1998 HEALTH CARE REPORT

Presented to the
Ohio Retirement Study Council

Presented by
The Police and Firemen's Disability and Pension Fund

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Introduction

The Police and Firemen's Disability and Pension Fund (PFDPF) offers an excellent medical expense benefits program including coverage for major medical, prescription drug, dental, vision and long term care. In 1998, over 32,000 retirees, survivors and their eligible dependents were enrolled in PFDPF health care benefits.

In 1974, PFDPF began to offer medical expense benefits to all retired members, survivors and eligible dependents as an optional benefit, as long as the cost of funding those benefits did not jeopardize funding of cash pension benefits (See Appendix A for the statutory authority for health care benefits, O.R.C. 742.45). At that time, only one plan was offered through Aetna Health Plans.

Due to rising health care costs, contributions were required for most benefit recipients beginning in July of 1992. In addition, cost saving plan design measures have been introduced since that time as well. Currently, two Preferred Provider Option (PPO) Networks, five Health Maintenance Organizations (HMOs) and four Medicare HMOs are available, as well as a separate prescription drug program. Supplemental dental, vision and long term care plans are also available. Long term care is the only PFDPF-sponsored benefit that is also offered to active members.

As required by Ohio Revised Code Section 742.14 (E), PFDPF has prepared the enclosed report to provide information regarding the health care program offered to PFDPF members in 1998. This year, the report also focuses on the methods used by the Fund for funding health care benefits and plans into the future. The PFDPF Board of Trustees realizes that one of the greatest and most difficult issues it must face is funding the rising cost of health care benefits without jeopardizing future pension, disability and survivor benefits. In addition to funding, the report also discusses eligibility, a breakdown of the plans available and financial information.

Health Care Funding

When PFDPF took on the responsibility of health care benefits in 1974, health care expenditures were approximately $3 million, compared to $84 million spent 24 years later in 1998. The health care expenses in 1998 increased 9.7 percent over 1997. In addition, the cost per health care participant rose to $2,556 in 1998, an 8.17 percent increase over 1997. This section addresses the current health care funding structure and how PFDPF anticipates addressing funding of these benefits into the future.

Senator Grace Drake specifically asked for information regarding health care funding in her memo dated May 19, 1999. Answers to these questions are found throughout this section, however, direct answers to each question raised in her memo can be found in Appendix B.

Current health care financing

In 1992, the Board of Trustees transferred $150 million in assets to establish a Health Care Stabilization Fund. As a result of the interest generated, along with retiree contributions, rebates and recoveries, and 6.5 percent of employer contributions expressed as a percentage of payroll, the stabilization fund increased to $271,995,961 as of December 31, 1998.

The specific breakdown of the Health Care Stabilization Fund over the last six years is shown on the *Schedule of Changes in Net Assets Available for Benefits* (See Appendix C). Deductions from that fund include actual health care expenses and administrative expenses related to health care. Health care expenses include major medical and prescription drug claim payments, premiums and associated administrative fees, as well as Medicare B reimbursements.

By law, medical expense benefits must be paid through retiree-paid contributions and through contributions that employers pay on behalf of active members. Currently, retiree-paid contributions pay for 6.35 percent of benefit costs and employer contributions pay for 93.65 percent of health care costs. In March of each year the Trustees set the retiree contribution levels for the following January. Retiree contributions have not been adjusted since they were first set in 1992.

PFDPF actuaries have determined that employer-paid health care costs must remain under 6.5 percent of active member payroll if the security of pension and disability benefits is to be safeguarded. So far, PFDPF has been able to stay under that payroll ceiling through many measures including the implementation of monthly medical expense benefits contributions in 1992, as well as cost saving measures such as the implementation of the network plans (Individual Option Network PPOs and HMOs). In fact, PFDPF has been able to enhance and expand benefit offerings to benefit recipients in the past few years without affecting the cost to benefit recipients.

Currently, the Fund is self-funded for the PPO and prescription drug plans, meaning that the Fund pays the full cost of claim dollars for these plans. HMOs are not self-funded and, therefore, are paid on a premium basis.

Every two years the actuarial valuation determines the adequacy of retiree contributions and employer contributions. The latest report predicts the Health Care Stabilization Fund will be insolvent by 2012 unless special actions are taken as discussed below.

As required by statute, this report also includes other financial information including Accounting, Asset Valuation and Funding Methods (See Appendix D), Plan Net Assets Available for Postemployment Health Care Benefits (See Appendix E), and Statement of Changes in Plan Net Assets Available for Postemployment Health Care Benefits (See Appendix F).

Cost saving measures

PFDPF has established several measures within the last several years to reduce health care costs. First, benefit recipients began contributing toward the cost of their health care in 1992. This contribution schedule has not changed since that time (See Appendix G). Secondly, the ORS Individual Option Networks (PPOs) were introduced in 1992. Under these plans, participants are encouraged to utilize participating network providers in order to pay less out of pocket for their health care expenses. Participating network providers have contractually agreed to charge less for their services, a savings which can then be passed on to the participants and to PFDPF. In addition, the introduction of a stand alone prescription drug program, as well as HMOs and Medicare HMOs save money for both PFDPF and plan participants.

Future funding strategies

The PFDPF Trustees must face the issue of funding the rising cost of health care benefits without jeopardizing future pension and disability benefits. Besides the fact that the costs for health care services all across the country keep rising, other factors affecting PFDPF benefit funding include future increases in Medicare premiums and deductibles and the extended life span of retirees. In addition, the number of active members is decreasing compared to the number of retirees. The current ratio is 1.7 active members to every 1 retired member and is expected to be 1.5 to 1 by 2008.

As part of the *Health Care Funding Policy* (See Appendix H) adopted by the PFDPF Board in December, 1997, the Board will utilize forecast studies prepared by the actuary on at least a quinquennial basis (every five years) or other studies commissioned by the Board on an ad hoc basis to determine the affordable level of health care. The forecast studies will be prepared following each Quinquennial Experience Study, so as to best reflect current expectations of PFDPF pension and health care liabilities.

Under the policy, based on the projected health care costs included as part of the forecast studies and after paying costs covered by the current percentage of active member payroll or the amount of Health Care Stabilization Funds deemed prudent by the Board, the monthly contributions for benefit recipients and dependents will be adjusted to pay all remaining health care costs. When adjusting contributions by benefit recipients, the Board will apportion the contributions among the benefit recipient and dependent population after considering many factors.

