Ohio Public Employees Retirement System

Health Care

Keys to Preserving Health Care for the Future

OPERS 2012 Health Care Report

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OPERS

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Executive Report

Welcome

The theme of this year's report, *Keys to Preserving Health Care for the Future*, reflects two crucial elements, or *keys*, to providing meaningful retiree health care coverage in today's challenging environment. These *keys* are a solvent health care trust fund and a health care program designed specifically to be responsive to the current marketplace and sustainable into the future.

Health care in the U.S. was a leading topic of discussion and debate in 2012. Similarly, health care was a significant topic at OPERS. Since 1974, OPERS has funded its discretionary health care program through the establishment of a health care trust fund. This unique fund sets OPERS apart from almost every other pension fund in the U.S. Today, our health care trust fund has reached a market value of $12.8 billion. Nonetheless, the solvency of the fund was being challenged with changing demographics, a volatile investment market and the rising costs of health care.

The passage of Substitute Senate Bill 343 (Sub. S.B. 343) in 2012 strengthened our ability to provide secure pensions and also allows OPERS to continue to offer access to health care, which we believe is an important part of retirement security. While the OPERS health care trust fund is one of the largest in the U.S., funding health care within its ever-changing landscape remains a considerable challenge.

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Even with the enactment of pension reform, we still needed to make changes to the program to provide coverage within our funding level. After two years of extensive review in September 2012 (the same month the pension legislation was approved), the OPERS Board of Trustees approved significant changes to the current retiree health care plan with broad support from our members, retirees and stakeholders. These changes are an extension of the Health Care Preservation Plan adopted by the Board in 2004 and implemented in 2007. However, the 2012 changes are much more extensive and innovative and designed to allow OPERS to offer meaningful health care long into the future, while enhancing our members' responsibility to be good consumers.

To support our retiree population and, at the same time, take advantage of market place opportunities, we crafted a health care plan that recognized our funding capacity while adhering to key guiding principles that support the health care needs of our retirees. Although some changes will be difficult, we have held true to our goal of providing a sustainable health care program for current and future

generations of retirees. In addition, we created a transition period to help retirees adjust to the changes over time and we have taken advantage of the changes in the marketplace to provide retiree access to the most affordable plans.

In addition to the changes to the health care program, OPERS continues to work in the larger environment to help bring high-quality, affordable health care to our retirees. We have partnered with staff from Ohio Gov. John Kasich's office to initiate health care payment reform and to expand quality outcomes through Patient-Centered Medical Homes and Value-Based Insurance Designs.

Listed below are some of the highlights of 2012 for retiree health care coverage at OPERS. Greater detail on each of these items is provided in the report.

A Plan to Preserve Health Care for the Future—Considering the degree of challenges in the marketplace today, it is difficult to say that we've completely solved the health care dilemma retirement systems face. However, we are confident our solution presents positive long-term solvency. The new health care plan design adjusts three main components to achieve optimal savings while minimizing the risk to retirees—eligibility, participant cost and plan sponsorship.

Funding Retiree Health Care—With the adoption of the new health care program and the passage of Sub. S.B. 343 in 2012, the OPERS health care trust fund has the proper funding to support sustained access to quality health care coverage for our current and future retirees. OPERS is one of the few public pension systems in the country that pre-funds health care. Consequently, we have one of the largest health care funds and we are on our way to achieving a trust fund that supports the health care needs of all our current and future members.

Resource Efficiency and Utilization—OPERS participated in the Early Retiree Reinsurance Program (ERRP) offered through the Patient Protection Affordable Care Act (PPACA) and must justify to the Centers for Medicare and Medicaid Services (CMS) that all the ERRP funds were used according to its rules by choosing one of its prescribed methods. In 2012, OPERS used these funds to hold retiree rate increases to zero. The plan participants benefited from our participation in this program. OPERS was third in the nation for the amount of ERRP dollars received ($180 million). We also actively managed the implementation of our Medicare Part D Prescription Drug Plan (PDP) to maximize savings and provide Medicare retirees with optimal coverage.

As the health care marketplace has evolved, so has our willingness to adjust our program to support and implement new solutions in health care delivery and payment.

Health Care Marketplace Presence—As the health care marketplace has evolved, so has our willingness to adjust our program to support and implement new solutions in health care delivery and payment. New plan design elements including Patient-Centered Medical Homes (PCMH) and Value-Based Insurance Design (VBID) modeled the wave of the future for more appropriate use of available resources and proactive health management. Our involvement with Catalyst for Payment Reform (CPR) expresses our commitment to improving the

quality of health care by shifting from a payment system that rewards volume to one that recognizes the value of the care provided. Additionally, the Medicare individual market presents plan choice and administration opportunities that OPERS plans to implement in the near future.

Eye on Quality of Care—OPERS continues to focus on maximizing quality of care. The Clinical Quality Improvement Committee (CQIC) relies upon key clinical, utilization, participant satisfaction and financial metrics to evaluate initiatives designed to improve or maintain retiree health status and the quality of care retirees receive across key medical and pharmacy vendors.

In closing, 2012 marked a year of substantial change in OPERS' health care program. We are very proud of the deliberate and collaborative process that has resulted in an increase in health care solvency from 10 years to a period sufficient to meet the needs of our current and future members (indefinite solvency). We have provided a transition plan to allow members to plan for changes. We have developed a one-of-a kind model for health care that puts our members in control of their health care expenditures. Meanwhile, we continue to work with all groups to make changes in the health care model—changes focusing on outcomes. We are proud of our progress this year and are excited to share our information with you.

OPERS continues to focus on maximizing quality of care.

A Plan to Preserve Health Care for the Future

On September 19, 2012, after nearly two years of research, analysis, and discussion, OPERS adopted a set of key changes to the current retiree health care plan that will keep the program sustainable indefinitely within the available funding.

The newly adopted health care program is evidence of OPERS' commitment to providing Ohio's career public employees with meaningful health care coverage as long as resources allow. Although health care coverage is not mandated, we realize the importance of this coverage to our membership. This new program will allow us to honor our commitment to health care well into the future.

Challenges

Providing retiree health care coverage has become increasingly difficult in recent years. Challenges, including those listed here, made it impossible for OPERS to continue providing coverage at the current level. Without change, the health care program would have become increasingly unsustainable until the health care trust fund would have been exhausted in a matter of years.

- ***Health Care Coverage is Discretionary***—OPERS is required by law to fund and provide pension benefits, but health care coverage is not mandated. Only after we meet our pension obligations are we permitted to use some of the employer contributions to fund health care coverage. OPERS cannot use employee contributions to fund health care.
- ***Increase In Population***—Baby boomers are retiring. OPERS expects that its retiree population will increase by 40% (from 162,000 to 225,000) by 2022.
- ***Life Expectancy***—Retirees are living longer. The average OPERS member retires at age 57; using a 78.3 year average life expectancy, a retiree would have access to OPERS health care coverage for more than 21 years. This is far more than anticipated when we established the health care program in 1974.
- ***Health Care Fund***—The current market value of the OPERS health care fund is $12.8 billion. However, the fund would have been depleted within ten years if we had not adopted significant changes to the health care program.
- ***Health Care Inflation***—Technological advances as well as medical and pharmacy inflation are driving health care costs up at a much higher rate than the Consumer Price Index (CPI). In 2012, the rate of health care inflation was 3.21% while the CPI was 2.07%.

