# OPERS Health Care Report 2015

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# Contents



# Executive Summary

In 2015, the Ohio Public Employees Retirement System (OPERS or System) was focused on the implementation of the OPERS Medicare Connector (Connector) which became effective January 1, 2016. The Connector represents the most significant change to the OPERS retiree health care program since its inception in 1974. This change to a Connector model, which helped extend the longevity of the health care program, is a major milestone within the Health Care Preservation Plan adopted by the OPERS Board of Trustees in 2012.

Under this new model, with the help of the Connector administrator, Medicare-eligible retirees select an individual Medicare supplement, or Medigap plan, and a prescription drug plan or a Medicare Advantage plan that covers both medical and prescription drug. Eligible retirees are provided an allowance they may use to reimburse themselves for the premiums for individual medical and prescription plans as well as other qualified medical expenses through a health reimbursement arrangement (HRA).

By enrolling a Medicare-eligible retiree population close to 131,000 retirees, spouses and dependents, OPERS became the first public pension plan to move a population this large to a Connector in a single enrollment season. We are proud to be forward thinking and to have led this charge. With this change, OPERS has achieved its primary goal of providing retirees with more affordable health care options.

The Connector was implemented with the mandate to "leave no retiree behind." Every eligible retiree received multiple, personalized communications. OPERS employed mail, e-mail, video, in-person seminars, nursing home outreach and even in-home visits to be certain the entire population was contacted and made aware of the new plan selection process. These efforts culminated at the end of 2015 with the actual enrollment into new plans for 2016.

This was a completely new process, for both OPERS and our Medicare-eligible retirees. As with all changes this significant, the implementation was not without flaws and a few bumps in the road. Well into 2016, OPERS is still advocating for our retirees, providing resources and information and working with the Connector administrator to resolve escalated service issues. We will not consider this process complete until retirees are comfortable with the mechanics of their HRA account and are using it to their full advantage.

**Other key 2015 activities are summarized below:**

- Two new health care plans for retirees re-employed in the public sector were developed. As with all changes we propose and initiate, those affected received extensive education and communications.

- The System focused on the continued implementation of ongoing and incremental changes resulting from the passage of the 2012 pension legislation and health care changes. These changes include continued phase-out of covered premiums for spouses and reimbursement of Medicare Part B. OPERS established allowance amounts sufficient to provide for these items.

**Other key 2015 activities (continued)**

- The Governmental Accounting Standards Board (GASB) announced changes to health care financial reporting standards with GASB Statement No. 74 (GASB 74), *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, and GASB Statement No. 75 (GASB 75), *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*. GASB 74 affects OPEB (other post-employment benefits) sponsors like OPERS and is effective for fiscal years beginning after June 15, 2016, resulting in initial implementation in the OPERS 2017 Comprehensive Annual Financial Report (CAFR). GASB 75 is effective for OPERS participating employers for fiscal years beginning after June 15, 2017, resulting in initial implementation for employers generally in 2018 annual reports.

  These new accounting and reporting standards also break the link between accounting and funding, similar to GASB Statement No. 67, *Financial Reporting for Pension Plans-an amendment of GASB Statement No. 25*, and GASB Statement No. 68, *Accounting and Financial Reporting for Pensions-an amendment of GASB Statement No. 27*, for pensions.

  While these changes will affect the accounting measures, they do not have an effect on the actuarial methods and assumptions used by OPERS to determine the employer contributions needed to fund health care. The new standards will, however, impact the financial statement presentation for health care accounting and related disclosures for OPERS and participating employers. Among other things, participating employers will be required to include the net OPEB liability, and related activity, in their financial statements.

  OPERS has been preparing to implement these new standards and to assist all employers with the implementation in a manner similar to the pension standards.

- The 115 Health Care Trust was established as a funding vehicle to accommodate reimbursement mechanisms such as the HRA. Employer contributions to this trust began in September 2014, with the initial health care disbursements from this trust commencing with January 2016 premium reimbursements.

- OPERS, along with partners such as the Public Sector Healthcare Roundtable and Generic Pharmaceutical Association, engaged the U.S. Food and Drug Administration (FDA), as well as legislators, on the importance of biosimilar and generic drug competition.

- OPERS advocated in Washington for a repeal or an exemption from the excise tax, or "Cadillac tax," that was included as part of the Affordable Care Act (ACA). The tax was delayed until 2020.

OPERS health care coverage is neither mandated nor guaranteed—yet we continue to work toward the preservation of this coverage because access to health care for our retirees is an important aspect of a secure retirement.

# 2015 - The Year in Review

### OPERS Medicare Connector implementation

2015 marked a key milestone as OPERS implemented the OPERS Medicare Connector. For the first time, Medicare-eligible retirees were able to select an individual Medicare plan and a prescription drug plan for 2016. To prepare eligible retirees to select a plan and understand the new Health Reimbursement Arrangement Plan (HRA), OPERS carried out the most extensive communication and education campaign in the history of the health care program.

The Connector will provide more than 131,000 Medicare-eligible retirees, spouses and dependents with access to better and more affordable health care coverage than any group program OPERS could provide. Efforts in 2015 were focused on ensuring retirees had a complete understanding of the changes, basic Medicare knowledge, individual Medicare plans, the selection process and the HRA process.

### Health Care Preservation Plan implementation

With the implementation of the Connector in 2015, all changes making up the Health Care Preservation Plan adopted by the OPERS Board of Trustees in 2012 are in the process of being implemented. OPERS continually monitors funding for both pension and health care as we work to make a health care program available to both current and future retirees. The program must balance long-term sustainability with consistent coverage between generations. Annual plan design changes for our non-Medicare group plan will be made as necessary.

### Health care for retirees re-employed in the public sector

Because retirees who are re-employed by an OPERS-participating employer are not eligible to receive an allowance from an HRA, which is a key element of the Connector, OPERS developed two new health care plans for these retirees. These two plans, one for those re-employed retirees not yet eligible for Medicare and one for those who are Medicare eligible, were developed, communicated and implemented in 2015.

### 2015 Financial highlights

OPERS remains a strong pension system with sound funding. The 2012 changes to both the pension and health care plans strengthened, and will continue to strengthen, the funding status and established a path for improved funding levels.

### Funded status

Funded status measures the progress of accumulating the funds necessary to meet future obligations. OPERS maintains balance in virtually all market conditions by constantly monitoring the marketplace and changing to adapt to market conditions. The December 31, 2015 preliminary pension actuarial valuation shows a funded status of 85.0%, with the unfunded liability expected to be funded within 19 years on a funding basis.

OPERS is not required to pre-fund retiree health care coverage. However, OPERS has historically pre-funded this expense. The combined actions of our conservative approach to pre-funding and the changes to health care have yielded favorable results. As of December 31, 2014, which is the most recent health care actuarial valuation, OPERS health care was 62.2% funded with assets expected to be sufficient to fund future health care needs.

### Investment results

The investment market in 2015 was not typical—the global market was a bear market, while the domestic market was propped up by a few individual equities. The 2015 investment market was frustrating for investors with a wide range of asset classes and yielded low returns for the OPERS pension and health care portfolios.

The OPERS total return was a loss of 0.03%, or (0.03%), substantially less than the expected rate of return of 8% but better than the benchmark return of (0.06%). While these results are disappointing, OPERS is a long-term investor. We have experienced both strong market years as well as multiple substantial drops in investment market performance.

Difficult years such as 2015, compel us to remind members, retirees, and all stakeholders that pension systems are designed to be funded over a long period of time. As a long-term institutional investor, OPERS invests in a diverse set of asset classes to minimize the risk inherent in the market. We can withstand the impact of poor investment markets.

Despite a challenging year for investors, OPERS has the largest health care fund in the U.S. with a balance of $11.5 billion as of December 31, 2015.

# Funding Retiree Health Care

As adopted in 2012, the revised OPERS health care program includes new eligibility requirements, modifications to allowance allocations and new delivery models aimed at maintaining a solvent health care fund. The features of the new health care program are showing measurable results. Employer contributions and investment returns are the two main sources of health care funding and are designed to support long-range funding stability. OPERS employer contributions provide a more predictable flow of funding while a conservative investment philosophy for the health care fund provides less risk and allows for more accurate forecasting of returns.

### Employer contributions

OPERS has the discretion to set the percentage of employer contributions allocated to the health care fund each year. With the pension fund meeting the statutory requirement of a 30-year amortization period, employer contributions allocated to the health care fund can begin to move toward the funding goal of 4%. One of the essential keys to using the employer contribution rate was the pension reform changes. Without these changes, the employer contribution rate would not have been available to fund health care. In 2015, 2% of Traditional Pension Plan and Combined Plan employer contributions were allocated to fund retiree health care. After review of the pension funding status, OPERS will evaluate opportunities to increase health care funding with the goal of moving toward a full 4% allocation.

