health care

Striving to provide OPERS retirees with access to quality health care coverage

OPERS 2010 Health Care Report

Presented to:
Ohio Retirement Study Council
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Ohio Public Employees Retirement System

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OPERS

OPERS is providing the 2010 health care report to the Ohio Retirement Study Council (ORSC) 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.

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 potentially 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 2010 pertaining to the OPERS retiree health care plan include the following:

- On Jan. 1, 2010, Humana began administering the medical portion of the OPERS health care plan for Medicare-eligible retirees. Medical Mutual became the primary administrator for plan participants not yet eligible for Medicare. These new administrator relationships were the result of a year-long competitive bidding and selection process.
- In 2010, OPERS modified our 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, although some retirees did experience minimal increases in premiums.
- The Patient Protection and Affordable Care Act (PPACA), also referred to as health care reform, was signed into law by President Obama on March 23, 2010 and contained numerous provisions that will impact the OPERS health care plan in 2011 and may impact the plan between 2012 and 2018. Because this legislation is very complex, OPERS continues to analyze its impact on our plan in future years.
- In response to legislative requirements imposed by Senate Bill 267 (127th General Assembly), administrative rules were adopted requiring OPERS to verify the amount each retiree pays for Medicare Part B. Throughout 2010, OPERS reached out to retirees requiring certification of their Medicare Part B amount. Also in response to the legislation, the OPERS Board of Trustees capped the Medicare Part B reimbursement rate at $96.40 for 2010.
- 2010 marked the first full year of the OPERS Clinical Quality Improvement Committee (CQIC). Comprised of policy leaders and clinicians from the health care division, OPERS' vendor partners, and consultants, the CQIC is charged with favorably impacting OPERS' health care trend via improvements in clinical quality.
- During 2010, the health care fund returned 13.5 percent and outperformed its customized benchmark of 12.9 percent for the year by approximately 60 basis points largely due to manager outperformance and asset allocation activities.
- Health care expenses reached $1.6 billion in 2010 while the number of retirees, eligible dependents and beneficiaries increased 4.4 percent. Health care expenses increased by 4.9 percent over 2009.

The OPERS Board of Trustees and staff are aware of the significant challenges ahead in the form of rising 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 the baby boomer generation. In this environment, we continue to search for answers to meet these challenges that will

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. However, retirees enjoyed the benefit of large group rates. 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. OPERS also began the formal introduction of case management as a cost containment measure.

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

In 1993, OPERS added a second plan administrator. The plan was also switched from a pure indemnity plan to a Preferred Provider Organization (PPO) model. The second plan administrator was Medical Mutual of Ohio, known as Blue Cross and Blue Shield of Ohio at that time.

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. OPERS continued on that path in 2001; coverage for routine physical exams, EKGs and diabetes and cholesterol screenings were added.

Fiscal year 2003 began with the introduction of the Choices Plan, 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.

Until 2004, OPERS relied on its pharmacy benefit management company to help maximize drug rebates by switching members to preferred drugs. However, in 2004, OPERS began using formulary/non-formulary co-pays in its drug plan. This shift in strategy helped to engage retirees in keeping prescription drugs affordable.

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

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

In 2007, the Health Care Preservation Plan (HCPP) was implemented, establishing three groups of retirees, each with eligibility standards based on length of service and start date. The HCPP added two additional plan tiers or options for health care coverage. Retirees received a monthly health care allowance

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. Medco had provided pharmacy benefit management for the OPERS health care plan since 1981. OPERS made this change as the result of a competitive bidding process in collaboration with other Ohio retirement systems and The Ohio State University.

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

Also in 2009, OPERS worked to implement 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. The bill also requires the recipient of the reimbursement to report to OPERS the amount paid for the coverage. The reimbursement cannot exceed the amount paid for coverage.

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 on March 23, 2010 and contained numerous provisions that may impact the OPERS health care plan from 2011 to 2018.

In 2010, OPERS modified our 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.

The OPERS Board of Trustees capped the Medicare B reimbursement rate at $96.40 for 2010.

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.

OPERS partnered with Express Scripts to design a Medicare Part D prescription plan for Medicare-eligible plan participants. While the Medicare D plan was designed in 2010, it has an effective date of Jan.1, 2011. Prior to 2010, OPERS had discouraged retirees from enrolling in a Medicare Part D plan. The new Medicare Part D plan will provide plan participants with enhanced prescription coverage and is projected to provide a cost savings to OPERS.

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.

OPERS HEALTH CARE CHRONOLOGY OF PROGRESS

Health care coverage begins Group Rates – 0% subsidy	**1962**	
	1974	**OPERS pays premium** **OPERS begins funding health care trust**
OPERS offers Kaiser HMO	**1975**	
	1981	**OPERS/ORS secure mail pharmacy in Columbus**
Eligibility increases from 5 to 10 years of service	**1986**	
	1993	**PPO model replaces indemnity** 2 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 Coalition**	**2005**	**Investments contribute $900 million to health care fund** **$33M 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**
	2008	**OPERS introduces the Aetna Medicare Open Plan** **Express Scripts becomes the pharmacy benefit manager for the OPERS health care plan**
OPERS releases a Request for Proposal to select a medical coverage administrator(s) **Initiates implementation of Senate Bill 267**	**2009**	**OPERS increases lifetime health care coverage maximum to $3 million** **Changes administrator of Long-Term Care Plan to Prudential**
Federal health care reform legislation was signed into law **The OPERS Board of Trustees caps the Medicare B reimbursement amount at $96.40. OPERS begins Medicare B**	**2010**	**OPERS introduces the Humana Medicare Advantage Plan for Medicare-eligible plan participants** **OPERS partners with Express**

