Ohio Public Employees Retirement System

health care

Providing OPERS retirees with access to quality health care coverage

OPERS 2011 Health Care Report

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Ohio Public Employees Retirement System

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TABLE OF CONTENTS

Executive Summary 1

OPERS Health Care History 2

Operational and Financial Strategic Objectives 5

Financial Performance 12

Future Challenges and Opportunities 18

Statutory Requirements 19

Appendices 25

OPERS is pleased to provide to the Ohio Retirement Study Council (ORSC) a summary of the significant events of 2011 and a full accounting of the health care program as required by Section 145.22 of the Ohio Revised Code. The OPERS Board of Trustees recognizes that providing access to quality health care coverage is an important element in providing retirement security for our retirees and their dependents. As such, the OPERS Board manages the health care program responsibly to maximize the life of the health care trust fund.

OPERS utilizes a multi-faceted approach to managing its retiree health care program so that access to coverage can be provided to both current and future generations of retirees. The OPERS plan for managing the health care program involves controlling expenditures through active management, continually evaluating plan design and maximizing revenue through investment returns.

Events in 2011 pertaining to the OPERS retiree health care plan include the following:

- **Plan design changes** – In an effort to extend the solvency, or life, of the health care trust fund, the OPERS Board evaluated plan design change options. OPERS will communicate these potential changes to members in 2012 and ask for their feedback prior to the finalization of any changes.
- **Fund size** – Total health care fund assets at December 31, 2011 were $11.6 billion.
- **Investment income** – During 2011 the capital markets experienced a significant amount of volatility largely due to the European debt crisis and the political debate on increasing the U.S. debt ceiling. While the OPERS health care fund outperformed its benchmark by approximately 20 basis points, the fund retained a -0.52 percent resulting in a loss of approximately $1 million. In 2010 the fund returned 13.53 percent.
- **Patient Protection and Affordable Care Act (PPACA)** – Effective January 1, 2011, OPERS was compliant with all applicable requirements of the PPACA. Plan design enhancements required by the PPACA including an unlimited lifetime maximum were also introduced in 2011. OPERS also participated in the Early Retirement Reinsurance Program (ERRP), a provision of PPACA. OPERS received approximately $180 million in ERRP reimbursement. This is the third largest amount returned to any organization. These funds will be used to fund expenses related to the cost of providing health care coverage for retirees.
- **Medicare Part D** – In 2011 OPERS began offering a Medicare Part D Prescription Drug Plan to Medicare-eligible enrollees. The Medicare Part D Plan provided retirees with a number of enhancements including Medication Therapy Management, an annual out-of-pocket maximum and a low income subsidy.
- **Member cost share** – In an effort to achieve a 20 percent member cost-share target for 2012, changes were made to the non-Medicare Enhanced Plan including increasing deductibles and out-of-pocket maximums. Value-based plan design features were also adopted including a differential copayment for primary care physicians vs. specialists, a higher emergency room copayment for non-emergency conditions, and additional drug coverage.
- **Provider (vendor) changes** – Effective January 1, 2011, MetLife replaced Aetna as the dental plan provider for the OPERS health care plan.

The OPERS Board of Trustees and staff are aware of the significant challenges ahead in the form of increasing health care costs, health care reform implementation, increased longevity, reduced contributions to the health care fund and a growing retiree population due to the retirement of baby boomers. OPERS is committed to finding solutions to address these challenges so that we can continue to provide access to quality health care coverage for our retirees.

Prior to 1990

OPERS first offered health care coverage to its retirees in 1962. The plan was not subsidized by the system. The retiree paid the entire premium. In 1974, OPERS first began paying premiums for retirees.

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

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

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

1990 - 1999

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

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

2000 - 2005

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

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

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

2006 - 2010

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

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

In April 2007, the OPERS Board approved increasing the target solvency period from the 15-25 year range previously approved to a 20-40 year range. To achieve this goal, OPERS created an updated long-range, strategic proposal consistent with the principles of the HCPP.

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

In April 2008 Express Scripts, Inc. began serving as the pharmacy benefit manager (PBM) for the OPERS health care plan.

2006 - 2010 *(continued)*

The lifetime health care coverage maximum under the OPERS health care plan increased to $3 million in 2009.

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

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

The Patient Protection and Affordable Care Act (PPACA), also referred to as health care reform, was signed into law by President Obama in 2010 and contained numerous provisions that may impact the OPERS health care plan from 2011 to 2018.

In 2010, OPERS modified its medical plan design to incrementally increase retiree cost-share. The increase was seen in changes such as increased out-of-pocket maximums, deductibles and co-pays, as opposed to charging retirees more to participate in the plan.

In 2010, OPERS conducted a Request for Proposal (RFP) process to select an administrator(s) for the optional dental and vision coverage portions of the OPERS health care plan. An RFP process to select an administrator for the OPERS Retiree Medical Account (RMA) program was also launched.

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

2011

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

In 2011, OPERS began offering a Medicare Part D Prescription Drug Plan to Medicare-eligible enrollees. The Medicare Part D Plan provided retirees with a number of enhancements including Medication Therapy Management and an annual out-of-pocket maximum.

MetLife replaced Aetna as the dental plan provider for the OPERS health care plan. AultCare PPO plan was eliminated as a health plan option due to low enrollment.

Effective January 1, 2011, OPERS was compliant with all applicable requirements of the Patient Protection and Affordable Care Act (PPACA). OPERS participated in the Early Retirement Reinsurance Program (ERRP), a provision of PPACA. OPERS received approximately $180 million in ERRP reimbursement. This is the third largest amount returned to any organization. Plan design enhancements required by the PPACA including an unlimited lifetime maximum were also introduced.

OPERS also adopted additional value-based insurance plan design features in 2011, encouraging participants to use high valued services.

OPERS realized savings from the Employer Group Waiver Plan (EGWP) for Medicare-eligible participants and also partnered with Express Scripts to add a wrap plan to the existing EGWP to maximize savings.

2011 changes to the Non-Medicare prescription drug coverage included the introduction of an annual deductible for brand name prescriptions, coinsurance for brand drugs, and elimination of coverage for brand name Proton Pump Inhibitors (PPIs).

OPERS HEALTH CARE CHRONOLOGY OF PROGRESS

	Year	
Health care coverage begins Group Rates – zero percent subsidy	1962	
	1974	**OPERS pays premium** **OPERS begins funding health care trust**
OPERS offers Kaiser HMO	1975	
Eligibility increases from five to 10 years of service	1986	
	1993	**PPO model replaces indemnity** two health plan choices
Preventive services expand flu vaccines, physical, etc.	1999	
	2000	**Rx co-pay increases** OPERS consumerism model begins
Eligibility is tied to years of service **OPERS introduces Disease Management**	2003	
	2004	**OPERS introduces incentive formulary** deductibles, co-pays and out-of-pockets **Manages prescription drug costs below national average**
OPERS introduces active management of health care program **OPERS helps create National Public Sector Health Care Roundtable**	2005	**Investments contribute $900 million to health care fund** **$33 million in generic savings**
OPERS develops comprehensive wellness program	2006	**Contributions change** **Medicare D subsidy begins**
OPERS implements Health Care Preservation Plan **OPERS Board of Trustees approves Health Care Preservation Plan 2.0**	2007	**Implements wellness program** **Develops incentive structure and Medicare Advantage Plan strategy**
Express Scripts becomes the pharmacy benefit manager for the OPERS health care plan	2008	**OPERS introduces the Aetna Medicare Open Plan**
OPERS releases a RFP to select a medical coverage administrator(s)	2009	**OPERS increases lifetime health care coverage maximum to $3 million**
Federal health care reform legislation was signed into law	2010	**OPERS introduces the Humana Medicare Advantage Plan for Medicare-eligible plan participants**
OPERS was compliant with all applicable requirements of the Patient Protection and Affordable Care Act (PPACA) **OPERS participated in the Early Retirement Reinsurance Program (ERRP) and received approximately $180 million in ERRP reimbursement**	2011	**OPERS began offering a Medicare Part D Prescription Drug Plan to medicare-eligible enrollees** **OPERS adopted additional value-based insurance plan design features, encouraging participants to use high valued services**

