mutual) that allowed only a 1-day hospital stay for vaginal deliveries—known in the media coverage of the time as a "drive-through delivery." The 1-day stay did not allow time for MacKenzie's dangerous condition to be diagnosed. She had a blood type incompatibility with her mother that would have been known and treated with simple medical observation, blood typing and putting the baby under special sunlamps called bili-lights, had she been in the hospital. Consequently, within the first week of life MacKenzie suffered permanent brain damage, resulting in Quadriplegic Choreoathetoid Cerebral Palsy.

The McCarthy's wanted to make sure no other family suffered what they did by reason of the dangerous 1-day coverage the City's Plan imposed, so they sued the insurance company along with the medical providers. The McCarthys gave testimony to the State Legislature and the US Congress about the perils of drive-through deliveries, and MacKenzie was invited to both the State House and the White House for the signing of the law stopping insurance companies from imposing this dangerous practice. We are not permitted to discuss the terms of MacKenzie's settlement with the City's insurance company, other than to say that it was entered into with the understanding that she would have lifelong coverage so long as Chris was under the City's Plan. It is very frustrating that she again has to do battle for coverage that initially caused her injury, but then was promised going forward as long as Chris remained under the City's Plan. It is frustrating that Chris spent his career time from her birth and injury in 1993 onward in great part knowing that his employment insured his daughter's lifelong healthcare coverage. Now you want her to qualify to Social Security, which she easily could have done had Chris worked elsewhere.

Nonetheless, even though we obviously disagree with the propriety of your current requirements, our sole purpose here today is NOT to argue with you about your requirements, but only to get a commitment of coverage for a period of time that would allow us to complete your process and hopefully avoid further litigation.

I also want to make clear that nothing in our request constitutes a forbearance agreement. Our preliminary foray into the Social Security Administration process suggests that you are requiring determinations that Social Security does not make; for instance, it is our understanding that

they will not determine the date when MacKenzie's lifelong disability commenced. MacKenzie suffered a blood type incompatibility injury within the first days of life, but the Social Security Administration does not make determinations of the timing of commencement of disability. We understand, they will only determine that she has been disabled and will continue to be so for at least 12 months. So even if we get an SSI determination of disability, we are skeptical whether you will agree it meets your requirement. In plain language, you seem to be requiring something that can't be done.

Time is of the essence, so we need to hear from you by the close of business Friday next week whether you will extend MacKenzie's current Cobra coverage through July 2023, or as we submit you should, extend MacKenzie's coverage under the plan as promised to her family.

Thank you.

Proposal re Disabled Adult Children Cases
Amendment to CMC 203-48(a)(iii)

(iii) Coverage shall be extended if the Retiree's child is permanently and totally disabled in accordance with Social Security Disability Definition, 42 U.S.C. 416i(1), prior to the limiting age specified in Section (a)(ii) herein [AND MAINTAINS HIS OR HER RESIDENCE WITHIN THE HOUSEHOLD OF THE RETIREE]. For purposes of this section, the term "disability" means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months. Evidence of the incapacity shall be required to be provided to the Board[, SUCH AS A CERTIFICATE OF DISABILITY OR OTHER ADEQUATE PROOF FROM THE UNITED STATES SOCIAL SECURITY ADMINISTRATION], and shall be subject to approval by the Board.

Effective Date: Immediate.

Motion by Trustee Menkhaus.
Approved by CRS Benefits Committee, 9/22/2022.

MEMORANDUM

To: CRS Board of Trustees, Benefits Committee
From: Michael Barnhill, Executive Director
Date: October 3, 2022

Re: Additional Questions and Answers Regarding Disabled Adult Children Coverage

1. ***How do other pension systems handle health insurance coverage for disabled adult children?***

I reviewed several other pension systems' health plan documents. No plan had a requirement to reside with the retiree parent. No plan had a requirement that only the Social Security Administration could make the determination of disability. One plan reviewed (OPERS) is now a defined contribution health plan, and starting on 1/1/2022, it eliminated healthcare stipends for all child dependents.

Plans reviewed: Ohio PERS, Ohio Highway Patrol, Ohio STRS, City of Austin ERS, Milwaukee County Retiree Health Plan, Dallas ERS, Seattle ERS, and Denver ERP. Excerpts from the plan documents' eligibility requirements for disabled adult children are attached.

