STATE TEACHERS RETIREMENT SYSTEM OF OHIO

2021 ORSC HEALTH CARE REPORT

(FOR PERIOD JULY 1, 2020 – JUNE 30, 2021)

(Submitted to ORSC December 23, 2021)

As Required by Section 3307.51, Ohio Revised Code

Year in Review-2021

The State Teachers Retirement Board is permitted by law to offer a cost-sharing, multiple-employer health care plan. STRS Ohio provides access to health care coverage to eligible retirees who participated in the defined benefit or combined plan and their eligible dependents.

Coverage under the current program includes hospitalization, physicians' fees, prescription drugs and partial reimbursement of monthly Medicare Part B premiums. The State Teachers Retirement Board has discretionary authority over how much, if any, of the associated health care costs will be absorbed by the plan. Benefit recipients pay a portion of the health care cost in the form of a monthly premium. STRS Ohio has established a health care assistance program for low income career teachers that provides health care coverage at no cost to the benefit recipient.

The Retirement Board has established a Health Care Fund within the Employers' Trust Fund from which health care benefits are paid. For the fiscal year ended June 30, 2021, the Board continued to allocate 0% of covered payroll to the Health Care Fund. Assets in the Health Care Fund are reported at fair value, and investment earnings are credited at the market rates of return earned by the total pool of STRS Ohio investments.

In December 2018, the Retirement Board adopted a health care plan management policy. The policy states the board's objectives for the health care plan and lays out clear criteria for making decisions regarding changes to benefits, as well as when those changes should be considered by the board. The policy indicates the goal is to provide a sustainable long-term health care benefit and to make benefit adjustments as conditions allow or are necessary.

The Health Care Fund net position increased to $4.9 billion in fiscal 2021 from $3.9 billion in fiscal 2020 as a result of the significant investment earnings in fiscal year 2021.

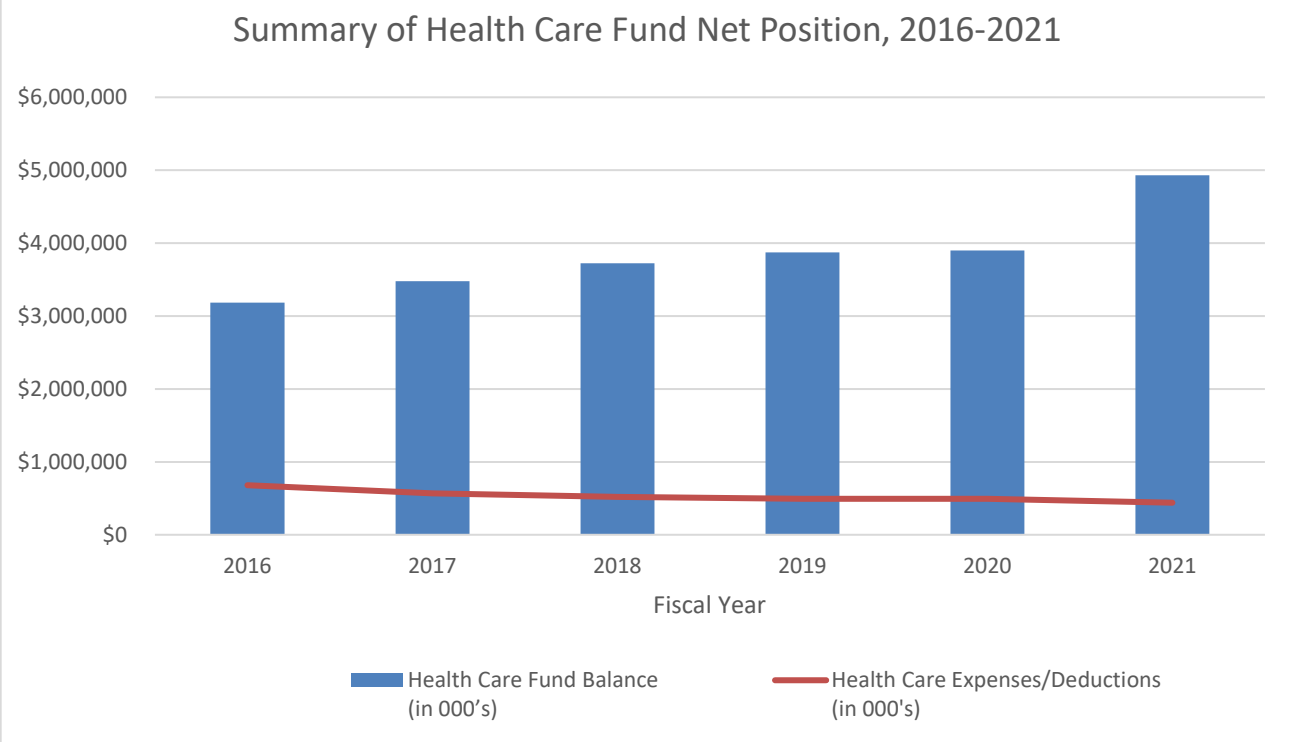
Benefit recipient health care premium income decreased by $42 million or 14%, in aggregate, during fiscal 2021 as a result of continued decreases in non-Medicare retiree health care enrollment and a $29 million premium rebate paid in December 2020. Government reimbursements (comprised of federal reinsurance and direct subsidies) were $96.5 million in fiscal year 2021 compared to $81.9 million in fiscal 2020 due to higher federal reinsurance recoveries in fiscal 2021. Payments for health care claims and provider administrative expenses totaled $437 million in fiscal 2021, a decrease of $53 million or 11% from the previous fiscal year. The decrease is largely driven by lower medical claims and continued decreases in non-Medicare retiree health care enrollment.