A study prepared by Fund actuaries in 1998 projected that the Fund's Health Care Stabilization Fund would be depleted by 2012 unless contributions were increased or benefits under the health care program were reduced. In 1998 the PFDPF board voted to incrementally increase the percentage of payroll allocated to health care (which the employer pays) from 6.5 percent in 1998 to 8 percent by 2003. The percentage has been increased to 7 percent in 1999 and will increase in .25 percent increments thereafter until it reaches 8 percent in 2003. At that time, the plan will be reassessed and the percentage may be increased to 9 percent by 2007.

The Board's Health Care Committee is currently considering several strategies for changing the current health care contribution rates paid by benefit recipients so that benefit recipients would begin to absorb some portion of that health care cost inflation. Actuaries have advised management that benefit recipients must eventually absorb 8 percent of the health care expenses. Currently, benefit recipients contribute only 6.35 percent toward their health care costs and the rest is subsidized by the Fund. As health care costs continue to rapidly escalate, actuaries predict that, by 2007, members will contribute less than 4 percent toward the cost of their health care. Under the *Health Care Funding Policy Statement*, reducing benefits would be considered only if changes in benefit recipient monthly contributions and active member employer payroll contributions still failed to offset rising health care costs.

Health Care Eligibility

Retirant and survivor eligibility

PFDPF members are eligible for health care benefits through PFDPF the first day after they are taken off their employer's payroll. In addition, health care coverage for eligible surviving spouses starts from the member's date of death and when survivor benefits begin. There are no pre-existing condition clauses.

Dependent eligibility

Benefit recipients must be enrolled in an individual plan in order to enroll their dependents in that plan. Dependents eligible for the PFDPF Medical Expense Benefits Program include:

- The benefit recipient's spouse;
- Unmarried child(ren) at least 14 days of age, but under 18 years of age, or under 22 if attending school* on a full-time basis (or at least a two-thirds basis) and primarily dependent upon the benefit recipient for support. Primarily dependent means that the child is validly claimed as an exemption for income tax (FITR) purposes** by the benefit recipient in the year that medical expenses are incurred;
- A dependent child (validly claimed as an exemption on FITR**), regardless of age, who is unable to earn a living because of a physical or mental handicap, but only if such child became incapacitated prior to attaining age 18 (age 22 if then attending school on a full-time or at least a two-thirds basis). A disabled child over age 22 may only apply for PFDPF medical expense benefits at the time the benefit recipient is FIRST eligible for PFDPF medical expense benefits. However, the disabled child must have met the regulations listed above prior to attaining age 22. The medical expense benefits administrator will determine if the child has met the requirements for eligibility and may also periodically require proof of continued disability and dependency; and
- Unmarried step-children, grandchildren or other children at least 14 days of age, but under 18 years of age, or under 22 if attending school on a full-time basis (or at least a two-thirds basis) for whom the benefit recipient is the legal guardian required to provide health care coverage. Step-children, grandchildren or other children must be financially dependent upon the benefit recipient for support and live with the benefit recipient in a regular parent-child relationship. Financially dependent means that the child is validly claimed as an exemption for income tax (FITR) purposes** by the benefit recipient in the year that medical expenses are incurred.

**An institution is considered a school if it: offers a regular schedule of courses on an annual or more frequent basis; has a full-time faculty and permanent administration; and includes some formal classroom sessions rather than just on-the-job training.*

*** To cover a child not claimed on FITR, the benefit recipient must be mandated by a qualified Court Order to pay both child support and medical expense benefits for that child. In addition, the child support payment must be deducted from the benefit recipient's benefit check and directly transferred from The Police and Firemen's Disability and Pension Fund to the child support enforcement agency.*

Current enrollment figures

As of December 31, 1998, there were 20,810 PFDPF benefit recipients. Benefit recipients includes retirees and survivors. Of those, approximately 93 percent participated in the PFDPF health care programs at that time. As of December, the breakdown of enrollees and dependents is as follows:

	Number Enrolled
Benefit recipients	19,398
Dependents	13,477
TOTAL	32,875

Ensuring accuracy of eligibility information

To keep PFDPF files accurate, all benefit recipients enrolled in PFDPF's Medical Expense Benefits Program are required to complete and return an Annual Health Care Eligibility Form once every year. This form requests current information regarding address, covered dependents, Workers' Compensation information, etc. It is mailed in the fall of every year. Benefit recipients who do not comply after several requests face termination of coverage.

Health Care Program Breakdown

The Police and Firemen's Disability and Pension Fund offers an excellent medical expense benefits program which includes coverage for major medical, prescription drug, dental, vision and long term care. This section describes these benefits in more detail.

Major medical

Based on their area of residence, benefit recipients have the choice between two different types of plans for major medical coverage, a Health Maintenance Organization (HMO) or the ORS Individual Option Network Preferred Provider Organization (PPO). Both plan types provide excellent coverage for expenses resulting from ordinary injuries or diseases, serious or prolonged disabilities, hospitalization and skilled nursing care.

HMOs—PFDPF offers HMOs through five different carriers–**Aetna, Kaiser Permanente, Medical Mutual of Ohio** (MMO), **Paramount** and **United HealthCare** (UHC). Eligibility for these plans is based on area of residence as determined by the carriers. The Kaiser HMO is restricted to the Akron/Cleveland area and requires the utilization of primary care physicians in participating Kaiser facilities only. The other HMOs offer participants the choice of primary care physicians who are independent practicing physicians located throughout the state. Health Maintenance Organizations (HMOs) provide comprehensive health care coverage, including preventive care services, diagnostic testing, inpatient medical/surgical services and more. In addition, there are no deductibles to meet and most services are paid 100 percent after a copayment (See Appendix I). Eligibility for these HMOs is limited to residents who live in specific counties of Ohio and certain contiguous states.

Medicare HMOs—PFDPF also offers four Medicare HMOs to Medicare eligibles who live in eligible areas (through **Aetna, Kaiser, Paramount** and **United HealthCare**). The Medicare HMO carriers actually administer Medicare benefits, instead of Medicare. The carriers obtain this right by entering into a contract with the Health Care Financing Adminstration (HCFA), an agency of the federal government. The government then pays a fixed monthly amount for each Medicare plan member to the carrier. The payment made by the government is based on how much it would cost the Medicare program if the Medicare beneficiary received services under the traditional fee-for-service program and the location of the HMO. Benefit recipients are still Medicare beneficiaries if they enroll in a Medicare HMO. The Medicare HMOs cover all services covered by traditional Medicare, plus much more such as routine vision, hearing and dental care–all at no additional cost (See Appendix I).