2. ***Why is CRS requiring disabled adult children to apply for SSI benefits, if eligibility for SSI results in the child being enrolled in Medicaid, and Medicaid is always secondary to CRS healthcare?***

In 2009, when the CRS Board of Trustees sought restricted eligibility for disabled adult children, the Benefits Committee minutes and documents suggest that the Board simply wanted the Social Security Administration (SSA) to make the determination of disability. It's not clear that in 2009 anyone involved (the Board, staff, or Law) had any awareness about the different programs under which an SSA disability determination could be made, or the type of healthcare that would result from such determinations. It's also not clear that anyone was aware in 2009 that the SSA would not make a determination of disability if the disabled adult child was otherwise ineligible for a Social Security disability benefit, even if the child was in fact permanently and totally disabled.

We now know that there are two programs under which SSA will make a determination of disability: SSDI and SSI.

- The SSDI (not needs based) program is only available for families where either a parent or the disabled child has worked in employment that participates in Social Security and has earned 20 work credits. Once eligible for SSDI, the disabled adult

child will be enrolled in Medicare after a 2-year waiting period. The City of Cincinnati has never participated in Social Security.

- The SSI (needs based) program is available regardless of participation in Social Security. The adult disabled child will be enrolled in Medicaid if found eligible. Existence of a trust fund that is not configured as a "special needs trust" can result in an applicant being ineligible for SSI even if they are permanently and totally disabled.

The CRS did not start requiring application to SSI in 2022. Since 2009, the CRS requirement is for retirees with disabled adult children to provide a SSA determination of disability, which can come from applying to either the SSI or SSDI programs. Note, until 2022 CRS also required the disabled adult child to be enrolled in Medicare, but I discontinued this administrative requirement since it is not specified in the CMC (the CMC expressly permits members to not be enrolled in Medicare).

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Horan compiled the following information from three sources: Ralph Blackwelder, President of Enrollment Management Services (EMS), Anthem and HORAN Individual Health Team - regarding the Medicaid-related questions.

Mr. Blackwelder included the following disclaimer regarding his responses:
EMS is not an attorney and therefore will not give legal advice. Further, EMS is not an authority for Medicaid assessments. However, EMS does have general knowledge, and based on our past experiences and knowledge of best practices will share our opinion on what we have seen in the past. I would advise that the member seek legal counsel or go directly to Job and Family Services to find out the specifics of their questions. However, for educational / training purposes, the following is our understanding of the current Medicaid procedure.

3. Is covered health care that is provided in a residential care facility, more expensive than the same covered care provided outside of a residential care facility? Note I am assuming that there is such a thing as covered care in a residential facility, even though the residential facility costs are excluded. This would include things like lab work and physician visits, I think.

- EMS Response: In order to answer this question, we need specifics - what is the provider's name, what is the provided care, and what is the location? With additional information, an answer can be determined. In general, Medicaid will pay for medically necessary care; however, it is up to the provider to determine if they will accept Medicaid.
- Anthem's Response: If a claim is filed and the place of service is listed as residential care facility, the claim could potentially deny since residential facilities are an exclusion under the Retiree medical benefits. We can't predict how the claim will be billed or how it will be processed until one is received. If a member receives care outside the residential

facility, like in a doctor's office or independent lab, the claim will process and apply to the appropriate benefit.

4. Does Medicaid cover residential care facility costs?

- EMS Response: Yes, Medicaid does have programs that help pay, but it is assets based (please see additional reading material below).

5. Are there deductibles with Medicaid?

- EMS Response: There are no deductibles for Medicaid in Ohio.

6. Is Anthem the sole Medicaid administrator in Ohio?

- EMS Response: No, there are several Ohio Medicaid MCO options - AmeriHealth Caritas, Anthem, Buckeye Health Plan, Care Source, Molina, and UHC Community Plan.

7. The City's Risk Mgmt division has referred a family with an adult disabled child to the federal marketplace for health insurance when their COBRA extensions expire. If they seek to enroll their child in marketplace insurance, I believe the application asks only for employment income, and for the child that is zero. I believe at that point, the marketplace application automatically refers the case to state Medicaid. Can you confirm?