Securing health care coverage

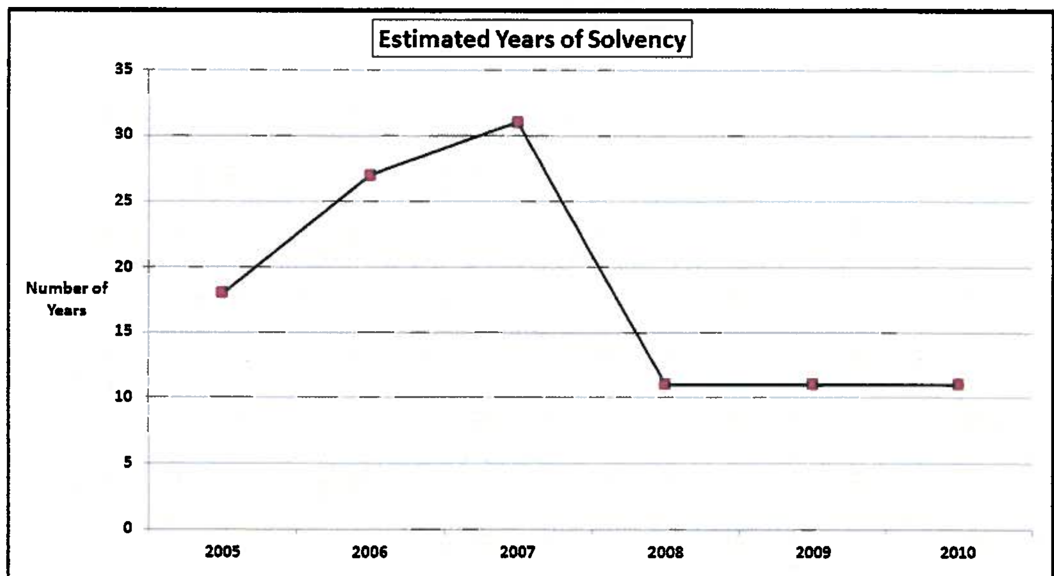
OPERS has a long history of providing retirement benefits and retiree health care coverage. But, like other payors of health care from the federal government to private industry, OPERS has experienced significant inflationary pressures resulting in increased annual expenditures. OPERS had the foresight and discipline with favorable financial results over the past decades to establish a $11.6 billion fund to prefund health care. Through investments and employer contributions, the System has also exercised the same discipline and thoughtful leadership to control spending to provide access to health care coverage for as long as possible.

A realistic plan; commitment to solvency

In 2004, the OPERS Board and staff had the foresight to adopt the Health Care Preservation Plan (HCPP). HCPP is a multi-faceted collaborative effort originally aimed at achieving an average of 15 to 25 years of solvency for the health care fund. The Board charged staff to implement a multi-platform plan design by January 1, 2007.

To help secure health care coverage for the future, OPERS has embraced a philosophy of active management where challenges such as escalating drug costs are tackled head-on using proactive strategies. The Board and staff have regularly reacted to marketplace developments to capitalize on cost saving opportunities. Based on current funding levels, OPERS' actuaries estimate that every $150 million in savings adds an additional year of solvency. As of December 31, 2011, the savings from HCPP changes cumulatively added approximately $2.78 billion to the OPERS health care fund.

As is shown in the chart below, the solvency of the OPERS health care fund was 11 years at the end of 2008, 2009 and 2010, meaning that if no additional contributions were made into that fund, it would be exhausted in 11 years assuming current health care costs. Note that solvency will automatically decrease by one each year. In order to maintain or increase solvency, savings must be achieved either through increased revenue (investment returns), reduced expenses or plan design changes.



Source: 2011 Comprehensive Annual Financial Report

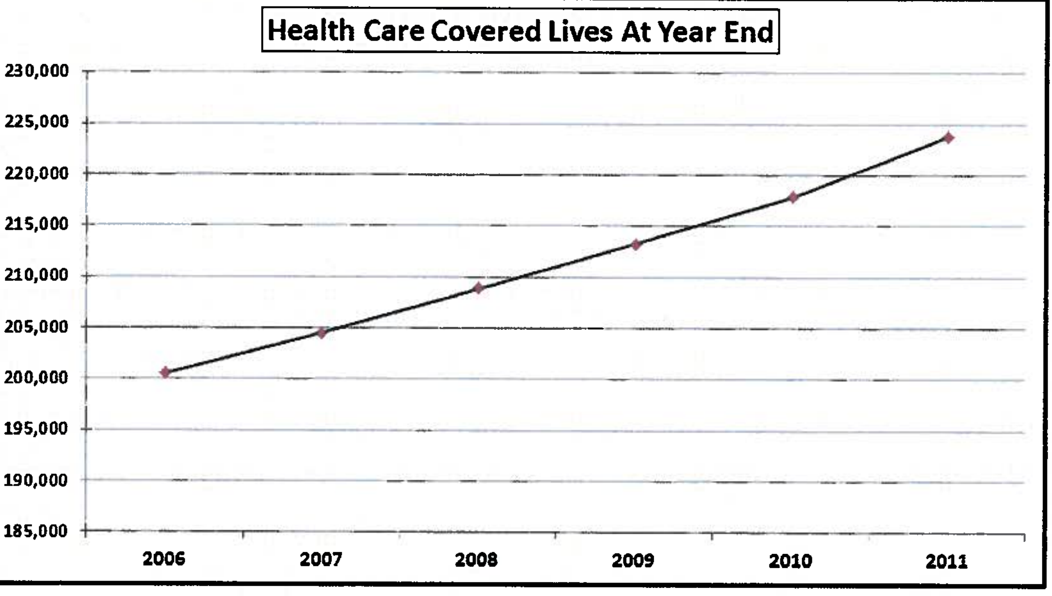
In 2007, the OPERS Board approved a policy to increase the funding and necessary cost controls to expand the target solvency period from the original rolling 15-25 years to a rolling 20-40 years.

The Board approved this increase in the targeted solvency period for multiple reasons, including:

A) Demographics – the average length of retirement has increased as a result of longer life spans. Life expectancy at age 60 has increased 8.16 years in the last 54 years based on the U.S. Department of Health, Education and Welfare, IRS.

B) Expected population growth – OPERS currently serves more than 217,000 covered lives. This population is expected to increase to 400,000 in less than 20 years, underscoring the need to provide access to health care coverage for future retirees, and help secure retirees' finances.

C) Estimated future health care cost projections – the peak of future health care cost projections is estimated to occur near 2046. One goal of the HCPP is to encourage our contributing members, or the active work force, to consider working longer to help pay for access to health care coverage and enroll at a later age. Working longer also allows members to save for future retiree health care costs through the Ohio Public Employees Deferred Compensation Program.



	2006	2007	2008	2009	2010	2011
Covered Lives	200.494	204,514	208,857	213,220	217,893	223,822
Percent Increase Over Prior Year	2.94%	2.01%	2.12%	2.09%	2.19%	2.72%

Source: 2011 Comprehensive Annual Financial Report

The future of the OPERS health care plan

As guided by the Health Care Preservation Plan originally implemented in 2007, OPERS continues to monitor industry developments, retiree population patterns and financial market factors that drive health care decisions for the future. OPERS has realized significant progress in keeping costs increases down with this approach.

Between 2007 - 2011 OPERS designed and implemented a much more dedicated program for wellness, worked collaboratively with the other Ohio retirement systems during the medical RFP process, finalized the transition to a new Pharmacy Benefit Manager (PBM) and introduced a Medicare Advantage Plan and a Medicare Part D Prescription Plan. OPERS continued to implement numerous changes over the course of these years with many initiatives still actively being developed and implemented in 2011.

Health Care Preservation Plan summary of current activities:

1. **Member Cost Share Policy 10-20 percent (2008-2012)**
   Status – Medicare-eligible participants currently pay approximately 18 percent of the cost not paid by Medicare. Non-Medicare participants pay approximately 14.7 percent of the cost. Projected plan design changes were made with a target of reaching the 20 percent cost share target with the next few years.
2. **Eligibility – spousal eligibility at 55 years of age (2011)**
   Status – Eliminates subsidy for spouses under the age of 55. Spouses under age 55 still have access to coverage but are required to pay 100 percent of the cost.
3. **Legislative initiatives – OPERS Board authority to set Medicare B reimbursement level**
   Status – The legislature approved allowing the OPERS Board to set the Medicare Part B reimbursement subject to a cap of $96.40 per month unless a recipient is receiving reimbursement from another source, in which case, the OPERS reimbursement will be reduced accordingly. The OPERS Board approved a reimbursement rate of $96.40 for 2011.
4. **Asset reallocation to improve investment return assumption (2007-2011)**
   Status – During 2011, the OPERS Investment Division continued implementation of the health care fund asset reallocation. The reallocation was designed to improve the projected level of future returns and reduce risk to better meet future health care coverage needs. Starting January 2012, a two percent additional allocation to fixed income will be made along with a reduction in public equities.

Health Care Preservation Plan – beyond 2011

The retirement of baby boomers, longer life expectancies, increasing health care costs and the decreased availability of employer contributions have resulted in the OPERS Board re-evaluating health care plan changes in order to preserve the program for as long as possible. Nationally, health care expenditures continue to increase.

These trends place OPERS' health care program in a challenging position. The OPERS $11.6 billion health care fund is one of the nation's best for public pension systems. Without substantive changes, projections indicate a potential decline of the fund to zero by 2020. Maintaining the status quo is not an option. The challenges are too far-reaching to consider simply maintaining the same plan.