The annual health care actuarial valuation showed that benefit payments for the 12-month period ending June 30, 2021, totaled $437.4 million. The funded ratio of the plan is 174.7%, assuming the fund earns 7.00% in all future years and all other plan experience matches assumptions, the fund is projected to remain solvent for all current members. However, the health care program remains susceptible to volatility from investment returns, government reimbursement changes, enrollment fluctuations and health care inflation.

Financial Information

Fiscal Year 2021 (in 000's)

Additions	Deductions	Fund Balance	Solvency Period	Employer Allocation
$1,472,191	$439,748	$4,929,739	Solvent for all current members	0%



Health Care Fund Balance (as graphed above)		
	Health Care Fund Balance (in 000's)	**Health Care Expenses/Deductions (in 000's)**
2016	$3,185,628	$679,648
2017	$3,475,779	$568,459
2018	$3,721,349	$519,897
2019	$3,872,158	$491,521
2020	$3,897,296	$492,817
2021	$4,929,739	$439,748

[1]Solvency period based on each system's individual valuation and underlining assumptions.

Average Monthly Cost Per Participant
Paid by State Teachers Retirement System
Fiscal Year 2021

Non-Medicare Recipients	Medicare Recipients
$590	$224

Non-Medicare recipients includes all benefit recipients who are not eligible for Medicare.

Medicare recipients includes all benefit recipients who are eligible for Medicare Part A and/or Part B. The enrollee premiums are based on pooling Medicare-eligible individuals together; therefore, the above STRS Ohio subsidies reflect costs averaged across enrollees with Medicare Parts A&B and Medicare Part B-only. Without this pooling, the actual cost for enrollees with Medicare Part B-only would be nearly two times higher than the combined cost.

Population of Benefit Recipients
As of June 30, 2021

Age and Service	Disability	All Others (Survivors, Beneficiaries, etc.)	Total Recipients	Percent Medicare A&B	Percent Medicare B-only	Percent Non-Medicare
93,045	3,277	4,237	100,559	79%	11%	10%

Aetna Basic (Non-Medicare)

	In-Network and Indemnity[1]	Out-of-Network[1]
Deductible[2]	$2,500 per enrollee	$5,000 per enrollee
Out-of-Pocket Limit[2]	$6,500 per enrollee (includes deductible, coinsurance and primary care physician copayments)	$13,000 per enrollee (includes deductible and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	Plan pays 50%
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 Indemnity and out-of-network payments are based on allowed amounts determined by the prevailing fee schedule in the geographical area where medically necessary services are performed as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

Medical Mutual Basic (Non-Medicare)

	In-Network and Indemnity[1]	Out-of-Network[1]
Deductible[2]	$2,500 per enrollee	$5,000 per enrollee
Out-of-Pocket Limit[2]	$6,500 per enrollee (includes deductible, coinsurance and primary care physician copayments)	$13,000 per enrollee (includes deductible and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	Plan pays 50%
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 Indemnity and out-of-network payments are based on allowed amounts determined by the prevailing fee schedule in the geographical area where medically necessary services are performed as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