Securing health care coverage now and in the future

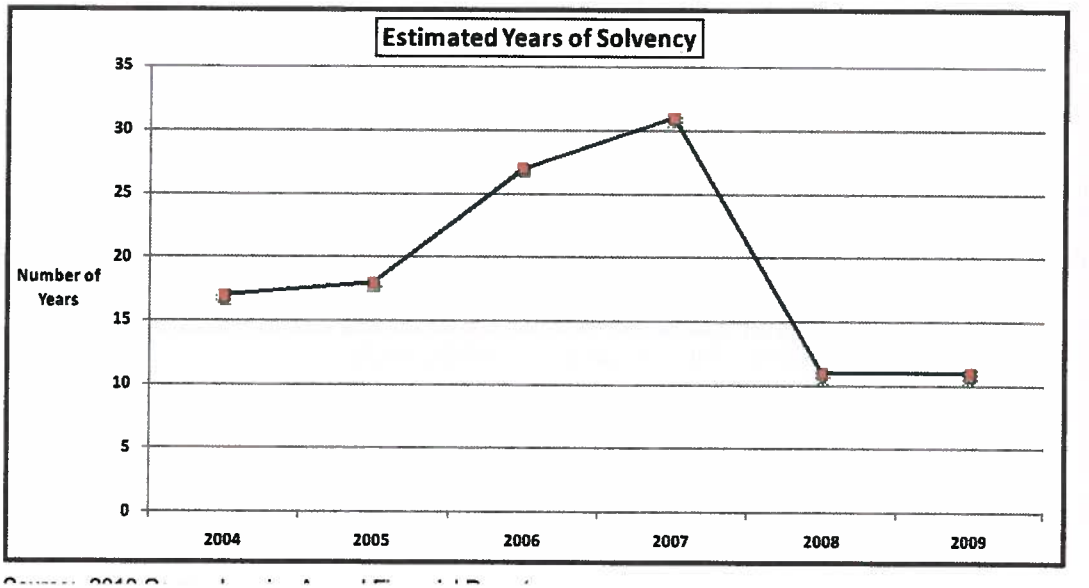
OPERS has a long history of providing dependable retirement benefits and retiree health care coverage. But, like other payors of health care from the federal government to private industry, OPERS has experienced significant inflationary pressures resulting in increased annual expenditures. OPERS had the foresight and discipline with favorable financial results over the past decades to establish a $12.3 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 and a commitment to solvency

In 2004, the OPERS Board and staff had the foresight to adopt the Health Care Preservation Plan (HCPP). The 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 Jan. 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 in order 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. The results are paying off. As of Dec. 31, 2010, HCPP and HCPP 2.0 cumulatively added approximately $2.57 billion to the OPERS health care fund. To arrive at this figure, the estimated annual effects of each of the HCPP changes were accumulated to Dec. 31, 2010 using the actual annual market returns of the retiree health fund.

As is shown in the chart below, the solvency of the OPERS health care fund was 11 years at the end of 2008 and 2009, meaning that if no additional contributions were made into that fund, it would be exhausted in 11 years assuming current health care costs.

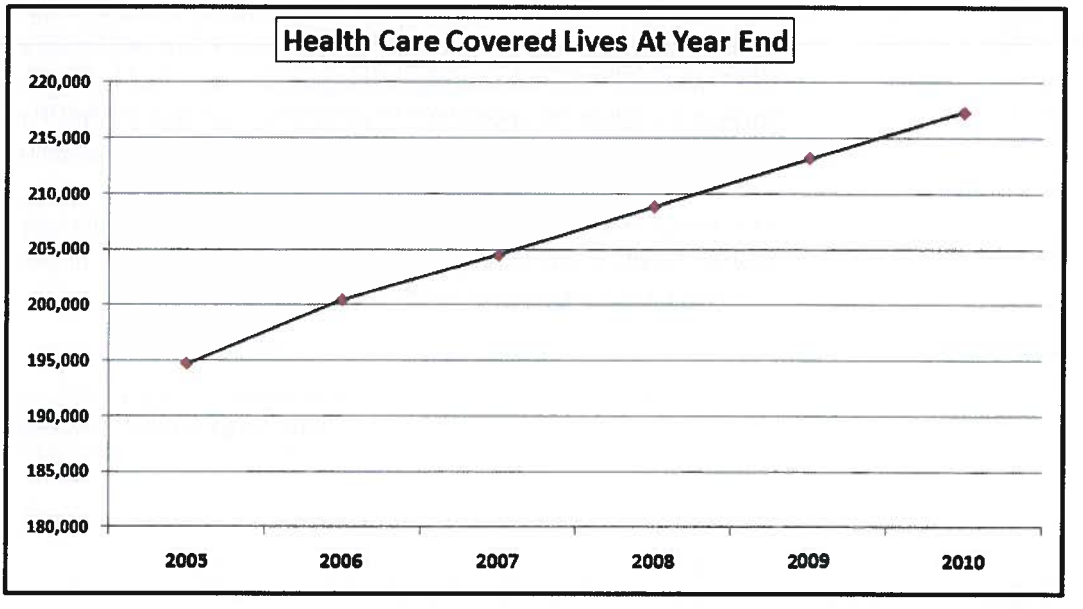


In 2007, the OPERS Board approved a policy to improve the funding and necessary cost controls to expand the target solvency period from the original 15-25 years to 20-40 years.

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. Source: 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 swell 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 draw benefits at a later age.



	2005	2006	2007	2008	2009	2010
Covered Lives	194,773	200,494	204,514	208,857	213,220	217,334
Percent Increase Over Prior Year	2.93%	2.94%	2.01%	2.12%	2.09%	1.93%

Source: 2010 Comprehensive Annual Financial Report

The future of the OPERS health care plan

As guided by the Health Care Preservation Plan implemented in 2007, OPERS continues to gauge and monitor industry developments, retiree population tendencies and financial market factors that drive health care decisions for the future. OPERS has realized distinct progress during the second phase of the Health Care Preservation Plan (HCPP 2.0) with its multi-disciplinary and strategic set of changes.

Between 2007 - 2010 OPERS designed and implemented a much more dedicated program for wellness, worked collaboratively with the other Ohio retirement systems during the medical Request For Proposal (RFP) process, finalized the transition to a new Pharmacy Benefit Manager (PBM) and introduced a Medicare Advantage Plan originally with Aetna changing over to Humana in 2010. OPERS continued to implement numerous changes over the course of these years with many initiatives still actively being developed and implemented in 2010.

HCPP 2.0 summary start dates and status:

1. **Member Cost Share Policy 10-20 percent (2008-2012)**
   Status – Medicare-eligible participants currently pay approximately 17.7 percent of the cost not paid by Medicare. Non-Medicare participants pay approximately 12.2 percent of the cost. Projected plan design changes will be made with the intent of reaching the 20 percent cost share target by 2012.

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 they pay 100 percent of the cost. Implemented communication plan with targeted letters, newsletter articles, open enrollment material and web presence geared for start date of Jan. 1, 2011.