### Investment returns on the health care portfolios

Since 1974, OPERS has been pre-funding health care for its retirees, providing health care plans and paying a large portion of monthly premiums. The 401(h) Health Care Trust portfolio returned a loss of 2.18%, or (2.18%), in 2015 and the 115 Health Care Trust portfolio returned a loss of 3.23%, or (3.23%). Total combined health care net assets were $11.5 billion as of December 31, 2015.

### 401(h) Health Care Trust

The 401(h) Health Care Trust, established under Section 401(h) of the Internal Revenue Code (IRC), provides coverage to eligible OPERS retirees. This trust is pre-funded and holds the portion of employer contributions from the Traditional Pension and Combined plans that are set aside for funding retiree health care. While the 401(h) trust is used to fund health care expenses, employer contributions to this trust ceased in September 2014 upon the establishment of the 115 Health Care Trust. Beginning in 2016, the 401(h) Health Care Trust will be consolidated into the 115 Health Care Trust.



### 115 Health Care Trust

The 115 Health Care Trust, established under Section 115 of the IRC, provides health care in much the same manner as the 401(h) Health Care Trust and similarly, will be for the benefit of members of the Traditional Pension and Combined plans. On January 1, 2016, OPERS launched the OPERS Medicare Connector. The 115 Health Care Trust was added as a vehicle to accommodate such reimbursement mechanisms as the Health Reimbursement Arrangement Plan (HRA). Employer contributions to this trust began in September 2014, with the initial health care disbursements from this trust commencing with January 2016 premium reimbursements. Currently, OPERS uses both the 401(h) and the 115 trusts to fund health care expenses for eligible retirees and their dependents of the Traditional Pension and Combined plans.

### Voluntary Employees' Beneficiary Association Trust

Member-Directed Plan participants are provided with a retiree medical account (RMA). The funding vehicle of the RMA is a Voluntary Employees' Beneficiary Association Trust (VEBA Trust) established under Section 501(c)(9) of the IRC. The VEBA Trust holds the portion of employer contributions of the Member-Directed Plan that are set aside for funding retiree health care.

Upon separation or retirement, the participant may use the vested funds in his/her RMA for qualified health care expenses. Vesting requirements for the RMA have changed over the life of the plan. The RMA originally required 10 years of participation to fully vest in the contributions and interest earned on the account. Effective January 1, 2009, contributions and interest vested with the participant over a five-year period. Effective July 1, 2015, new participants to the RMA are required to participate for 15 years to become fully vested.

### Subsequent event

In March 2016, OPERS received two favorable rulings from the IRS allowing OPERS to consolidate all health care assets into the 115 Health Care Trust. Transition to the new health care trust structure will occur during 2016. The OPERS Combining Statements of Changes in Fiduciary Net Position for the year ended December 31, 2016 will reflect a partial year of activity in the 401(h) Health Care Trust and VEBA Trust prior to the termination of these trusts and the assets and liabilities, or net position, of these trusts being consolidated into the 115 Health Care Trust.

### Sources of income

Additions to the Health Care Trusts are comprised primarily of employer contributions and investment returns. Retiree-paid health care premiums, federal subsidies and vendor rebates provide additional funding support for the health care trusts. Retiree-paid health care premiums are the portion of plan premiums paid by a retiree and dependents for health care coverage. Federal subsidies include funds provided by the federal government for participation in programs like Retiree Drug Subsidy, Medicare Part D rebates and previous programs like the Early Retiree Reinsurance Program.

# Future Challenges and Opportunities

### Addressing changing demographics

Retirees are living longer than ever before and our retiree population is growing at the fastest rate in the System's history. In response, OPERS has developed a strategic plan to help us prepare for an estimated retiree population increase of 40% in the next 10 years.

### Promoting chronic disease prevention and management

The prevalence of preventable chronic conditions among OPERS health care participants supports the continued need for wellness efforts aimed at preventing the onset of and complications associated with chronic conditions such as diabetes and heart disease.

### Medical Homes

OPERS continues to support the availability of Medical Homes for retirees through plan design and participant education. The model promotes improvements in how care is delivered and paid for, recognizing the importance of coordinated care and performance-based reimbursements. The model is showing promise of yielding improved clinical quality, a better overall patient experience, and lower health care costs.

OPERS continues to educate retirees on the value of Medical Homes and encourage their utilization of recognized Medical Homes via newsletters and other communication vehicles. These efforts are coupled with a plan design that offers reduced office visit copay to non-Medicare enrollees when care is provided by a Medical Home. In 2015, the number of OPERS participants who took advantage of the innovative primary care model continued to grow. In 2015, more than 10,500, or 14.7%, of OPERS' non-Medicare participants residing in Ohio sought care from a Medical Home. This is an increase from 12.6% in 2014.

### Value-based insurance design (VBID)

In light of rising health care costs, many plan sponsors across the country are focusing on the quality of health care coverage more than ever before. In addition, it is also important to ensure that plan participants have easy access to provider care.

In 2015, OPERS continued to offer important VBID features to maximize the value of our health care fund and support participants' efforts to improve their health and quality of life.

### Aligning active employee and retiree health and wellness efforts

Recognizing that current active employees will become future OPERS retirees, a significant opportunity exists to promote the health of current active employees by aligning OPERS' wellness initiatives with those undertaken by Ohio's public employers. In support of this effort, we held an OPERS employer forum where we collaborated with public employers to determine best wellness practices and better align programs between public employers and the OPERS retiree health plans.

### Helping retirees to take charge of their own health

Anticipated transformations in care delivery and payment methods create a unique opportunity to assist our participants in taking an active role in their personal health and health care decision making. For example, OPERS implemented coverage maximums for our medical plan for non-Medicare participants. A coverage maximum is the highest amount the plan will pay for a given laboratory test. Effective January 1, 2016, we applied coverage maximums to 40 lab tests. Retirees can minimize out-of-pocket costs by using Medical Mutual's online tool, MyCareCompare, to search for lab providers whose charges are less than the coverage maximum.

### New generics to the marketplace

OPERS' traditional drug trend and overall drug trend were positively influenced by continued growth in the use of generic drugs by participants. In 2015, 90.1% of prescriptions filled for OPERS participants were filled using generic drugs. We saved $32 million in 2015 due to increased generic drug utilization. The increase can be attributed to new generic drugs becoming available in the market, OPERS communications efforts and OPERS value-based insurance design programs.

### OPERS biosimilar and generic drug efforts

OPERS, along with partners such as the Public Sector Healthcare Roundtable and Generic Pharmaceutical Association, engaged the U.S. Food and Drug Administration (FDA), the U.S. Department of Health and Human Services (HHS) and legislators on the importance of biosimilar and generic drug competition. OPERS will continue these efforts in 2016.

Additionally, on March 6, 2015, the FDA approved the first biosimilar drug, Zarxio, produced by Sandoz. Zarxio is used to help prevent infections in cancer patients receiving chemotherapy.

### Complying with new accounting compliance standards

In 2015, GASB approved reporting standards to change how other post-employment benefits (or OPEB), such as health care, will be reported. These new standards will require the System to allocate the health care unfunded liability, or net OPEB liability, to all contributing employers, very similar to the pension standards. OPERS has been preparing to implement these new standards and to assist all employers with the implementation in a manner similar to the pension standards.

### Cadillac tax delayed until 2020

OPERS advocated in Washington for a repeal or an exemption from the excise tax, or "Cadillac tax," that was included as part of the Affordable Care Act. The Cadillac tax would be assessed to health care plan providers when their coverage value exceeds certain thresholds. For OPERS, the excise tax could have had a significant impact starting in 2018 if the group plan design was not modified to reduce its total cost.

The excise tax was scheduled to take effect in 2018. The enactment of the tax is delayed until 2020 as part of an omnibus budget bill (Consolidated Appropriations Act, 2016) introduced by Congress and signed into law by President Obama on December 18, 2015. While a delay is helpful, OPERS staff will continue their advocacy efforts for a full repeal of the excise tax or, alternatively, an exemption for public retirement systems from the tax. Absent that additional plan design, reductions will need to occur to avoid hitting the tax in 2020.

# Statutory Requirements

The OPERS Board of Trustees (Board) shall have prepared annually a report giving a full accounting of the revenues and costs relating to the provision of health coverage under Sections 145.325 and 145.58 of the Ohio Revised Code (ORC). The report shall be made as of December 31, 1997 and the thirty-first day of December of each year thereafter.

The following information fulfills the requirements of OPERS as outlined in ORC Section 145.22(E). The requirements and the System's responses follow:

### 1 A description of the statutory authority for the benefits provided

Appendixes B and C are copies of ORC Section 145.58 (Group hospitalization coverage; ineligible individuals; service credit; alternate use of HMO) and ORC Section 145.584 (Medicare-equivalent benefits for members ineligible for Medicare), as they existed during the majority of 2015. Both sections were amended by Substitute Senate Bill (Sub. S.B.) 343, effective January 7, 2013.