- EMS Response: That sounds correct, but an applicant can choose to skip the financial questions to bypass the determination for tax credits and or Medicaid and just enroll for the full price of an individual plan If the member is not currently enrolled in Medicaid or Medicare.
- HORAN Individual Health Team Response: Regarding Marketplace eligibility and income, the main question is, do they claim this child as a dependent on their taxes? If so, the marketplace will ask about total household income for all individuals on the tax return. If they do not claim the child, then they will only look at the child's income. This includes all taxable income. Here is a helpful resource for questions related to income and household members: https://www.healthcare.gov/income-and-household-information/how-to-report/ . The HORAN Individual Health Team also shared the Medicaid links and Consumer Hotline below under Additional References (as they, too, offered the disclaimer, they are not Medicaid experts).

8. If enrollment in Medicaid is done through the marketplace (as opposed to SSI) do assets ever come into the process?

- EMS Response: In Ohio, the expanded ACA Medicaid coverage is income based; therefore, no asset test is applied. So potentially a person with no income is eligible regardless of assets.

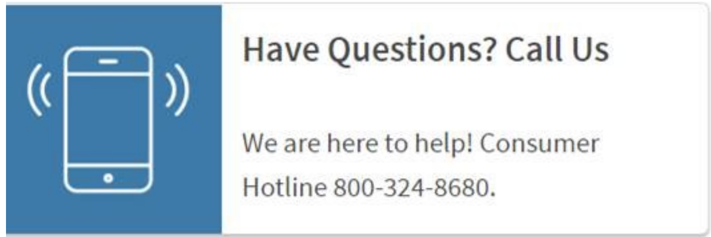
9. Can the disabled adult child be enrolled directly in Medicaid, without consideration of trust fund assets, with no clawback requirement?

- EMS Response: There are different parts to Medicaid. So, the short answer is if the member is just enrolled in the ACA expanded Medicaid, then no asset test. If the member is getting approved through "Aged, Blind, and or Disabled" for additional benefits, then asset testing would likely come into play. This requires follow up with Ohio Department of Job and Family Services with additional details that are based on the individual situation.

Additional References:
Assisted Living Medicaid Waiver Program
This Medicaid program covers care in an assisted living facility for eligible Ohioans.
Assisted living combines a home-like setting with personal support services to provide more intensive care than is available through home care services. Care in these settings is generally less expensive and less restrictive than similar care in a nursing home. Ohio's Assisted Living Waiver Program pays the costs of care in a participating assisted living facility for eligible people with Medicaid, allowing the consumer to use his or her resources to cover "room and board" expenses.

For Medicaid eligibility-related questions and questions about cost/benefits, please reference the link below and/or contact the Medicaid consumer hotline listed on that page.

- https://medicaid.ohio.gov/families-and-individuals/coverage/coverage
- Applying for Medicaid: https://benefits.ohio.gov/



Appendix – Other Pension System Health Plan Provisions
Re: Eligibility of Disabled Adult Children

Ohio PERS (DC Healthplan)

Dependent Children

Effective January 1, 2022, retirees no longer receive an additional allowance for eligible dependent children, regardless of age, ability or mental capacity. The retiree is able to use their HRA to reimburse any qualifying medical expenses incurred by their eligible dependents.

(3) A summary of the eligibility requirements for the benefits:

Eligibility requirements for 2021 OPERS health care plans are as follows:

Eligible Dependents

In accordance with Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code (IRC), retirees receiving a monthly age-and-service or disability benefit may enroll their legal spouse and any eligible children under the age of 26.

- The member or retiree's eligible children are a biological or legally adopted child or minor grandchild if the grandchild is born to an unmarried, un-emancipated minor

child and ordered by the court to provide coverage pursuant to Ohio Revised Code Section 3109.19.

- For a child to be eligible for coverage, the child must be under the age of 26 (regardless of enrollment as a full-time student or marital status). Coverage may be extended if the child is permanently and totally disabled prior to age 22. This means that the child is not able to work in any substantial gainful activity because of a physical or mental impairment which has lasted or is expected to last for at least 12 months. Evidence of the incapacity is required and is subject to approval by OPERS.

Ohio Highway Patrol Retirement

OH Admin Code Rule 5505-7-04

(J)

(1) Notwithstanding the provisions of paragraphs (H)(1)(b) and (H)(2) of this rule, health care coverage will continue for a disabled child who meets all of the following:

(a) Is unmarried;

(b) Is mentally or physically incapable of earning his or her own living;

(c) Became disabled prior to the attainment of the limiting age for coverage of children;

(d) The child met the eligibility requirements included in paragraph (F) of this rule at the time the disability occurred;

(e) Is chiefly dependent upon the retirant for support and maintenance; and

(f) Is not eligible for medicare part A and medicare part B.