3. **Legislative Initiatives – OPERS Board authority to set Medicare B reimbursement level**
   Status – Board capped Medicare B reimbursement at $96.40 per month unless a recipient is receiving Medicare B reimbursement from another source, in which case, the OPERS reimbursement will be reduced accordingly.

4. **Disability Management Enhancements/Updates (2009-2010)**
   Status – Hired MLS Group as vendor to provide guidance on disability plan design.

5. **Asset Reallocation to Improve Investment Return Assumption (2007-2011)**
   Status – the OPERS Board approved a reallocation plan in October 2009, effective January 2010. As of year-end 2010, the transition toward the new long-term targets was approximately 85 percent complete.

6. **Increase Contribution Allocation to Health Care (2008)**
   Status – Based on the economic environment, contribution allocations were realigned in 2010.

In December 2010, the OPERS Board reviewed the status of the retiree health care fund and possible changes that could take place in the near future to help preserve the fund's solvency. The board reviewed the original guiding principles to determine their soundness moving forward and identified a timeline for further analysis of the health care plan, its funding and the overall health care environment going into 2011.

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' 2010 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 to allow for the early identification of potential health concerns.

- Personal health coaches provide Lifestyle Coaching 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 17,000 OPERS Medicare participants participated in Silver Sneakers in 2010.

Retiree and dependent participation in OPERS' personal health management programs is voluntary. In 2010, almost 63,000 retirees and eligible dependents completed a health assessment and/or underwent an annual physical exam. In addition, approximately 10,000 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 2010, approximately $4.6M was deposited into RMA accounts for 69,500 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% 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% one routine physical exam each year.

The number of OPERS participants who take advantage of preventive services has increased each year. OPERS' rates of many preventive screenings increased in 2010 with OPERS' results exceeding national norms in many categories. Concerted communication efforts emphasizing the importance of preventive screenings is expected to further increase the percent of the population that undergoes important preventive screenings.

Clinical Quality Improvement

2010 marked the first full year of the OPERS Clinical Quality Improvement Committee (CQIC). Comprised of thought leaders and clinicians from the Health Care division, OPERS' vendor partners, and consultants, the CQIC is charged with favorably impacting OPERS' health care trend via improvements in clinical quality. Key to the success of the CQIC is the collaborative manner in which the committee conducts its business.

The focus of the CQIC's efforts is on four strategic initiatives that are expected to favorably impact the OPERS Health Care Plan in the long term. 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 CQIC has been instrumental in the development of a Clinical Report Card that will be used by OPERS to measure and monitor key quality and utilization outcomes against industry benchmarks and target performance measures. The Clinical Report Card will facilitate the ongoing identification of opportunities for improving the OPERS retiree Health Care Program and the evaluation of any/all interventions centered around the four strategic initiatives and other areas of the CQIC's focus.

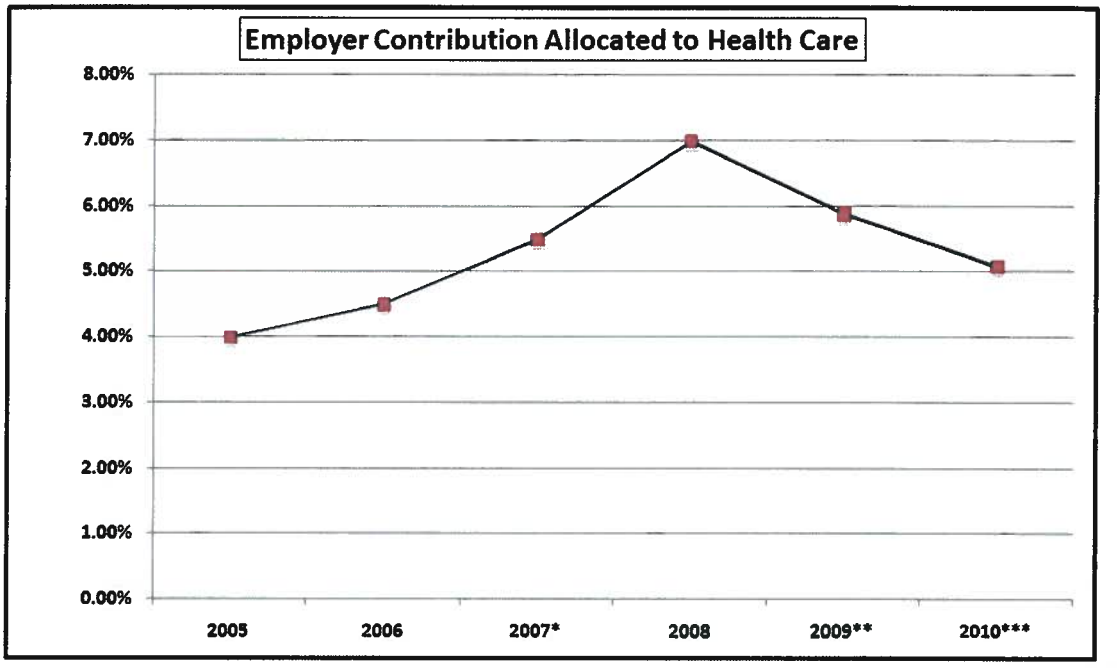
Legislation

In November 2009, the OPERS Board of Trustees recommended to the legislature a series of changes to benefits designed to strengthen the pension system and with the added goal of maintaining adequate funding for health care. These changes require enactment by the Ohio General Assembly. Depending on legislative implementation, the recommended changes to benefits will build on past actions by the Board to prepare for longer life expectancies of retirees, to encourage member engagement in their retirement planning and to correct inequities resulting from benefit subsidization. The ORSC asked all five of Ohio's public pension systems to examine changes to a number of benefit plan elements with the goal of ensuring the long-term fiscal strength of the systems. The Board had been considering plan design changes for more than a year prior to the ORSC request.

The recommended changes include:

1. Adding two years to age and service retirement eligibility - 32 years of service, minimum age 55 or age 67 with five years of service for an unreduced pension. For a reduced pension, retirement at age 57 with 25 years of service or age 62 with five years of service;
2. Modifying the benefit formula;
3. Tying the Cost of Living Adjustment (COLA) to the Consumer Price Index; and
4. Extending the final average salary calculation from three to five years.