### 2 A summary of coverage for 2015

The following is an outline of OPERS health care coverage in 2015:

#### The 2015 OPERS Retiree Health Plan for non-Medicare participants

The 2015 OPERS health care plan administrator, Medical Mutual, utilized a Preferred Provider Organization (PPO) for our non-Medicare benefit recipients. PPO networks are based on a partnership between doctors, hospitals, health plan administrators and participants. Doctors and medical facilities that belong to the PPO network agree to perform services at discounted rates. Therefore, through plan design and education, OPERS encouraged the use of these providers. While participants were able to choose any provider and still receive coverage, they received a higher level of reimbursement if they chose network providers of service. All states in the U.S. were within the PPO network. Participants living outside of the U.S. were able to choose any provider of services (regardless of Medicare status) without a decrease in coverage.

#### The Humana Medicare Advantage Plan

The Humana Medicare Advantage Plan continued to be offered to Medicare-eligible participants in 2015. A Medicare Advantage Plan is a plan offered by an insurer that contracts with Medicare to provide plan participants with all Medicare Part A and Part B benefits. To be eligible, participants must have Medicare Part B and must continue to pay Part B premiums.

Humana offers plan participants care management programs not always available with other administrators, including: access to the Silver Sneakers program, personal health programs and wellness coaching, disease management programs, case management (help with home health care and equipment), and transition of care services.

**Prescription drug coverage –** Retirees enrolled in the OPERS Retiree Health Care Plan (Medical Mutual) or the Humana Medicare Advantage Plan receive prescription drug coverage through Express Scripts.

**OPERS Non-Medicare prescription drug coverage –** In 2015, plan participants could receive up to a 30-day supply of medication, plus refills, as prescribed by their physician at a retail pharmacy. Plan participants could receive up to a 90-day supply of medication, plus refills, as prescribed by their physician, through the Express Scripts home delivery program. Cost-share for prescriptions differs based on the delivery method, whether a drug is a generic or a name brand and its formulary status. In 2015, Medication Therapy Management continues to be available for eligible participants.

**OPERS Medicare Part D prescription drug coverage –** In 2015, OPERS continued to offer a Medicare Part D Prescription Drug Plan to Medicare-eligible enrollees. The Medicare Part D Plan provided retirees with a number of enhancements including Medication Therapy Management for eligible participants and coverage for medications adjudicated in the "donut hole."

### Medicare

The following requirements regarding Medicare were in effect for 2015:

- If an OPERS health care participant was eligible for Medicare Part A (hospital) at no cost, OPERS required enrollment in Medicare coverage (if covered by OPERS health care). If Medicare Part A was not available to the participant without cost, OPERS provided comparable substitute coverage.
- Participants who turned age 65, or who qualify for Medicare prior to age 65 (and who are enrolled in OPERS health care), were also required to enroll in Medicare Part B (medical).
- When a participant or covered spouse reached the age of 65, OPERS requested a copy of the Medicare card. If the covered individual was not eligible for free Medicare Part A, OPERS requested a copy of his or her card showing Part B coverage or a letter from Social Security stating there would be a charge assessed for Medicare Part A.

### Medicare Part B reimbursement

If an OPERS retiree was enrolled in OPERS health care, and was not being reimbursed from another source for his or her Medicare Part B premium, he or she was eligible for OPERS reimbursement of a portion of the Medicare B premium. In order to receive this reimbursement, the retiree was required to send a copy of his or her Medicare card, showing enrollment in Part B. As long as the participant remained enrolled in Part B coverage, the allowable reimbursement was added to the recipient's monthly retirement check. Enrolled spouses are not eligible for this reimbursement. As part of program changes approved by the Board in 2012, the Medicare Part B reimbursement is being phased-out over a three-year period with the final reduction next year, resulting in no reimbursements beginning January 1, 2017.

### The dental plan

During 2015, voluntary dental coverage was made available to all OPERS retirees, and their eligible dependents, regardless of their participation in OPERS health care. The dental plan, administered by MetLife, was intended to help defray the costs of dental care, including oral examinations, diagnostic services, and extractions, as well as crowns, bridges, and dentures. If a retiree chose to be covered under the dental plan, a premium payment was deducted from each monthly benefit check. OPERS does not subsidize this plan.

### The vision plan

Voluntary vision coverage was offered to all OPERS retirees, and their eligible dependents, regardless of their participation in OPERS health care. The vision plan, administered by Aetna, covers services provided by ophthalmologists, optometrists, or opticians for examinations, frames, and lenses. A premium payment was deducted from each monthly benefit check for those recipients who chose to participate. OPERS does not subsidize this plan.

### 3 A summary of the eligibility requirements for health care coverage in 2015:

Listed here are the eligibility requirements for OPERS health care plans funded through the 401(h) Health Care Trust and the 115 Health Care Trust.

#### Age-and-Service retirement

All OPERS members are in one of three retirement groups: Group A, Group B or Group C. The group determines when members are eligible to retire and how retirement benefits will be calculated. The group also affects when members will be eligible for health care coverage through OPERS.

When applying for age-and-service retirement with an effective date of January 1, 2015 or later, a benefit recipient must have attained age 60 and have 20 years of qualifying health care service credit or have 30 years of qualifying health care service credit at any age under Group A, 31 years at any age under Group B, and 32 years at any age under Group C to be eligible for OPERS retiree health care. Out-of-state or certain military service purchased after January 29, 1981; service credit granted under a retirement incentive plan; or exempt service purchased after May 4, 1992, are examples of service credit that do not count toward health care eligibility.

In September 2014, OPERS limited the types of service credit counted toward health care eligibility to the following for those with a benefit effective date of January 1, 2014 and beyond:

- Contributing service
- Service transfers from other Ohio retirement systems
- Service purchased under USERRA (military service that interrupts public service)
- Restored service credit
- Unreported service

In order for service credit other than these types to count toward health care eligibility, the retirement effective date must be on or before December 1, 2013. Once a retiree voluntarily withdraws from OPERS health care on or after January 1, 2014, he or she cannot re-enroll absent proof of creditable coverage or a recent involuntary termination under another plan.

Beginning January 1, 2014, contributing service credit for health care will be accumulated only if the member's eligible salary is at least $1,000 per month. Partial health care credit will not be granted for months in which eligible salary is less than $1,000. Credit earned prior to January 2014 will not be affected by this requirement.

#### Disability retirement

Recipients of disability benefits prior to January 1, 2014 have continued access to health care coverage while the disability benefit continues and will not be subject to the five-year rule described below. The allowance will be determined in the same way as an age-and-service retiree. If the recipient does not meet minimum age-and-service requirements, the minimum allowance will be used. Recipients with an initial disability effective date on or after January 1, 2014, will have coverage during the first five years of disability benefits. After five years, the recipient must meet minimum age-and-service health care eligibility requirements or be enrolled in Medicare due to disability status to remain enrolled in OPERS health care. If enrolled, the allowance will be determined in the same way as an age-and-service retiree.

## Coverage for surviving spouses

**For survivor benefit effective dates prior to January 1, 2015 –** If a member retired, chose a joint and survivor annuity plan of payment (Plan A, C, D or F) and died, the surviving spouse was entitled to health care coverage if the deceased retiree was eligible.

If a member dies before retirement, health care coverage may be available to his or her survivors receiving monthly benefits regardless of the member's years of service credit.

**For survivor benefit effective dates January 1, 2015 or after –** If a member retired, chose a joint and survivor annuity plan of payment (Plan A, C, D or F) and died, the surviving spouse was entitled to health care coverage if the deceased retiree met the OPERS health care eligibility requirements.

If a member dies before retirement, health care coverage may be available to his or her survivors receiving monthly benefits if the deceased retiree met the OPERS health care eligibility requirements of age 60 and with 20 years of qualifying health care service credit or 30 years of qualifying health care service credit at any age under Group A, 31 years at any age under Group B, and 32 years at any age under Group C.

## 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.

OPERS does not subsidize the monthly health care premium costs for spouses under the age of 55.

- This rule does not apply to children, spouses of disability recipients, spouses with early Medicare or any spouse who is receiving a benefit as the surviving spouse of an age-and-service retiree (joint and survivor annuity) or as the surviving spouse of a deceased working member (receiving a survivor benefit).

- A spouse under age 55 may participate in the plan; however, the retiree is responsible for the full health care premium.

- The month the enrolled spouse reaches age 55, OPERS will then subsidize a portion of his or her health care premium.

Their child(ren)—This must be a biological or legally adopted child or minor grandchild if the grandchild is born to an unmarried, unemancipated minor child and they are ordered by the court to provide coverage pursuant to Ohio Revised Code Section 3109.19.

In order 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.

Participants in OPERS health care receiving a monthly benefit as the surviving spouse or beneficiary of a deceased retiree or deceased member may only enroll those dependents that would have been eligible dependents of the deceased retiree or member as defined on this page.

It is the retiree's responsibility to notify OPERS, in writing, within 30 days of the date his or her dependent fails to meet eligibility requirements. Failure to notify OPERS could result in overpaid health care claims for which the retiree will be responsible.