AultCare PPO (Non-Medicare)

	In-Network	Out-of-Network[1]
Deductible[2]	$2,500 per enrollee	$5,000 per enrollee
Out-of-Pocket Limit[2]	$6,500 per enrollee; includes deductible, copayments and coinsurance	$13,000 per enrollee; includes deductible, copayments and coinsurance
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	Plan pays 50%
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 Out-of-network payments are based on allowed amounts determined by the prevailing fee schedule in the geographical area where medically necessary services are performed as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

Paramount Health Care (Non-Medicare)

	In-Network and Indemnity[1]	Out-of-Network[1]
Deductible[2]	$2,000 per enrollee	Not applicable
Out-of-Pocket Limit[2]	$4,000 per enrollee; includes deductible, copayments and coinsurance	Not applicable
Lifetime Maximum	Unlimited	Not applicable
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	No coverage
Mental Health	Inpatient: Plan pays 80% Outpatient: Enrollee pays $20	No coverage
Surgery	Plan pays 80%	No coverage
Emergency Services		
Emergency Room	Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	No coverage
Flu Vaccines	Enrollee pays 0% (no deductible)	No coverage
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	No coverage

1 Enrollee must use HMO network providers. Out-of-network benefits do not apply, except for emergency and medically necessary acute onset urgent care services.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted.

Medical Mutual Health Care Assistance Plan (Non-Medicare)

	In-Network and Indemnity[1]	Out-of-Network[1]
Deductible[2]	$300 per enrollee	$300 per enrollee
Out-of-Pocket Limit[2]	$1,100 per enrollee (includes deductible and coinsurance)	$3,300 per enrollee (includes deductible and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	Plan pays 50%
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays $150 then 20% after deductible. Copay waived if admitted	
Urgent Care	Enrollee pays $40 then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 Indemnity and out-of-network payments are based on allowed amounts determined by the prevailing fee schedule in the geographical area where medically necessary services are performed as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

Aetna Medicare Plan (Medicare)

	In-Network or Extended Service Area[1]	Out-of-Network[1]
Deductible[2]	$150 per enrollee	$500 per enrollee
Out-of-Pocket Limit[2]	$1,500 per enrollee; includes deductible, copayments and coinsurance	$2,500 per enrollee; includes deductible, copayments and coinsurance
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 96%	Plan pays 92%
Mental Health	Inpatient: Plan pays 96% Outpatient: Enrollee pays $25 (no deductible)	Inpatient: Plan pays 92% Outpatient: Enrollee pays $55 after deductible
Surgery	Plan pays 96%	Plan pays 92%
Emergency Services		
Emergency Room	Enrollee pays $75 (no deductible); waived if admitted	
Urgent Care	Enrollee pays $40 (no deductible)	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 If providers do not accept Medicare assignment or charge in excess of Medicare payments, the enrollee is responsible for excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are combined.

Medical Mutual Basic (Medicare)

	In-Network and Indemnity[1]	Out-of-Network[1]
Deductible[2]	$2,500 per enrollee	$5,000 per enrollee
Out-of-Pocket Limit[2]	$6,500 per enrollee; includes deductible, coinsurance and primary care physician copayments	$13,000 per enrollee; includes deductible and coinsurance
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%[4]	Plan pays 50%[4]
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient: Plan pays 50% Outpatient: Plan pays 80%
Surgery	Plan pays 80%	
Emergency Services		
Emergency Room	Enrollee pays $150 then 20% after deductible. Copay waived if admitted waived	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 Indemnity and out-of-network payments are based on allowed amounts determined by the prevailing fee schedule in the geographical area where medically necessary services are performed as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

3 Benefits are payable after Medicare payments.

4 Enrollees with Medicare Part B-only must use in-network providers for hospital services to receive maximum claims payment.

AultCare PrimeTime Health Plan (Medicare)

	In-Network	Out-of-Network[1]
Deductible[2]	$150 per enrollee	$500 per enrollee
Out-of-Pocket Limit[2]	$1,500 per enrollee; includes deductible, copayments and coinsurance	$2,500 per enrollee; includes deductible, copayments and coinsurance
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 96%	Plan pays 92%
Mental Health	Inpatient: Plan pays 96% Outpatient: Enrollee pays $25	Inpatient: Plan pays 92% Outpatient: Enrollee pays $55
Surgery	Plan pays 96%	Plan pays 92%
Emergency Services		
Emergency Room	Enrollee pays $75 (no deductible); waived if admitted	
Urgent Care	Enrollee pays $40 (no deductible)	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Task Force recommendations	

1 Out-of-network payments are based on allowed amounts determined by the prevailing fee schedule in the geographical area where medically necessary services are performed as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are combined.