With that in mind, OPERS has evaluated health care plan changes. The OPERS Board has been reviewing key health care issues for many months, focusing on providing a health care program for career employees. OPERS will share preliminary decisions with members and gather their feedback prior to the finalization of changes in 2012.

Wellness and disease prevention
OPERS continues to invest in the health and wellness of OPERS retirees and eligible dependents. Wellness, disease management, and other personal health management-related programs and resources are offered through OPERS' medical plan administrators, Medical Mutual of Ohio for Non-Medicare participants (over 18 years of age) and Humana for Medicare beneficiaries. Personal health management resources include the following:

- A Health Assessment to help individuals understand their health risks and develop a plan for reducing the risk of developing chronic conditions such as heart disease and diabetes.
- Continuation of 100 percent coverage for an annual physical exam and preventive services recommended by the United States Preventive Services Task Force to allow for the early identification of potential health concerns.
- Personal health coaches provide Lifestyle Coaching Programs to OPERS participants focused on a broad range of health topics including weight management, tobacco cessation, stress management, healthy eating, physical activity, back care and preventive health. Structured weight management programs (e.g. Weight Watchers) and smoking cessation programs are also available.
- Access to Disease Management coaches who work one-on-one with participants who have chronic conditions such as asthma, heart disease, heart failure, diabetes, and others. Specially trained registered nurses provide phone-based coaching to help Disease Management participants manage their health in between doctor visits.

In addition, OPERS participants enrolled in Humana are offered condition-specific classes and seminars in Humana's Guidance Centers located in Columbus, Cincinnati and Cleveland as well as many other states throughout the country. Humana participants also have access to Silver Sneakers, a nationally known health, wellness, and exercise fitness program helping older adults and seniors live fit, active and independent lifestyles and see benefits of healthy aging. Approximately 19,000 OPERS Medicare participants participated in Silver Sneakers in 2011.

Retiree and dependent participation in OPERS' personal health management programs is voluntary. In 2011, almost 82,000 retirees and eligible dependents completed a health assessment and/or received an annual physical exam. In addition, approximately 13,000 OPERS retirees and dependents took advantage of the lifestyle/wellness or Disease Management offerings from Medical Mutual of Ohio and Humana.

To promote the awareness of health risks by retirees and personal health management, OPERS offers participants financial incentives for completing specific wellness-related activities. Participants may earn up to $100 per year into their Retiree Medical Account (RMA) for the following activities:

- Complete a Health Risk Assessment
- Undergo an Annual Physical Exam
- Complete a Wellness Program
- Successfully participate in a Disease Management Program

In 2011, approximately $4.2 million was deposited into RMA accounts for 75,000 OPERS retirees and eligible dependents as incentives for participating in and/or completing wellness-related activities.

Preventive services

Preventive care helps doctors and participants diagnose and treat potential health problems earlier. It shifts the focus of health care delivery from treating disease to preventing disease. This shift will ultimately result in lower healthcare expenses and a better quality of life for retirees. OPERS covers at 100 percent all preventive services recommended by the U.S. Preventive Services Task Force that have received an "A" or "B" grade from the Task Force. OPERS also covers at 100 percent one routine physical exam each year.

Clinical quality improvement

During 2011, the Clinical Quality Improvement Committee (CQIC), which is comprised of health care strategists and clinicians from the Health Care division, OPERS' vendor partners, and consultants focused its attention on the development of a Clinical Report Card. The Clinical Report Card contains key clinical, utilization, participant satisfaction, and financial metrics OPERS will use to evaluate initiatives aimed at improving or maintaining retiree and dependent health status, improving the quality of care provided enrollees, and/or positively impacting the OPERS Health Care Fund. Comparing OPERS' results for the key metrics to industry benchmarks and performance targets will facilitate the CQIC's identification of opportunities for improvement and evaluation of any/all interventions centered around OPERS' strategic initiatives for the CQIC. The four strategic initiatives include:

- Supporting the availability of medical homes for OPERS members,
- Improving the management of and costs associated with specialty drugs,
- Promoting generic drug utilization by members, and
- Where appropriate and feasible, encouraging any/all efforts to vertically integrate programs to address the needs of public employees from active employment through retirement years.

The importance of legislation

In 2009, the OPERS Board of Trustees recommended to the legislature a series of pension benefit changes designed to strengthen the retirement system and maintain adequate funding for health care coverage. These changes were intended to improve pension funding to the point that OPERS would be able to allocate four percent of employer contributions to fund retiree health care.

The proposed pension changes primarily relate to pension, however, the proposal includes two provisions that directly impact health care. The pension proposal increases the age and service eligibility criteria required to receive a full pension and establishes a minimum retirement age. Additionally, reductions for early retirement will increase. Both of these provisions will likely result in a decrease in the number of non-Medicare retirees. The proposed changes also include the elimination of the Medicare Part B reimbursement cap and would provide the OPERS Board the authority to set the Medicare Part B reimbursement rate.

In February 2011, placeholder bills, House Bill 69 and Senate Bill 3, were introduced in the Ohio House of Representatives and Ohio Senate respectively. Subsequently, in May 2012 Senate Bill 343 was introduced and passed unanimously by the Senate. The House of Representatives are expected to act on pension legislation following the results of the actuarial study commissioned by the Ohio Retirement Study Council (ORSC).

Impact of no legislation

Regardless of whether the proposed pension legislation is enacted in 2012, OPERS must modify its retiree health care plan to maintain solvency with a four percent funding level. Therefore, the OPERS Board has been evaluating health care plan design changes for the past year. These potential changes will be shared with members for feedback during 2012 prior to finalization. These changes, which are within the Board's discretion and do not require legislative approval, would likely be effective in either 2014 or 2015.

The OPERS Board of Trustees is fiscally responsible for the fund and as such, constantly reviews and recommends changes necessary to strengthen the fund. If the proposed pension legislation is not enacted in 2012, the OPERS Board would be required to adopt more drastic changes, likely eliminating most of the non-statutory health care coverage. OPERS remains optimistic that pension legislation will have a successful outcome in 2012. OPERS continues to educate and solicit members on the potential changes required both with and without pension legislation.

Health care policy affiliations

In 2011, OPERS began partnering with the Governor's Office of Health Transformation. The purpose of this collaboration is to explore ways in which public entities can work together to bring much needed changes to physician and hospital reimbursement mechanisms and with the goal of reducing medical errors and improving quality of care. Governor Kasich established the Governor's Office of Health Transformation (OHT) to carry out the immediate need to address Medicaid spending issues, plan for the long-term and immediate administration of the Ohio Medicaid Program and to improve overall health system performance in Ohio.

By partnering with the Governor's Office on Health Transformation to bring about payment reform, OPERS was the second pension system in the nation to join Catalyst for Payment Reform (CPR). CPR is an independent organization led by health care purchasers, with active involvement of providers, health plans, consumers and labor groups working to improve quality and reduce costs by identifying and coordinating workable solutions to improve how we pay for health care in the U.S.

OPERS continues to participate in the Rx Ohio Collaborative (RxOC), a joint-purchasing group for four Ohio pension systems. RxOC is an expanding initiative for Ohio employers to save on prescription drug costs at both the institutional and consumer level. Extending its buying power to all self-insured Ohio employee health plans, the RxOC is focused on improving value in prescription drug use by reducing the cost of drugs while helping to improve health outcomes.

In 2011, OPERS continued to participate in the Public Sector Health Care Roundtable. This group is a non-partisan, grass roots coalition that has been organized to give public sector employers and plan sponsors a voice in the critical national debate on health care policy and to insure that the concerns of the public sector are addressed. Efforts in 2011 focused on the evaluation of the potential outcomes of the Supreme Court decision on the Affordable Care Act, group purchasing models, how to increase generic drug utilization and payment reform initiatives. Participating in this group allows systems to share best practices and strategize ways to improve the health care delivery system. OPERS serves as a founding member and retains a seat on the board of this organization.

Funding update

Beginning in fiscal year 2006, the Government Accounting Standards Board (GASB) required retirement systems to estimate their liability for health care similar to the manner in which pension liabilities are estimated. However, unlike pensions, the health care coverage OPERS provides (with the exception of Medicare B reimbursements) is not a guaranteed benefit. As of December 31, 2010, the date of the latest actuarial valuation, OPERS has an estimated liability for future health care of $26.9 billion. OPERS is one of a relatively few retirement systems that has systematically set aside assets to fund health care. As of December 31, 2010, OPERS had $11.3 billion in assets as stated on a funding basis (actuarially smoothed over a four-year period), leaving an unfunded liability of $15.6 billion. Simply put, OPERS had accumulated 41.8 percent of the assets necessary to pay these expenses. The market value of the health care assets was $12.3 billion and was greater than the actuarial or funding value of assets of $11.3 billion. By comparison, the health care liability as of December 31, 2009 was $31.5 billion compared to the actuarial value of assets of $10.9 billion, leaving an unfunded liability of $20.6 billion and a funded ratio of 34.7 percent.