## Coverage options

In 2015, OPERS provided monthly allowances for health care coverage for retirees and their eligible dependents, both over and under the age of 65, based on the retiree's Medicare status. For those retiring on or after January 1, 2015, the allowance (subsidy) provided by OPERS will be based on age and years of qualifying service credit when a recipient first enrolls in OPERS health care. At the completion of a three-year transition that ends in 2018, monthly allowances will range between 51% and 90% of the full monthly premium and the same allowance table will be used for all retirees. Those who retired prior to January 1, 2015, with an allowance at or above 75%, will not have an allowance below 75%. Members retiring at any age with 30 (based on retirement group) or more years of qualifying service will have at least a 71% allowance.

In 2015, OPERS offered medical and pharmacy plans for recipients yet to enroll in Medicare and those already enrolled in Medicare, typically at age 65. Monthly allowances are used to offset the monthly premium for the coverage provided. The plan for participants who are enrolled in Medicare is a fully insured group Medicare Advantage plan and includes pharmacy coverage through a Medicare Part D prescription drug plan. OPERS self-insures the medical coverage for participants who are not eligible for Medicare and for pharmacy costs regardless of the retiree's age.

Beginning in 2016, OPERS will cease offering the group plan for medical and pharmacy to Medicare-eligible retirees. Instead, their allowance will be deposited to an HRA and may be used to reimburse the cost of coverage selected through the OPERS Medicare Connector (Connector). The Connector is a relationship with a vendor selected by OPERS and tasked with assisting retirees, spouses and dependents with selecting a medical and pharmacy plan. OPERS introduced the Connector in 2015, with an effective date of January 1, 2016, for Traditional Pension and Combined plan retirees enrolled in Medicare Parts A and B. OPERS will continue offering a medical plan and prescription drug plan for non-Medicare participants.

Over a three-year period beginning in 2015, spouses will transition from their current monthly allowance to zero. Spouses under age 65 will have access to OPERS coverage at full cost through at least 2020. Spouses over age 65 will have access to the Connector beginning in 2016. Spouses of deceased members will no longer assume the retiree's health care allowance. If the retiree has at least 20 years of qualifying service and is enrolled in OPERS health care, children (up to age 26) will receive half of the retiree's allowance percentage. If the recipient has less than 20 years of qualifying service, children (up to age 26) will transition from the current allowance to zero over three years (2015-2017) but will have access to OPERS coverage at the full cost through at least 2020.



### Voluntary Employees' Beneficiary Association Trust (VEBA Trust)

Member-Directed Plan participants are provided with a retiree medical account (RMA). The funding vehicle of the RMA is a VEBA Trust established under Section 501(c)(9) of the IRC. The VEBA Trust holds the portion of employer contributions of the Member-Directed Plan that are set aside for funding retiree health care. Upon separation or retirement, the participant may use the vested funds in his RMA for qualified health care expenses.

### 4 A statement of the number of participants eligible for the benefits

As of December 31, 2015, there were 189,826 OPERS retirees eligible to participate in OPERS health care.

### 5 A description of the accounting, asset valuation and funding method used to provide the benefits

OPERS financial statements are prepared using an accrual basis of accounting under which deductions are recorded when the liability is incurred and revenues are recognized when earned. Under this method, OPERS estimates health care claims which have been incurred at year end, but which have not yet been reported to the System as of fiscal year end. Health care reimbursements are recognized when they become measurable and due to OPERS based on contractual requirements. Therefore, health care reimbursements contain estimates based on information received from health care vendors and other sources. Investment purchases and sales are recorded as of their trade date.

Investments are reported at fair value. Fair value is the amount that the System can reasonably expect to receive for an investment in a current sale between a willing buyer and a willing seller, that is, other than in a forced or liquidation sale. All investments, with the exception of real estate, private equity and hedge funds, are valued based on closing market prices or broker quotes. Securities not having a quoted market price have been valued based on yields currently available on comparable securities of issuers with similar credit ratings. The fair value of real estate investments is based on estimated current values and independent appraisals. The fair value of private equity is based on management's valuation of estimates and assumptions from information and representations provided by the respective general partners, in the absence of readily ascertainable market values.

While OPERS total pension portfolio included investments in real estate and private equity, the 401(h) Health Care Trust portfolio and the 115 Health Care Trust portfolio were not invested in real estate and private equity as of December 31, 2015. The fair value of hedge funds is based on a net asset value, which is struck by the fund or by the fund's third party administrator.

Employer contributions and investment earnings are used to fund health care expenses. Employer contributions equal to 2% of covered payroll were credited to the 115 Health Care Trust for the period of January 1, 2015 through December 31, 2015. Retiree-paid health care premiums (amounts paid by retirees towards the cost of OPERS-provided health care for the retiree, their spouse and dependents), federal subsidies, contract and other receipts, and other miscellaneous income comprise the balance of health care additions.

OPERS has consistently prefunded health care through a trust established under Section 401(h) of the Internal Revenue Code (IRC). However, in 2014, OPERS established the 115 Health Care Trust (115 Trust) under Section 115 of the IRC. This trust will fund health care in much the same manner as the 401(h) Health Care Trust and similarly, will be for the benefit of members of the Traditional Pension and Combined plans. On January 1, 2016, OPERS launched the Connector, a program whereby enrolled retirees over the age of 65 will have an allowance deposited to a health reimbursement arrangement (HRA) account to apply towards the health care program of their choice selected with the assistance of an OPERS vendor. As OPERS prepared to change the manner of funding health care for Medicare-eligible retirees, OPERS needed a vehicle, like the 115 Trust, that could accommodate such reimbursement mechanisms as the HRA. Employer contributions to the 115 Trust began in September 2014 with the initial health care disbursements from this trust commencing with January 2016 premium reimbursements.

The funded status of the 401(h) Health Care Trust as of December 31, 2014, the most recent actuarial valuation, was 62.2%. There is no actuarial accrued liability for the 115 Health Care Trust as of December 31, 2014. Participants in the Connector were eligible for allocations beginning January 1, 2016. Therefore, the covered lives were already included in the health care actuarial valuation as of December 31, 2014. The funding progress of health care is measured in terms of solvency years, or the number of years that funds are projected to be available to pay health care expenses under the current plan design before health care would be reduced to a pay-as-you-go basis. Health care is solvent for an indefinite period under actuarial terms as of the December 31, 2014 valuation. An indefinite solvency period indicates that health care assets are expected to be sufficient to fund future health care needs.

**6 A statement of the fiduciary net position (or net assets) available for the provision of the coverage as of the last day of the fiscal year.**

Please see Appendix D, “Statements of Fiduciary Net Position—Health Care”.

**7 A statement of any changes in the net position (or net assets) available for the provision of health care coverage, including participant and employer contributions, net investment income, administrative expenses, and benefits provided to participants, as of the last day of the fiscal year.**

Please see Appendix E, “Statements of Changes in Fiduciary Net Position - Health Care”.

**8 For the last six consecutive fiscal years, a schedule of the net position available for health care coverage, the annual cost of health care, administrative expenses incurred, and annual employer contributions allocated for the provision of coverage.**

Please see Appendix E, “Statements of Changes in Fiduciary Net Position - Health Care”.



### 9 A description of any significant changes that affect the comparability of the report required under this division.

In 2014, OPERS established the 115 Health Care Trust under Section 115 of the IRC. This trust will provide funding for health care in much the same manner as the 401(h) Health Care Trust and similarly, will be for the benefit of members of the Traditional Pension and Combined plans. On January 1, 2016, OPERS launched the Connector, a program whereby enrolled retirees over the age of 65 have an allowance allocated to a health reimbursement arrangement (HRA) to apply toward the health care program of their choice selected with the assistance of an OPERS vendor. As OPERS prepared to change the manner of funding health care for Medicare-eligible retirees, OPERS added a vehicle, like the 115 Health Care Trust, that could accommodate such reimbursement mechanisms as the HRA. Thus, OPERS will use both the 401(h) and the 115 trusts to fund health care expenses. Employer contributions to the 115 Health Care Trust began in September 2014 with the initial health care disbursements from this trust commencing with January 2016 premium reimbursements.

In March 2016, OPERS received two favorable rulings from the Internal Revenue Service allowing OPERS to consolidate all health care assets into the 115 Health Care Trust. Transition to the new health care trust structure will occur during 2016. The OPERS Combining Statements of Changes in Fiduciary Net Position for the year ending December 31, 2016 will reflect a partial year of activity in the 401(h) Health Care Trust and VEBA Trust prior to the termination of these trusts and the assets and liabilities, or net position, of these trusts being consolidated into the 115 Health Care Trust.

### 10 A statement of the amount paid under division (C) of section 145.58 of the Revised Code.

OPERS paid approximately $77.9 million in Medicare Part B premiums to its benefit recipients in 2015.

# **Appendix A**—OPERS' Health Care History

### Prior to 1990

OPERS first offered health care coverage to its retirees in 1962. The plan was not subsidized by the System. The retiree paid the entire premium. In 1974, OPERS established a health care program, began pre-funding health care and began paying premiums for retirees.