Individual Option Networks (PPOs)—The Ohio Retirement Systems Individual Option Network (PPO) is a group of independent doctors, hospitals and other health care providers who have agreed to offer their services at set, discounted fees under contract with a network administrator. Currently, PFDPF benefit recipients may choose between two different administrators when enrolling in the Individual Option Network (PPO) plan—**Aetna U.S. Healthcare** and **Medical Mutual of Ohio** (MMO). Both administrators cover the same types of services, and also have the same deductibles and copayments. The only difference between these carriers is that different providers participate in each network.

Anyone who resides in a network area and enrolls in the Individual Option Network must utilize participating PPO providers to receive maximum benefits. Under the PPO plans, a plan participant simply chooses a doctor or hospital from the administrator's provider listing at the time services are needed. Plan participants are not required to utilize network providers, however, there are definite advantages for participants who do. Special, reduced fees have been negotiated with all network providers, and plan participants will not be responsible for paying the difference between the provider's normal charge and the specially-negotiated fee. In addition, when using network providers, there are no claim forms to file, deductibles are lower and the maximum yearly out-of-pocket is lower.

Plan participants who utilize a provider outside of the network will incur more out-of-pocket costs. Because special fees have not been negotiated with non-network providers, participants have a lower benefit level and will be responsible for paying any amount between the provider's fee and the usual, customary and reasonable (UCR) allowance determined.

The carriers do not have networks in all areas of the country. Benefit recipients who reside in one of these non-network areas still choose either Aetna or MMO as their claims administrator. These individuals can then use any provider or hospital and still receive most benefits at the "network" benefit level. When utilizing non-network providers, however, these benefit recipients must still file their own claim forms, pre-certify themselves and pay any amount between the provider's fee and the usual, customary and reasonable (UCR) allowance determined by the carrier.

Please see Appendix J for a chart indicating network states and Appendix K for a chart describing the various benefit levels.

Prescription drugs

Prescription drug coverage is administered by Merck-Medco Rx Services, regardless of which carrier or plan a benefit recipient chooses for major medical coverage. All benefit recipients and their dependents who enroll in major medical coverage are also automatically enrolled in prescription drug coverage at the same time. Benefit recipients receive a separate card for prescription drugs which contains the PAID Prescriptions logo. The prescription drug program allows participants to purchase their medications at discounted rates at either a retail location or, for the greatest savings, through the mail (See Appendix L).

Supplemental dental and vision

Most of the HMO plans cover routine dental and vision services, however, the PPO plans do not. To supplement their medical coverage, benefit recipients have the option to enroll in separate dental and vision plans. These plans are offered in addition to the medical expense benefit plans, and have separate contribution amounts. Benefit recipients may also enroll in these plans if they do not elect to enroll in a PFDPF-sponsored medical expense benefit plan. Enrollment in these plans is only permitted once every year during the fall open enrollment period. The Fund does not subsidize the cost of these plans—enrollees pick up the full premium. Please see Appendix

M for a breakdown of dental coverage, Appendix N for a breakdown of vision coverage and Appendix O for contribution amounts for both plans.

Long term care

Long term care refers to a wide range of personal health care services for people of all ages who need custodial care because of a chronic illness or long-lasting disability. This does not include acute medical care which helps people recover from an illness or injury. PFDPF's major medical plans to not cover custodial care and Medicaid only covers longer term care for people living at or below the poverty level.

To help pay the cost of long term care, PFDPF offers a separate long term care policy through Aetna U.S. Healthcare. Enrollees are eligible for a benefit of $40 to $100 per day toward custodial nursing home expenses, and half of the covered amount toward home care, adult day care or other long term care expenses. Premiums are based on the person's age at the time of enrollment and are paid directly to Aetna U.S. Healthcare. This plan is available to active PFDPF members, their spouses and parents, as well as current PFDPF benefit recipients and their dependents.

Open Enrollment

Every year, plan participants have the opportunity to change plans during the open enrollment period. This major project involves creating a customized booklet for health care participants which specifically outlines the plans available in their area of residence.

Medicare Part B Reimbursements

Upon eligibility for Medicare Part B, benefit recipients and surviving spouses are eligible for reimbursement of the Medicare Part B premium through PFDPF (as required by O.R.C. 742.45, Section C, See Appendix A). The reimbursement is made in their monthly benefit payments at the current annual contribution rate or the rate that the person is being charged, whichever is less. Dependent spouses are not reimbursed for the Medicare Part B premium, but their premiums are eliminated. In 1998, PFDPF paid out over $4.65 million in Medicare B reimbursements.

When becoming eligible for Medicare Part B, benefit recipients should submit a copy of their Medicare card and Medicare billing statement as soon as possible. Upon notification of a benefit recipient's death, the surviving spouse will be sent instructions regarding applying for the Medicare Part B reimbursement. Retirees and surviving spouses who are eligible to receive the Medicare B reimbursement from another Ohio Retirement System or from another source are not eligible for the PFDPF reimbursement. Reimbursement will not begin until the proper information is received. No retroactive reimbursements are made.

APPENDIX A

Statutory Authority for Health Care Benefits

§ 742.45 Deduction for group health insurance.

(A) The board of trustees of the police and firemen's disability and pension fund 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 benefits, or any combination thereof, for those individuals receiving service or disability pensions or survivor benefits subscribing 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 and for any of the eligible individual's sponsored dependents as the board considers appropriate.

If all or any portion of the policy or contract premium is to be paid by any individual receiving a service, disability, or survivor pension or benefit, the individual shall, by written authorization, instruct the board to deduct from the individual's benefit the contribution 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 police and firemen's disability and pension fund. The cost paid from the funds of the police and firemen's disability and pension fund shall be included in the employer's contribution rates provided by sections 742.33 and 742.34 of the Revised Code.

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 benefits as authorized by the rules of the board.

(B) If the board provides health, medical, hospital, or surgical benefits through any means other than a health insuring corporation, it shall offer to each individual eligible for the benefits the alternative of receiving benefits through enrollment in a health insuring corporation, if all of the following apply:

(1) The health insuring corporation provides health care services in the geographical area in which the individual lives;

(2) The eligible individual was receiving health care benefits through a health or a health insuring corporation before retirement;

(3) The rate and coverage provided by the health insuring corporation to eligible individuals is comparable to that currently provided by the board under division (A) of this section. If the rate or coverage provided by the health insuring corporation is not comparable to that currently provided by the board under division (A) of this section, the board may deduct the additional cost from the eligible individual's monthly benefit.