Although health care coverage is not mandated, we realize the importance of this coverage to our membership. This new program will allow us to honor that well into the future.

Research and Decision Process

As early as the fall of 2010, OPERS was engaged in discussions aimed at designing a long-term health care program that supports the needs of the OPERS retiree population while prolonging the solvency of the health care trust fund. In order to gain ample insight into areas of financial, technological, regulatory and population risk, OPERS utilized many different sources and methods to provide the right level of expertise and proficiency to reach reasonable decision points.

OPERS used internal and external resources to analyze data, perform robust research, examine and assess alternative plan opportunities and provide substantive options for the OPERS Board of Trustees' consideration. A formal work group, comprised of staff with a variety of backgrounds and expertise, was responsible for presenting different aspects of the proposed plan to the Board on a monthly basis. To further support this process, OPERS sought the expertise of consultants, as well as the involvement and interaction with its external stakeholders, members and retirees. OPERS also surveyed its members about the type of changes being considered. Approximately 25,000 members responded to the survey. Additionally, OPERS offered education sessions throughout the state to share information with members.

Guiding Principles

The OPERS Board and staff adopted and referred to these guiding principles for direction during the creation of the new program:

1. Preserve access to quality health care coverage, with or without a health care allowance, for all eligible retirees and their eligible dependents.
2. Commit to a long-term solvency period.
3. Strive to balance health care changes between current and future retirees.
4. Encourage health care participants to share responsibility for prudent personal health management and medical expenditures.
5. Consider career service, membership status, and affordability in determining health care premiums.
6. Manage the health care program using sound business practices consistent with industry norms and marketplace developments.
7. Support short and long-term population health management initiatives for both active and retiree groups.
8. Review the program, at a minimum, annually to evaluate health care delivery, legislation, and program trends.

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9. Consider member needs and program costs in the design of the health care program.
10. Influence health care public policy changes and related advocacy activities.
11. On an ongoing basis, communicate with and educate all stakeholders as early as possible.

Health Care Plan Design

The new health care plan adjusts three main components to achieve optimal savings and plan longevity—Eligibility, Participant Cost (allowance) and Plan Sponsorship (in the form of a Medicare Connector). Following is a summary of the key changes comprising the new plan:

- ***Retiree Eligibility***—To be eligible for OPERS retiree health care coverage, members with a retirement effective date on or after January 1, 2015 must retire with 20 or more years of service and be age 60, or retire with 30 years of service at any age. The 30 years of service at any age requirement will increase to 32 years of service as the minimum years of service to qualify for a full pension benefit increases to 32 years.
- ***Participant Cost***—Beginning January 1, 2015, the amount OPERS pays toward the total monthly cost of coverage (allowance) will be based on the retiree's years of service and age at first enrollment in the OPERS health care plan using a revised allowance table.
- ***Spouse Coverage***—Spouses not yet eligible for Medicare will have access to the OPERS retiree health plan through 2020. Premium allowances for all spouses will be phased out beginning in 2016 leading to a $0 allowance in 2018. Beginning in 2016, spouses over the age of 65 and enrolled in Medicare Parts A and B can use the Medicare Connector to select a plan on the individual Medicare market. Spouses will receive an allowance in 2016 and 2017, but by 2018, the allowance will be phased out to $0. However, depending on the member's health care selection, the member may have sufficient allowance to fund a portion of the spousal coverage (see Medicare Connector).
- ***Surviving Spouse Coverage***—The surviving non-Medicare spouse of a deceased retiree will have access to the OPERS health care plan through 2020. All surviving spouse's allowance will be phased out beginning in 2016 leading to a $0 allowance in 2018. Beginning in 2016, surviving spouses over age 65 and enrolled in Medicare Parts A and B can use the OPERS Medicare Connector and will receive an allowance in 2016 and 2017. By 2018, the allowance will be phased out to $0.

- ***Child(ren) Coverage***—Dependent children of members with 20 years or more of service will receive an allowance equal to 50% of the retiree's allowance percentage.
- ***Qualifying Service Credit***—Only the following types of service credit will apply toward health care eligibility and allowance level effective January 1, 2014: contributing service, Ohio Retirement System service, USERRA (military service that interrupts public employment), unreported time and restored (refunded) service. In order to earn a full year of service credit applicable to health care coverage eligibility, an OPERS member must earn a minimum of $1,000 per month.
- ***Medicare Part B Premium Reimbursement***—The monthly Medicare Part B premium reimbursement provided to retirees enrolled in Medicare Part B will be reduced from $96.40 to $0 over a three-year period, beginning in 2015 (2015—reimbursement reduced to $63.62, 2016—reimbursement reduced to $31.81, 2017—reimbursement reduced to $0).
- ***Delayed Enrollment***—Retirees may delay entry into the OPERS health care plan. Effective January 1, 2015, their allowance will be determined based on their years of qualifying service at retirement and age first enrolled in the OPERS health care plan. Retirees between the ages of 60 and 65 can increase their allowance by 3% for every year of age gained while not enrolled in the OPERS health care plan.
- ***Voluntary Withdrawal***—Effective January 1, 2014: Once a retiree voluntarily withdraws from the OPERS health care plan, he or she cannot re-enroll, with the exception of re-employment in an OPERS-covered position.
- ***Minimum Earnable Salary Requirement***—Effective January 1, 2014: In order to earn a full year of service credit applicable to health care coverage eligibility, an OPERS member must earn a minimum of $1,000 per month. Earnings below $1,000 per month will not be prorated and will not qualify toward health care coverage eligibility.
- ***Income-Based Discount Program***—Beginning January 1, 2015, an income-based discount will be provided for retirees who have a household income at or below 200% of the federal poverty level (FPL) and at least 20 years of qualifying service. Eligible retirees will receive a 30% discount on their monthly premiums for the OPERS health care plan. An income-based discount for the OPERS Medicare Connector allowance has yet to be acted on by the OPERS Board. This is an increase from the current standard of 150% of the FPL.
- ***Plan Sponsorship***—Beginning in 2016, health care coverage for retirees and spouses over age 65 and enrolled in Medicare Parts A and B will be available for purchase via the Medicare Connector. Health care coverage for retirees and spouses under age 65 (and over age 65 but not eligible for Medicare Part A) will be provided through an OPERS-sponsored plan.

Beginning in 2016, health care coverage for retirees and spouses over age 65 and enrolled in Medicare Parts A and B will be available for purchase via the Medicare Connector.

Medicare Connector

In 2016, OPERS plans to introduce a Medicare Connector. A Medicare Connector is a company that partners with OPERS to help retirees and spouses eligible for Medicare Part A and Part B select an individual Medicare Supplement or Medicare Advantage Plan. Health care coverage for retirees and spouses under age 65 (and over age 65 but not eligible for Medicare Part A) will continue to be provided through an OPERS-sponsored plan.