OPERS signed an agreement with Kaiser Permanente in 1975, thereby offering its first Health Maintenance Organization (HMO). Through the following years, OPERS offered as many as six alternative plans (HMOs) in a given year, further expanding retirees' options.

Mail order prescription services were first offered in 1981. Using National Rx as a business partner, a 90-day supply could be obtained initially for a $1 co-pay.

In 1986, the five-year service eligibility requirement to qualify for health care coverage under OPERS increased to 10 years.

### 1990—1999

In 1993, OPERS added a second health care administrator, Medical Mutual of Ohio. Health care was switched from a pure indemnity plan to a Preferred Provider Organization (PPO) model.

In 1999, OPERS made significant strides in its attention to preventive services and wellness. Coverage was provided for influenza and pneumonia vaccines, and several enhancements were made to coverage of preventive services and screenings.

### 2000—2005

In 2003, the Choices Plan was introduced, effective for newly hired employees only. Choices introduced a service-based approach to the cost of access to health care coverage upon retirement, replacing the one-size-fits-all 10 year eligibility method. The first comprehensive disease management program was also introduced.

In 2004, OPERS began using formulary/non-formulary co-pays in its drug plan to help retirees better manage their prescription medication costs and save OPERS money as well.

Dependent eligibility definitions became more restrictive in 2005. Over-the-counter medicines, non-sedating antihistamines and other medications were eliminated from coverage.

### 2006—2012

In 2006, the emergency room co-pay was increased to $75. The hospital admission deductible was introduced and our subsidy of dental and vision coverage was reduced by half and subsequently eliminated. OPERS' partnership with the Ohio QuitLine smoking cessation program was established.

In 2007, the Health Care Preservation Plan was implemented, establishing three groups of retirees, each with eligibility standards based on length of service and start date. The program added two additional plan tiers or options for health care coverage. Retirees received a monthly health care allowance to be applied toward their selection of one of the three medical/prescription plan offerings and optional dental and vision coverage.

In April 2007, the OPERS Board of Trustees (Board) approved increasing our target solvency period to be consistent with the principles of the Health Care Preservation Plan.

## Appendix A—OPERS' Health Care History

In January 2008, OPERS began offering the Aetna Medicare Open Plan to Medicare-eligible retirees and their covered, Medicare-eligible spouses.

In April 2008, Express Scripts, Inc. began serving as the benefit recipients' pharmacy benefit manager (PBM).

In 2009, OPERS implemented Senate Bill 267, which took effect on March 24, 2009. SB 267 established the monthly reimbursement by OPERS for Medicare Part B premiums at an amount that is not less than $96.40, as determined by the Board.

In 2010, Humana began administering the medical portion of OPERS health care for Medicare-eligible retirees. Medical Mutual became the sole administrator for health care participants not yet eligible for Medicare.

The Patient Protection and Affordable Care Act (PPACA), also referred to as health care reform, was signed into law by President Obama in 2010. PPACA contained numerous provisions that impacted OPERS health care. Notably, OPERS added the required preventive care coverage, increased dependent eligibility to age 26 and removed the lifetime maximum.

The OPERS Clinical Quality Improvement Committee (CQIC) began working toward improvements in clinical quality in 2010. The CQIC is comprised of leaders and clinicians from the OPERS Health Care division, OPERS' vendor partners, and consultants.

OPERS implemented legislation that capped the Medicare B reimbursement rate at $96.40 for 2010 and retained this rate for 2011.

In 2011, OPERS began offering a Medicare Part D Prescription Drug Plan to Medicare-eligible enrollees.

OPERS participated in the Early Retirement Reinsurance Program (ERRP), a provision of PPACA. OPERS received approximately $180 million in ERRP reimbursement over the life of the program.

On September 19, 2012, OPERS adopted a set of key changes to current retiree health care designed to keep the program sustainable within available funding. The new plan design adjusted three main levers to achieve optimal savings while minimizing the risk to retirees. Eligibility, participant cost and plan sponsorship are the key components.

Also in 2012, OPERS introduced the concept of Medical Homes (MH).

### 2013

OPERS began implementation of the health care changes approved by the Board in September 2012. In March of 2013, the Board approved delaying certain aspects of these changes, including the eligibility requirements, allowance transition, and the Medicare Connector by one year so OPERS could better communicate and set up internal infrastructure to support these changes.

OPERS began partnering with the Ohio Department of Aging to promote their Chronic Disease Self-Management Programs (Healthy U) to Medical Mutual participants. OPERS saved approximately $40 million in 2013 due to increased generic drug utilization.

In 2013, OPERS moved from three levels of coverage to one for our non-Medicare group medical plan.

# Appendix A—OPERS' Health Care History

## 2014

To plan for the launch of the OPERS Medicare Connector in 2015, OPERS selected OneExchange to assist retirees in finding, evaluating and enrolling in an individual Medicare plan that best fits their needs and lifestyle.

OPERS continued our focus on implementing essential changes to the health care program as approved by the Board in 2012. Several of the key elements of the new health care program came to fruition in 2014. These included changes in qualifying service for health care eligibility, rules regarding voluntary plan termination, Medicare Part A premium reimbursement and health care eligibility for disability recipients. We embarked on an unprecedented communication campaign addressing each facet of the key health care changes with specific communication methods and techniques to ensure the appropriate audience was reached and concerns and issues were addressed.

Also in 2014, OPERS established the 115 Health Care Trust under Section 115 of the Internal Revenue Code. This trust will fund a Health Reimbursement Arrangement Plan (HRA) to Medicare-eligible retirees of the Traditional Pension and Combined plans. In the summer of 2015, with an effective date of January 1, 2016, the administrator of the Connector, OneExchange, partnering with OPERS, began providing education, as well as plan selection and enrollment support, to retirees and dependents enrolled in Medicare Parts A and B. In addition, OneExchange was planned to administer all aspects of the HRA. Retirees will select among multiple, individual Medicare plan options (Medicare Supplement Plans, Medicare Advantage Plans, Medicare Advantage with Prescription Drug Plans, and Part D Drug Plans).

## 2015

2015 marked a key milestone as OPERS implemented the Connector with open enrollment at the end of 2015. Medicare-eligible retirees selected an individual Medicare plan and a prescription drug plan for 2016 coverage. To prepare eligible retirees to select a plan and understand the new HRA, OPERS carried out the most extensive communication and education campaign in our health care history.

In 2015, OPERS developed two new health care plans for retirees re-employed in an OPERS-covered position. These two plans, one for those retirees not yet eligible for Medicare and one for those who are Medicare eligible, were developed, communicated and implemented in 2015.

With the intent to encourage broader use of generic medications, OPERS adopted a high performance formulary putting some additional restrictions on common brand medications.

In accordance with the Affordable Care Act guidance, OPERS reduced the out-of-pocket maximum on its non-Medicare prescription drug plan from $4,550 to $3,250 per year in 2015.

2015 was the first year for new health care eligibility rules. Access to OPERS health care in retirement now requires 20 years of qualifying service at age 60 instead of 10 years with no age requirement. Eligibility is attainable prior to age 60 depending on total years of qualifying service and retirement group status. Over a three-year period beginning in 2015, spouses will transition from their current monthly allowance to zero. Spouses of deceased members will no longer assume the retiree's health care allowance.

Beginning January 1, 2015, Medicare Part B reimbursement is being phased-out over a three-year period resulting in no reimbursements beginning January 1, 2017.

# **Appendix B**—Ohio Revised Code Sec. 145.58

**Group hospitalization coverage; ineligible individuals; service credit; alternative use of HMO**

(A) The public employees retirement board shall adopt rules establishing eligibility for any coverage provided under this section. The rules shall base eligibility on years and types of service credit earned by members. Eligibility determinations shall be made in accordance with the rules, except that an individual who, as a result of making a false statement in an attempt to secure a benefit under this section, is convicted of violating section 2921.13 of the Revised Code is ineligible for coverage.

(B) The board may enter into agreements with insurance companies, health insuring corporations, or government agencies authorized to do business in the state for issuance of a policy or contract of health, medical, hospital, or surgical coverage, or any combination thereof, for eligible individuals receiving age and service retirement, or a disability or survivor benefit subscribing to the plan, or for PERS retirants employed under section 145.38 of the Revised Code, for coverage in accordance with division (D)(2) of section 145.38 of the Revised Code. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children and for any of the eligible individual's sponsored dependents as the board determines appropriate. If all or any portion of the policy or contract premium is to be paid by any individual receiving age and service retirement or a disability or survivor benefit, the individual shall, by written authorization, instruct the board to deduct the premium agreed to be paid by the individual to the company, corporation, or agency.

The board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the public employees retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by sections 145.48 and 145.51 of the Revised Code. The board may by rule provide coverage to individuals who are not eligible under the rules adopted under division (A) of this section if the coverage is provided at no cost to the retirement system. The board shall not pay or reimburse the cost for coverage under this section or section 145.584 of the Revised Code for any such individual.

The board may provide for self-insurance of risk, or level of risk as set forth in the contract with the companies, corporations, or agencies, and may provide through the self-insurance method specific coverage as authorized by rules of the board.