OPERS continues to make changes to the health care plan design. The investment losses of 2008 have reduced the period of time that the accumulated assets will be able to provide coverage, known as the solvency period, from 31 years as of December 31, 2007 to 11 years at December 31, 2008. The investment gains of 2009 and 2010 have maintained this 11-year solvency period through December 31, 2010 despite the annual health care expenses. OPERS continues to proactively pursue plan design changes to extend the solvency period of the fund while maintaining the funding priority of pension benefits.

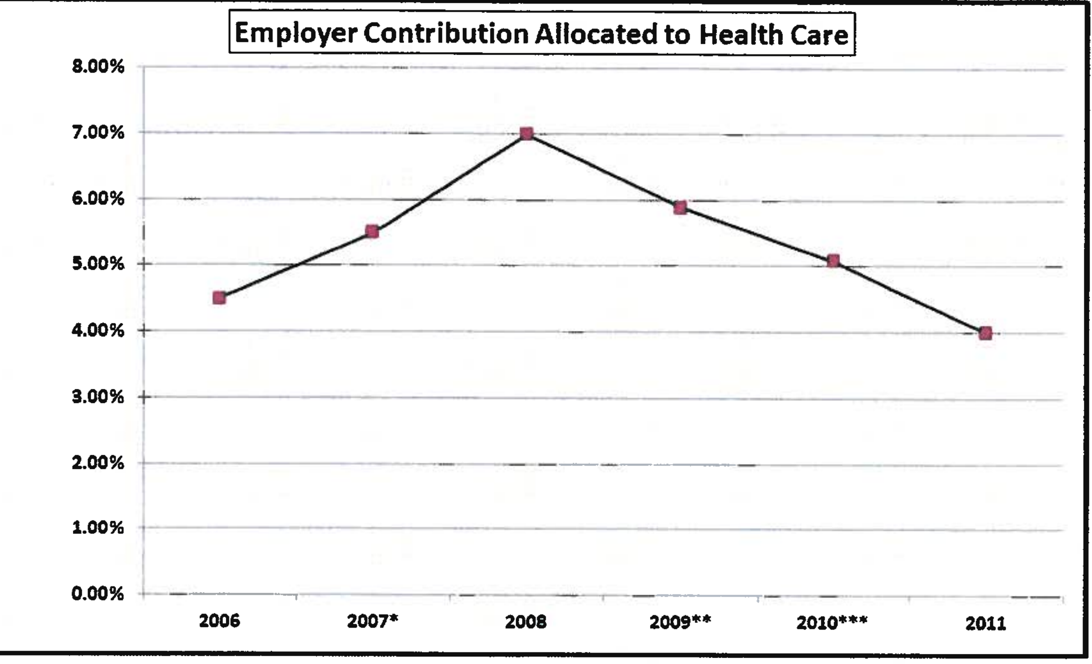
Additions to the health care fund

Additions to the health care fund are comprised primarily of employer contributions and investment returns. Revenues from member contributions, federal subsidies, and contract and other receipts comprise the balance.

1. Investment Income – The Health Care portfolio experienced a loss of 0.52 percent in 2011, compared to investment gains of 13.53 percent and 24.80 percent in 2010 and 2009, respectively.

2. Employer Contributions – Employer contributions as a percent of active member payrolls added $503.5 million to the fund in 2011 – a decrease of nearly 20 percent from the 2010 revenue of $628.7 million. Due to the market losses of 2008, OPERS reduced the portion of the total employer contribution rate directed to fund health care from 7.0 percent in 2008 to an average of 5.88 percent in 2009, 5.08 percent in 2010, and 4.0 percent in 2011. OPERS's funding objective, by statute, is to first meet the long-term pension benefit obligations, and to the extent possible, fund health care coverage. Therefore, the portion of employer contributions allocated to health care will fluctuate based on the funding status of the defined benefit pension plans. In order to preserve the System's future financial stability, plan design changes to both pension and health care are under consideration. Changes to the pension plan were submitted to the legislature in 2009. Pending legislative approval of the proposed pension changes, the portion of the employer contribution rate allocated to health care is scheduled to decline to zero percent by 2014.

In addition, the market volatility of 2008 resulted in many employers denying or deferring pay raises in both 2009 and 2010, implementing furlough days, and reducing the number of employees. The market recovery of 2009 and 2010 began to reverse these trends in 2011, however the number of actively contributing members continues to decline. Actively contributing members declined by 2.12 percent in 2011, 2.33 percent in 2010, and 2.35 percent in 2009.



	2006	2007*	2008	2009**	2010***	2011
Percent of Contribution Rate Funding Health Care	4.50%	5.50%	7.00%	5.88%	5.08%	4.00%

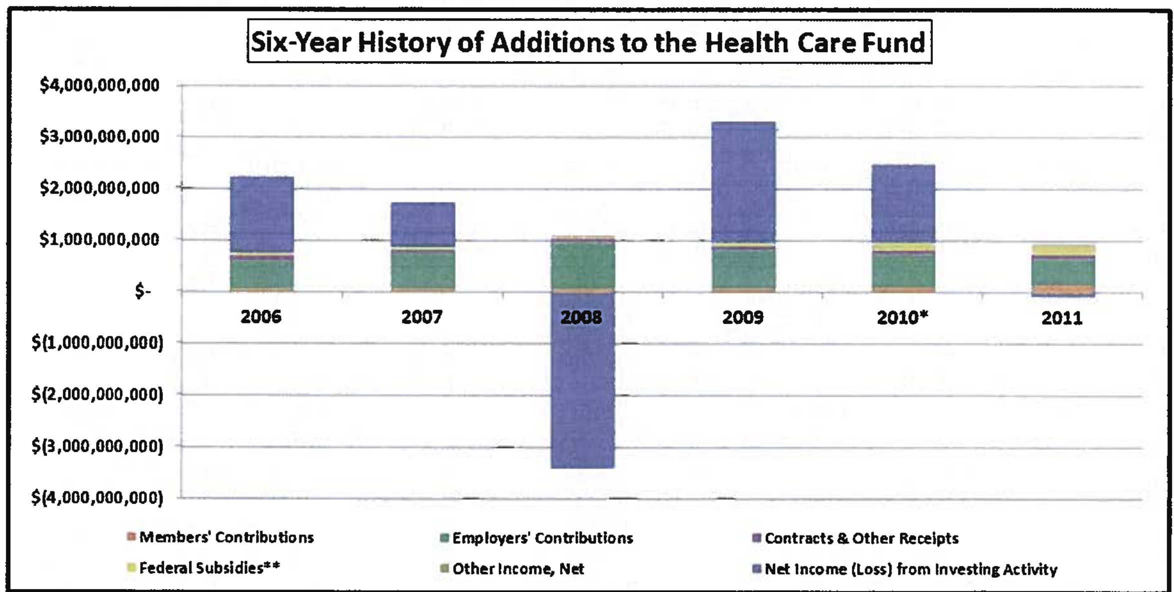
Source: 2011 Comprehensive Annual Financial Report
Notes:
* The portion of the employer contribution rate allocated to fund health care was 5 percent for the period January 1, 2007 through June 30, 2007 and increased to 6 percent for the period July 1, 2007 through December 31, 2007. The overall effective rate for the year was 5.5 percent.
** The portion of the employer contribution rate allocated to fund health care was 7 percent for the period January 1, 2009 through March 31, 2009 and decreased to 5.5 percent for the period April 1, 2009 through December 31, 2009. The overall effective rate for the year was 5.88 percent.
*** The portion of the employer contribution rate allocated to fund health care was 5.5 percent for the period January 1, 2010 through February 28, 2010 and decreased to 5 percent for the period March 1, 2010 through December 31, 2010. The overall effective rate for the year was 5.08 percent.

3. Member Contributions – Member contributions represent amounts paid by retirees toward the cost of OPERS-provided health care for the retiree, their spouse and dependents. In 2011 these contributions totaled $148.4 million, compared to $111.6 million in 2010 and $94.4 million in 2009. This increase reflects the rising cost of health care coverage, an increase in the retiree population, and the impact of program design changes. The number of retirees eligible for health care increased by 2.6 percent compared to 2010, with a corresponding increase of 3.1 percent in the number of dependent recipients eligible for health care coverage. By comparison, the total number of benefit recipients in 2010 increased by 2.2 percent over the 2009 levels.

Plan design changes adopted in 2004 and 2009 shifted a greater portion of health care expense to the retiree. In 2004 the Board adopted the Health Care Preservation Plan to extend the number of years the health care fund would be available to provide coverage to current and future retirees. The plan featured three coverage levels, and provides monthly allowances for health care coverage for retirees and their eligible dependents based on the retiree's years of service.