The health insuring corporation shall accept as an enrollee any eligible individual who requests enrollment.

The board shall permit each eligible individual to change from one plan to another at least once a year at a time determined by 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, disability, or survivor benefits under the police and firemen's disability and pension fund who is eligible for medical insurance coverage under part B of "The Social Security Amendments of 1965," 79 Stat. 301, 42 U.S.C.A. 1395j, as amended, an amount equal to the basic premiums for such coverage.

(D) The board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section with any similar coverage, payment, or benefit made available to the same individual by the public employees retirement system, 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.

History
HISTORY: 135 v H 430 (Eff 11-20-73); 136 v H 268 (Eff 8-20-76); 139 v H 126 (Eff 6-13-81); 139 v H 236 (Eff 2-2-82); 140 v H 631 (Eff 3-28-85); 142 v S 124 (Eff 10-1-87); 144 v H 382 (Eff 6-30-91); 146 v S 82 (Eff 3-7-97); 147 v S 67. Eff 6-4-97.

Analogous to former RC § 742.45 [131 v 318], repealed by § 2 of H 430 (135 v -) Eff 11-20-73.

APPENDIX B

Response to Questions Raised in Senator Drake's Memo Dated May 19, 1999

1) How does the retirement system currently fund retiree health care costs?

In 1992, the Board of Trustees transferred $150 million in assets to establish a Health Care Stabilization Fund. As a result of the interest generated, along with retiree contributions, rebates and recoveries, and 6.5 percent of employer contributions expressed as a percentage of payroll, the stabilization fund increased to $271,995,961 as of December 31, 1998.

2) What is the current and anticipated ratio of active members to retired members and the impact thereof upon the retirement system's funding of retiree health care cost?

The ratio was 1.7 active member to every 1 retired member in 1998. By 2008, it is anticipated that the ratio will be reduced to 1.5 to 1. Therefore, it is important to start changing our revenue streams now in order to keep up with this change.

3) What are the retirement system's ten-year projections for retiree health care costs as a percent of payroll and the underlying assumptions for those projections?

Net health care costs are currently 6.75 percent of active payroll. We expect the percentage to increase to 8.8 percent by 2008 which assumes a 1 percent increase in active members and a continued baseline health care trend as determined by actuarial assumptions. This also assumes an increase in the percentage of health care costs paid by benefit recipients through contributions.

4) How does the retirement board intend to address these future costs within the constraints of current revenue sources?

The Board's Health Care Committee is currently considering several strategies for changing the current health care contribution rates paid by benefit recipients so that benefit recipients would begin to absorb some portion of that health care cost inflation. Actuaries have advised management that benefit recipients must eventually absorb 8 percent of the health care expenses. Currently, benefit recipients contribute only 6.35 percent toward their health care costs and the rest s subsidized by the Fund. As health care costs continue to rapidly escalate, actuaries predict that, by 2007, members will contribute less than 4 percent toward the cost of their health care. Under the *Health Care Funding Policy Statement*, reducing benefits would be considered only if changes in benefit recipient monthly contributions and active member employer payroll contributions still failed to offset rising health care costs.

In 1998 the PFDPF board voted to incrementally increase the percent of payroll allocated to health care from 6.5 percent in 1998 to 8 percent by 2003. The percentage has been increased to 7 percent for 1999 and will increase in quarter percent increments thereafter until it reaches 8 percent in 2003. At that time, the plan will be reassessed and the percentage may be increased to 9 percent by 2007.

5) What percentage of gross health care costs are paid through the retirement system's funds? Through retiree premium charges?

For the year 1998, retirees contributed 6.35 percent towards health care. The remainder, 93.65 percent, was paid from the Health Care Stabilization Fund which is comprised of employer contributions (6.5 percent of member payroll) and interest generated from the account. The Health Care Stabilization Fund balance was $271,995,961 as of December 31, 1998.

6) When are the retirement system's health care fund balances expected to become depleted?

A study prepared by Fund actuaries in 1998 projected that the Fund's Health Care Stabilization Fund would be depleted by 2012 unless participant contributions were increased or benefits under the health care program were reduced. In 1998, benefit recipients contributed only 6.35 percent toward their health care costs and the rest was subsidized by the Fund. As health care costs continue to rapidly escalate, actuaries predict that, by 2007, members will contribute less than 4 percent toward the cost of their health care. The Fund's actuary has recommended that increasing employer contributions to 9 percent of payroll and increasing participant contributions to 8 percent of total program costs would maintain or increase the health care fund balances through 2027.

APPENDIX C

The Police and Firemen's Disability and Pension Fund
Schedule of Changes in Net Assets Available for Benefits
1993-1998

	1993	1994	1995	1996	1997	1998
Additions:						
Contribution of Pension Asset						
Employer Contributions	$60,635,808	$62,791,082	$67,128,959	$71,890,062	$75,277,682	$79,553,768
Retirant Contributions	4,810,931	4,897,139	4,965,059	5,119,195	5,251,898	5,331,515
Investment Income	12,641,884	14,006,268	15,382,302	17,021,606	20,647,822	23,034,445
Recoveries and Rebates	240,175	345,329	387,953	1,576,239	979,352	979,352
TOTAL ADDITIONS	78,328,799	82,039,818	87,864,273	95,607,102	102,156,754	108,899,080
Deductions:						
Healthcare Expenses	65,291,348	65,230,088	69,152,432	72,300,761	76,459,832	83,928,305
Administrative Expenses					3,048,819	2,396,457
TOTAL DEDUCTIONS	65,291,348	65,230,088	69,152,432	72,300,761	79,508,651	86,324,762
Net Increase	13,037,451	16,809,730	18,711,842	23,306,341	22,648,103	22,574,318
Net assets held in trust for postemployment healthcare benefits:						
Balance, Beginning of year	154,908,178	167,945,629	184,755,359	203,467,200	226,773,540	249,421,643
Balance, End of year	$167,945,629	$184,755,359	$203,467,200	$226,773,540	$249,421,643	$271,995,961

NOTES:

1. The Health Care Stabilization Fund was established in 1992 with an initial allocation of $150 million from the pension fund.
2. Retirant contributions toward healthcare expenses began in June, 1992.
3. Amounts for 1993-1996 are on a basis of cash receipts and disbursements; beginning in 1997, amounts are accrual basis as prescribed by GASB Statement No. 26.
4. Administrative expenses relating to healthcare were not allocated to the Health Care Fund prior to 1997.