Paramount Elite (Medicare)

	In-Network and Indemnity[1]	Out-of-Network[1]
Deductible[2]	$150 per enrollee	Not applicable
Out-of-Pocket Limit[2]	$1,500 per enrollee; includes deductible, copayments and coinsurance	Not applicable
Lifetime Maximum	Unlimited	Not applicable
Medical Services (% covered by plan)		
Outpatient	Plan pays 96%	No coverage
Mental Health	Inpatient: Plan pays 96% Outpatient: Enrollee pays $20	No coverage
Surgery	Plan pays 96%	No coverage
Emergency Services		
Emergency Room	Enrollee pays $75 (no deductible); waived if admitted	
Urgent Care	Enrollee pays $40 (no deductible)	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	No coverage
Flu Vaccines	Enrollee pays 0% (no deductible)	No coverage
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	No coverage

1 Enrollee must use HMO network providers. Out-of-network benefits do not apply, except for emergency and medically necessary acute onset urgent care services.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted.

Medical Mutual Health Care Assistance Plan (Medicare)

	In-Network and Indemnity[1]	Out-of-Network[1]
Deductible[2]	$300 per enrollee	$300 per enrollee
Out-of-Pocket Limit[2]	$1,100 per enrollee (includes deductible and coinsurance)	$3,300 per enrollee (includes deductible and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%[3]	Plan pays 50%[3]
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays $150; waived if admitted	
Urgent Care	Enrollee pays $40 then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 Indemnity and out-of-network payments are based on allowed amounts determined by the prevailing fee schedule in the geographical area where necessary services are performed as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

3 Enrollees with Medicare Part B-only must use in-network providers for hospital services to receive maximum claims payment.

Express Scripts Prescription Plan (Non-Medicare)

For Medical Mutual Basic, Aetna Basic, AultCare PPO and Paramount Health Care

<table>
<tr><th></th><th>Retail Preferred/Home Delivery</th><th>Retail Non-Preferred</th></tr>
<tr><td>Annual Deductible</td><td colspan="2">$275 per enrollee for covered brand-name drugs, including specialty</td></tr>
<tr><td>Generic</td><td>Enrollee pays
Retail: $10
Home Delivery:
$9 Low-Cost Generic Drug Program medications;
$25 for all other generic medications</td><td rowspan="4">Enrollee pays the copayment/coinsurance charged at a preferred pharmacy, plus a $10 fee per fill</td></tr>
<tr><td>Formulary
Covered Brand-Name</td><td>After Deductible, Enrollee pays
Retail: $30
Home Delivery: $75</td></tr>
<tr><td>Nonformulary Brand</td><td>Not covered</td></tr>
<tr><td>Specialty Drugs</td><td>After deductible, Enrollee pays
the lesser of:
13% of the cost
or
$450 for supply of 1–31 days
$900 for supply of 32–60 days
$1,350 for supply of 61–90 days</td></tr>
<tr><td>Maximum Annual Expense</td><td colspan="2">If an enrollee pays a total of $5,100 out of pocket in copayments/coinsurance/deductible for generic, covered brand-name and specialty medications, that enrollee pays nothing for covered medications for the remainder of the year.</td></tr>
</table>

Express Scripts Prescription Plan (Non-Medicare)

For Health Care Assistance Program

	Retail Preferred/Home Delivery	Retail Non-Preferred
Annual Deductible	Not applicable	
Generic	**Retail:** Enrollee pays $5 **Home Delivery:** Enrollee pays $9 for Low-Cost Generic Drug Program medications; $10 for all other generic medications	
Formulary Covered Brand-Name	**Retail:** Enrollee pays $20 **Home Delivery:** Enrollee pays $40	
Nonformulary Brand	Not covered	
Specialty Drugs	**Retail:** Enrollee pays $20 **Home Delivery:** Enrollee pays $40	
Maximum Annual Expense	If an enrollee pays a total of $500 out of pocket in copayments for generic and covered brand-name medications, that enrollee pays nothing for covered medications for the remainder of the year.	