Advantages to providing Medicare-eligible retirees with access to a Medicare Connector include:

- Maximizes health care plan choice and flexibility
- Offers health care plan(s) that meet retirees' individual needs and budget
- Supports active consumerism by Medicare-eligible retirees
- Potentially provides a savings to participants

The Medicare Connector will provide an initial enrollment process for each eligible retiree. A licensed Medicare counselor will assist retirees with choosing a plan that best meets their needs. Retirees will use their health care allowance amount from OPERS to purchase this plan. Depending on their selection, the Medicare Connector should increase participants' purchasing power to offset some of the changes OPERS has made to preserve the health care fund.

A Medicare Connector is a company that partners with OPERS to help retirees and spouses eligible for Medicare Part A and Part B select an individual Medicare Supplement or Medicare Advantage Plan.

Funding Retiree Health Care

OPERS' main goal in creating the new health care plan was to design a sustainable program within the available funding.

OPERS has two main sources of funding for the retiree health care program:

Employer Contributions—Depending on pension funding, OPERS has the discretion to direct a portion to fund health care. A portion of the employer contribution is currently allocated to fund retiree health care. The plan design assumes that a portion of employer contributions will continue to be allocated to the retiree health care plan each year.

Investment Returns—Investment returns on the health care portfolio. OPERS has established a separate health care trust fund with a balance of $12.8 billion as of December 31, 2012.

OPERS monitors the status of the health care trust fund using two key indicators: the self-funding rate and the solvency period.

Self-Funding Rate (SFR)—SFR is the percentage of the employer contribution rate required to fund health care indefinitely (indefinitely is defined as 100 years). OPERS' goal has been to decrease the self-funding rate to 4%. The board then approved a health care plan design that can be funded by 4%.

The health care program in place prior to the adoption of the new program required 7.6% of employer contributions. The goal of the new plan is to design a health care program that could be funded using only 4% of employer contributions.

Solvency Period—The solvency period refers to the period of time the health care plan will have assets available to pay health care costs (remain solvent) based on the projected contributions, investment income, health care trends, actual claims experience, and other relevant factors. The solvency period does not represent an absolute number; it is an estimate reviewed and recalculated each year by the actuary using plan experience.

OPERS has two main sources of funding for the retiree health care program: employer contributions and investment returns

A New Funding Framework

OPERS instituted a new method, or funding framework, for stabilizing the health care fund with the adoption of the new health care program. The new method works in conjunction with the self-funding rate and solvency-period measures. Additionally, the funding framework helps smooth out the health care funding level so it is not adversely impacted by market fluctuations.

Passage of Substitute Senate Bill 343 (Sub. S.B. 343)

On September 26, 2012, Ohio Gov. John Kasich signed Sub. S.B. 343 into law after a unanimous vote of support by both the Ohio House and Senate. With the passage of this important legislation, OPERS can continue to offer its retirees access to meaningful health care coverage. The fund now has the proper support to allow for the continued administration of a quality health care program for current and future retirees.

Sub. S.B. 343 did not significantly impact the OPERS health care program; however, it did change the program in three important ways:

1. The bill removed the minimum Medicare Part B reimbursement OPERS was required to pay to its retirees enrolled in Medicare Part B. Prior to Sub. S.B. 343, OPERS could not provide less than $96.40 when reimbursing members for their Medicare Part B premiums.
2. The bill also provided the OPERS Board with the ability to continue providing Medicare Part A equivalency coverage to the spouses of members who were not permitted to pay into Medicare during their working career.
3. The bill modified the pension plan, which allowed OPERS to modify the health care funding.

The enactment of Sub. S.B. 343 capped a three-year period during which the OPERS Board reduced the amount of the amount of employer contributions allocated to the health care fund in an effort to keep the fund's amortization period below the 30-year maximum required by statute.

If Sub. S.B. 343 had not been enacted; OPERS would not have been able to allocate any incoming employer contributions to fund health care coverage beginning in 2014. Without any new employer contributions going into the fund, OPERS would have been forced to decrease its health care expenditures drastically to avoid spending down the balance of the OPERS health care fund.

The OPERS Board showed foresight and determination in approving far-reaching reforms to OPERS' pension program. And, the Ohio General Assembly demonstrated leadership in supporting the Board's proposed changes. Finally, we cannot forget the contributions of our members and retirees, who, in many cases, wrote letters, sent postcards, made calls, and otherwise contacted their elected officials in support of the changes.

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OPERS Health Care Funding—National Comparison

Comparatively, our health care funding level exceeds the vast majority of funds across the nation. OPERS has pre-funded its health care liability since 1974. This is something most public and private sector employers and retirement systems do not do, opting instead to follow a pay-as-you-go model. The most recent data available, regarding state retiree health care funding levels, shows OPERS leads the nation as the fourth-best funded retiree health care plan in the nation (Source: *The Pew Charitable Trusts State and Consumer Initiatives Report*, June 18, 2012).

Resource Efficiency and Utilization

Early Retiree Reinsurance Program (ERRP)

As a participant in the ERRP, OPERS applied for and received more than $180 million, the third-highest amount nationally. ERRP is a $5 billion program providing reimbursement to participating employment-based plans for a portion of the costs of providing health care coverage for early retirees between the ages of 55 and 64 and early retirees' spouses, surviving spouses, and dependents. The program was authorized in the Patient Protection Affordable Care Act (PPACA). OPERS staff worked diligently to submit a timely and correct application for the ERRP funds, ensuring we were able to take advantage of this unique opportunity.

EERP was a temporary program, established June 1, 2010 and the funds received must be used no later than December 31, 2014. Participants may use ERRP reimbursement funds in a manner permitted under the statute, regulation, and other ERRP program guidance. Based on current actuarial projections, OPERS will satisfy the CMS requirements by December 31, 2014. In anticipation of these results, OPERS held the health care self-supporting rate flat for 2012 (0% increase over 2011 rates) to satisfy the CMS requirements. The OPERS plan participants benefited from this action.

The below represents the top five ERRP recipients in the nation as of January 19, 2012:

1. UAW Retiree Trust, $387.2 million
2. AT&T Inc., $213.8 million
3. Ohio Public Employees Retirement System, $180.1 million
4. Verizon Communications Inc., $163.0 million
5. California Public Employees' Retirement System, $131.4 million

OPERS staff worked diligently to submit a timely and correct application for the ERRP funds, ensuring we were able to take advantage of this unique opportunity.

A Careful Eye on Prescription Drug Costs and Trends

In 2012, OPERS renegotiated its contract with prescription drug program provider Express Scripts. The total projected savings for the 2014-2016 contract renewal, together with a re-negotiation of 2013 terms is projected to be $105 million. OPERS also realized savings from the Employer Group Waiver Plan Plus Wrap.