APPENDIX D

Accounting, Asset Valuation and Funding Methods

1. Summary Of Significant Accounting Policies

The following are the significant accounting policies followed by the Police and Firemen's Disability and Pension Fund of Ohio (the Fund).

Basis of Accounting - The Fund's financial statements have been prepared using the accrual basis of accounting. Revenues are recognized when earned and measurable, and expenses are recorded when a liability is incurred.

Investments - Investment purchases and sales are recorded on a trade date basis. Dividend income is recognized on the ex-dividend date, while interest and rental income is recognized when earned.

Investments are reported at fair value. Short term investments are valued at cost, which approximates fair value. Securities traded on a national or international exchange are valued at the last reported sales price at current exchange rates. Mortgages are valued on the basis of future principal payments discounted at prevailing interest rates for similar instruments. The fair value of real estate is based on independent appraisals and internal valuations. Investments that do not have an established market are reported at estimated fair value. Venture capital limited partnership interest is based on values established by valuation committees.

Net appreciation (depreciation) is determined by calculating the change in the fair value of investments between the end of the year and the beginning of the year, less the cost of investments purchased, plus sales of investments at fair value. Investment expense consists of those administrative expenses directly related to the Fund's investment operations and a proportional amount of all other administrative expenses allocated based on the ratio of the Fund's investment staff to total Fund staff.

The Fund has no individual investment that exceeds 5 percent of net assets available for benefits.

Federal Income Tax Status - The Fund was determined to be exempt from Federal income taxes under Section 501(a) of the Internal Revenue Code.

Property and Equipment - Property and equipment are recorded at cost. Depreciation is computed using the straight-line method over the estimated useful lives of the related assets. The range of estimated useful lives is as follows:

Buildings	40 years
Furniture, fixtures and equipment	3 to 10 years

Contributions and Benefits - Member and employer contributions are recorded in the period the related member salaries are earned. Benefits and refunds are recognized when due and payable in accordance with the terms of the plan.

2. Asset Valuation Method

Valuation assets equal the net cost (book) value of all Fund assets, except common and preferred stocks are included in valuation assets with a value equal to that developed under the 4-year Market Adjustment Method, with an initial value equal to market value. Under this method realized and unrealized gains are recognized in the assets over a 4-year period: valuation assets equal market value less 75 percent of the previous year's realized and unrealized gains, 50 percent of the second previous year's realized and unrealized gains, and 25 percent of the third previous year's realized and unrealized gains. Future payments on the Employer Accrued Liability are capitalized at the valuation interest rate and the result is added to valuation assets. The balance in the Health Care Stabilization Fund is excluded from total assets to arrive at valuation assets for pension and disability benefits. Contributions due to be refunded to terminated members are also excluded from valuation assets.

3. Funding Method

Health care benefits are funded on a pay-as-you-go basis. In 1992 the Health Care Stabilization Fund (HCSF) was established by the Board of Trustees with an initial allocation of $150,000,000. This fund is credited with a portion of employer contributions equal to 6.5 percent of payroll, all retiree healthcare contributions, as well as investment income equal to the actuarial interest rate of 8.25 percent per year. The fund is charged with all health care expenses. As of December 31, 1998, the balance in the HCSF was $271,995,961.

APPENDIX E

The Police and Firemen's Disability and Pension Fund
Plan Net Assets Available for Postemployment Health Care Benefits
as of December 31, 1998

Assets	
Cash and Short-term Investments	$ 7,593,523
Receivables:	
Employers' Contributions	24,102,167
Accrued Investment Income	1,217,272
Investment Sales Proceeds	717,412
Total Receivables	26,036,851
Investments, at fair value:	
Bonds	41,106,875
Mortgage & Asset Backed Securities	48,746,845
Stocks	112,933,173
Real Estate	21,299,011
Commercial Mortgage Funds	3,429,284
Venture Capital	1,035,373
International Securities	23,936,228
Mortgage Note Receivables	397,942
Total Investments	252,884,731
Collateral on Loaned Securities	20,819,199
Fixed Assets:	
Furniture and Equipment	125,797
Accumulated Depreciation	(85,921)
Total Fixed Assets	39,876
Prepaid Expenses and Other	6,471
TOTAL ASSETS	307,380,651
Liabilities	
Medical Benefits Payable	9,840,916
Investment Commitments Payable	4,435,548
Accrued Administrative Expenses	145,047
Other Liabilities	143,980
Obligations Under Securities Lending	20,819,199
TOTAL LIABILITIES	35,384,690
Net assets held in trust for postemployment healthcare benefits	**$ 271,995,961**

APPENDIX F

The Police and Firemen's Disability and Pension Fund Statement of Changes in Plan Net Assets Available for Postemployment Health Care Benefits Year Ending December 31, 1998

Additions:	
Contributions:	
Employers	$ 79,553,768
Retirants	5,331,515
Total Contributions	84,885,283
Investment Income:	
Net Appreciation (Depreciation) of Fair Value of Investments	16,756,111
Bond Interest	4,836,135
Dividends	657,275
Real Estate Operating Income, net	933,198
Foreign Securities	133,375
Other	9,315
Less Investment Expenses	(325,236)
Net Investment Income	23,000,173
From Securities Lending Activities:	
Securities Lending Income	954,562
Securities Lending Expense:	
Borrower Rebates	(898,944)
Management Fees	(21,346)
Total Securities Lending Expense	(920,290)
Net Income from Securities Lending	34,272
Other Income	979,352
TOTAL ADDITIONS	108,899,080
Deductions:	
Healthcare Benefits	83,928,305
Administrative Expenses	2,396,457
TOTAL DEDUCTIONS	86,324,762
Net Increase	22,574,318
Net assets held in trust for postemployment healthcare benefits:	
Balance, Beginning of year	249,421,643
Balance End of year	$ 271,995,961

APPENDIX G

Major Medical Plan Premiums

Contributions for major medical and prescription drug coverage are deducted monthly from the benefit recipient's check. Most benefit recipients and their eligible dependents are charged a monthly premium for major medical coverage. The contributions required for participation in all parts of the PFDPF Medical Expense Benefits Program are indicated below.