(C) The board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, pay monthly to each recipient of service retirement, or a disability or survivor benefit under the public employees retirement system who is eligible for coverage under part B of the medicare program established under Title XVIII of "The Social Security Act Amendments of 1965," 79 Stat. 301 (1965), 42 U.S.C.A. 1395j, as amended, an amount determined by the board for such coverage, except that the board shall make no such payment to any individual who is not eligible for coverage under the rules adopted under division (A) of this section or pay an amount that exceeds the amount paid by the recipient for the coverage.

## Appendix B— Ohio Revised Code Sec. 145.58

At the request of the board, the recipient shall certify to the retirement system the amount paid by the recipient for coverage described in this division.

(D) The board shall establish by rule requirements for the coordination of any coverage or payment provided under this section or section 145.584 of the Revised Code with any similar coverage or payment made available to the same individual by the Ohio police and fire pension fund, state teachers retirement system, school employees retirement system, or state highway patrol retirement system.

(E) The board shall make all other necessary rules pursuant to the purpose and intent of this section.

# Appendix C—Ohio Revised Code Sec. 145.584

**Medicare-equivalent benefits for members ineligible for Medicare**

(A) Except as otherwise provided in division (B) of this section, the board of the public employees retirement system shall make available to each retirant or disability benefit recipient receiving a monthly allowance or benefit on or after January 1, 1968, who has attained the age of sixty-five years, and who is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program without payment of premiums, one of the following:

(1) Hospital insurance coverage substantially equivalent to the federal hospital insurance benefits, Social Security Amendments of 1965, 79 Stat. 291, 42 U.S.C.A. 1395c, as amended;

(2) An amount, determined by the board, to reimburse the retirant or disability benefit recipient for payment of premiums for federal hospital insurance benefits described in this division, which amount shall not exceed the premiums paid.

This coverage or amount shall also be made available to the spouse, widow, or widower of such retirant or disability benefit recipient provided such spouse, widow, or widower has attained age sixty-five and is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program without payment of premiums. The widow or widower of a retirant or disability benefit recipient shall be eligible for such coverage or amount only if he or she is the recipient of a monthly allowance or benefit from this system. A portion of the cost of the premium or amount for the spouse may be paid from the appropriate funds of the system. The remainder of the cost shall be paid by the recipient of the allowance or benefit.

The cost of such coverage or amount, paid from the funds of the system, shall be included in the employer's rate provided by section 145.48 of the Revised Code. The retirement board is authorized to make all necessary rules pursuant to the purpose and intent of this section, and may contract for such coverage as provided in section 145.58 of the Revised Code.

At the request of the board, the recipient of reimbursement under this section shall certify to the retirement system the premium paid for the federal insurance benefits described in division (A) of this section. Payment of the amount described in division (A)(2) of this section shall begin for the first month that the recipient is participating in both the federal hospital insurance benefits and a health care arrangement offered by the system.

(B) The board need not make the hospital insurance coverage or amount described in division (A) of this section available to any person for whom it is prohibited by section 145.58 of the Revised Code from paying or reimbursing the premium cost of such insurance.

# Appendix D—Statements of Fiduciary Net Position—Health Care

| 401(h) Health Care Trust | 2015 | 2014 | 2013 | 2012 | 2011* | 2010* |
|---|---|---|---|---|---|---|
| **Assets** | | | | | | |
| **Cash and Short-Term Investments** | **$437,888,805** | **$503,893,407** | **$491,371,340** | **$446,851,345** | **$516,841,401** | **$673,728,399** |
| **Receivables** | | | | | | |
| Members and Employers | | 12,096,566 | 19,417,032 | 43,429,976 | 51,989,914 | 62,635,516 |
| Early Retirement Incentive Plan | | 6,062 | 64,600 | 177,884 | 773,991 | 2,183,860 |
| Vendor and Other | 677,725 | 1,309,906 | 147,929,032 | 147,616,824 | 67,535,218 | 133,916,383 |
| Investment Sales Proceeds | 43,193,263 | 64,470,004 | 75,148,940 | 261,962,739 | 185,275,974 | 135,342,122 |
| Accrued Interest and Dividends | 39,359,404 | 47,590,193 | 47,924,681 | 47,650,966 | 49,585,342 | 49,049,361 |
| **Total Receivables** | **83,230,392** | **125,472,731** | **290,484,285** | **500,838,389** | **355,160,439** | **383,127,242** |
| **Investments, at fair value** | | | | | | |
| Fixed Income | 3,733,008,136 | 4,434,483,598 | 4,313,177,166 | 4,731,050,357 | 4,349,713,914 | 4,355,743,585 |
| Domestic Equities | 2,969,522,823 | 3,296,381,497 | 3,594,242,223 | 3,293,138,146 | 3,642,820,108 | 3,950,499,244 |
| Private Equity | | | 110,263,964 | 73,443,686 | 54,927,514 | 27,877,976 |
| International Equities | 2,221,451,642 | 2,661,469,316 | 3,333,565,455 | 3,506,799,272 | 3,310,599,792 | 3,649,437,854 |
| Other Investments | 1,390,445,167 | 1,615,807,236 | 1,159,221,629 | 563,094,682 | 134,339,269 | 27,740,509 |
| **Total Investments** | **10,314,427,768** | **12,008,141,647** | **12,510,470,437** | **12,167,526,143** | **11,492,400,597** | **12,011,299,168** |
| **Collateral on Loaned Securities** | | | | | | **1,517,578,594** |
| **Capital Assets** | | | | | | |
| Land | 916,220 | 916,220 | 729,981 | 729,981 | 665,394 | 665,394 |
| Building and Building Improvements | 27,256,121 | 27,261,277 | 21,476,205 | 21,737,564 | 19,627,154 | 19,641,200 |
| Furniture and Equipment | 29,358,536 | 28,536,399 | 26,907,290 | 24,688,709 | 24,809,991 | 22,850,746 |
| Total Capital Assets | 57,530,877 | 56,713,896 | 49,113,476 | 47,156,254 | 45,102,539 | 43,157,340 |
| Accumulated Depreciation | (30,510,198) | (28,082,475) | (24,246,817) | (20,530,484) | (18,156,668) | (16,294,444) |
| **Net Capital Assets** | **27,020,679** | **28,631,421** | **24,866,659** | **26,625,770** | **26,945,871** | **26,862,896** |
| **TOTAL ASSETS** | **10,862,567,644** | **12,666,139,206** | **13,317,192,721** | **13,141,841,647** | **12,391,348,308** | **14,612,596,299** |
| **Liabilities** | | | | | | |
| Undistributed Deposits | 243,005 | 183,002 | 146,606 | 69,659 | 62,273 | 80,073 |
| Benefits Payable | 91,451,759 | 99,279,185 | 90,019,865 | 100,495,333 | 118,529,285 | 142,952,643 |
| Investment Commitments Payable | 76,923,764 | 113,120,724 | 99,797,215 | 194,165,994 | 294,572,622 | 253,257,695 |
| Accounts Payable Wellness RMA Claims | 22,880,935 | 13,033,505 | 15,544,228 | 18,485,339 | 19,183,817 | 16,114,872 |
| Obligations Under Securities Lending | | | | | | 1,517,578,594 |
| **TOTAL LIABILITIES** | **191,499,463** | **225,616,416** | **205,507,914** | **313,216,325** | **432,347,997** | **1,929,983,877** |
| **Net Position Held in Trust for Post-employment Health Care, as Restated** | **$10,671,068,181** | **$12,440,522,790** | **$13,111,684,807** | **$12,828,625,322** | **$11,959,000,311** | **$12,682,612,422** |

**Source: 2010 through 2015 Comprehensive Annual Financial Reports**

*Net Position by Plan was restated to correct the allocation of investment income as of December 31, 2010, with the restatement rolled forward through 2011 and 2012. The adjustment is reflected in the Cash and Short-Term Investments line and has no impact on the total net position of the System.