Express Scripts Medicare Part D Prescription Plan (Medicare)

For Aetna Medicare Plan, Medical Mutual Basic, AultCare PrimeTime Health Plan and Paramount Elite

<table>
<tr><th></th><th>Retail Preferred/Home Delivery</th><th>Retail Non-Preferred</th></tr>
<tr><td>Annual Deductible</td><td colspan="2">$275 per enrollee for covered brand-name drugs, including specialty</td></tr>
<tr><td>Generic</td><td>Enrollee pays
Retail: $10
Home Delivery:
$9 Low-Cost Generic Drug Program medications;
$25 for all other generic medications</td><td rowspan="4">Enrollee pays the copayment/coinsurance charged at a preferred pharmacy, plus a $10 fee per fill</td></tr>
<tr><td>Formulary Covered Brand-Name</td><td>After Deductible, Enrollee pays
Retail: $30
Home Delivery: $75</td></tr>
<tr><td>Nonformulary Brand</td><td>Not covered</td></tr>
<tr><td>Specialty Drugs</td><td>After deductible, Enrollee pays
the lesser of:
13% of the cost
or
$450 for supply of 1–31 days
$900 for supply of 32–60 days
$1,350 for supply of 61–90 days</td></tr>
<tr><td>Maximum Annual Expense</td><td colspan="2">Once what pharma reimburses the plan for brand drugs obtained while an enrollee is in the coverage gap, combined with what an enrollee pays out of pocket in copayments/coinsurance/deductible for generic, covered brand-name and specialty medications, reaches $6,550, that enrollee pays nothing for covered medications for the remainder of the year.</td></tr>
</table>

Express Scripts Medicare Part D Prescription Plan (Medicare)

For Health Care Assistance Program

	Retail Preferred/Home Delivery	Retail Non-Preferred
Annual Deductible	Not applicable	
Generic	**Retail:** Enrollee pays $5 **Home Delivery:** Enrollee pays $9 for Low-Cost Generic Drug Program medications; $10 for all other generic medications	
Formulary Covered Brand-Name	**Retail:** Enrollee pays $20 **Home Delivery:** Enrollee pays $40	
Nonformulary Brand	Not covered	
Specialty Drugs	**Retail:** Enrollee pays $20 **Home Delivery:** Enrollee pays $40	
Maximum Annual Expense	If an enrollee pays a total of $500 out of pocket in copayments for generic and covered brand-name medications, that enrollee pays nothing for covered medications for the remainder of the year.	

Health Care Future – Fiscal Year 2021

The STRS Ohio Health Care Program remains in solid financial position even with the reduction in the expected rate of investment return from 7.45% to 7.00%. As of June 30, 2021, the program is 174.7% funded, meaning there is, if all actuarial assumptions are met, long-term solvency for all current retirees and STRS Ohio members upon retirement. The current subsidy strategy calls for pre-Medicare subsidies to be frozen at the increased 2022 levels and for Medicare subsidy increases to be capped at the lesser of 6% or the actual trend. In addition, service retirees and disability recipients enrolled in the STRS Ohio Health Care Program and Medicare Part B, receive $29.90 per month as partial premium reimbursement.

Due to the strong funding level, the Retirement Board will continue evaluating possible changes to the program for implementation Jan. 1, 2023. For 2022, the Board voted to increase the 2022 non-Medicare subsidy levels; to allow some level of inflation protection for the pre-Medicare subsidy when the prior year's actual costs are below what was actuarily projected in future years; and, for the system to cover all the additional cost for individuals not enrolled in Medicare Part A because they are not eligible for premium-free Medicare Part A instead of sharing the cost with enrollees.

A significant contributor to the solid funding status has been the continuing strong consistent levels of federal government reimbursements resulting from operating a Medicare Advantage and self-insured Prescription Part D (MAPD) program and the increasing formulary drug rebates. STRS Ohio recognizes these payments are not guaranteed and are subject to significant volatility. Additionally, the system recognizes the investment return volatility associated with the current asset mix. It is also important to note that employer contributions to the Health Care Fund ceased beginning July 1, 2014. As a result of potential funding volatility and lack of employer contributions, benefit changes are likely to be gradually introduced.

An upcoming eligibility change for the STRS Ohio Health Care Program will occur next August. Members who retire on or after Aug. 1, 2023, must have at least 20 years of total service credit to access coverage. Members who retire before Aug. 1, 2023, will be grandfathered under their current requirements. This change was first announced ten years ago and has been continually communicated since then.