Members who were eligible to retire on January 1, 2007 with at least 10 years of service (Group 1) receive an allowance equal to 100 percent of the cost of health care coverage under the enhanced plan. Members hired prior to January 1, 2003 but eligible to retire after January 1, 2007 (Group 2), receive allowances ranging from 50 percent to 100 percent, while members hired after January 1, 2003 (Group 3) receive allowances ranging from 25 percent to 100 percent. The allowances for Groups 2 and 3 increase with each year of service, up to the maximum of 100 percent with 30 years of service. Prior to 2011 the majority of retirees participating in the health care plan represented Group 1 members who were provided allowances covering the majority of their health care premium. However by 2011, 13.5 percent of the retirees in the health care plan were Group 2 and 3 members receiving lower allowances and required to pay a portion of their health care premiums. In addition, effective in 2011 OPERS ceased subsidizing health care coverage for retiree spouses under the age of 55. These spouses may continue to participate in the health care program, but must pay 100 percent of the premium cost. The plan design changes increased member contribution revenues for health care by $36.7 million in 2011 compared to 2010 revenues.

4. Contract and Other Receipts – Contract and other receipts include vendor rebates, performance guarantees, gain sharing agreements and funds received from other retirement systems.



	2006	2007	2008	2009	2010*	2011
Members' Contributions	$ 71,718,182	$ 79,198,959	$ 82,695,255	$ 94,370,543	$ 111,638,313	$ 148,370,246
Employers' Contributions	$ 538,312,995	$ 695,967,837	$ 891,561,073	$ 740,817,891	$ 628,685,237	$ 503,458,216
Contracts & Other Receipts	$ 93,724,104	$ 45,534,017	$ 66,343,542	$ 58,649,547	$ 83,572,868	$ 89,087,996
Federal Subsidies**	$ 58,987,181	$ 59,075,120	$ 63,310,194	$ 69,132,772	$ 142,658,293	$ 192,118,407
Other Income, Net	$ 1,306,783	$ 70,498	$ 614,989	$ 654,031	$ 7,163,609	$ 10,915,043
Net Income (Loss) from Investing Activity	$ 1,471,059,831	$ 858,614,433	$ (3,400,647,342)	$ 2,356,554,863	$ 1,511,164,964	$ (78,923,627)

Source: 2011 Comprehensive Annual Financial Report
* 2010 restated for reclassification of Early Retirement Reinsurance Program to Federal Subsidies and the reclassification of the Pending Medical Claims adjustment from Health Care Benefits to Other Income. Pending Medical Claims consists of the annual adjustment made to the Incurred But Not Reported liability included in Medical Benefits Payable.
**Includes: Medicare Part D Reimbursements effective in 2006. Early Retiree Reinsurance Program effective in 2010. Medicare qualified prescription drug plan (PDP) effective in 2011.
Notes: Members' Contributions reflect retiree cost share of premium.
Beginning in 2007, OPERS began recording estimated accruals for vendor performance guarantees, rebates, Medicare Part D, and ORS receipts.

In 2011, OPERS received $70.6 million from the federal government under the Early Retirement Reinsurance Program (ERRP), as reimbursement for a portion of the health care claims incurred by retirees under the age of 65. This revenue was reported under the contract and other receipts category in last year's report. However, in 2011 these receipts are reported under the category Federal Subsidies. The 2010 financial statements were restated to reflect this change.

The majority of this increase in the Contracts and Other Receipts category represents gain sharing revenues received in conjunction with the Medicare Advantage program. OPERS is self-insured for retirees under the age of 65, but contracts with a vendor to provide a premium-based Medicare Advantage program for retirees over the age of 65. The premium is estimated at the beginning of the year, and adjusted at year end based on OPERS' actual claims experience. In essence, these revenues represent a premium adjustment based on actual experience. In 2011 gain sharing revenues totaled $46.8 million compared to $22.0 million in 2010. The increase in gain sharing revenues is offset in part by a reduction in prescription drug rebates from $49.0 million in 2010 to $35.0 million in 2011. Participation in a Medicare eligible prescription drug plan requires the use of specific formularies which reduces the purchase volumes subject to the rebate program.

OPERS retirees and/or their spouses who are receiving retirement benefits from other systems may choose which system will provide their health care coverage. Funds are transferred to the system providing the benefit based on the value of coverage that would have been provided to the member by the other system (known as health care waivers). Effective January 1, 2007, this election was changed to require retirees and their spouses who qualify for retirement under another Ohio retirement system to elect coverage under that system's health care plan. OPERS health care may only be elected as secondary coverage. Receipts will vary based on actual claims experience for those who elected OPERS coverage prior to 2007, but are expected to slowly decline in the future as retirees / spouses receiving benefits under the pre-January 1, 2007 election rules drop from the retirement rolls.

5. Federal Subsidies - Federal subsidies are comprised of reimbursements and direct subsidies OPERS received from the federal government for participation in Medicare drug programs and the Early Retirement Reinsurance Program.

In 2011 and 2010 OPERS received $109.5 million and $70.6 million, respectively, from the federal government under the Early Retirement Reinsurance Program as reimbursement for a portion of the health care claims incurred by retirees under the age of 65. Future receipts under this program are not expected to continue as the federal funds set aside for this program are exhausted except for claims in process. To date, OPERS has received the third highest distribution of nationwide recipients participating in the program.

Employers that offer a high-quality prescription drug program for retirees and their dependents are eligible for a federal subsidy under either the Medicare Part D program or a qualified prescription drug plan (PDP). The Medicare Part D program provides reimbursement of approximately 25-28 percent of eligible retiree prescription drug costs, and represented over $72.1 million in revenue for OPERS in 2010. These revenues declined to $0.8 million in 2011 with the implementation of the prescription drug plan (PDP).

The PDP is also a Medicare drug plan but is structured as a direct subsidy. OPERS receives a fixed amount per member based on the member's risk score, regardless of the member's actual claims experience. Members participate in either the Medicare Part D reimbursement program or the PDP program, but not both. In 2011 the PDP subsidies totaled $81.8 million for a combined Medicare total reimbursement of $82.6 million.

6. Other Income, Net – Other income includes miscellaneous income and significant adjustments to prior years' expense accruals. Historically, at the end of each year OPERS estimates the value of claims incurred but not yet reported (IBNR), and records an expense necessary to adjust the medical accounts payable liability for the value of these claims. Payment of these delayed claims may lag several years beyond the incurred date. Accordingly, the accrual is estimated based on an average of the historical claims experience for the preceding four years. Participation in the Medicare Advantage program is mandatory when a retiree and their spouse reach age 65, and as a premium based program, OPERS does not bear the risk of unreported claims. As the retiree population ages and moves to the Medicare Advantage program, the IBNR reserve also decreases with a corresponding charge to other income for the write-off of prior years' expense. The liability account is gradually being reduced over a four year period commensurate with the claims lag history. The amounts included in other income for 2011 and 2010 for the reversal or prior years' accruals are $10.7 million and $6.6 million respectively.

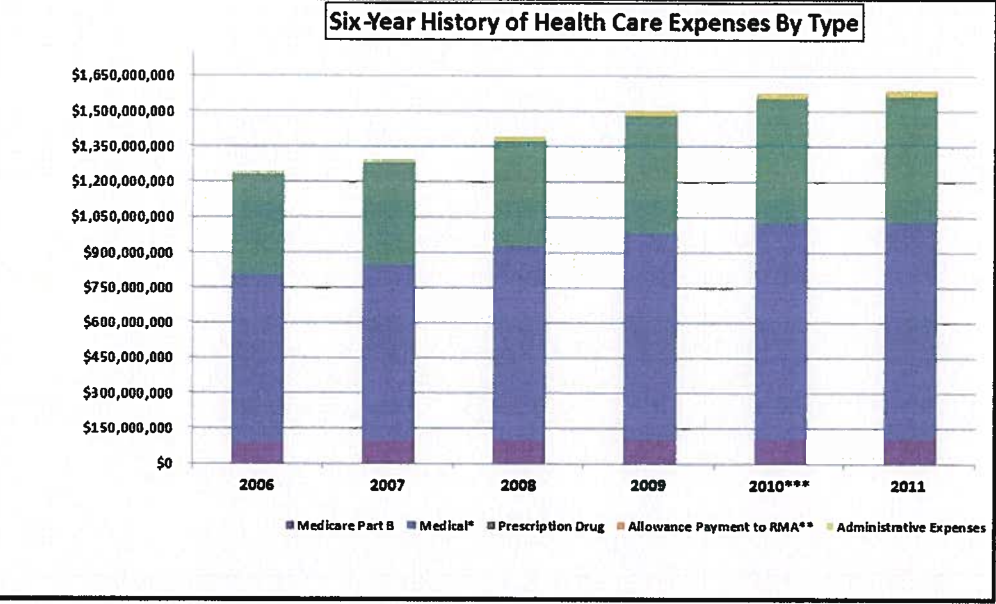
Health care expenses

The expenses displayed in the graph on the following page reflect the cost of health care expenses for retirees, their spouses and their dependents, exclusive of OPERS operating expenses. The increase in health care expenses reflects the expanding retiree population and the nation-wide trend in health care inflation that continues to be well in excess of general inflation. However through a combination of plan design changes, cost-sharing changes and extensive cost containment efforts, OPERS' 2011 health care expenses rose only 0.5 percent over the 2010 expenses. The Health Care Preservation Plan adopted by the Board of Trustees in 2004 became effective in 2007. As noted previously, the goal of HCPP was to extend the period of time the health care assets were expected to last (the plan solvency years).