## Appendix D—Statements of Fiduciary Net Position—Health Care

| 115 Health Care Trust* | 2015 | 2014 |
|---|---|---|
| **Assets** | | |
| **Cash and Short-Term Investments** | **$228,930,728** | **$7,797,254** |
| | | |
| **Receivables** | | |
| Employers | 31,146,407 | 20,597,780 |
| Vendor and Other | 140,747,042 | 175,326,214 |
| Investment Sales Proceeds | 744,048 | 988,589 |
| Accrued Interest and Dividends | 1,246,089 | 728,607 |
| **Total Receivables** | **173,883,586** | **197,641,190** |
| | | |
| **Investments, at fair value** | | |
| Fixed Income | 296,365,386 | 66,380,103 |
| Domestic Equities | 82,245,096 | 50,172,724 |
| International Equities | 58,142,626 | 41,687,272 |
| Other Investments | 48,222,156 | 24,508,856 |
| **Total Investments** | **484,975,264** | **182,748,955** |
| | | |
| **Capital Assets** | | |
| Furniture and Equipment | 1,441,984 | |
| Total Capital Assets | 1,441,984 | |
| Accumulated Depreciation | | |
| **Net Capital Assets** | **1,441,984** | |
| **TOTAL ASSETS** | **889,231,562** | **388,187,399** |
| | | |
| **Liabilities** | | |
| Undistributed Deposits | 10,021 | |
| Benefits Payable | 1,634,811 | |
| Investment Commitments Payable | 1,789,658 | 1,803,774 |
| Accounts Payable and Other Liabilities | 480,036 | 303,453 |
| Accounts Payable HRA Claims | 44,204,996 | |
| **TOTAL LIABILITIES** | **48,119,522** | **2,107,227** |
| | | |
| **Net Position Held in Trust for Post-employment Health Care** | **$841,112,040** | **$386,080,172** |

**Source: 2014 and 2015 Comprehensive Annual Financial Reports**
*The 115 Health Care Trust was established in 2014.

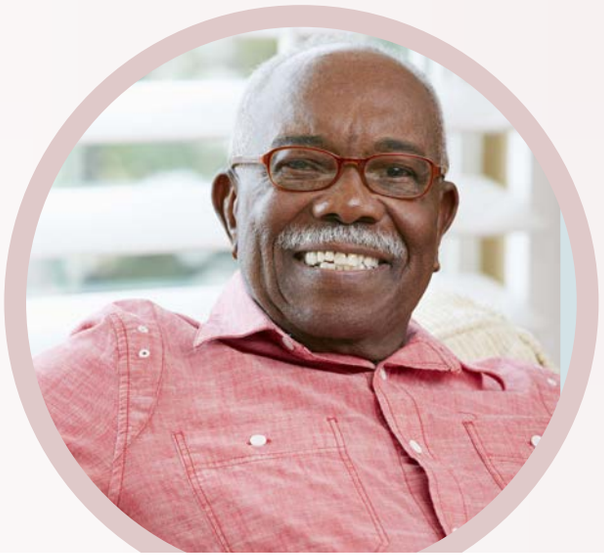
# Appendix D—Statements of Fiduciary Net Position—Health Care

| Voluntary Employees' Beneficiary Association Trust | 2015 | 2014 | 2013 | 2012 | 2011* | 2010* |
|---|---|---|---|---|---|---|
| **Assets** | | | | | | |
| **Cash and Short-Term Investments** | **$4,675,584** | **$4,148,957** | **$5,707,117** | **$2,355,351** | **$1,838,812** | **$3,628,331** |
| **Receivables** | | | | | | |
| Members and Employers | 13,932,389 | 11,647,166 | 7,953,038 | 1,573,325 | 1,717,956 | 1,387,638 |
| Investment Sales Proceeds | 532,305 | 628,545 | 610,262 | 2,104,651 | 997,981 | 680,236 |
| Accrued Interest and Dividends | 437,722 | 465,050 | 405,596 | 361,199 | 288,278 | 253,839 |
| **Total Receivables** | **14,902,416** | **12,740,761** | **8,968,896** | **4,039,175** | **3,004,215** | **2,321,713** |
| **Investments, at fair value** | | | | | | |
| Fixed Income | 37,189,326 | 38,408,780 | 33,339,330 | 31,937,847 | 24,133,945 | 16,517,502 |
| Domestic Equities | 27,429,090 | 28,230,500 | 28,196,827 | 23,579,831 | 22,849,059 | 24,022,054 |
| Real Estate | 17,627,759 | 16,410,600 | 14,791,023 | 12,281,837 | 8,891,222 | 6,414,385 |
| Private Equity | 19,309,205 | 19,895,505 | 15,746,087 | 12,285,901 | 7,717,274 | 4,198,886 |
| International Equities | 28,135,488 | 31,447,388 | 32,934,729 | 28,205,829 | 22,672,643 | 20,634,299 |
| Other Investments | 23,392,047 | 24,639,714 | 13,488,024 | 5,687,375 | 1,208,097 | 113,493 |
| **Total Investments** | **153,082,915** | **159,032,487** | **138,496,020** | **113,978,620** | **87,472,240** | **71,900,619** |
| **Collateral on Loaned Securities** | **18,887,694** | **17,067,184** | **13,199,734** | **10,986,106** | **13,766,599** | **8,332,987** |
| **Capital Assets** | | | | | | |
| Land | 26,508 | 26,508 | 19,731 | 19,731 | | |
| Building and Building Improvements | 788,568 | 788,717 | 617,485 | 587,546 | | |
| Furniture and Equipment | 2,196,905 | 2,171,989 | 2,148,108 | 2,020,876 | 1,800,555 | 1,747,573 |
| Total Capital Assets | 3,011,981 | 2,987,214 | 2,785,324 | 2,628,153 | 1,800,555 | 1,747,573 |
| Accumulated Depreciation | (2,180,336) | (2,101,775) | (1,989,331) | (1,767,867) | (1,736,914) | (1,709,801) |
| **Net Capital Assets** | **831,645** | **885,439** | **795,993** | **860,286** | **63,641** | **37,772** |
| **TOTAL ASSETS** | **192,380,254** | **193,874,828** | **167,167,760** | **132,219,538** | **106,145,507** | **86,221,422** |
| **Liabilities** | | | | | | |
| Benefits Payable | 208,449 | 254,216 | 16,688 | 11,171 | 422 | 9,320 |
| Investment Commitments Payable | 843,360 | 1,017,665 | 876,994 | 1,623,282 | 1,670,566 | 1,135,244 |
| Due to Other Plans | 5,992,744 | | | | | 121,798 |
| Obligations Under Securities Lending | 18,888,895 | 17,063,783 | 13,189,782 | 10,969,210 | 13,778,387 | 8,332,987 |
| **TOTAL LIABILITIES** | **25,933,448** | **18,335,664** | **14,083,464** | **12,603,663** | **15,449,375** | **9,599,349** |
| **Net Position Held in Trust for Post-employment Health Care, as Restated** | **$166,446,806** | **$175,539,164** | **$153,084,296** | **$119,615,875** | **$90,696,132** | **$76,622,073** |

**Source: 2010 through 2015 Comprehensive Annual Financial Reports**

* Net Position by Plan was restated to correct the allocation of investment income as of December 31, 2010, with the restatement rolled forward through 2011 and 2012. The adjustment is reflected in the Cash and Short-Term Investments line and has no impact on the total net position of the System.





# Appendix E—Statements of Changes in Fiduciary Net Position—Health Care

| 401(h) Health Care Trust | 2015 | 2014 | 2013 | 2012 | 2011* | 2010** |
|---|---|---|---|---|---|---|
| **Additions** | | | | | | |
| Employer Contributions | | $135,522,351 | $120,056,440 | $494,048,415 | $503,458,216 | $628,685,237 |
| Contract and Other Receipts | $9,435 | 10,950,386 | 126,941,889 | 94,730,390 | 89,087,996 | 83,572,868 |
| Retiree-Paid Health Care Premiums+ | 248,601,375 | 238,406,380 | 178,140,822 | 159,614,898 | 148,370,246 | 111,638,313 |
| Federal Subsidy | | 44,715,641 | 105,965,762 | 182,579,917 | 192,118,407 | 142,658,293 |
| Other Income, net | | 7,601,841 | 13,483,861 | 11,774,199 | 10,915,043 | 7,163,609 |
| **Total Non-investment Income** | **248,610,810** | **437,196,599** | **544,588,774** | **942,747,819** | **943,949,908** | **973,718,320** |
| **Income From Investing Activities** | | | | | | |
| Net Appreciation/(Depreciation) in Fair Value | (453,577,747) | 209,726,745 | 1,106,685,064 | 1,183,656,950 | (401,560,941) | 1,240,024,373 |
| Bond Interest | 157,207,141 | 284,087,239 | 116,748,678 | 201,317,018 | 202,859,266 | 137,927,458 |
| Dividends | 105,609,193 | 186,495,341 | 206,180,289 | 183,422,898 | 134,235,895 | 134,809,505 |
| International Income/(Loss) | (11,506) | 18,941 | (4,659) | 10,894 | (92,053) | 48,675 |
| Other Investment Income | 652,343 | 4,302,396 | 13,183,549 | 10,861,876 | 3,671,640 | 3,778,346 |
| External Asset Management Fees | (27,988,205) | (30,811,500) | (40,036,389) | (24,118,062) | (13,648,040) | (10,904,604) |
| **Net Investment Income/(Loss)** | **(218,108,781)** | **653,819,162** | **1,402,756,532** | **1,555,151,574** | **(74,534,233)** | **1,505,683,753** |
| From Securities Lending Activity | | | | | | |
| Security Lending Income | | | | | | 14,236,338 |
| Security Lending Expenses | | | | | | (4,259,969) |
| Net Security Lending Income | | | | | | 9,976,369 |
| **Net Income from Securities Lending** | | | | | | **9,976,369** |
| Investment Administrative Expenses | (5,355,603) | (5,252,268) | (5,407,709) | (5,180,680) | (4,389,394) | (4,495,158) |
| **Net Income/(Loss) from Investing Activity** | **(223,464,384)** | **648,566,894** | **1,397,348,823** | **1,549,970,894** | **(78,923,627)** | **1,511,164,964** |
| **TOTAL ADDITIONS** | **25,146,426** | **1,085,763,493** | **1,941,937,597** | **2,492,718,713** | **865,026,281** | **2,484,883,284** |
| **Deductions** | | | | | | |
| Health Care Expenses | 1,774,989,836 | 1,738,596,173 | 1,642,525,598 | 1,607,921,528 | 1,575,561,578 | 1,567,551,611 |
| Administrative Expenses | 19,611,199 | 18,329,337 | 16,352,514 | 15,172,174 | 13,076,814 | 12,782,968 |
| **TOTAL DEDUCTIONS** | **1,794,601,035** | **1,756,925,510** | **1,658,878,112** | **1,623,093,702** | **1,588,638,392** | **1,580,334,579** |
| Net Increase/(Decrease) | (1,769,454,609) | (671,162,017) | 283,059,485 | 869,625,011 | (723,612,111) | 904,548,705 |
| Net Position Held in Trust for Post-employment Health Care Balance, Beginning of Year | 12,440,522,790 | 13,111,684,807 | 12,828,625,322 | 11,959,000,311 | 12,682,612,422 | 11,415,195,274 |
| **Balance, End of Year** | **$10,671,068,181** | **$12,440,522,790** | **$13,111,684,807** | **$12,828,625,322** | **$11,959,000,311** | **$12,319,743,979** |

