City of Cincinnati Retirement System
Benefits Committee

City Hall Council Chambers and via Zoom
September 22, 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
- July 14, 2022

Unfinished Business
- Disabled Adult Children Insurance Coverage
  - Horan Consulting Presentation

Adjournment

Next Meeting: TBD

City of Cincinnati Retirement System
Benefits Committee Meeting
Minutes
July 14, 2022/ 12:00 P.M.
City Hall – Council Chambers and remote

Board Members Present
Tom Gamel, Chair
Mark Menkhaus, Jr.
Don Stiens
Bill Moller

Administration
Mike Barnhill
Ann Schooley
Linda Smith

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, Steins, and Moller were present. Committee members Winstead and Juech were absent. Trustee Rahtz was present.

New Business
Summary of Disabled Adult Children Issues
Director Barnhill provided a summary of the issues related to three matters involving the denial of retiree healthcare benefits to retirees who have a disabled adult child. Director Barnhill advised that he has prepared a comprehensive memorandum and posted it on the Board's confidential portal. Mr. Barnhill then summarized the non-confidential sections of that memo.

These cases initially arose in 2020. At that time, the CRS was guided by (1) the governing eligibility ordinance, CMC 203-48, and an internal eligibility policy that implemented the municipal code. The policy had three elements: (1) determination of permanent and total disability by the Social Security Administration, (2) enrollment in Medicare, and (3) residence in the home of the retiree. If any of the elements is missing, the child is determined ineligible. That was the process used to determine the three disabled adult children ineligible.

Mr. Barnhill then provided a legislative history of CMC 203-48. In 2007 a gap in the City's Code with respect to eligibility for retiree healthcare. Tax counsel Ice Miller advised that in order to maintain qualification under the Internal Revenue Code, the City needed to amend its Code to set out eligibility for retiree healthcare. The CRS Benefits Committee met frequently during 2007-2009 and considered multiple

drafts of what ultimately became CMC 203-48. The early drafts were less restrictive; over time the Benefits Committee added eligibility requirements. In the fall of 2008 the Benefits added the residence requirement to the draft. In early 2009, the Benefits Committee added the requirement that the determination of disability needed to be made by the Social Security Administration. In June 2009, the Benefits Committee submitted an ordinance drafting request to the Law Department. The Law Dept draft made wording changes, which Mr. Barnhill believes were non-substantive. The City Council passed the ordinance in June of 2009. The effective date was ultimately January 1, 2011. Notice was provided to retirees, but the notice did not set out the three elements of eligibility in the CRS internal policy. Specifically, the notice did not state that eligibility required enrollment in Medicare. Director Barnhill explained that he recommends that Medicare enrollment be removed from the CRS internal policy, because it is not a requirement of the provision the Council enacted in the Municipal Code. Director Barnhill observed that the Code does not require anyone to enroll in Medicare; the provisions just state that for any member or eligible person who is eligible for Medicare that the CRS insurance will pay as secondary coverage.

Trustee Moller asks if the CSA has relevance to the interpretation of the Municipal Code section at issue. Director Barnhill expressed the view that the CSA does not directly bear on this matter. Trustee Gamel referenced a section in the CSA that requires the retiree plan to be the same as the active plan. Director Barnhill suggested a summary of the CSA provisions related to healthcare could be helpful.

Trustee Moller asked about the lack of a requirement in the Municipal Code related to Medicare enrollment. Director Barnhill explained that while the Municipal Code does not explicitly require enrollment in Medicare, retirees should be encouraged to enroll at age 65, because there are substantial penalties if they do not.

Trustee Gamel asked about issues related to differences between the active to the retiree plan. Director Barnhill acknowledged that there are differences between the active, pre-65 and 65+ health plans. The issue is whether such differences are material or disruptive. He explained that is one of the reasons he recommended the Board retain Horan Consulting so that these differences could be identified and analyzed. At a minimum, knowing and understanding these differences is important for purposes of providing member education.

Trustee Stiens asked about how the plan pays as secondary if the member is not enrolled in Medicare. Director Barnhill indicated that is a topic to be discussed with Anthem.

Trustee Gamel asked whether the notice given in 2011 regarding the eligibility changes to the Municipal Code were given to active employees. Director Barnhill indicated he would research that and provide that information later.

Trustee Rahtz expressed her view that the Law Department wording changes made in the draft were substantive and that the language added was intended to broaden eligibility such that a determination of disability by the Social Security Administration is not the sole means by which such a determination could be made. Director Barnhill acknowledged the different interpretation of Trustee Rahtz, and observed that the Board could take up making an amendment to the Municipal Code if it so wished.