(g) A pre-medicare disabled child that qualifies for coverage beyond age twenty-six under this rule that has access to other medical and/or prescription coverage must secure the other coverage as primary coverage, regardless of cost.

(2) To determine whether a disabled dependent child qualifies for coverage under this rule, the retirement board may require -

(a) A physician's statement;

(b) An independent medical examination;

(c) Two years of federal tax returns from both the parents and the dependent child;

(d) Proof that the disabled child applied for medicare insurance; and

(e) Any other information that the board deems relevant.

Ohio STRS

Disabled Adult Child

Eligibility must be verified before enrollment. Contact STRS Ohio to begin the eligibility determination process.

A disabled adult child is a person age 26 or older who meets the following requirements:

- Has never been married; and
- Is a biological child, legally adopted child prior to age 18 or a stepchild of a living or deceased primary benefit recipient or member; or a child for whom a primary benefit recipient has been legally appointed as guardian prior to the child attaining age 18; and
- Continuously meets the requirements for physical or mental incompetency as set forth in Administrative Code Rule 3307:1-8-01; and
- Either was adjudged physically or mentally incompetent by a court prior to age 22; or was continuously physically or mentally incompetent and continuously unable to earn a living where both conditions occurred prior to age 22.

City of Austin ERS

- **Disabled Children:** To continue City coverage for an eligible dependent past the age 26, the child must be covered as a dependent at the time, unmarried, and must also meet the following definitions:
  - ❖ A disabled child must rely on you for more than 50 percent of support.
  - ❖ A child is considered disabled if they are incapable of earning a living at the time the child would otherwise cease to be a dependent and depend on you for principal support and maintenance, due to a mental or physical disability.
  - ❖ A disabled child continues to be considered an eligible dependent as long as the child remains incapacitated and dependent on you for principal support and maintenance, and you continuously maintain the child's coverage as a dependent under the plan from the time they otherwise would lose dependent status.
  - ❖ A dependent child who loses eligibility and later becomes disabled is not eligible for coverage. A disabled child who was not covered as a dependent immediately prior to the time the child would otherwise cease to be a dependent is not eligible for coverage.
  - ❖ A disabled child must be covered continuously on the medical and dental plans. If coverage is dropped, the disabled child will not be allowed to re-enroll.

COVERAGE FOR A DISABLED CHILD

If an enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

1. The child is unable to be self-supporting due to a mental or physical handicap or disability.
2. The child depends mainly on you for more than 50% of support.
3. You provide to the Employee Benefits Division proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age.
4. You provide proof, upon the Employee Benefits Division's request, that the child continues to meet the conditions.

The proof might include medical examinations. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Milwaukee County Retiree Health Plan

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to Milwaukee County proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon Milwaukee County's request, that the child continues to meet these conditions.

The proof might include medical examinations at Milwaukee County's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Dallas ERS

Dependent Child Child who is married or unmarried up to age 26* and is the biological child, legally adopted child, grandchildren or stepchild of you and/or your spouse, domestic partner or common-law spouse. Note: Dependent children will become insured on their date of birth if you elect Dependent Insurance no later than 30 days after the birth. If you do not elect to insure your newborn child within such 30 days, coverage for that child will end on the 30th day.	• Copy of Birth Certificate showing you as a parent, or • Copy of Verification of Birth Form (accepted for up to 3 months post-birth only) • Copy of Adoption Agreement, or • Copy of court custody or guardianship documents, or • Copy of the portion of the divorce decree showing the dependent, or • Copy of Qualified Medical Court Support Order (QMCSO) **Additional documentation required for disabled dependents:** • Physician affirmation of such condition and dependence
Dependent Grandchild Grandchild who is married or unmarried up to age 26* and is the biological grandchild of you and/or your spouse, domestic partner or common-law spouse. You must have guardianship or cover the child to cover a grandchild.	

*Dependent children and dependent grandchildren are covered until the end of the month of their 26th birth month, for medical, dental and vision coverage and until the age of 25 for life insurance. Disabled children are eligible to be covered past their 26th birthday if they are unmarried, primarily supported by you, and incapable of self-sustaining employment by reason of mental or physical disability.