HCPP included significant changes to the health care plan design by linking the amount of health care subsidy to years of service, and allowed for variables in deductibles and cost containment efforts. Cost containment efforts included participation in federally subsidized programs such as the Medicare Part D reimbursements, the Medicare prescription drug plan program, Early Retirement Reinsurance Program, and the Medicare Advantage program. In addition, wellness programs were initiated that provide retirees with financial incentives for healthy lifestyles and participation in programs such as smoking cessation. In the five years since the plan effective date, health care expenses have risen an average of 5.6 percent, well below the national average of approximately 8.4 percent for the same period. At the same time, the number of retirees and eligible dependents and beneficiaries has steadily increased by 2.1 percent in 2008, 2.1 percent in 2009, 2.2 percent in 2010, and 2.7 percent in 2011.

The majority of health care expenses are comprised of medical, dental, vision, and prescription drug costs, as well as reimbursements to retirees for Medicare Part B premiums. These expenses increased by $7.7 million in 2011 compared to an increase of $75.9 million in 2010. Medical expenses increased by $2.1 million or 0.2 percent, and prescription drug costs rose by $4.3 million or 0.8 percent in 2011 over the 2010 levels. Statutorily required Medicare Part B reimbursements increased by $1.3 million. Legislative changes that became effective in 2009 permit the Board to determine the value of Medicare Part B reimbursements above a base threshold. This change effectively permits the Board to establish a cap on these reimbursements, which limited the increases in these expenses to approximately 1.8 percent for both 2009 and 2010. The overall breakdown of health care expenses for 2010 and 2009 reflect similar distributions, with medical expenses averaging approximately 59 percent of the total, followed by prescription drugs at approximately 33 percent and Medicare Part B reimbursements and other expenses of 7 percent.

Other health care expenses are comprised of payments to retiree medical accounts for retirees who elect the basic (lower level) coverage plan and claims paid through the VEBA. These expenses continue to rise with the changing member demographics, but comprise less than 1 percent of the total annual health care expenses for each of the past three years.



	2006	2007	2008	2009	2010***	2011
Medicare Part B	$ 92,268,184	$ 99,175,973	$ 103,934,337	$ 105,854,803	$ 107,770,173	$ 109,072,281
Medical*	$ 711,461,624	$ 749,174,151	$ 827,135,910	$ 877,861,028	$ 920,503,462	$ 922,595,862
Prescription Drug	$ 428,140,230	$ 431,405,495	$ 441,059,097	$ 494,674,419	$ 526,054,523	$ 530,404,030
Allowance Payment to RMA**	$ -	$ 3,020,425	$ 5,016,829	$ 9,642,605	$ 13,223,453	$ 13,489,405
Administrative Expenses	$ 10,892,971	$ 10,796,417	$ 13,596,943	$ 13,033,595	$ 12,782,968	$ 13,076,814

Source: 2011 Comprehensive Annual Financial Report
*Includes Medical, Disease Management, Wellness, Dental and Vision (OPERS receives member contributions for Dental and Vision).
**Retiree Medical Account (RMA) commenced January 1, 2007
***2010 Post-employment Health Care expenses restated for reclassification of Pending Medical Claims adjustment from Health Care Benefits to Other Income. Pending Medical Claims consists of the annual adjustment made to the Incurred But Not Reported liability included in Medical Benefits Payable. This liability fluctuates from year to year based on changes in the claims experience.

Challenges and opportunities

While the challenges remain significant, OPERS has taken steps to meet each challenge including:

- **Pension legislation** – Assuming proposed pension legislation is approved, OPERS will redesign the health care program. Those changes will likely modify both the eligibility criteria and the funding for coverage of members. If the Ohio legislature does not approve the proposed pension legislation in 2012, OPERS will cease funding health care beginning in 2014 and will adopt more drastic reductions, likely eliminating the nonstatutory required coverage elements.

- **OPERS baby boomer population retiring** – The retiree population is expected to double in less than 20 years, which will require multiple approaches and increased demand for health care education and communications. The OPERS Strategic Plan provides direction to help us prepare for a population of covered lives projected to reach 400,000 by 2030. In 2011, there are 40,749 OPERS members eligible to retire within the next year and an additional 5,227 becoming eligible in 2012.

- **Increased life expectancy** – The average life expectancy has been steadily increasing in the U.S. Overall life expectancy now stands at an estimated 78.2 years, an increase of 4.5 years since 1980. The percentage of the U.S. population age 65 and over will increase dramatically in the next years. Increased life expectancy and baby boomers retiring means that OPERS is providing health care coverage to more people with the same or fewer dollars.

- **Promoting a culture of wellness and disease prevention** – The high prevalence of preventable chronic conditions among OPERS plan participants supports the continued need for wellness efforts aimed at preventing the onset of chronic conditions such as diabetes and heart disease.

- **Aligning active employee and retiree health and wellness efforts** – Recognizing that current active employees are future OPERS retirees, significant opportunity exists to promote the health of current active employees by aligning OPERS' wellness initiatives with those undertaken by Ohio's public employers.

- **Federal health care reform** – The PPACA decision currently rests with the Supreme Court of the United States. The Court has heard oral arguments regarding the issues set for review, including the constitutionality of the individual mandate, and is expected to hand down its decision by the end of June 2012. OPERS will continue to monitor this issue closely.

- **Ongoing health care inflation management** – Advances in medical technology continue to contribute to OPERS' health care cost trends. In particular, the management of specialty drugs continues to be a challenge as new specialty drugs enter the market and providers seek ways to preserve revenue sources.

- **Investment returns** – With events, such as the continuing European debt crisis, upcoming general election, and potential return of the debt ceiling debate, the market volatility seen in 2011 could possibly continue in the near future. The Board's revised plan, being considered during 2012, takes this into consideration with the proposed solutions.

The following information fulfills the requirements of the Ohio Public Employees Retirement System as outlined in Ohio Revised Code Section 145.22(E). The requirements and the System's responses follow:

The Board shall have prepared annually a report giving a full accounting of the revenues and costs relating to the provision of health benefits under Sections 145.325 and 145.58 of the Revised Code. The report shall be made as of December 31, 1997 and the thirty-first day of December of each year thereafter. The report shall include the following:

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

Appendix A and B are copies of ORC Sec. 145.325 (Medicare benefits for members of Ohio Public Employees Retirement System), and ORC Sec. 145.58 (Group Hospitalization coverage; ineligible individuals; service credit; alternate use of HMO).

2. A summary of coverage

The following is an outline of the current OPERS health care coverage:

The 2011 OPERS Health Care Plan for non-Medicare participants

The 2011 OPERS health care plan, Medical Mutual, utilized a Preferred Provider Organization (PPO) for our non-Medicare benefit recipients. PPO networks are based on a partnership between doctors, hospitals, health plan administrators and participants. Doctors and medical facilities that belong to the PPO network agree to perform services at discounted rates. Therefore, through plan design and education, OPERS encouraged the use of these providers. While participants were able to choose any provider and still receive coverage, they received a higher level of reimbursement if they chose network providers of service. All states in the U.S. were within the PPO network. Participants living outside of the U.S. were able to choose any provider of services (regardless of Medicare status) without a decrease in coverage.

The Humana Medicare Advantage Plan

The Humana Medicare Advantage Plan continued to be offered to Medicare-eligible participants in 2011. A Medicare Advantage Plan is a plan offered by an insurer that contracts with Medicare to provide plan participants with all Medicare Part A and Part B benefits. To be eligible, participants must have both Medicare Part A and Part B and must continue to pay Part B premiums.

A Medicare Advantage Plan simplifies the combination of Medicare and the OPERS health care plan. A Medicare Advantage Plan allows participants to carry only one ID card because all medical claims go directly to Humana for processing.

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

Alternate health care coverage

Kaiser Permanente HMO was available in 2011 to OPERS health care plan participants who resided in certain counties in Ohio. Kaiser offered hospital and medical services through participating physicians and facilities.

Plan participants were responsible for the cost difference in HMO coverage if that cost was more than the cost of coverage under Medical Mutual or the Humana Medicare Advantage Plan.

Prescription drug coverage

Retirees enrolled in the OPERS health care plan (Medical Mutual), the Humana Medicare Advantage Plan or an alternate plan (Kaiser) receive prescription drug coverage through Express Scripts, Inc.