In order to remain below the statutorily-required 30-year amortization period, the OPERS Board voted to accelerate its plan to reallocate new employer contributions from the retiree health care fund to the pension fund. Following this decision, OPERS will gradually reduce the portion of employer contributions directed to fund retiree health care coverage until 2014, when zero percent of employer contributions will be allocated to the retiree health care fund. 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. The 2010 employer contribution rate was further reduced to an average of 5.08 percent. This percentage will continue downward if the Ohio General Assembly does not act on the benefit plan changes. However, if the Ohio General Assembly approves the Board's recommended benefit plan changes, OPERS intends to be able to restore health care funding to four percent of employer contributions moving forward. See chart on page 11.



	2005	2006	2007*	2008	2009**	2010***
Percent of Contribution Rate Funding Health Care	4.00%	4.50%	5.50%	7.00%	5.88%	5.08%

Source: 2010 Comprehensive Annual Financial Report
Notes:
* The portion of the employer contribution rate allocated to fund health care was 5% for the period January 1, 2007 through June 30, 2007 and increased to 6% for the period July 1, 2007 through December 31, 2007. The overall effective rate for the year was 5.5%.
** The portion of the employer contribution rate allocated to fund health care was 7% for the period January 1, 2009 through March 31, 2009 and decreased to 5.5% for the period April 1, 2009 through December 31, 2009. The overall effective rate for the year was 5.88%.
*** The portion of the employer contribution rate allocated to fund health care was 5.5% for the period January 1, 2010 through February 28, 2010 and decreased to 5.0% for the period March 1, 2010 through December 31, 2010. The overall effective rate for the year was 5.08%.

Federal Health Care Reform

The Patient Protection and Affordable Care Act (PPACA), also referred to as health care reform, was signed into law by President Obama on March 23, 2010 and contained numerous provisions that will impact the OPERS health care plan in 2011 and may impact the plan between 2012 and 2018. Because this legislation is very complex, OPERS continues to analyze its impact on our plan in future years.

As a result of this legislation, at the end of 2010, OPERS had plans to allow children up to age 26 to enroll in the OPERS health care plan, eliminate the medical lifetime maximum for non-Medicare plan participants, and add to our list of covered preventive tests and services effective Jan. 1, 2011. OPERS also completed an application and was approved to participate in the Early Retiree Reinsurance Program (ERRP) beginning in 2011.

Funding:
Beginning in fiscal 2006, the Government Accounting Standards Board (GASB) required retirement systems to estimate their liability for health care benefits 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, 2009, the date of the latest actuarial valuation, OPERS had an estimated liability for health care of $31.5 billion. Also as of December 31, 2009, OPERS had $10.9 billion in assets as stated on a funding basis (actuarially smoothed over a four year period), leaving an unfunded liability of $20.6 billion. By comparison, the health care liability as of December 31, 2008 was $29.6 billion compared to the actuarial value of assets of $10.7 billion, leaving an unfunded liability of $18.9 billion. While the funding ratio declined from 36.3% in 2008 to 34.7% in 2009, OPERS remains one of a relatively few retirement systems that has systematically set aside assets to fund health care (the accounting requirements do not mandate pre-funding of health care coverage).

As noted above, health care coverage is not a statutorily guaranteed benefit, and may be changed to ensure the long-term solvency of the fund and OPERS' ability to provide future benefits. The funding progress of the health care plan is measured in terms of solvency years, or the number of years that funds are projected to be available to pay health care costs under the current plan structure before the plan would be reduced to a pay-as-you-go basis. The market losses of 2008 reduced the solvency years of the health care fund from 31 years as of December 31, 2007, to 11 years for the years ended December 31, 2008 and 2009.

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, Medicare Part D reimbursements, and contract and other receipts comprise the balance.

1. Investment Income – The health care portfolio earned an investment return of 13.53 percent for the year ended December 31, 2010 compared to returns of 24.80 percent and -25.77 in 2009 and 2008 respectively.

2. Employer Contributions – Employer contributions as a percent of active member payrolls added $628.7 million to the fund in 2010 – a decrease of 15 percent from the 2009 revenue of $740.8 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. The 2010 employer contribution rate was further reduced to an average of 5.08 percent. 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. In order to preserve the System's future financial stability, plan design changes to both pension and health care are under consideration. If no changes are made, the portion of the employer contribution rate allocated to health care will decline to 0 percent by 2014.

In addition, the market volatility of 2008 resulted in many employers denying or deferring raises in both 2009 and 2010, implementing furlough days, and reducing the number of employees. The decline in the number of actively contributing members that began in 2008, continued through 2010 as a weak Ohio economy contributed to layoffs and downsizing by employer units. Actively contributing members declined by 2.33% in 2010, 2.35% in 2009, and 2.14% in 2008.

Additions to the Health Care Fund *(continued)*:

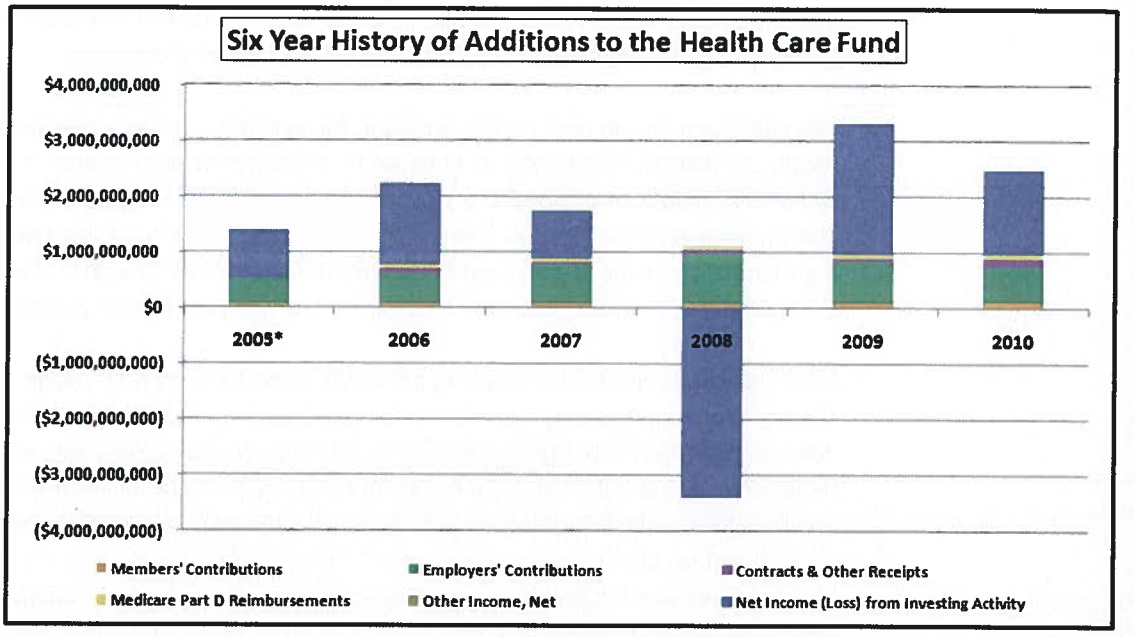
3. Member Contributions – Member contributions represent amounts paid by retirees towards the cost of OPERS-provided health care for the retiree, their spouse and dependents. In 2010 these contributions totaled $111.6 million, compared to $94.4 million in 2009, or an 18.3% increase. This increase reflects the rising cost of health care coverage, an increase in the retiree population, and program design changes that are intended to gradually increase the retiree cost share to approximately 20%.