Seattle ERS

How you can extend coverage for your disabled child beyond the plan age limits

You have the right to extend coverage for your dependent child beyond plan age limits, if the child is not able to be self-supporting because of mental or physical disability and depends mainly (more than 50% of their income) on you for support.

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won’t ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don’t, we can terminate coverage for your dependent child.

Benefit Eligibility

Who is eligible to enroll in insurance coverage through DERP?

Members receiving a DERP Pension Benefit, and their eligible dependents, may enroll in medical, dental, and/or vision insurance with DERP.

Who can I cover on my plan?

You can enroll eligible dependents if you are enrolled in a DERP health insurance plan(s). Eligible dependents include:

- Your spouse
- Your children to age 26
- Your dependent children of any age who are physically or mentally unable to care for themselves (legal documentation is required)

Supporting documents are required to prove dependency. Acceptable documentation includes:

- Spouse: marriage certificate, common-law affidavit, or the first page of your most currently filed federal tax return
- Child: certified birth certificate, guardianship paperwork, or adoption paperwork

MEMORANDUM

To: CRS Board of Trustees, Benefits Committee
From: Michael Barnhill, Executive Director
Date: October 3, 2022

Re: Proposed Amendments to CMC ch. 203 Regarding Regarding Retiree Healthcare

The purpose of this memo is to identify areas where the administration of the retiree health plans is at variance with the CMC provisions that govern the retiree health plans. The Board may wish to consider proposing CMC amendments to address these issues, at some point after it has resolved the pending issues related to disabled adult children.

1. Grandfathered Select Plan Members. Some retirees who are eligible for the Model Plan under CMC 203-44 have been administratively grandfathered into the Select Plan under CMC 203-43, and a points grid administratively created for them. These are individuals who retired or were eligible for retirement and had at least 15 years of service prior to 1/1/2016. There are five or fewer individuals in this category.

Recommendation: Conform the CMC to the CRS administrative practice, by amending CMC 203-42 to add a Select Plan points grid and eligibility provision for these retirees.

2. Requirement to Enroll in Medicare. CRS, as an administrative practice, has required Medicare enrollment when a member or eligible spouse turns 65. Eligible persons who do not enroll in Medicare are removed from the CRS post-65 health plan. The City's Municipal Code, however, does not require Medicare enrollment. The CMC provides that when an eligible person becomes eligible for Medicare, health claims for such person be processed as secondary to Medicare regardless of whether the person is enrolled in Medicare.

Recommendation: Conform the CMC to the CRS administrative practice, by amending CMC 203-42, 203-43, and 203-44 to require eligible persons to enroll in Medicare.

3. Secure Plan $30,000 Income Cap. The CRS administers a $0 premium/$0 deductible healthcare plan (Secure Plan) for individuals who have annual household income of less than $30,000. The plan is closed and is limited to members (and their spouses) who retired before 9/1/2007, and who met the household income limitation as of 1/1/2012. As of 12/31/2021 there were 74 participants remaining in the plan; as of 6/30/2021 there are 65 participants in the plan. The Municipal Code requires participants to annually submit their federal tax return to demonstrate their household income remains below $30,000. The $30,000 cap was put in place in 2009, and is not inflation adjusted.

CRS has not systematically required the annual submission of federal tax returns. The last time an audit was completed was 2018. Of the remaining 65 members in the plan (average age is 85), one member has a pension benefit that exceeds $30,000 by $803. This member is 90 years old. Assuming for the sake of argument that enforcement of the $30,000 household income provision resulted in removing all of the remaining members from this plan, and placing them in the Select Plan, which charges a 5% monthly premium, the total amount of increased premiums collected would amount to less than $12,000 in 2023.

Recommendation: Amend CMC 203-42 to remove the $30,000 income cap for the remaining members of the Secure plan. Alternatively, consider adding an inflation adjustment to the income cap.

4. Model Plan Grid 5% Premium Share. Retirees who are eligible for the Model Healthcare Plan and who have earned 90 points under the terms of CMC 203-44, are being charged 10% of the premium. The CMC provides that such retirees should be charged only 5% of the premium. CMC 203-44(c). The Model points grid is currently being negotiated as one of the remaining open issues under the CSA.

Recommendation: Make no changes at this time, pending resolution of the Model Grid issue in the CSA negotiations. When such negotiations are completed, if the 5% category remains (and unless directed otherwise by the outcome of the negotiations), CRS will provide refunds to retirees who paid 10%, but were eligible to pay only 5%.