Supplementary Statutory Requirements

The following is provided in accordance with the requirements of Revised Code section 3307.51(E)

(1) A description of the statutory authority for the benefits provided:

Ohio Revised Code, section 3307.39, states:

> The state teachers retirement board may enter into an agreement 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 those individuals receiving, under the STRS defined benefit plan, service retirement or a disability or survivor benefit who subscribe to the plan. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children as the board considers appropriate.
>
> 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 state teachers retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by section 3307.28 of the Revised Code.

Ohio Revised Code section 3307.39, also states "the board may make a monthly payment to each recipient of service retirement, or a disability or survivor benefit under the STRS defined benefit plan who is enrolled in coverage under part B of the Medicare program established under Title XVIII of "The Social Security Amendments of 1965," 79 Stat. 301 (1965), 42 U.S.C.A. 1395j, as amended."

(2) A summary of coverage for 2021:

A summary of the coverage for calendar year 2021 is provided on pages 6 through 19 in the attached ORSC Health Care Report.

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

In general, service retirees are required to have 15 years of qualified service credit to be eligible for the STRS Ohio Health Care Program, and eligibility is extended to disability recipients and some survivor annuitants and survivor benefit recipients.

More details on eligibility requirements for the STRS Ohio Health Care Program are provided in Attachment A on pages 26 through 27.

(4) A statement of the number of participants eligible for the benefits:

As of June 1, 2021, there were 142,834 benefit recipients eligible to participate in the STRS Ohio Health Care Program.

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

The Retirement Board has established a Health Care Fund within the Employers' Trust Fund from which health care benefits are paid. For the fiscal year ended June 30, 2021, the Board continued to allocate 0% of covered payroll to the Health Care Fund. Assets in the Health Care Fund are reported at fair value, and investment earnings are credited at the market rates of return earned by the total pool of STRS Ohio investments.

The Actuarially Determined Contribution (ADC) is calculated as the normal cost determined under the Entry Age Normal Actuarial Cost Method, plus the amortization of the unfunded actuarial liability over a 30-year open level percent of pay, plus anticipated administrative expenses. Currently, the ADC is negative and is projected to remain negative, thus the employer is not expected to make any future contributions to the Health Fund.

(6) A statement of the net assets available for the provision of the benefits as of the last day of the fiscal year:

Post-Employment Health Care
Statement of Fiduciary Net Position
As of June 30, 2021
(In Thousands)

Assets:	
Cash and short-term investments	$ 72,832
Receivables:	
Accrued interest and dividends	13,126
Securities sold	17,593
Medical benefits receivable	24,862
Total receivables	55,581
Investments, at fair value:	
Fixed income	972,547
Domestic equities	1,336,713
International Equities	1,080,900
Real estate	516,057
Alternative investments	1,047,581
Total investments	4,953,798
Invested securities lending collateral	33,960
Total assets	5,116,171
Liabilities:	
Securities purchased and other investment liabilities	22,306
Debt on real estate investments	109,194
Accrued expenses and other liabilities	1,781
Medical benefits payable	19,205
Obligations under securities lending program	33,946
Total liabilities	186,432
Fiduciary net position restricted for post-employment health care coverage:	4,929,739

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

Post-Employment Health Care
Statement of Changes in Fiduciary Net Position
As of June 30, 2021
(In Thousands)

Additions:	
Contributions:	
Employer	$ 0
Government reimbursements	96,478
Benefit recipient health care premiums	254,014
Total contributions	350,492
Investment income from investing activities:	
Net appreciation in fair value of investments	1,059,270
Interest	24,227
Dividends	42,750
Real estate income	10,093
Investment income	1,136,340
Less internal investment expenses	(2,081)
Less external asset management fees	(12,909)
Net income from investing activities	1,121,350
Securities lending income	388
Securities lending expenses	(39)
Net income from securities lending activities	349
Net investment income	1,121,699
Total additions	1,472,191
Deductions:	
Health care benefits	437,404
Administrative expenses	2,344
Total deductions	439,748
Net increase in net position	1,032,443
Fiduciary net position restricted for post-employment health care coverage:	
Beginning of year	3,897,296
End of year	4,929,739