Monthly Major Medical Contribution Schedule (includes prescription drug coverage)

CATEGORY	NO MEDICARE	MEDICARE A & B	MEDICARE B ONLY
Member with Service Pension LESS than $10,000 annually	$0.00	$0.00	$0.00
Member with Service Pension $10,000 or MORE annually	$10.00	$5.00	$5.00
Member with Disability Pension LESS than $10,000 annually			
Permanent & Total	$0.00	$0.00	$0.00
Maximum Partial	0.00	0.00	0.00
Below Maximum Partial	40.00	5.00	5.00
Off Duty	40.00	5.00	5.00
Pre-1947	0.00	0.00	0.00
Member with Disability Pension $10,000 or MORE annually			
Permanent & Total	$10.00	$5.00	$5.00
Maximum Partial	10.00	5.00	5.00
Below Maximum Partial with 25 or MORE years of service	10.00	5.00	5.00
Below Maximum Partial with LESS than 25 years of service	40.00	5.00	5.00
Off Duty	40.00	5.00	5.00
Pre-1947	10.00	5.00	5.00
Surviving Spouse with Pension LESS than $10,000 annually (including any death benefit)	$0.00	$0.00	$0.00
Surviving Spouse with Pension $10,000 or MORE annually (including any death benefit)	$40.00	$0.00	$0.00
Surviving Spouse who remarries	$40.00	$40.00	$40.00
Dependent Spouse	$40.00	$0.00	$0.00
Dependent Child(ren)			
Under age 18	$0.00	$0.00	$0.00
Full-time student, ages 18 to 22 (per student)	$50.00	$0.00	$0.00
Orphan	$0.00	$0.00	$0.00
This information is for Kaiser Permanente participants only:			
Kaiser Member with Pension LESS than $10,000 annually	$0.00	$0.00	$0.00
Kaiser Member with Pension $10,000 or MORE annually	$0.00	$5.00	$5.00
Kaiser Surviving Spouse with Pension LESS than $10,000 annually (including any death benefit)	$0.00	$0.00	$0.00
Kaiser Surviving Spouse with Pension $10,000 or MORE annually (including any death benefit)	$0.00	$5.00	$5.00
Surviving Spouse who remarries	$40.00	$40.00	$40.00
Kaiser Dependent Spouse	$0.00	$0.00	$0.00
Kaiser Dependent Child(ren)			
Under age 18	$0.00	$0.00	$0.00
Full-time student, ages 18 to 22 (per student)	$50.00	$0.00	$0.00

APPENDIX H

Health Care Funding Policy

The Police and Firemen's Disability and Pension Fund Board of Trustees recognizes the limitations imposed by law on the cost of health care benefits. The Fund will manage the terms of the health care benefits program in a manner that, over the long term, ensures the solvency of the Fund with respect to providing pension and disability benefits.

To determine the affordable level of health care costs, the Board will utilize forecast studies prepared by the actuary on at least a quinquennial basis (every five years) or other studies commissioned by the Board on an ad hoc basis. The forecast studies will be prepared following each Quinquennial Experience Study, so as to best reflect current expectations of PFDPF pension and health care liabilities.

The cost of health benefits is funded through benefit recipient paid contributions and through contributions that employers pay on behalf of active members. The Fund understands that the employers contribution for all benefits, both pension and health care, has been set by statute as a percentage of payroll. The assumed level percentage of 6.5 percent of active member payroll was determined in 1991, via a forecast study, to be the long-term affordable level to be devoted to health care based on actuarial experience at that time. The Fund will adjust the percentage of active member payroll used for health care benefits at least every five years to the maximum level consistent with the Fund's primary obligation to pay pension benefits.

Based on the projected health care costs included as part of the forecast studies and after paying costs covered by the current percentage of active member payroll and the amount of Health Care Stabilization Funds deemed prudent by the Board, the monthly contributions for benefit recipients and dependents will be adjusted to pay all remaining health care costs. When adjusting contributions by benefit recipients, the Board will apportion the contributions among the benefit recipient and dependent population after considering many factors.

If changes in benefit recipient monthly contributions and active member payroll contributions fail to offset rising health care costs, the Board will consider changes to health care benefit levels.

The Fund will ensure that this funding policy is effectively communicated to the Fund's membership and will work toward improving the membership's understanding of the issues surrounding the funding of health care benefits.

APPENDIX I

Health Maintenance Organization (HMO) Coverage

HMO Benefit Comparison Chart

Description	Aetna	MMO	Kaiser	Paramount	United HealthCare
PHYSICIAN SERVICES					
Office Visit with PCP	$5 copay	$10 copay	$5 copay	$5 copay	$5 copay
Specialist					
Consultation	$5 copay	$10 copay	$5 copay	$5 copay	$5 copay
Treatment	100%	100%	$5 copay	$5 copay	$5 copay
Immunizations & Inoculations	100%	100%	100%	$5 copay	$5 copay
Allergy Treatment/Testing	$5 copay	copays: $10 /$25	100%	$5 copay	$5 copay
Diagnostic x-ray & Lab testing	100%	100%	100%	100%	100%
Podiatrists	$5 copay (if medically necessary)	$10 copay	$5 copay (if medically necessary)	$5 copay if medically necessary/2 preventive visits per year	$5 copay/1 preventive visit per yr
Chiropractors	$5 copay for 20 visits per year/50% for visits after 20	$10 copay, 20 visits per year (includes physical therapy)	Subluxation: $5 copay	Subluxation: $5 copay Other: $5 copay for 20 visits/then 50% unlimited	Subluxation:$5 copay Other: $5 copay, limit of 20 visits
PREVENTIVE SERVICES (one per year)					
Physical Exams	$5 copay	$10 copay	$5 copay	$5 copay	$5 copay
Routine PSA Test	100%	100%	$5 copay	$5 copay	$5 copay
Routine Mammogram	100%	100%*	$5 copay	$5 copay	$5 copay
Routine PAP Smear	100%	100%*	$5 copay	$5 copay	$5 copay
Routine Eye Exam	$5 copay	Not Covered	$5 copay	$5 copay	$5 copay
Routine Hearing Exam	$5 copay	Not Covered	$5 copay	$5 copay	$5 copay
**one gynecological exam per year covered with participating GYN, without PCP referral*					
HOSPITAL SERVICES					
Hospital Confinement	100%	100%	100%	100%	100%
In-patient Physician Visit	100%	100%	100%	100%	100%
Surgical procedures (inpatient and outpatient)	100%	100%	100%	100%	100%
EMERGENCY ROOM					
Hospital Charges	$25 copay waived if admitted	$50 copay waived if admitted	$25 copay waived if admitted	$25 copay waived if admitted	$25 copay waived if admitted
Ambulance	100%	$25 copay	100%	100%	100%
MENTAL HEALTH					
Inpatient Confinement	100% (unlimited)	100%, 30 days/ calendar yr. (3 per lifetime)	100% (unlimited)	100%	100% (unlimited)
Outpatient Care	$5 copay (unlimited)	$10 copay, 20 visits per yr.	$5 copay (unlimited)	$5 copay (unlimited)	Group: $5 copay Individual: $10 copay (both unlimited)

The benefits for each carrier's Medicare HMO and regular HMO are equivalent.