Trustee Moller asked about the term “Certificate of Disability.” Director Barnhill indicated that CRS

expected to get such a document in one of the cases from the Social Security Administration and would let the Board know how it was titled.

Trustee Moller asked about members who are Medicare age and not enrolled in Medicare. Director Barnhill explained that the recent practice has been to disenroll such members from the CRS healthcare plan. Director Barnhill explained that at this point, the Board has a choice. The Board can seek to conform the Municipal Code to this practice by explicitly requiring Medicare enrollment. Conversely, the Board ca leave the current language in place. In the latter case, Director Barnhill explained that CRS would work with Anthem to provide secondary coverage for such members.

Trustee Moller asked if any members of Medicare age are not eligible for Medicare. Director Barnhill expressed the view that all members of CRS are eligible for Medicare, but for members hired prior to April 1, 1986, they may not be eligible for premium free Medicare Part A. For those members, CRS processes claims as a primary insurer.

The Committee then accepted a presentation from Attorney Dan Spraul and Chris McCarthy on the subject insurance coverage for disabled adult children. Mr. Spraul explained that Mr. McCarthy's daughter was not eligible for Social Security benefits and therefore it was an impossibility for her to get a Certificate of Disability from the Social Security Administration.

Executive Session

At 12:40pm, Trustee Gamel made a motion, and Trustee Moller seconded, for the Benefits Committee to go into executive session pursuant to ORC 121.22(G) and CMC 121-7 to consider the medical records and financial information of several disabled adult children and their eligibility for CRS retiree healthcare coverage. The motion passed unanimously on roll call vote.

At 1:42pm, the Benefits Committee resumed open session. Trustee Gamel advised that during the executive session, the Benefits Committee did not take any votes or deliberate.

Trustee Moller made a motion, and Trustee Stiens seconded, for the Law Department to provide advice on an appeals process for these matters. The motion passed by unanimous roll call vote.

Trustee Stiens moved, and Trustee Menkhaus seconded, making a change to the residency requirements for when a dependent goes into a residential care facility. Trustee Menkhaus clarified that the change should also cover when the parent goes into a residential care facility, thus separating the parent from the child. Trustee Stiens agreed that was the intent of his motion. Trustee Stiens then requested that the motion be tabled so that he could draft it and return it later for the Committee's consideration.

Director Barnhill summarized his list of information requests and tasks. Trustee Moller and Gamel added to this list. The complete list of "to-dos" is as follows.

(1) Was the notice of the enactment of CMC 203-48 provided to both actives and retirees?
(2) Adopt a practice to send letters to retirees with disabled adult children advising them of the eligibility requirements for retiree healthcare for their children, as well as to provide follow-up letters as needed.
(3) Establish communication with Risk Management to identify similar situated cases in the active

employee population, and provide targeted communication about the eligibility requirements of CMC 203-48 in advance of retirement.

(4) Research the costs of residential facilities for disabled patients, and whether such costs are covered by insurance and Medicare, as well as by the active and retiree healthcare plans.
(5) Provide a definition of residential facility.
(6) Research the various ways that permanent and total disability is determined, including how the Social Security Administration makes this determination. Provide clarification on these definitions.
(7) Provide information on the different standards in place between the retiree and active health care plans.

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 1:54 P.M.

Meeting video link: https://archive.org/details/crs-benefits-7-14-22

Next Meeting: TBD in August

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Secretary

City of Cincinnati
Retirement Benefits
Disabled Adult Dependent Coverage

September 22, 2022

Describe the types of medical costs that the retiree health plan covers for disabled people. How much are those costs? What are the typical costs of residential care for a disabled adult child?

- Disabled members have the same coverage as non-disabled members and the medical/pharmacy costs vary widely

- Typical Cost Ranges:
  - 2020 Annual = $0 - $85,374
  - 2021 Annual = $40 - $97,628
  - 2022 thru July = $144 - $40,443

- Residential Care is not covered on the Retiree Plan (or the Active Plan); however, Skilled Nursing Facility benefits are covered under both the Active (90 days/year) and Retiree Plan (180 days/year)

Does the retiree plan cover residential facility costs? What is the plan definition of a covered residential facility?

➢ Residential Treatment Facility costs are excluded on the Retiree Plan

➢ **Residential Treatment Center/Facility**
A Provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
- A staff with one or more Doctors available at all times.
- Residential treatment takes place in a structured Facility-based setting.
- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Describe the various ways permanent and total disability is determined. How does Social Security Administration make this determination?

- SS pays only for total disability; no benefits for partial or STD
- SSA utilizes a 5-step process to determine total disability:
  1. Are you working?
  2. Condition severe?
  3. Condition found in list of disabling conditions? Listing of Impairments
  4. Can you do work you did previously?
  5. Can you do any other type of work?
- Applications must be submitted through SSA. SSA forwards applications to Ohio's Division of Disability Determination (DDD) for review and decision.
- Decision timeframe is 3-5 months

What is the Social Security definition of permanent and total disability?