(8) For the last six consecutive fiscal years, a schedule of the net assets available for the benefits, the annual cost of benefits, administrative expenses incurred, and annual employer contributions allocated for the provision of benefits:

Six-Year History

Fiscal Year Ended (in Thousands)

	2021	2020	2019	2018	2017	2016
Employer contributions	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
Government reimbursements	$ 96,478	$ 81,876	$ 84,789	$ 107,197	$ 79,357	$ 58,812
Benefit recipient premiums	$ 254,014	$ 295,779	$ 312,841	$ 329,305	$ 339,056	$ 339,927
Net investment income	$ 1,121,699	$ 140,300	$ 244,700	$ 328,965	$ 440,197	$ 17,001
Health care benefits	$ 437,404	$ 490,559	$ 489,169	$ 517,470	$ 565,962	$ 676,993
Administrative expenses	$ 2,344	$ 2,258	$ 2,352	$ 2,427	$ 2,497	$ 2,655
Fiduciary net position available for benefits	$ 4,929,739	$ 3,897,296	$ 3,872,158	$ 3,721,349	$ 3,475,779	$ 3,185,628

(9) A description of any significant changes that affect the comparability of the report required under this division:

There were no significant changes that affect the comparability of the report provided herein.

(10) A statement of the amount paid under division (B) of section 3307.39 of the Revised Code:

In 2019 and 2020, STRS Ohio reimbursed benefit recipients who were enrolled in an STRS Ohio health care plan and Medicare Part B $29.90 per month toward their total Medicare Part B premium. In 2021, the Medicare Part B premium reimbursement will continue at $29.90 per month for these benefit recipients.

Attachment A – Summary of STRS Ohio Eligibility Requirements for the Benefits

3307:1-11-03 Health care services - medical plan.

(A) Eligibility

The following individuals shall be eligible to participate in a medical plan offered by the retirement system:

(1) A service retiree with an effective benefit date:

(a) Before January 1, 2004; or

(b) Between January 1, 2004 and July 1, 2023 and the benefit is based on fifteen or more years of total service credit; or

(c) After July 1, 2023 and the benefit is based on twenty or more years of total service credit.

(2) A service retiree who began receiving service retirement benefits with no break in monthly benefits following the termination of disability benefits, with a disability effective benefit date:

(a) Before January 1, 2004; or

(b) Between January 1, 2004 and July 1, 2023 and the service retiree benefit is based on fifteen or more years of total service credit; or

(c) After July 1, 2023 and the service retiree benefit is based on twenty or more years of total service credit.

(3) A disability benefit recipient.

(4) A survivor annuitant.

(5) A survivor benefit recipient under division (C)(1) of section 3307.66 of the Revised Code who was eligible for coverage as a dependent at the time of the member's or disability benefit recipient's death where the effective date of survivor benefits or the effective date of disability benefits of the deceased member is:

(a) Before January 1, 2004; or

(b) Between January 1, 2004 and July 1, 2023 provided that the deceased member had fifteen or more years of total service credit at the time of death; or

(c) After July 1, 2023 provided the deceased member had twenty or more years of total service credit at the time of death.

(6) A survivor benefit recipient under division (C)(2) of section 3307.66 of the Revised Code who was eligible for coverage as a dependent at the time of the member's or disability benefit recipient's death.

(7) Dependents, to the extent that a medical plan and/or ancillary plan allows for dependent coverage.

(8) Notwithstanding paragraphs (A)(1) to (A)(7) of this rule, an individual not eligible for medicare coverage is not eligible for primary coverage in a medical plan offered by the retirement system if the individual is employed and has access to an entity's medical plan or if similarly situated, non-retired employees have access to an entity's medical plan, provided the medical plan includes prescription coverage and provides equivalent coverage at a cost no more than what is available to full-time employees as defined by the entity. The retirement board may require each enrollee to annually file a verification of employment statement disclosing the availability for enrollment as an employee in an entity's medical plan.

(a) When an individual is enrolled in an entity's medical plan and a medical plan offered by the retirement system, coverage in the retirement system's medical plan will be limited to secondary coverage applied only to those covered medical expenses not paid by the entity's medical plan.

(b) An employed individual not eligible for Medicare who does not file a verification of employment statement with the retirement system when requested by the retirement system; does not enroll in the entity's medical plan when eligible to enroll, or is excluded from the entity's medical plan based upon being an enrollee is not eligible to enroll or remain enrolled in a medical plan offered by the retirement system.