OPERS Non-Medicare prescription plan – In 2011, plan participants could receive up to a 30-day supply of medication, plus refills, as prescribed by their physician at a retail pharmacy. Plan participants could receive up to a 90-day supply of medication, plus refills, as prescribed by their physician, through the Express Scripts home delivery program. Co-payments for prescriptions differ based on the delivery method, whether a drug is a generic or a name brand and its formulary status.

OPERS Medicare Part D prescription plan – In 2011, OPERS began offering a Medicare Part D Prescription Drug Plan to medicare-eligible enrollees. The Medicare Part D Plan provided retirees with a number of enhancements including Medication Therapy Management and an annual out-of-pocket maximum.

Medicare

The following requirements regarding Medicare were in effect for 2011:

If an OPERS health care plan participant was eligible for Medicare Part A (hospital) at no cost, OPERS required enrollment in Medicare coverage (if covered by the OPERS health care plan). If Medicare Part A was not available to the participant without cost, OPERS provided comparable substitute coverage.

Plan participants who turned age 65, or who qualify for Medicare prior to age 65 (and who are enrolled in OPERS health care) were required to enroll in Medicare Part B (medical).

When a plan participant or covered spouse reached the age of 65, OPERS requested a copy of the Medicare card. If the covered individual was not eligible for free Medicare Part A, OPERS requested a copy of his or her card showing Part B coverage or a letter from Social Security, stating there would be a charge assessed for Medicare Part A.

Medicare Part B reimbursement

If an OPERS retiree was enrolled in the OPERS health care plan and was not being reimbursed from another source for his or her Medicare Part B premium, he or she was eligible for OPERS reimbursement. In order to receive this reimbursement, the retiree was required to send a copy of his or her Medicare card, showing enrollment in Part B. As long as the plan participant remained enrolled in Part B coverage, the allowable reimbursement was added to the recipient's monthly retirement check. Enrolled spouses are not eligible for this reimbursement.

The Dental Plan

During 2011, voluntary dental coverage was made available to all OPERS retirees and their eligible dependents regardless of his or her participation in the OPERS health care plan. The dental plan, administered by MetLife effective January 1, 2011, was intended to help defray the costs of dental care, including oral examinations, diagnostic services, and extractions, as well as crowns, bridges, and dentures. If a retiree chose to be covered under the dental plan, a premium payment was deducted from each monthly benefit check. OPERS does not subsidize this plan.

The Vision Plan

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

The Long-Term Care Plan

The voluntary long term care plan, administered by Prudential, is a program in which any OPERS retiree, his or her spouse, adult children, parents and parents-in-law are able to apply for protection from the expense of long- term care. OPERS does not subsidize this plan.

This plan is designed to cover those long term care expenses not covered by the basic hospital/medical coverage (e.g. custodial care), including Medicare. Its intent is to provide daily cash benefits when the insured is no longer able to independently perform the activities of daily living.

3. A summary of the eligibility requirements for health care coverage

Following are the eligibility requirements for the OPERS health care plan. These requirements were in effect during 2011:

Age and Service Retirement

When applying for age and service retirement, a benefit recipient must have 10 years of Ohio service credit to qualify for the OPERS health care plan. These 10 years may not include out-of-state or certain military service purchased after January 29, 1981; service credit granted under a retirement incentive plan; or exempt service purchased after May 4, 1992.

Disability Retirement

If a person is receiving a disability benefit from OPERS, health care coverage is provided even if he or she has less than 10 years of service credit.

Coverage for surviving spouses

If a member retired, chose a joint and survivor annuity plan of payment (Plan A, C, D or F) and died, the surviving spouse was entitled to health care coverage if the deceased retiree was eligible.

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

Eligible dependents

In accordance with Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code, retirees receiving a monthly age and service or disability benefit may only enroll:

Their legal spouse – This must be a person of the opposite gender and they must have a valid marriage certificate recognized by Ohio law.

Effective January 1, 2011, OPERS no longer subsidizes the monthly health care premium costs for spouses under the age of 55.

- This rule does not apply to children, spouses of disability recipients, spouses with early Medicare or any spouse who is receiving a benefit as the surviving spouse of an age and service retiree (joint and survivor annuity) or as the surviving spouse of a deceased working member (receiving a survivor benefit).
- A spouse under age 65 may participate in the plan; however, the retiree is responsible for the full health care premium.
- The month the enrolled spouse reaches age 55, OPERS will again subsidize a portion of his or her health care premium.

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

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

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

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

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

As of December 31, 2011, there were 173,969 OPERS retirees eligible to participate in the OPERS health care plan.

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

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

Plan investments are reported at fair value. Fair value is the amount that a plan can reasonably expect to receive for an investment in a current sale between a willing buyer and a willing seller that is, other than in a forced or liquidation sale. All investments, with the exception of private equity, are valued based on closing market prices or broker quotes. The fair value of private equities are based on management's valuation of estimates and assumptions from information and representations provided by the respective general partners, in the absence of readily ascertainable market values.

Member and employer contributions and investment earnings are used to fund health care expenses. Employer contributions equal to 4 percent of covered payroll were credited to the health care fund for the period of January 1, 2011 through December 31, 2011. Revenues from member contributions (amounts paid by retirees towards the cost of OPERS-provided health care for the retiree, their spouse and dependents), federal subsidies, contract and other receipts, and other miscellaneous income comprise the balance of health care additions. The market losses of 2008 and the subsequent reduction in the employer contribution rate used to fund health care reduced the solvency years of the health care fund from 31 years as of December 31, 2007, to 11 years as of December 31, 2008, 2009 and 2010.

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

Please see Appendix C, "Statements of Fiduciary Net Assets - Health Care".

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.

Please see Appendix D, "Statements of Changes in Plan Net Assets - Health Care."

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.

Please see Appendix D, "Statements of Changes in Plan Net Assets - Health Care."

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

No significant changes affect these reports.

10. A statement of the amount paid under Division (C) of Section 145.58 of the Revised Code.

OPERS paid approximately $109 million in Medicare Part B premiums to its benefit recipients in 2011.

Sec. 145.325. Medicare equivalent benefits.

A) Except as otherwise provided in division (B) of this section, the board of the public employees retirement system shall make available to each retiree or disability benefit recipient receiving a monthly allowance or benefit on or after January 1, 1968, who has attained the age of 65 years, and who is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program, hospital insurance coverage substantially equivalent to the federal hospital insurance benefits, Social Security Amendments of 1965, 79 Stat. 291, 42 U.S.C.A. 1395c, as amended. This coverage shall also be made available to the spouse, widow, or widower of such retiree or disability benefit recipient provided such spouse, widow, or widower has attained age 65 and is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program. The widow or widower of a retiree or disability benefit recipient shall be eligible for such coverage only if he or she is the recipient of a monthly allowance or benefit from this system. One-half of the cost of the premium for the spouse shall be paid from the appropriate funds of the public employees retirement system and one-half by the recipient of the allowance or benefit.

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

B) The board need not make the hospital insurance coverage described in division (A) of this section available to any person for whom it is prohibited by section 145.58 of the Revised Code from paying or reimbursing the premium cost of such insurance. HISTORY: HB 402, Eff. 12/14/67; HB 1, Eff. 6/13/75; HB 1, Eff. 8/26/77; HB 126, Eff. 6/13/81; SB 346, Eff. 7/29/92; HB 628, 9/21/00).

Sec. 145.58 Group hospitalization coverage; ineligible individuals; service credit; alternative use of HMO

(A) As used in this section, "ineligible individual" means all of the following:

1. A former member receiving benefits pursuant to section 145.32, 145.33, 145.331, 145.34, or 145.46 of the Revised Code for whom eligibility is established more than five years after June 13, 1981, and who, at the time of establishing eligibility, has accrued less than ten years' service credit, exclusive of credit obtained pursuant to section 145.297 or 145.298 of the Revised Code, credit obtained after January 29, 1981, pursuant to section 145.293 or 145.301 of the Revised Code, and credit obtained after May 4, 1992, pursuant to section 145.28 of the Revised Code;

2. The spouse of the former member;

3. The beneficiary of the former member receiving benefits pursuant to section 145.46 of the Revised Code.

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

The board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the public employees retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by sections 145.48 and 145.51 of the Revised Code. The board may by rule provide coverage to ineligible individuals if the coverage is provided at no cost to the retirement system. The board shall not pay or reimburse the cost for coverage under this section or section 145.325 of the Revised Code for any ineligible individual.

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

(C) The board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, pay monthly to each recipient of service retirement, or a disability or survivor benefit under the public employees retirement system who is eligible for medical insurance coverage under part B of Title XVIII of "The Social Security Act," 79 Stat. 301 (1965), 42 U.S.C.A. 1395j, as amended, an amount determined by the board for such coverage that is not less than $96.40, except that the board shall make no such payment to any ineligible individual or pay an amount that exceeds the amount paid by the recipient for the coverage.