OPERS continues to monitor new developments in medication manufacturing and usage within the pharmaceutical industry. Specialty medications are high-cost drugs that are typically injected or infused, but sometimes taken by mouth, and usually require special storage and close monitoring. A biosimilar is a generic version of a specialty medication that has comparable structure, safety and efficacy as a brand name, specialty drug. Biosimilars would be expected to cost considerably less than specialty medications, which can cost thousands per month. Competition from biosimilars would improve access to specialty drugs and save billions each year in treatment costs.

OPERS continued efforts to influence the federal government and the Food and Drug Administration on: 1) Implementing an approval pathway for biosimilars in a timely manner, 2) Promoting brand and biosimilar interchangeability, and 3) Reducing the exclusivity period for brand specialty drug products.

OPERS continues to closely monitor and manage our specialty drug expenditures because specialty drugs are expected to account for 50% of all drug costs by 2018 (Source: *Prime Therapeutics*, April 2013).

Specialty Drug Trend	Traditional Drug Trend
Actual 2012*	**Actual 2012***
16.4% Medicare	(6.8)% Medicare
22.3% Non-Medicare	(1.7)% Non-Medicare
Projected**	**Projected****
2013—17.8%	2013—(1.0)%
2014—19.6%	2014—(1.7)%
2015—18.4%	2015—(1.4)%

*Source: 2012 annual report furnished by Express Scripts
**Source: *2012 Express Scripts Drug Trend Report*

OPERS' Percentage of Total Pharmacy Costs Associated with Specialty Drugs

Year	Medicare	Non-Medicare
2010	8.4%	14.9%
2011	9.5%	17.2%
2012	13.9%	22.8%

*Source: 2012 annual report furnished by Express Scripts

Health Care Marketplace Presence

OPERS is Evolving with the Health Care Marketplace

In 2012, as part of an ongoing effort to meet the health and wellness needs of OPERS retirees while remaining within available funding, we devoted considerable effort to evaluating health care resources available to retirees individually and as a population. Constantly rising health care costs, an expanding population of aging baby boomers and increasing life expectancies are the driving forces behind our push to explore innovative solutions to best serve our program participants. We are challenged with identifying opportunities that will educate and empower individuals to take responsibility for their own health as both health care costs and chronic disease continue to rise at rates which are unsustainable.

OPERS began looking toward proven, non-profit and community-based resources as additional tools to address retirees' personal health-management needs and gaps in care. In 2012, we began partnering with the Ohio Department of Aging to offer programs designed to promote self-management and provide support to those with chronic conditions. Additional partnerships are being researched such as uniting with Ohio-based YMCAs to provide additional health-promotion programs for retirees.

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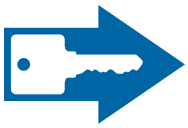
Public Sector Health Care Roundtable (PSHR)

OPERS continued its participation in the Public Sector Health Care Roundtable, a non-partisan, member-directed coalition that exists to give public employers, and their health plan administrators, a voice in critical national discussions. One area the PSHR will be examining is the area of generic specialty medications and how we can jointly speed their entry into the marketplace.

Patient-Centered Medical Homes (PCMH)

The support of the PCMH model is a strategic initiative that is expected to favorably impact the OPERS health care program. The model promotes improvements in how care is delivered and paid for, recognizing the importance of coordinated care and performance-based reimbursements. The model addresses health and wellness needs of retirees, takes advantage of the value of primary care, and is expected to ultimately yield improved clinical quality and a better overall patient experience.



Value-Based Insurance Design (VBID)

In 2012, OPERS adopted important VBID features to maximize the value of our health care fund. Enrollee cost-share was reduced and/or eliminated for higher-valued services including primary care office visits and generic medications for chronic conditions such as high blood pressure and depression. Costs were increased for lower-valued services such as the use of emergency rooms for non-emergency conditions. The elimination of member cost-share for generic medications to treat certain chronic conditions resulted in increased medication adherence for individuals taking depression, blood pressure and cholesterol drugs.

Changes to prescription drug coverage

To increase price sensitivity on the part of retirees, the 2012 changes to prescription drug coverage for Medicare-eligible participants included coinsurance for brand-name drugs. In addition, the concept of a preferred retail pharmacy network was introduced to participants enrolled in the OPERS Intermediate Plan.

Medication Therapy Management

Express Scripts provides a Medication Therapy Management program to Medicare participants. In 2012, approximately 31,000 (22%) of OPERS' Medicare Part D participants met the criteria for participation in the program and were extended an invitation for a one-on-one medication counseling session with a pharmacist. Almost 3,100 (10%) participants engaged in these personalized counseling sessions in 2012, which was an increase of nearly 13% over 2011 participation levels.

Catalyst for Payment Reform (CPR)

OPERS joined a national effort to improve the current health care payment system and achieve better value and quality of patient care by aligning with other public and private employers as part of CPR. CPR is an independent, non-profit corporation working on behalf of large employers to catalyze improvements to how we pay for health care in the United States. During 2012, OPERS negotiated CPR contract terms with our self-insured plan administrator for the contract term beginning January 1, 2013. We will continue working throughout 2013 to support the CPR initiative.

In 2012, OPERS adopted important VBID features to maximize the value of our health care fund.

Medicare Individual Market Offers Future Opportunities

Within the individual Medicare marketplace, Private Medicare Health Care Connectors have been emerging as an evolving business model. Connectors provide retirees an opportunity to select a health care plan that best suits their individual situation and medical needs as well as work with a defined health care budget. Beginning in 2016, eligible OPERS retirees will receive an allowance to purchase a plan through the Medicare Connector.

Connectors serve as an intermediary between an organization's retiree population and the individual Medicare marketplace. Their role is to provide education as well as plan selection and enrollment support to Medicare-eligible retirees and their dependents. Retirees are able to select among multiple individual Medicare plan options (Medicare Supplement Plans, Medicare Advantage Plans, Medicare Advantage with Prescription Drug (MAPD) Plans, Special Needs Plans (SNP), and Part D Drug Plans). Given the large Medicare population (47 million), there are more affordable options on the individual Medicare market than our group plan can offer.

Connectors provide retirees an opportunity to select a health care plan that best suits their individual situation and medical needs as well as work with a defined health care budget.

Eye on Quality of Care

OPERS Maintains Focus on Maximizing Quality of Care

In 2012, OPERS conducted a Participant Experience Survey. Approximately 10,000 OPERS health care program participants were surveyed and we experienced a 30% completion rate. The purpose of the survey was to assess respondents' self-reported health status, participation in OPERS health and wellness programs, motivation for participating, primary sources of health information, and perceived value of their health care coverage. For ongoing evaluation, the survey will be repeated again in 2013 and beyond.

Clinical Quality Improvement Committee (CQIC)

Comprised of thought leaders, clinicians from OPERS' Health Care division, and health care vendor partners and consultants, the CQIC continues its mission to favorably impact OPERS' health care trend via improvements in clinical quality. At the end of 2012, the committee focused on finalizing the CQIC Report Card. The report card is being used to measure and monitor quality and utilization outcomes against industry benchmarks on an ongoing basis. Going forward, CQIC participants will turn their attention toward using the report card to identify opportunities for improving clinical outcomes and evaluating the impact of agreed-upon interventions.