**Source: 2010 through 2015 Comprehensive Annual Financial Reports**

*Net Position by Plan was restated to adjust the allocation of investment income as of December 31, 2010, with the restatement shown in the beginning net position of 2011. The restatement by plan does not impact the total net position of the System.

**The year 2010 was restated for reclassification of Early Retirement Re-insurance Program from Contracts and Other Receipts to Federal Subsidy, and the reclassification of the Pending Medical Claims adjustment from Health Care Expenses to Other Income. Pending Medical Claims consists of the annual adjustment made to the incurred but not reported liability included in Benefits Payable. This liability fluctuates from year to year based on changes in the claims experience.

+Beginning in 2015, Retiree-Paid Health Care Premiums was reported separately and not included in the Member Contributions line item. For comparability, this activity has been reclassified from Member Contributions to Retiree-Paid Health Care Premiums for all prior years presented.

| 115 Health Care Trust* | 2015 | 2014 |
|---|---|---|
| **Additions** | | |
| Employer Contributions | $253,673,333 | $111,561,319 |
| Contract and Other Receipts | 95,860,582 | 143,813,190 |
| Federal Subsidy | 175,930,875 | 131,904,250 |
| Other Income, net | 10 | 76,970 |
| **Total Non-investment Income** | **525,464,800** | **387,355,729** |
| | | |
| **Income From Investing Activities** | | |
| Net Depreciation in Fair Value | (17,539,101) | (2,660,677) |
| Bond Interest | 6,517,201 | 535,544 |
| Dividends | (9,556,397) | 1,019,374 |
| International Income/(Loss) | (1,178) | 223 |
| Other Investment Income | (43,576) | |
| External Asset Management Fees | (2,147,433) | (61,239) |
| **Net Investment Income/(Loss)** | **(22,770,484)** | **(1,166,775)** |
| Investment Administrative Expenses | (302,871) | (26,581) |
| **Net Income/(Loss) from Investing Activity** | **(23,073,355)** | **(1,193,356)** |
| | | |
| **TOTAL ADDITIONS** | **502,391,445** | **386,162,373** |
| | | |
| **Deductions** | | |
| Health Care Expenses | 45,184,620 | |
| Administrative Expenses | 2,174,957 | 82,201 |
| | | |
| **TOTAL DEDUCTIONS** | **47,359,577** | **82,201** |
| | | |
| Net Increase/(Decrease) | 455,031,868 | 386,080,172 |
| Net Position Held in Trust for Post-employment Health Care Balance, Beginning of Year | 386,080,172 | |
| | | |
| **Balance, End of Year** | **$841,112,040** | **$386,080,172** |

**Source: 2014 and 2015 Comprehensive Annual Financial Reports**
*The 115 Health Care Trust was established in 2014

# Appendix E—Statements of Changes in Fiduciary Net Position—Health Care

| Voluntary Employees' Beneficiary Association Trust | 2015 | 2014 | 2013 | 2012 | 2011* | 2010 |
|---|---|---|---|---|---|---|
| **Additions** | | | | | | |
| Employer Contributions** | | $14,702,198 | $18,256,171 | $16,883,868 | $15,982,848 | $13,986,794 |
| Contract and Other Receipts | | 20,484 | 3,061 | 9,233 | 9,082 | 7,367 |
| Other Income, net | | | | | | 338 |
| Interplan Activity | | | | 63,641 | | 26,276 |
| **Total Non-investment Income** | | **14,722,682** | **18,259,232** | **16,956,742** | **15,991,930** | **14,020,775** |
| | | | | | | |
| **Income From Investing Activities** | | | | | | |
| Net Appreciation/(Depreciation) in Fair Value | ($5,883,465) | 958,805 | 10,641,920 | 8,718,790 | (2,877,126) | 6,104,389 |
| Bond Interest | 1,902,518 | 1,625,463 | 1,635,744 | 1,271,636 | 947,608 | 677,020 |
| Dividends | 826,237 | 2,547,764 | 2,062,309 | 1,351,077 | 790,885 | 661,715 |
| Real Estate Operating Income, net | 2,959,962 | 3,017,022 | 2,028,598 | 1,288,261 | 914,755 | 325,044 |
| International Income/(Loss) | 371 | 240 | (43) | 81 | (562) | 239 |
| Other Investment Income | 1,724,353 | 3,584,241 | 2,210,914 | 1,785,191 | 810,818 | 626,072 |
| External Asset Management Fees | (907,438) | (692,565) | (645,737) | (386,839) | (236,503) | (126,600) |
| **Net Investment Income/(Loss)** | **622,538** | **11,040,970** | **17,933,705** | **14,028,197** | **349,875** | **8,267,879** |
| | | | | | | |
| From Securities Lending Activity | | | | | | |
| Security Lending Income | 106,312 | 77,985 | 83,192 | 98,909 | 72,422 | 78,171 |
| Security Lending Expenses | (23,811) | (6,747) | (11,881) | (25,735) | (17,305) | (23,391) |
| Net Security Lending Income | 82,501 | 71,238 | 71,311 | 73,174 | 55,117 | 54,780 |
| Unrealized Gains/(Losses) | (1,202) | 3,401 | 9,952 | 16,896 | (11,788) | |
| **Net Income from Securities Lending** | **81,299** | **74,639** | **81,263** | **90,070** | **43,329** | **54,780** |
| Investment Administrative Expenses | (75,920) | (71,081) | (60,287) | (68,480) | (81,707) | (37,732) |
| **Net Income/(Loss) from Investing Activity** | **627,917** | **11,044,528** | **17,954,681** | **14,049,787** | **311,497** | **8,284,927** |
| | | | | | | |
| **TOTAL ADDITIONS** | **627,917** | **25,767,210** | **36,213,913** | **31,006,529** | **16,303,427** | **22,305,702** |
| | | | | | | |
| **Deductions** | | | | | | |
| Health Care Expenses | 2,396,972 | 2,217,933 | 1,719,043 | 1,236,169 | 895,574 | 514,332 |
| Administrative Expenses | 1,330,559 | 1,094,409 | 1,026,449 | 850,617 | 914,578 | 851,770 |
| Interplan Activity | 5,992,744 | | | | 28,172 | 101,658 |
| | | | | | | |
| **TOTAL DEDUCTIONS** | **9,720,275** | **3,312,342** | **2,745,492** | **2,086,786** | **1,838,324** | **1,467,760** |
| | | | | | | |
| Net Increase/(Decrease) | (9,092,358) | 22,454,868 | 33,468,421 | 28,919,743 | 14,465,103 | 20,837,942 |
| Net Position Held in Trust for Post-employment Health Care Balance, Beginning of Year | 175,539,164 | 153,084,296 | 119,615,875 | 90,696,132 | 76,231,029 | 55,784,131 |
| | | | | | | |
| **Balance, End of Year** | **$166,446,806** | **$175,539,164** | **$153,084,296** | **$119,615,875** | **$90,696,132** | **$76,622,073** |

**Source: 2010 through 2015 Comprehensive Annual Financial Reports**

*Net Position by Plan was restated to adjust the allocation of investment income as of December 31, 2010, with the restatement shown in the beginning net position of 2011. The restatement by plan does not impact the total net position of the System.

**Beginning in October 2014, the Board approved the funding of the VEBA Trust participant accounts using the reserves in the VEBA Trust rather than the allocation of employer contributions. Instead, employer contributions were allocated to the Member-Directed Plan to repay the original plan start-up and administrative costs.

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