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

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. In 2008, OPERS recorded accrued revenues for historical amounts due from other systems for health care waivers not yet received as of December 31, 2008. This accrual increased revenues from other systems to nearly $18.8 million in 2008. These revenues were $5.2 million in 2009 and $8.6 million in 2010. 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 coverage under the pre January 1, 2007 election rules drop from the retirement rolls.

OPERS also received $70.6 million 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 set aside is nearly exhausted. Additional receipts of $22.0 million were received in conjunction with the new Medicare Advantage program for retirees over the age of 65. This is a premium-based program administered by an outside vendor rather than the self insured program OPERS operates for the under 65 population. The funds represent a premium rebate based on OPERS actual claims experience compared to the experience history used to set the initial premium rate.

5. Medicare Part D Reimbursements - Employers that offer a high-quality prescription drug program for retirees and their dependents are eligible for a federal subsidy under Medicare Part D. The subsidy, which reflects a reimbursement of approximately 25-28% of eligible retiree prescription drug costs, represented over $72.1 million in revenue for OPERS in 2010, compared to $69.1 million in 2009 and $63.3 million in 2008.



	2005*	2006	2007	2008	2009	2010
Members' Contributions	$63,408,347	$71,718,182	$79,198,959	$82,695,255	$94,370,543	$111,638,313
Employers' Contributions	$457,325,506	$538,312,995	$695,967,837	$891,561,073	$740,817,891	$628,685,237
Contracts & Other Receipts	$7,234,092	$93,724,104	$45,534,017	$66,343,542	$58,649,547	$154,130,632
Medicare Part D Reimbursements	$0	$58,987,181	$59,075,120	$63,310,194	$69,132,772	$72,100,529
Other Income, Net	$548,364	$1,306,783	$70,498	$614,989	$654,031	$605,275
Net Income (Loss) from Investing Activity	$868,900,661	$1,471,059,831	$858,614,433	($3,400,647,342)	$2,356,554,863	$1,511,164,964

Source: 2010 Comprehensive Annual Financial Report
Notes:
* Additions were restated to delineate contracts and other receipts.
Members' Contributions reflect retiree cost share of premium.
Medicare Part D Reimbursements effective in 2006.
Beginning in 2007, OPERS began recording estimated accruals for vendor performance guarantees, rebates, Medicare Part D, and ORS receipts.

Health Care Expenses:

The expenses displayed in the following graphs reflect the cost of health care expenses for retirees, their spouses and their dependents, exclusive of OPERS operating expenses.

The increase in health care coverage 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, the expenses incurred by OPERS in 2010 also reflect the impact of the combination of significant plan design changes, cost-sharing changes and extensive cost containment efforts. Fiscal year 2010 represents the fourth year of implementation for the Health Care Preservation Plan (HCPP). The goal of HCPP was to extend the period of time the health care assets were expected to last (the plan solvency years).

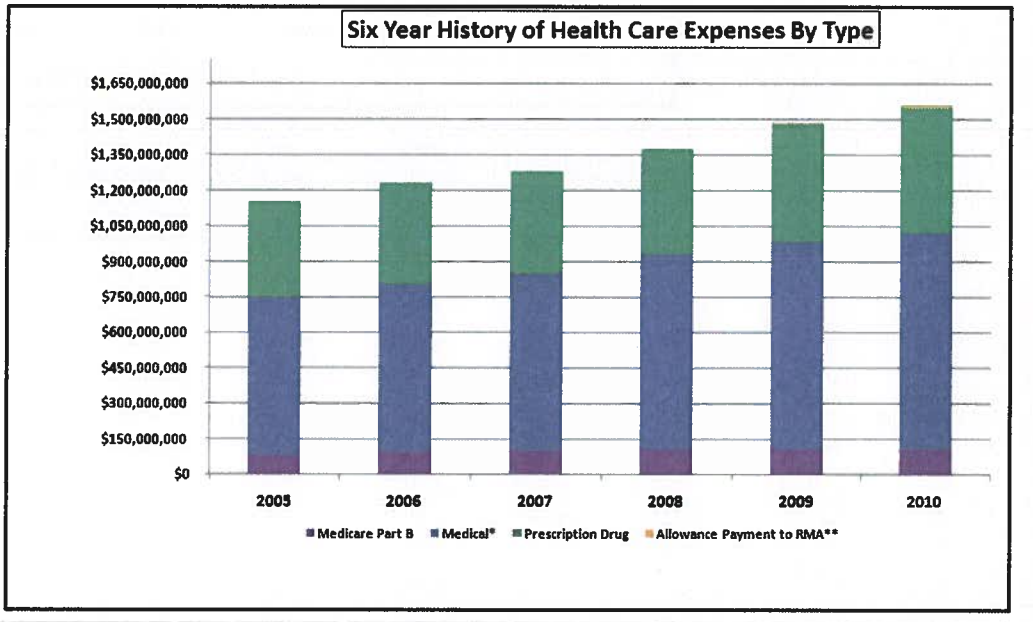
HCPP included significant changes to the health care plan design by linking the amount of health care subsidy to years of service, and allowed for variables in deductibles and cost containment efforts. Cost containment efforts included participation in federally subsidized programs such as the Medicare Part D reimbursements 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. Based on the relatively low growth in the health care expenses since plan inception in 2006, the plan has been successful. Health care expenses have risen at a fairly consistent rate from $1.4 billion in 2008 to $1.5 billion in 2009 and to $1.6 billion in 2010. At the same time, the number of eligible retirees, dependents and beneficiaries increased by, 3.2% in 2008, 3.3% in 2009, and 4.4% in 2010. The 2010 increase in eligible dependents also reflects the federal mandate to provide coverage for dependents up to the age of 26.