The CQIC continues its mission to favorably impact OPERS' health care trend via improvements in clinical quality.

Future Challenges and Opportunities

OPERS Baby-Boomer Population Retiring—The retiree population is expected to double in less than 20 years, which will require multiple approaches and will result in an 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, 40,749 OPERS members were eligible to retire within the next year, and 45,976 were 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 few years.

Both an increased life expectancy and retiring baby boomers contribute to the fact that OPERS is providing health care coverage to more people with the same, or less, funding.

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—On June 28, 2012, the U. S. Supreme Court upheld the Patient Protection and Affordable Care Act (PPACA). To date, OPERS has adopted required plan design changes and participated in the Early Retiree Reinsurance Program (ERRP), which added $180 million to the health care fund. Future challenges such as the uncertainty surrounding Medicaid expansion, health care exchanges and the current administration's continual review and analysis of the Medicare market will require persistent attention and evaluation to ascertain the short- and long-term impact to the plan—and the population we serve. As we transition spouses under the age of 65 off the OPERS health care plan, many of them will look to the Health Insurance Marketplace (exchanges) created by PPACA for options.

The retiree population is expected to double in less than 20 years, which will require multiple approaches and will result in an increased demand for health care education and communications.

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. The medical and pharmacy combined specialty drug trend is expected to increase 63% between 2013 and 2015* due to new specialty drugs, additional indications for existing specialty drugs and drug price inflation. The greatest threats to an even higher growth in specialty drug trend are higher-than-projected inflation rates, significant growth in new high cost orphan and ultra-orphan drugs and biosimilars not becoming available in the U.S. market.

The medical and pharmacy combined specialty drug trend is expected to increase 63% between 2013 and 2015* due to new specialty drugs, additional indications for existing specialty drugs and drug price inflation.

*Source Medical Mutual of Ohio

Financial Performance

Funding Update

The information presented in this section is based on the latest actuarial valuation, which is as of December 31, 2011. Thus, this report does not reflect the substantial changes made to the health care program, described throughout this report. Nor does the latest actuarial valuation reflect the favorable investment market results from fiscal year 2012. Given that the impact of the health care changes will be significant, we will present the historical financial information based on the latest available results, but will supplement that information with the expected impact of the health care plan changes.

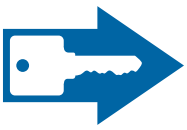
Beginning in fiscal year 2006, the Government Accounting Standards Board (GASB) required retirement systems to estimate their liability for health care benefits similar to the manner in which pension liabilities are estimated. However, unlike pensions, the health care coverage OPERS provides (with the exception of Medicare Part B reimbursements) is not statutorily guaranteed. Substitute S.B. 343 modified Medicare Part B reimbursements to be phased out over a three-year period. Nonetheless, OPERS has pre-funded its health care liability since 1974. This is something most public and private-sector employers and retirement systems do not do, opting instead to follow a pay-as-you-go model. The most recent data available, regarding state retiree health care funding levels, shows that OPERS leads the nation as the fourth-best funded retiree health care plan in the nation (Source: *The Pew Charitable Trusts State and Consumer Initiatives Report*, June 18, 2012). As of December 31, 2011, OPERS' health care fund stood at $12.1 billion.

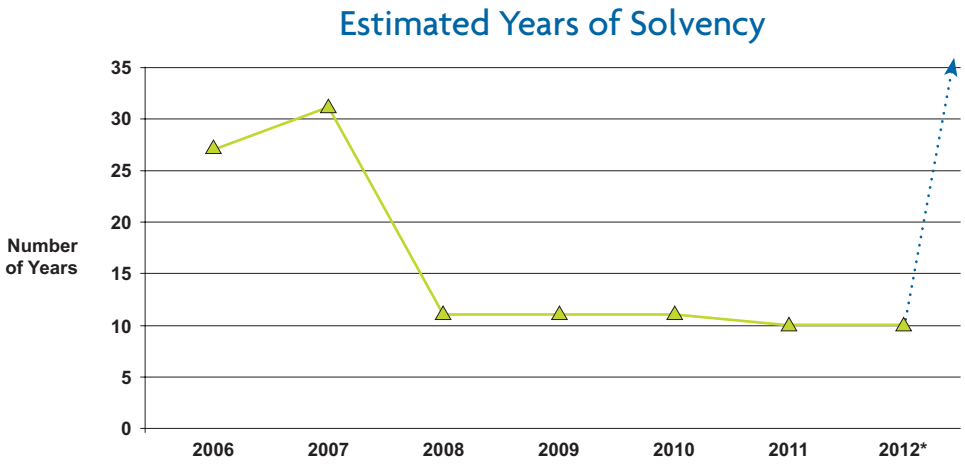
The most recent data available, regarding state retiree health care funding levels, shows that OPERS leads the nation as the fourth-best funded retiree health care plan in the nation.

The actuarial value of assets used to calculate funded status is not based on year-end fair value (market value) as of the valuation date. Market gains and losses for actuarial funding purposes are smoothed over a rolling four-year period subject to a 12% market corridor. The reality of actuarial smoothing techniques is that the fair value (market value) of assets may be different (but no more than 12%) from the funding value (actuarial value) of assets at a given point in time. This means that, in periods of extended market decline, the fair value of assets will usually be less than the funding, or actuarial value, of assets. This was the case with OPERS during the extended down market from 2000 to 2002, and in 2008. Conversely, during periods of extended market gains, the fair value of assets will usually be greater than the funding, or actuarial value of assets.

As of December 31, 2011, the date of the latest annual actuarial valuation report, the market value of the health care assets was $11.6 billion. The estimated health care liability as of that date was $31.0 billion and the actuarial value of assets was $12.1 billion, leaving an unfunded liability of $18.9 billion and a funded ratio of 39%. The solvency period, which is the number of years the current trust fund is expected to last based on current expenditures, is 10 years. While the 2012 health care annual valuation is being finalized as of the date of this report and the final results are not yet available, the estimated health care liability will decrease significantly due to the changes made to the health care plan. The market value of assets as December 31, 2012 is $12.8 billion (different from the actuarial value of assets). The funding period is expected to increase from 10 years to an indefinite period of time (calculated financially as 100 years). As noted previously, changes were made to the health care program to improve the long-term funding and to provide a stable and consistent plan.

The graph below shows the historical trend of the estimated years of solvency. OPERS has historically strived to maintain a rolling 15-25-year solvency period. However, the investment market volatility plays a strong role in our ability to achieve that goal. Following each significant market downturn, OPERS has introduced modifications to the health care plan. In an effort to maintain the continuity and consistency of the health care program between generations, OPERS' latest plan changes were designed to provide a stable health care program that could be funded with an achievable contribution rate and investment return. These changes have yielded a solvency period that, according to the actuaries, will last for an indefinite period of time (defined mathematically as 100 years).