- Considered qualifying disability under SSA rules if the following are true:
  - Cannot work or adjust to other work and engage in substantial gainful activity with average earnings above $1,350/month ($2,260/month if blind) due to medically determinable physical or mental impairment(s)
  - Condition expected to last for a continuous period of not less than 12 months or expected to result in death

- How You Qualify | Disability Benefits | SSA

- SSI Eligibility Requirements

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SSI vs. SSDI

FACTOR	SSI (Supplemental Security Income)	SSDI (Social Security Disability Insurance)
Eligibility	Age (65+) OR blindness (any age) OR disability (any age) AND limited/no income and resources	Disability AND sufficient work credits through own/family employment
Benefits Begin	1st full month after the date the claim was filed or, if later, the date found eligible for SSI	6th full month of disability; 6-month period begins with the first full month after the date the SSA decides the disability began
Health Coverage	Medicaid – automatically qualifies upon receipt of SSI	Medicare – automatically qualifies after a 24-month waiting period for most from time SSDI benefits begin

If another plan is primary (Medicare, Medicaid, Federal Exchange), describe how the retiree plan would coordinate with that plan.

- Medicare: Medicare approved amount is the Allowable Expense. Medicare payments, combined with the Retiree Plan Benefits, will not exceed 100% of the total Allowable Expense.

- Medicaid: No coordination with Medicaid. The Retiree Plan would be primary over Medicaid in all circumstances.

- Federal Exchange: Standard COB – Up to Higher Allowed Amount.

Coordination of Benefits Example

Plan as Primary
Billed Charge = $1,000
Allowed Amount = $500
Payment = $500 (any deductible/copays would be taken from expected payment)

Plan as Secondary
Billed Charge = $1,000
Plan Allowed Amount = $500
Other Insurance as Primary Payment = $300*
Plan Payment = $200

***In a secondary arrangement, Anthem cannot process the secondary claim until the other insurance has paid. Anthem will never pay more than their Allowed Amount so either the Allowed Amount is paid or what is owed after the other insurance has paid.**

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Describe how a family would obtain other insurance for an adult disabled child. What would the cost of that insurance be?

- Other insurance is available via The Health Insurance Marketplace
  - Cost varies and is based on age and zip code
  - Federal subsidies are based on income
  - Health insurance plans & prices | HealthCare.gov
  - Estimated total annual cost $15,378 (assumptions: 35, Male, Gold Level, Anthem, High Use); factor in 10% annual trend increase; new exchange plans are issued in November each year
- Ohio Medicaid is the standard insurance option available for disabled adults

Describe how the active employee plan currently covers disabled adult children? Is this different than the retiree plan?

- Active Plan
  - Dependent covered until end of the month upon turning age 26
  - Disabled Dependent Coverage Request Form must be certified by physician
  - Information provided on form will determine permanent disability or if recertification is required in 1-2 years

- Retiree Plan
  - Determination the child is permanently and totally disabled per Social Security definition of disability
  - Determination the child was disabled
    - Prior to the child turning 19, or
    - If the child is a full-time student, prior to the child turning 24
  - Child maintains residence within the household of the retiree
  - Determination of disability is from the Social Security Administration (SSA)

How would the Medicare Advantage plan provide coverage for a disabled adult child?

- Once Medicare-eligibility is earned as a result of total disability, the disabled adult child may be enrolled on the Medicare Advantage Plan
- Medicare eligibility starts after 24 months of SSDI
- Coverage is identical to the coverage for a retired, Medicare-eligible former employee

Are there standard ways or best practices of providing coverage for disabled adult children in retiree health plans?

- Disabled adult dependents have the same coverage as all other covered dependents under the Retiree plan.

Discuss the treatment of trust funds in eligibility determination for disability benefits - SSDI.

- SSDI is not a needs-based program
- Only employment earned income considered
- For 2022, unable to receive SSDI and make more than $1,350/month
- Entitled to SSDI benefits regardless of other financial accounts, assuming you've earned enough work credits to qualify for SSDI
- Trust income has no impact

Discuss the treatment of trust funds in eligibility determination for disability benefits - SSI.

- SSI is a means-tested program based on limited income and resources
- Trusts can reduce SSI benefits for some beneficiaries; counted as resources

- Special needs trusts are an exception and the general rules include:
  - Contains the assets of an individual who is under age 65 and is disabled
  - Established for the benefit of such individual through the actions of the individual, a parent, a grandparent, a legal guardian or a court
  - Provides that the State will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State Medicaid plan

Thank You!