The majority of the OPERS health care fund expenses are comprised of medical and prescription drug costs, as well as reimbursements to retirees for Medicare Part B premiums. These expenses increased by $75.9 million in 2010 compared to an increase of $106.3 million in 2009. Medical expenses increased by $42.6 million or 4.9%, and prescription drug costs rose by $31.4 million in 2010 or 6.3% over the 2009 levels. Statutorily required Medicare Part B reimbursements increased by $1.9 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% for both 2009 and 2010. By comparison, Medicare Part B reimbursements in 2008 were 4.8% higher than in 2007, as the federal premiums continued to rise. The overall breakdown of health care expenses for 2009 and 2008 reflect similar distributions, with medical expenses averaging approximately 59% of the total, followed by prescription drugs (33%) and Medicare Part B reimbursements and other expenses (8%).

Health Care Expenses *(continued)*:

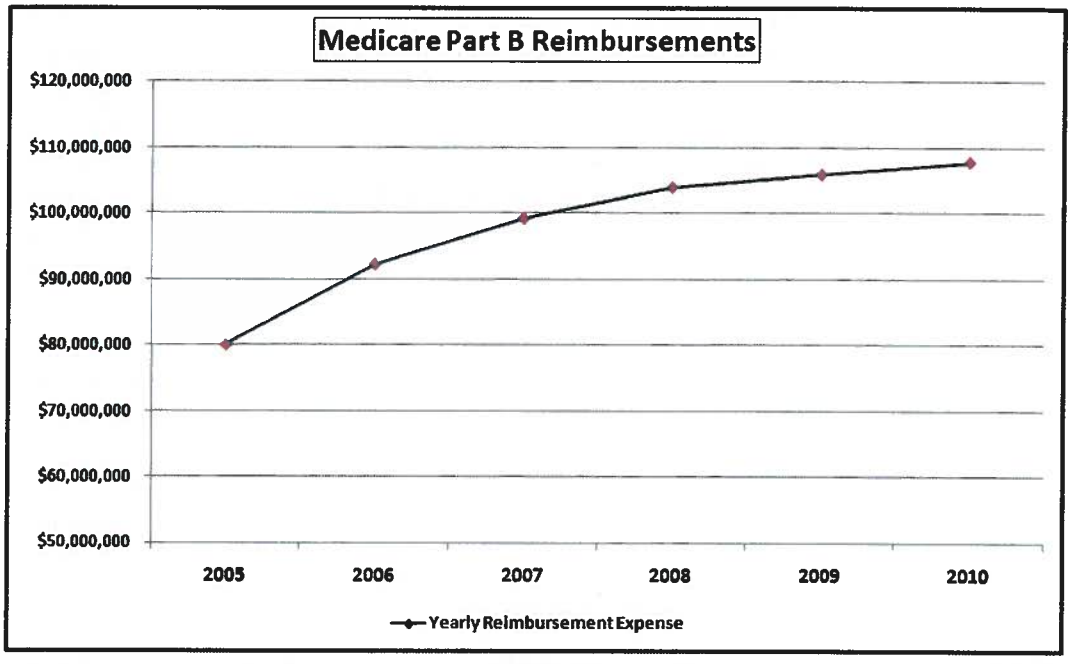
OPERS participation in the premium based Medicare Advantage program has also resulted in a reduction in the expense for claims incurred but not yet reported (IBNR). At the end of each year OPERS estimates the value of claims incurred but not yet reported, and records an expense necessary to adjust the medical accounts payable liability for the value of these claims. Participation in the Medicare Advantage program is mandatory when a retiree and their spouse reach age 65 unless they have enrolled dependent children, 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 reduction in expense. In 2010, this adjustment was $6.6 million.

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



	2005	2006	2007	2008	2009	2010
Medicare Part B	$80,094,041	$92,268,184	$99,175,973	$103,934,337	$105,854,803	$107,770,173
Medical*	$669,663,632	$711,461,624	$749,174,151	$827,135,910	$877,861,028	$913,945,128
Prescription Drug	$403,184,288	$428,140,230	$431,405,495	$441,059,097	$494,674,419	$526,054,523
Allowance Payment to RMA**	$0	$0	$3,020,425	$5,016,829	$9,642,605	$13,223,453

Source: 2010 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 Jan. 1, 2007



	2005	2006	2007	2008	2009	2010
Yearly Reimbursement Expense	$80,094,041	$92,268,184	$99,175,973	$103,934,337	$105,854,803	$107,770,173
Annual Percent Increase Over Prior Year	19.02%	15.20%	7.49%	4.80%	1.85%	1.81%

Source: 2010 Comprehensive Annual Financial Report

The future holds many challenges and opportunities

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

- **Health care funding** - During 2010, the OPERS investment division began the process of reallocating the Health Care Fund assets. The reallocation was designed to improve the projected level of future returns at acceptable levels of risk to better meet future health care coverage needs. OPERS investment division expects this reallocation plan to be complete by the end of 2011.

- **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.

- **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.

- **Focus on quality** – The Patient Protection and Accountability Care Act (PPACA) contains efforts to overhaul the health care system including cost control and an emphasis on quality of care. The development of accountable care organizations, implementation of patient-centered medical homes, and utilization of global payment methods will give rise to value-based purchasing by OPERS and others.

- **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.

- **Federal Mid-Term Elections** – In November 2010, the make up of Congress changed significantly. Republicans regained control of the U.S. House of Representatives and reduced the Democrat majority in the Senate. Significantly, many of the new Republican members of Congress campaigned on a platform of repealing federal health care reform. It remains to be seen whether the 112th Congress will repeal or significantly modify the Patient Protection and Affordable Care Act.

- **Retiree education** – In 2010, OPERS provided health care education to retirees by including health care focused articles in every issue of *Ohio PERS NEWS for Retirees* and also providing retiree organizations with educational articles for their member publications. We also increased educational opportunities on the OPERS website by adding videos of the retiree and open enrollment seminars. The OPERS health care education team delivered educational presentations to 20,433 participants in 2010, an 8 percent increase from 2009. Health care educators also delivered presentations

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 Dec. 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 2010 OPERS Health Care Plan for non-Medicare participants

The 2010 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

Effective Jan. 1, 2010, OPERS began enrolling Medicare-eligible plan participants into the Humana Medicare Advantage Plan. 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 your Part B premiums.