* Expected 2012 years of solvency
Source: *2012 Comprehensive Annual Financial Report*

Additions to the OPERS Health Care Fund

Additions to the OPERS health care fund are comprised primarily of employer contributions and investment returns. Revenues from member contributions (portion of the monthly cost of OPERS health care paid by retired members), federal subsidies, and contract and other receipts comprise the balance.

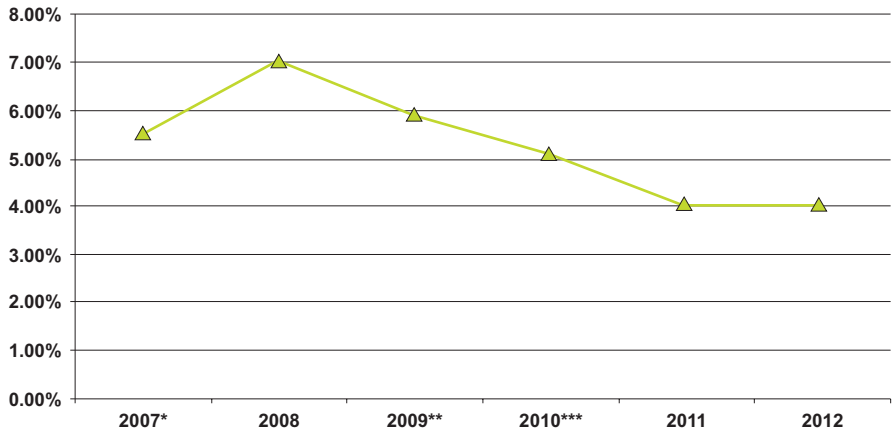
1. ***Investment Income***—The health care portfolio experienced a gain of 13.72% in 2012, compared to a loss of 0.52% in 2011, and a gain of 13.53% in 2010.

2. ***Employer Contributions***—Employer contributions as a percentage of active member payrolls added $494 million to the fund in 2012—a decrease of nearly 2% from the 2011 revenue of $503.5 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% in 2008 to an average of 5.88% in 2009, 5.08% in 2010, and 4% in 2011 and 2012. In 2013, the rate decreases to 1%. OPERS' funding objective is to first meet the long-term pension benefit obligations and, to the extent possible, fund post-employment health care. The passage of pension plan design changes in Sub. S.B. 343, and the adoption of the new health care program, will help keep both pension benefits and the health care program solvent well into the future. Once the transition periods associated with these plan changes are complete, the employer contributions to fund post-employment health care should stabilize at 4% per year.

   In addition, the economic downturn and budget constraints 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 continued to decline in 2012. The decline in actively contributing members that began in 2008 continued through 2011 at a rate in excess of 2% per year, slowing to a decline of 0.3% in 2012.

The passage of pension plan design changes in Sub. S.B. 343, and the adoption of the new health care program, will help keep both pension benefits and the health care program solvent well into the future.

Employer Contribution Allocated to Health Care



Source: *2012 Comprehensive Annual Financial Report*

* 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%

3. ***Member Contributions***—Member contributions represent amounts paid by retired members toward the cost of OPERS-provided health care for the retiree, their spouse and dependents. In 2012, these contributions totaled $159.6 million, compared to $148.4 million in 2011 and $111.6 million in 2010. This increase reflects the rising cost of health care, an increase in the retiree population, and the impact of program design changes. The number of retirees eligible for health care in 2012 increased by 1.6% compared to 2011. However, the number of dependents and beneficiaries receiving health care coverage remained basically the same as in 2011. By comparison, the number of retirees, dependents and beneficiaries receiving health care coverage in 2011 increased by 2.9% and 3.1%, respectively, over the 2010 populations.

   Because OPERS is self-insured for health care provided to retirees under the age of 65, the member's cost share is not based on market premiums. Retirees over the age of 65 are covered by the Medicare Advantage program. To determine the member's cost share, OPERS determines self-supporting rates for each population based on claims and premium experience. In 2011 and 2012, the self-supporting rates were frozen using funds received from the ERRP to cover cost increases that otherwise would have been passed on to the retirees. Under the federal guidelines, these ERRP funds must be used by 2014.

   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% 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% to 100%. Members hired after January 1, 2003 (Group 3) receive allowances ranging from 25% to 100%. The allowances for Groups 2 and 3 increase with each year of service, up to the maximum of 100% with 30 years of service.

The majority of retirees participating in the health care plan represent Group 1 members who were provided allowances covering the majority of their health care premium. However, by 2012, 16.9% 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% of the premium cost. The plan design changes increased member contribution revenues for health care by $11.2 million in 2012 over the 2011 revenues. By comparison, member contributions for health care in 2011 were $36.7 million higher than 2010. The decline in growth of both the member health care contributions and the number of participating dependents may indicate the withdrawal of these dependents from participating in the plan on a full-cost basis.

However, this plan was substantially modified by Board approval in September 2012. The new plan becomes effective in 2015 with the Medicare Part B reimbursement changes coming in 2014.

4. ***Contract and Other Receipts***—Contract and other receipts include vendor rebates, performance guarantees, gain sharing agreements, and funds received from other retirement systems. These receipts totaled $94.7 million in 2012, reflecting a 6.3% increase over the $89.1 million earned in 2011.

   The majority of this increase 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 2012, gain sharing revenues provided to OPERS by Humana totaled $52.2 million, compared to $46.8 million in 2011 and $22.0 million in 2010.

OPERS received the third-highest distribution of ERRP funds.

Prescription drug rebates also increased, from $35.0 million in 2011 to $37.6 million in 2012. In 2010, these revenues were $49 million; however, participation in a Medicare-eligible prescription drug plan in 2011 required the use of specific formularies that reduced the purchase volumes subject to the rebate program.

Lastly, OPERS retirees and/or their spouses who are receiving retirement benefits from other systems were able to choose which system would 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.

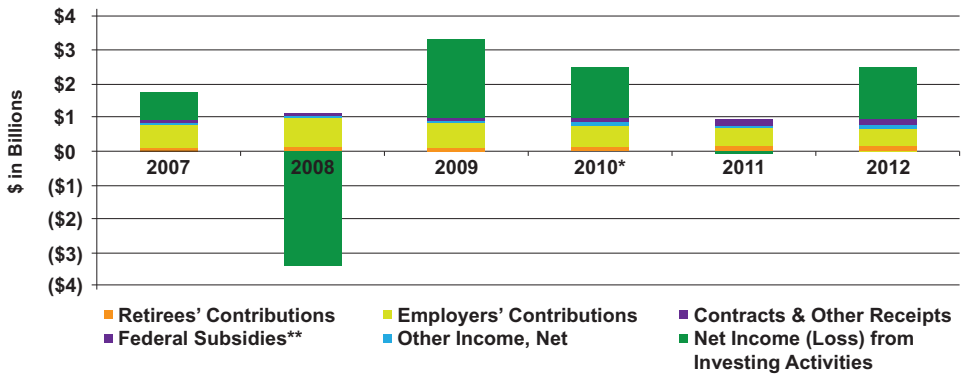
5. ***Federal Subsidies***—Federal subsidies are comprised of reimbursements and direct subsidies OPERS received from the federal government for participation in Medicare prescription drug programs (PDP) and the ERRP.