Health Maintenance Organization (HMO) Coverage (cont'd)

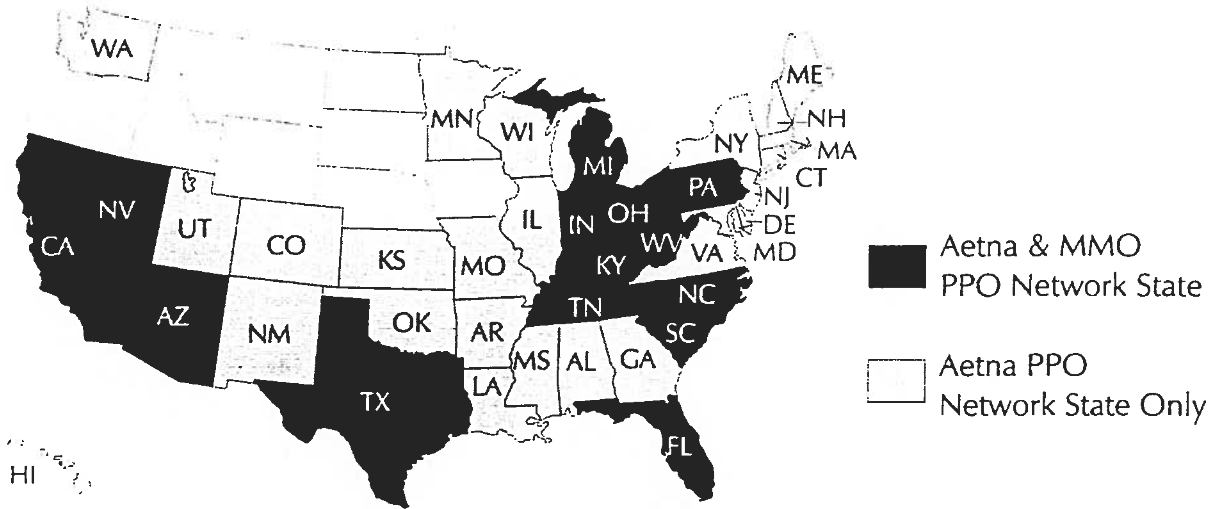
HMO Benefit Comparison Chart

Description	Aetna	MMO	Kaiser	Paramount	United HealthCare
ALCOHOL & SUBSTANCE ABUSE					
Inpatient Confinement	100% (unlimited)	100%, 30 days/ calendar yr.	100%	100%	100%
Outpatient Care	$5 copay (unlimited)	$10 copay, 20 visits per yr.	$5 copay	$5 copay (unlimited)	$5 copay
OTHER SERVICES					
Skilled Care Facility	100%, 100 days/ benefit period	100%, 100 days/ calendar year	100%, 100 days/ calendar yr. or benefit prd.	100%, up to 100 days/ benefit period	100%
Home Health Care	100% (unlimited)	100%	100%	100%	100%
Hospice Services	100%	100%	100%	100%	100%
Outpatient Therapy Services	$5 copay (unlimited)	$10 copay, 10 visits, speech 20 visits, other	100%	100%	100%
Durable Medical Equipment	100%	100%	100%	100%	100%
Hearing Aid Allowance	$700 every 36 mos.	Not Covered	100% every 3 years	$700 every 3 years	$700 every 3 years
Vision--Glasses & Contacts (Covered 100% under all plans if if in conjunction with cataract surgery)	$200 every 24 mos.	Not Covered	Lenses: 100% every yr.* Contacts: $100 every yr. (in lieu of lenses) Frames: $90 every 2 yrs	$500 every 2 years	$300 every 2 years
DENTAL COVERAGE					
Deductible	None	n/a	None	$50 per person/$150 family maximum	$50 single
Annual Maximum	None	n/a	None	$1500 per year	$1500 per year
Preventive	$2 copay	Not Covered	100%	100% with no deductible	100%, no deductible
Basic Care	Discounted fees	Not Covered	Discounted copays	80% after deductible	80% after deductible
Major Restorative Care	Discounted fees	Not Covered	Discounted copays	50% after deductible	50% after deductible
Network Providers Required	Yes	n/a	Yes	Recommended	Yes

Primary Care Physician must provide and/or arrange for all health care. United HealthCare is the only HMO which allows participants to utilize specialists without a referral (must utilize UHC participating providers, however). All benefits subject to medical necessity requirements and/or prior approval by the HMO.

APPENDIX J

ORS Individual Option Network (PPO) States



APPENDIX K

Individual Option Network (PPO) Benefits Comparison Chart

The benefit coverage for benefit recipients residing in areas considered "in-network" and "non-network" are explained in the Network (PPO) Comparison Chart below. For complete information, please refer to the individual administrator's medical plan description or contact PFDPF Benefit Services Department. Please note that routine health check-ups and claims that the insurance company determines are for maintenance care are NOT covered under the Individual Option Network (PPO).

Description	Non-Network *Medicare A&B eligible/ Permanent residents of non-network area.*	Network *Member & dependents assigned to a PPO network and using network providers.*	Out-of-Network *Member & dependents assigned to a PPO network, but using non-network providers.*
GENERAL INFORMATION			
Major Plan Features	Use any provider	Use network provider	Use any provider
Deductible (per plan year):			
Benefit recipient	$100.00	$100.00	$250.00
Family	200.00	200.00	500.00
(no carryover)			
Max. Annual Out-of-Pocket:	Excludes deductible	Excludes deductible	Excludes deductible
Benefit recipient	$500.00	$500.00	$1,500.00
Family	750.00	750.00	2,250.00
Lifetime Maximum	$1,000,000.00	$1,000,000.00	$1,000,000.00
Claim Forms	Yes	No	Yes
Pre-certification/ Utilization review	Patient responsible	Provider responsible	Patient responsible
Pre-certification penalty:			
Inpatient (per admission)	$200.00	None	$200.00
Outpatient	100.00	None	100.00
Managed Second Opinion			
Surgery	$100.00	None	$100.00
PHYSICIAN SERVICES			
Office visits	80%	$10.00 copay	70%
Surgeon/Consultation fees	80%	80%	70%
Services not available in network	80%	80%	80%
Surgeons/Surgery fees	80%	80%	70%
OB/Maternity visits & delivery	80%	80%	70%
Diagnostic, x-ray & lab fee	80%	80%	70%
HOSPITAL SERVICES			
Per admission deductible	None	None	$100.00
Inpatient coinsurance	100%	100%	70%
Outpatient			
Pre-admission testing	100%	100%	70%
Surgery	100%	100%	70%
All other	80%	80%	70%
EMERGENCY ROOM			
Hospital Emergency Care* (includes associated tests & physician charges)	$50 copay for facility (waived if admitted); 80% other charges	$50 copay for facility (waived if admitted); 80% other charges	$50 copay for facility (waived if admitted); 80% other charges

Individual Option Network Benefits Comparison Chart, cont'd.