A Medicare Advantage Plan simplifies the combination of Medicare and the OPERS health care plan. Participants no longer have to worry about multiple filings and coordination of benefits between Medicare and the OPERS plan because all medical claims go directly to Humana for processing. A Medicare Advantage Plan allows participants to carry only one ID card.

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

Alternate health care coverage was available in 2010 to OPERS health care plan participants who resided in certain counties in Ohio. These products included Kaiser Permanente HMO and AultCare PPO. HMO products 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 or Aultcare) receive prescription drug coverage through Express Scripts, Inc.

In 2010, 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. The home delivery program was heavily marketed to participants in 2010 because of the cost savings it provides to OPERS and the participant. Co-payments for prescriptions differ based on the delivery method, whether a drug is a generic or a name brand and its formulary status.

Medicare

The following requirements regarding Medicare were in effect for 2010:

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.

Medicare Part D

Medicare Part D is prescription drug coverage. In 2010, OPERS did not recommend that plan participants sign up for Medicare Part D coverage outside of OPERS because it may require an additional premium.

The Dental Plan

During 2010, 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 Aetna, 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

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 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 2010:

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 Jan. 29, 1981; service credit granted under a retirement incentive plan; or exempt service purchased after May 4, 1992.

Disability Retirement

If a person was 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 the Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code, if a retiree receives a monthly age and service or disability benefit, he or she may only enroll:

- A legal spouse. This must be a person of the opposite gender and the retiree must have a valid marriage certificate recognized by Ohio law.
- A biological or legally adopted child or minor grandchild if the grandchild is born to an unmarried, un-emancipated minor child and the retiree is ordered by the court to provide coverage pursuant to Ohio Revised Code Section 3109.19.

In 2010, for a child to be eligible for coverage, the child must be under 18 and never married or under age 22, never married, and attending an accredited school on a full-time basis for at least 5 months of the calendar year. Certain farm training programs qualify as accredited schools. Coverage may be extended if the child is permanently and totally disabled prior to the limiting ages listed above. 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.

For all children:

The retiree must be allowed to claim this child as a dependent on his or her federal tax return in accordance to Section 152 of the Internal Revenue Code. The child cannot provide more than half of his or her own support for the calendar year and the child must reside with the retiree for more than half of the calendar year (unless residing at school) unless:

- The retiree is divorced, legally separated, separated under a written separation agreement, or is living apart at all times during the last six months of the calendar year and the retiree is the parent of the child.
- The child is in the custody of the retiree or his/her other parent for more than one-half of the calendar year.
- The retiree provides over one-half of the child's support, subject to the provisions of Section 152 of the Internal Revenue Code regarding multiple support agreements.

If an individual receives a monthly benefit as a surviving spouse or a beneficiary of a deceased retiree or deceased member, he or she may only enroll those dependents who would have been eligible dependents of the deceased retiree or member as defined above.

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 Dec. 31, 2010, there were 217,334 OPERS retirees and dependents covered under 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 are not yet known to the Retirement System. 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 exclusively 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 real estate and private equity, are valued based on closing market prices or broker quotes. The fair value of real estate investments is based on estimated current values and independent appraisals. 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.

Employer contributions and investment earnings are used to fund health care expenses. Under this method, employer contributions equal to an average rate of 5.08 percent of covered payroll were used to fund health care liabilities for the period of Jan. 1, 2010 through Dec. 31, 2010. Additionally, revenues from member contributions (amounts paid by retirees towards the cost of OPERS-provided health care for the retiree, their spouse and dependents), Medicare Part D reimbursements, and contract and other receipts 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 Dec. 31, 2007, to 11 years as of Dec. 31, 2008 and Dec. 31, 2009.

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 Plan 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 $107.8 million in Medicare Part B premiums to its benefit recipients in 2010.

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 Jan. 1, 1968, who has attained the age of sixty-five years, and who is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program, 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 sixty-five 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: 132 v H 402 (Eff 12-14-67); 136 v H 1 (Eff 6-13-75); 137 v H 1 (Eff 8-26-77); 139 v H 126 (Eff 6-13-81); 144 v S 346 (Eff 7-29-92); 148 v H 628 (Eff 9-21-2000).

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 ninety-six dollars and forty cents, 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)

	2010	2009	2008	2007	2006	2005
Assets						
Cash and Short-Term Investments	**$310,859,956**	**$82,384,335**	**$214,267,049**	**$166,407,166**	**$322,120,585**	**$250,418,690**
Receivables:						
Members' and Employers'	62,635,516	70,351,872	99,321,334	107,187,056	82,850,806	67,383,947
Retirement Incentive Plan	2,183,860	3,185,825	344,045	676,337	762,533	1,805,631
Vendor and Other	133,916,383	49,921,976	57,775,901	36,025,605	34,882,853	
Investment Sales Proceeds	135,342,122	884,914,266	57,319,401	33,489,810	80,471,902	7,776,993
Accrued Interest and Dividends	49,049,361	37,732,716	46,426,349	64,843,050	67,341,496	51,057,887
Total Receivables	**383,127,242**	**1,046,106,655**	**261,187,030**	**242,221,858**	**266,309,590**	**128,024,458**
Investments, at fair value:						
Global Bonds	4,355,743,585	3,746,406,051	4,363,406,922	6,581,396,111	6,116,700,706	4,226,384,980
Domestic Equities	3,960,117,840	3,806,887,666	2,731,493,461	4,186,123,350	4,388,937,986	4,623,642,722
Real Estate						505,301,728
Private Equity	45,999,889	39,341,186	5,150,008			
International Equities	3,649,437,854	2,974,380,740	2,201,764,403	2,282,909,655	1,973,897,814	2,281,196,185
Total Investments	**12,011,299,168**	**10,567,015,643**	**9,301,814,794**	**13,050,429,116**	**12,479,536,506**	**11,636,525,615**
Collateral on Loaned Securities	**1,517,578,594**	**299,502,780**	**2,297,927,070**	**2,072,493,713**	**2,015,624,266**	**1,749,802,181**
Capital Assets:						
Land	665,394	665,394	665,394	665,394	665,394	665,394
Building and Building Improvements	19,641,200	19,660,159	19,663,497	19,852,388	19,679,465	19,096,169
Furniture and Equipment	22,850,746	20,582,082	17,141,828	14,941,722	11,420,812	9,411,311
Total Capital Assets	43,157,340	40,907,635	37,470,719	35,459,504	31,765,671	29,172,874
Accumulated Depreciation	(16,294,444)	(13,530,325)	(11,267,149)	(8,853,297)	(7,340,277)	(6,266,653)
Net Capital Assets	**26,862,896**	**27,377,310**	**26,203,570**	**26,606,207**	**24,425,394**	**22,906,221**
TOTAL ASSETS	**14,249,727,856**	**12,022,386,723**	**12,101,399,513**	**15,558,158,060**	**15,108,016,341**	**13,787,677,165**
Liabilities:						
Undistributed Deposits	80,073	52,974	52,974	8,385		
Medical Benefits Payable	142,952,643	134,007,772	131,776,992	142,701,327	145,895,911	138,450,016
Investment Commitments Payable	253,257,695	163,153,464	69,811,443	57,017,727	108,410,835	53,711,956
Accounts Payable and Other Liabilities				569,998	26,250	
Accounts Payable RMA Claims	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	1,749,802,181
TOTAL LIABILITIES	**1,929,983,877**	**607,191,449**	**2,505,317,436**	**2,275,210,578**	**2,269,957,262**	**1,941,964,153**
Net Assets Held in Trust for Pension and Post-Employment Health Care Benefits	**$12,319,743,979**	**$11,415,195,274**	**$9,596,082,077**	**$13,282,947,482**	**$12,838,059,079**	**$11,845,713,012**