   In 2012, total federal subsidies decreased by $9.5 million, from $192.1 million in 2011 to $182.6 million in 2012, primarily due to the termination of the ERRP. In 2011 and 2010, OPERS received ERRP funds totaling $109.5 million and $70.6 million, respectively, as reimbursement for a portion of the health care claims incurred by retirees under the age of 65. The funds for this program available from the federal government were exhausted in 2011; however, OPERS 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% 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 and $0.9 million in 2012 with the implementation of the Medicare prescription drug plan (PDP) in 2011. The Medicare PDP is structured as a direct subsidy rather than a reimbursement program. OPERS receives a fixed amount per member based on the member's risk score, regardless of the member's actual claims experience. Plan sponsors participate in either the Medicare Part D reimbursement program or the PDP subsidy program, but not both. In 2012, the PDP subsidies totaled $181.7 million compared to $81.8 million in 2011. This was an increase of $99.9 million in Medicare PDP revenue. Receipts from Medicare-related programs are expected to continue to rise as the OPERS retiree population ages into Medicare and these expenses grow with age-related conditions.

6. ***Other Income, Net***—Other income includes miscellaneous income and significant adjustments to expense accruals for prior years. Historically, at the end of each year, OPERS estimates the value of health care claims incurred but not yet reported (IBNR), and records an expense necessary to adjust the medical accounts payable liability for the value of these pending 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 or spouse reaches age 65; 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 needed also decreases, with a corresponding charge to other income for the write-off of expense accruals for prior years. The liability account is gradually being reduced over a four-year period, commensurate with the lagging claims history. The amounts included in other income for 2012, 2011, and 2010 for the reversal of accruals for prior years are $10.7 million, $10.7 million and $6.6 million, respectively.

Six-Year History of Additions to the Health Care Fund



Source: *2012 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 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 Ohio retirement system receipts.

The Health Care Preservation Plan included significant changes to the health care plan design by linking the amount of health care subsidy to years of service.

Deductions to the health care fund

The expenses displayed in the graph on page 31 reflect the cost of health care expenses for retirees, their spouses and their dependents. This graph does not reflect the changes approved in September 2012.

The increase in post-employment health care expenses reflects the expanding retiree population and the nationwide trend in health care inflation that continues to be in excess of general inflation. National health care cost trends in 2012 showed a 4% increase in health care costs, compared to a general inflation rate of 2.3%. Despite the increase in total health care recipients, OPERS' health care costs increased a modest 2.1%. The Health Care Preservation Plan adopted by the Board of Trustees in 2004 became effective in 2007. As mentioned previously, the goal of the plan was to extend the solvency period of the health care fund through a combination of plan design and cost-sharing changes, and extensive cost containment efforts.

The Health Care Preservation Plan 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 six years since the plan effective date, health care expenses have risen an average of 5.1% per year, well below the national average of more than 8% for the same period. At the same time, the number of retirees, dependents and beneficiaries eligible for post-employment health care has steadily increased by 2.1% in 2008 and 2009, 1.9% in 2010, 3% in 2011, and 1.2% in 2012.

The majority of OPERS' health care expenses are comprised of medical and prescription drug costs, as well as reimbursements to retirees for Medicare Part B premiums.

The majority of OPERS' health care expenses are comprised of medical and prescription drug costs, as well as reimbursements to retirees for Medicare Part B premiums. Medical, dental and vision costs represent approximately 59% of the total health care expenses for the years 2010, 2011, and 2012, followed by prescription drug costs at 34% and Medicare Part B premium reimbursements at 7% of the total. Total health care expenses (excluding Voluntary Employees Beneficiary Association [VEBA]) increased by $32.4 million in 2012, compared to an increase of $8 million in 2011 and $79.5 million in 2010.

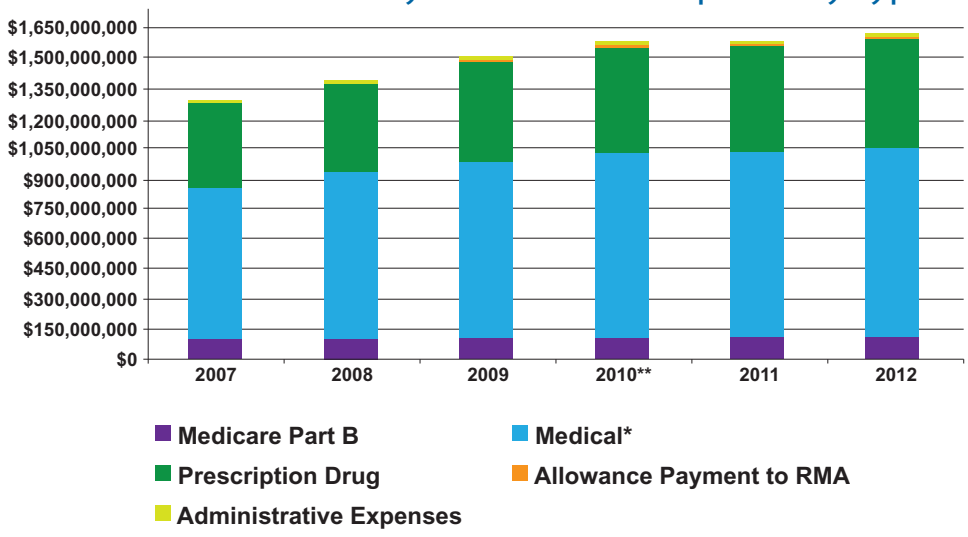
Medical expenses increased from $920.5 million in 2010, to $922.6 million in 2011, and to $943 million in 2012. Prescription drug costs rose from $526.1 million in 2010 to $530.4 million in 2011 and $541.6 million in 2012. Because OPERS is self-insured for the health care expenses of recipients under the age of 65, these costs will fluctuate based on the timing of claims incurrence and the magnitude of catastrophic claims.

Statutorily required Medicare Part B reimbursements increased by $3.5 million in 2012, compared to an increase of $1.3 million in 2011. Legislative changes effective in 2009 permitted 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 1.2% in 2011, and 1.8% in 2010. However, Sub. S.B. 343 included changes that allow OPERS to effectively phase out the Medicare Part B reimbursement beginning in 2014.

As of December 31, 2011 (the most recent actuarial valuation), the average age of OPERS retirees was 69. In 2012, the Board of Trustees also adopted a new retiree health care program, increasing the age and years of service required for eligibility in the health care plan and phasing out the Medicare Part B reimbursement. The new program includes a transition plan, but will ultimately result in the elimination of these expenses.

Other health care expenses include 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.

Six-Year History of Health Care Expenses By Type



Source: *2012 Comprehensive Annual Financial Report*

* Includes Medical, Pending Medical Claims (2007), Disease Management, Wellness, Dental and Vision (OPERS receives member contributions for Dental and Vision).