Description	Non-Network	Network	Out-of-Network
MENTAL HEALTH**			
Inpatient & partial hospitalization coinsur. (includes drug abuse)	100%	100%	70%
Mental/Nervous & Drug Abuse outpatient coinsur.	80%	80%	70%
Alcoholism inpatient coins.	100%	100%	70%
Alcoholism outpatient coinsurance	80%; annual maximum benefit=$550.00	80%; annual maximum benefit=$550.00	70%; annual maximum benefit=$550.00
PREVENTIVE CARE***			
Well baby/child care	Age 0-1=80%, $500/yr Age 1-9=80%, $150/yr	Age 0-1=80%, $500/yr Age 1-9=80%, $150/yr	70%
Routine PAP Smear Max. one per calendar yr.	80%	$10 copay for physician services; 80% for lab	70%
Routine Mammogram Max. $85 annual benefit	80%	$10 copay for physician services; 80% for lab	70%
Routine PSA Max. $85 annual benefit	80%	$10 copay for physician services; 80% for lab	70%
OTHER COVERED EXPENSES			
Skilled nursing facility	100%, up to 365 days	100%, up to 365 days	70%, up to 365 days
Chiropractors & physical therapists**, durable medical equipment & ambulance**	80%	80%	70%, limit of 24 chiropractic visits
Acupuncturist (in lieu of anesthesiologist)	80%	80%	70%
Private duty nurse, home health care	80%, private duty limit of 120 8-hr shifts per calendar year	80%, private duty limit of 120 8-hr shifts per calendar year	70%, private duty limit of 120 8-hr shifts per calendar year
Hospice care	*Lifetime maximum=*	*Lifetime maximum=*	*Lifetime maximum=*
Inpatient	100%, up to 30 days	100%, up to 30 days	80%, up to 30 days
Outpatient	80%, limited to benefit of $3,000.00	80%, limited to benefit of $3,000.00	70%, limited to benefit of $2,000.00

**Must be on same day as injury or illness*

***Covered for alcohol or drug abuse treatment only if treatment is for underlying causes leading to rehabilitation from such addiction. Detoxification alone is not covered.*

****Routine health check-ups and claims that the insurance company determines are for maintenance care are NOT covered under the Individual Option Network. The HMOs do cover these services.*

*****Chiropractic care must be non-maintenance care, and physical therapy treatments must be performed by registered therapist and recommended by physician.*

APPENDIX L

Prescription Drug Benefits

Prescription Drug Benefits Chart

The chart below lists the benefits available through the Prescription Drug Program. Benefit recipients should consult their Prescription Drug Program brochure for more information on using the retail and mail prescription services.

DESCRIPTION	RETAIL PROGRAM	MAIL PROGRAM
When to use	Short-term or immediate need	Long-term or ongoing use
You pay	**Participating Pharmacies:** $5.00 for generic $10.00 for brand names **Non-participating Pharmacies:** $7.50* for generic $15.00* for brand name **After deductible is satisfied*	$1.00 for generic $5.00 for brand names
Drug supply per Rx (as prescribed by physician)	Up to 60 days	Up to 60 days
Drug deductible	**Participating Pharmacies:** None **Non-Participating Pharmacies & when claim forms filed:** $50.00 per person $100.00 family maximum	None
Claim form required	**Participating Pharmacies:** No **Non-participating Pharmacies:** Yes	No

APPENDIX M

Supplemental Dental Coverage

Dental Coverage Chart

Deductible (per year)
$50 single/$100 family
Calendar Year Maximum
$1,500 per person

ONE PLAN WITH TWO NETWORKS. This dental plan consists of two networks–the DeltaPreferred Option Plus and the DeltaPremier. Participants receive the maximum benefit level when utilizing the DeltaPreferred Network.

DESCRIPTION OF PROCEDURE	*DeltaPreferred Option Plus Utilizing DeltaPreferred Option Plus Network dentist*	*DeltaPremier & any dentist Utilizing Premier Network or dentist in neither network/ Pays up to usual, customary & reasonable limits*
Class I Benefits	**Delta Dental Pays**	**Delta Dental Pays**
Diagnostic Services	100% with no deductible	80% with no deductible
Preventive Services	100% with no deductible	80% with no deductible
Emergency Palliative	100% with no deductible	80% with no deductible
Radiographs	100% with no deductible	80% with no deductible
Oral Surgery (minor)	60% after deductible	50% after deductible
Minor Restorative	60% after deductible	50% after deductible
Periodontics (minor)	60% after deductible	50% after deductible
Endodontics	60% after deductible	50% after deductible
Class II Benefits	**Delta Dental Pays**	**Delta Dental Pays**
Prosthodontics	25% after deductible	25% after deductible
Major Restorative	25% after deductible	25% after deductible

APPENDIX N

Supplemental Vision Coverage

DESCRIPTION	PLAN PAYS
Eye Exams*	$50 for one exam every 12 months
Frames	$20 for one pair every 24 months
Lenses	Every 24 months:
Single Vision	$30
Bifocals	$40
Trifocals	$60
Lenticular	$100
Contact Lenses	$160 every 24 months

**This is for routine eye exams only! If the doctor determines that there is a related medical condition at the time of the exam (i.e. glaucoma, cataracts, etc.), then the claim will NOT be paid under this vision plan. The claim may be paid, however, under the benefit recipient's major medical benefits and subject to the deductibles of the medical plan.*

APPENDIX O

Supplemental Dental and Vision Plan Premiums

Who's Covered	Aetna Vision	Delta Dental
Benefit Recipient (including survivors)	$5.63	$12.82
Benefit Recipient & Spouse	11.26	25.05
Benefit Recipient & Child(ren)	9.56	24.03
Benefit Recipient, Spouse & Child(ren)	15.19	40.78