Source: 2010 Comprehensive Annual Financial Report

	2010	2009	2008	2007	2006*	2005*
Additions:						
Members' Contributions	$111,638,313	$94,370,543	$82,695,255	$79,198,959	$71,718,182	$63,408,347
Employers' Contributions	628,685,237	740,817,891	891,561,073	695,967,837	538,312,995	457,325,506
Contract and Other Receipts	154,130,632	58,649,547	66,343,542	45,534,017	93,724,104	7,234,092
Medicare Part D Reimbursements	72,100,529	69,132,772	63,310,194	59,075,120	58,987,181	
Other Income, Net	605,275	654,031	614,989	70,498	1,306,783	548,364
Total Non-Investment Income	**967,159,986**	**963,624,784**	**1,104,525,053**	**879,846,431**	**764,049,245**	**528,516,309**
Income/ (Loss) from Investing Activities:						
Net Appreciation / (Depreciation) in Fair Value	1,240,024,373	2,081,098,064	(3,734,049,668)	479,748,239	1,048,846,038	382,822,937
Bond Interest	137,927,458	152,358,418	182,944,355	211,556,481	179,769,220	124,871,047
Dividends	134,809,505	134,487,014	139,099,121	160,715,579	106,148,349	99,647,424
International Income	48,675	52,944	552,901	9,981	143,649,645	262,947,660
Other Investment Income / (Loss)	3,778,346	661,628	147,998	13,229,442	2,829,179	6,773,879
External Asset Management Fees	(10,904,604)	(7,709,148)	(8,674,498)	(10,491,258)	(10,797,650)	(7,188,895)
Net Investment Income / (Loss)	1,505,683,753	2,360,948,920	(3,419,979,791)	854,768,464	1,470,444,781	869,874,052
From Securities Lending Activity:						
Security Lending Income	14,236,338	2,336,740	103,004,243	120,699,574	94,382,644	34,774,894
Security Lending Expenses	(4,259,969)	(562,862)	(79,967,808)	(113,044,477)	(89,727,122)	(31,691,948)
Net Securities Lending Income	9,976,369	1,773,878	23,036,435	7,655,097	4,655,522	3,082,946
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**	**3,082,946**
Less: Investment Administrative Expenses	(4,495,158)	(3,771,803)	(3,703,986)	(3,809,128)	(4,040,472)	(4,056,337)
Net Income / (Loss) from Investing Activity	**1,511,164,964**	**2,356,554,863**	**(3,400,647,342)**	**858,614,433**	**1,471,059,831**	**868,900,661**
TOTAL ADDITIONS	**2,478,324,950**	**3,320,179,647**	**(2,296,122,289)**	**1,738,460,864**	**2,235,109,076**	**1,397,416,970**
Deductions:						
Health Care Benefits	1,560,993,277	1,488,032,855	1,377,146,173	1,282,776,044	1,231,870,038	1,152,941,961
Administrative Expenses	12,782,968	13,033,595	13,596,943	10,796,417	10,892,971	7,875,355
TOTAL DEDUCTIONS	**1,573,776,245**	**1,501,066,450**	**1,390,743,116**	**1,293,572,461**	**1,242,763,009**	**1,160,817,316**
Net Increase/ (Decrease)	904,548,705	1,819,113,197	(3,686,865,405)	444,888,403	992,346,067	236,599,654
Net Assets Held in Trust for Pension and Post-employment Health Care Benefits Balance, Beginning of Year	11,415,195,274	9,596,082,077	13,282,947,482	12,838,059,079	11,845,713,012	11,609,113,358
BALANCE, END 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**

Source: 2010 Comprehensive Annual Financial Report

*Additions and Health Care Benefits were restated to delineate contracts and other receipts.

OPERS Board of Trustees

The 11-member OPERS Board of Trustees is responsible for the administration and management of OPERS. Seven of the 11 members are elected by the groups that they represent (i.e., college and university non-teaching employees, state, county, municipal, and miscellaneous employees, and retired members); the Director of the Department of Administrative Services for the state of Ohio is a statutory member, and three members are investment experts appointed by the Governor, the Treasurer of State, and jointly by the Speaker of the Ohio House of Representatives and the President of the Ohio Senate.

Elected Board Members

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Retired Members

John W. Maurer
Retired Members

Kimberly Russell
State College and University Employees

Matthew Schulz
State Employees

Cinthia Sledz
Vice Chair
Miscellaneous Employees

Ken Thomas
Chair
Municipal Employees

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Statutory Board Member

Robert Blair
Director, Department of Administrative Services

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Investment Expert
Governor Appointee

Charlie Adkins
Investment Expert
Treasurer of State Appointee

James R. Tilling
Investment Expert
General Assembly Appointee

Karen Carraher
Interim Executive Director