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

(D) The board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section or section 145.325 of the Revised Code with any similar coverage, payment, or benefit made available to the same individual by the Ohio Police and Fire Pension Fund, State Teachers Retirement System, School Employees Retirement System, or State Highway Patrol Retirement System.

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

(ENACTED: SB 256, Eff. 10/14/59; HB 957, Eff. 10/27/61; HB 225, Eff. 11/13/65; HB 430, Eff. 11/20/73; HB 268, Eff. 8/20/76; HB 1, Eff. 8/26/77; HB 126, Eff. 6/13/81; HB 236, Eff. 2/2/82; HB 631, Eff. 3/28/85; HB 706, Eff. 12/16/86; SB 124, Eff. 10/1/87; HB 382, Eff. 6/30/91; HB 383, Eff. 5/4/92; SB 346, Eff. 7/29/92; HB 151, Eff. 2/9/94; SB 82, Eff. 3/6/97; SB 67, Eff. 6/4/97; HB 222, Eff. 11/2/99; HB 535, Eff. 4/1/01; SB 247, Eff. 10/1/02; SB267, Eff. 3/24/09)

APPENDIX C – STATEMENT OF PLAN NET ASSETS

	2011	2010	2009	2008	2007	2006
Assets						
Cash and Short-Term Investments	$153,972,958	$310,859,956	$82,384,335	$214,267,049	$166,407,166	$322,120,585
Receivables:						
Members' and Employers'	51,989,914	62,635,516	70,351,872	99,321,334	107,187,056	82,850,806
Retirement Incentive Plan	773,991	2,183,860	3,185,825	344,045	676,337	762,533
Vendor and Other	67,535,218	133,916,383	49,921,976	57,775,901	36,025,605	34,882,853
Investment Sales Proceeds	185,275,974	135,342,122	884,914,266	57,319,401	33,489,810	80,471,902
Accrued Interest and Dividends	49,585,342	49,049,361	37,732,716	46,426,349	64,843,050	67,341,496
Total Receivables	355,160,439	383,127,242	1,046,106,655	261,187,030	242,221,858	266,309,590
Investments, at fair value:						
Global Bonds	4,349,713,914	4,355,743,585	3,746,406,051	4,363,406,922	6,581,396,111	6,116,700,706
Domestic Equities	3,642,820,108	3,950,499,244	3,806,887,666	2,731,493,461	4,186,123,350	4,388,937,986
Private Equity	54,927,514	27,877,976	39,341,186	5,150,008		
International Equities	3,310,599,792	3,649,437,854	2,974,380,740	2,201,764,403	2,282,909,655	1,973,897,814
Other Investments	134,339,269	27,740,509				
Total Investments	11,492,400,597	12,011,299,168	10,567,015,643	9,301,814,794	13,050,429,116	12,479,536,506
Collateral on Loaned Securities	-	1,517,578,594	299,502,780	2,297,927,070	2,072,493,713	2,015,624,266
Capital Assets:						
Land	665,394	665,394	665,394	665,394	665,394	665,394
Building and Building Improvements	19,627,154	19,641,200	19,660,159	19,663,497	19,852,388	19,679,465
Furniture and Equipment	24,809,991	22,850,746	20,582,082	17,141,828	14,941,722	11,420,812
Total Capital Assets	45,102,539	43,157,340	40,907,635	37,470,719	35,459,504	31,765,671
Accumulated Depreciation	(18,156,668)	(16,294,444)	(13,530,325)	(11,267,149)	(8,853,297)	(7,340,277)
Net Capital Assets	26,945,871	26,862,896	27,377,310	26,203,570	26,606,207	24,425,394
TOTAL ASSETS	12,028,479,865	14,249,727,856	12,022,386,723	12,101,399,513	15,558,158,060	15,108,016,341
Liabilities:						
Undistributed Deposits	62,273	80,073	52,974	52,974	8,385	
Medical Benefits Payable	118,529,285	142,952,643	134,007,772	131,776,992	142,701,327	145,895,911
Investment Commitments Payable	294,572,622	253,257,695	163,153,464	69,811,443	57,017,727	108,410,835
Accounts Payable and Other Liabilities					569,998	26,250
Accounts Payable RMA Claims	19,183,817	16,114,872	10,474,459	5,748,957	2,419,428	
Obligations Under Securities Lending		1,517,578,594	299,502,780	2,297,927,070	2,072,493,713	2,015,624,266
TOTAL LIABILITIES	432,347,997	1,929,983,877	607,191,449	2,505,317,436	2,275,210,578	2,269,957,262
Net Assets Held in Trust for Pension and Post-Employment Health Care Benefits	$11,596,131,868	$12,319,743,979	$11,415,195,274	$9,596,082,077	$13,282,947,482	$12,838,059,079

Source: 2011 Comprehensive Annual Financial Report

	2011	*2010	2009	2008	2007	2006
Additions:						
Members' Contributions	$148,370,246	$111,638,313	$94,370,543	$82,695,255	$79,198,959	$71,718,182
Employers' Contributions	503,458,216	628,685,237	740,817,891	891,561,073	695,967,837	538,312,995
Contract and Other Receipts	89,087,996	83,572,868	58,649,547	66,343,542	45,534,017	93,724,104
Federal Subsidies	192,118,407	142,658,293	69,132,772	63,310,194	59,075,120	58,987,181
Other Income, Net	10,915,043	7,163,609	654,031	614,989	70,498	1,306,783
Total Non-Investment Income	**943,949,908**	**$973,718,320**	**963,624,784**	**1,104,525,053**	**879,846,431**	**764,049,245**
Income/ (Loss) from Investing Activities:						
Net Appreciation / (Depreciation) in Fair Value	(401,560,941)	1,240,024,373	2,081,098,064	(3,734,049,668)	479,748,239	1,048,846,038
Bond Interest	202,859,266	137,927,458	152,358,418	182,944,355	211,556,481	179,769,220
Dividends	134,235,895	134,809,505	134,487,014	139,099,121	160,715,579	106,148,349
International Income / (Loss)	(92,053)	48,675	52,944	552,901	9,981	143,649,645
Other Investment Income / (Loss)	3,671,640	3,778,346	661,628	147,998	13,229,442	2,829,179
External Asset Management Fees	(13,648,040)	(10,904,604)	(7,709,148)	(8,674,498)	(10,491,258)	(10,797,650)
Net Investment Income / (Loss)	(74,534,233)	1,505,683,753	2,360,948,920	(3,419,979,791)	854,768,464	1,470,444,781
From Securities Lending Activity:						
Security Lending Income	-	14,236,338	2,336,740	103,004,243	120,699,574	94,382,644
Security Lending Expenses	-	(4,259,969)	(562,862)	(79,967,808)	(113,044,477)	(89,727,122)
Net Securities Lending Income	-	9,976,369	1,773,878	23,036,435	7,655,097	4,655,522
Unrealized Loss	-		(2,396,132)			
Net Income/(Loss) from Securities Lending	-	**9,976,369**	**(622,254)**	**23,036,435**	**7,655,097**	**4,655,522**
Less: Investment Administrative Expenses	(4,389,394)	(4,495,158)	(3,771,803)	(3,703,986)	(3,809,128)	(4,040,472)
Net Income / (Loss) from Investing Activity	**(78,923,627)**	**1,511,164,964**	**2,356,554,863**	**(3,400,647,342)**	**858,614,433**	**1,471,059,831**
TOTAL ADDITIONS	**865,026,281**	**2,484,883,284**	**3,320,179,647**	**(2,296,122,289)**	**1,738,460,864**	**2,235,109,076**
Deductions:						
Health Care Benefits	1,575,561,578	1,567,551,611	1,488,032,855	1,377,146,173	1,282,776,044	1,231,870,038
Administrative Expenses	13,076,814	12,782,968	13,033,595	13,596,943	10,796,417	10,892,971
TOTAL DEDUCTIONS	**1,588,638,392**	**1,580,334,579**	**1,501,066,450**	**1,390,743,116**	**1,293,572,461**	**1,242,763,009**
Net Increase/ (Decrease)	(723,612,111)	904,548,705	1,819,113,197	(3,686,865,405)	444,888,403	992,346,067
Net Assets Held in Trust for Pension and Post-employment Health Care Benefits Balance, Beginning of Year	12,319,743,979	11,415,195,274	9,596,082,077	13,282,947,482	12,838,059,079	11,845,713,012
BALANCE, END OF YEAR	**$11,596,131,868**	**$12,319,743,979**	**$11,415,195,274**	**$9,596,082,077**	**$13,282,947,482**	**$12,838,059,079**

Source: 2011 Comprehensive Annual Financial Report

*2010 restated for reclassification of Early Retirement Reinsurance Program to Federal Subsidies and the reclassification of the Pending Medical Claims adjustment from Health Care Benefits to Other Income. Pending Medical Claims consists of the annual adjustment made to the Incurred But Not Reported liability included in Medical Benefits Payable. This liability fluctuates from year to year based on changes in the claims experience.

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