** 2010 Post-employment Health Care expenses restated for reclassification of Pending Medical Claims adjustment from Health Care 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.

Statutory Requirements

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 coverage 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) as they existed during 2012. Both sections were amended by Sub. S.B. 343, effective January 7, 2013.

2. A summary of coverage for 2012

The following is an outline of OPERS health care coverage in 2012:

The 2012 OPERS Retiree Health Plan for non-Medicare participants

The 2012 OPERS health care plan provider, 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 2012. 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.

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 2012 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 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.

OPERS Non-Medicare prescription plan—In 2012, 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 2012, 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 2012:

- 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 also 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 2012, 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, 2012, 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, covers services provided by ophthalmologists, optometrists, or opticians for examinations, frames, and lenses. A premium payment was deducted from each monthly benefit check for those recipients who chose to participate. OPERS does not subsidize this plan.

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 or medical coverage (such as custodial care), including Medicare. The 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 in 2012:

Following are the eligibility requirements for the OPERS health care plan. **These requirements were in effect during 2012:**

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.

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

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

- A spouse under age 55 may participate in the plan; however, the retiree is responsible for the full health care premium.
- The month the enrolled spouse reaches age 55, OPERS will 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 that would have been eligible dependents of the deceased retiree or member as defined on this page.

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

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

As of December 31, 2012, there were 175,610 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' financial statements are prepared using an accrual basis of accounting under which deductions are recorded when the liability is incurred and revenues are recognized when earned. Under this method, OPERS estimates health care claims which have been incurred at year end, but which have not yet been reported to the 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.

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. Securities not having a quoted market price have been valued based on yields currently available on comparable securities of issuers with similar credit ratings. The fair value of private equities is based on management's valuation of estimates and assumptions from information and representations provided by the respective general partners, in the absence of readily ascertainable market values.

Retired member and employer contributions and investment earnings are used to fund health care expenses. Employer contributions equal to 4% of covered payroll were credited to the health care fund for the period of January 1, 2012 through December 31, 2012. Revenues from retired member contributions (amounts paid by retirees toward 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 investment loss of 2008 reduced the solvency years of the health care fund from 31 years as of December 31, 2007, to 11 years for the year ended December 31, 2008. The investment gains of 2009 and 2010 maintained this 11-year solvency period through December 31, 2010. However, the 2011 investment loss reduced the solvency period to 10 years for the year ended December 31, 2011.

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

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

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

Please see Appendix E, Statements of Changes in Fiduciary Net Position—Health Care.

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

Please see Appendix E, Statements of Changes in Fiduciary Net Position—Health Care.

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

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 $112.5 million in Medicare Part B premiums to its benefit recipients in 2012.

Appendix A—
OPERS' Health Care History

Prior to 1990

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

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

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

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

1990—1999

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

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

In 1974, OPERS established a health care fund, began pre-funding health care and began paying premiums for retirees.

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 ten year eligibility method. The first comprehensive disease management program was also introduced.

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

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

2006—2011

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

In 2007, the Health Care Preservation Plan was implemented, establishing three groups of retirees, each with eligibility standards based on length of service and start date. The 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 health care preservation plan.

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.

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

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. PPACA contained numerous provisions that may impact the OPERS health care plan through 2018. Notably, OPERS added the required preventive care coverage, increased dependent eligibility to age 26 and removed the lifetime maximum.

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.

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.

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 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.

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 VBID design features in 2011, encouraging participants to use high valued services.

2012

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

On September 26, 2012, Ohio Gov. John Kasich signed Substitute Senate Bill 343 into law. With the passage of this important legislation, OPERS can continue to allocate a portion of incoming employer contributions to the OPERS health care trust fund. The fund now has the proper support to allow for the continued administration of a quality health care program for current and future retirees.

In 2012, Express Scripts made a Medication Therapy Management program available to Non-Medicare participants. Approximately 31,000 (22%) of OPERS' Medicare Part D participants met the criteria for participation in the program and were extended an invitation for a one-on-one medication counseling session with a pharmacist.

On September 19, 2012, after nearly two years of research and discussion, OPERS adopted a set of key changes to the current retiree health care plan designed to keep the program sustainable within available funding.

Also in 2012, OPERS introduced the concept of Patient-Centered Medical Homes (PCMH). The support of the PCMH model is a strategic initiative that is expected to favorably impact the OPERS health care program by promoting improvements in how care is delivered and paid for, recognizing the importance of coordinated care and performance based reimbursements.

Appendix B—
Ohio Revised Code Sec. 145.35

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).

Appendix C—
Ohio Revised Code Sec. 145.58

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 D— Statements of Fiduciary Net Position—Health Care

	2012	2011*	2010*	2009	2008	2007
Assets						
Cash and Short-Term Investments	**$446,851,345**	**$516,841,401**	**$673,728,399**	**$82,384,335**	**$214,267,049**	**$166,407,166**
Receivables:						
Members' and Employers'	43,429,976	51,989,914	62,635,516	70,351,872	99,321,334	107,187,056
Retirement Incentive Plan	177,884	773,991	2,183,860	3,185,825	344,045	676,337
Vendor and Other	147,616,824	67,535,218	133,916,383	49,921,976	57,775,901	36,025,605
Investment Sales Proceeds	261,962,739	185,275,974	135,342,122	884,914,266	57,319,401	33,489,810
Accrued Interest and Dividends	47,650,966	49,585,342	49,049,361	37,732,716	46,426,349	64,843,050
Total Receivables	**$500,838,389**	**$355,160,439**	**$383,127,242**	**$1,046,106,655**	**$261,187,030**	**$242,221,858**
Investments, at fair value:						
Fixed Income	4,731,050,357	4,349,713,914	4,355,743,585	3,746,406,051	4,363,406,922	6,581,396,111
Domestic Equities	3,293,138,146	3,642,820,108	3,950,499,244	3,806,887,666	2,731,493,461	4,186,123,350
Private Equities	73,443,686	54,927,514	27,877,976	39,341,186	5,150,008	
International Equities	3,506,799,272	3,310,599,792	3,649,437,854	2,974,380,740	2,201,764,403	2,282,909,655
Other Investments	563,094,682	134,339,269	27,740,509			
Total Investments	**$12,167,526,143**	**$11,492,400,597**	**$12,011,299,168**	**$10,567,015,643**	**$9,301,814,794**	**$13,050,429,116**
Collateral on Loaned Securities	**-**	**-**	**1,517,578,594**	**299,502,780**	**2,297,927,070**	**2,072,493,713**
Capital Assets:						
Land	729,981	665,394	665,394	665,394	665,394	665,394
Building and Building Improvements	21,737,564	19,627,154	19,641,200	19,660,159	19,663,497	19,852,388
Furniture and Equipment	24,688,709	24,809,991	22,850,746	20,582,082	17,141,828	14,941,722
Total Capital Assets	47,156,254	45,102,539	43,157,340	40,907,635	37,470,719	35,459,504
Accumulated Depreciation	**(20,530,484)**	**(18,156,668)**	**(16,294,444)**	**(13,530,325)**	**(11,267,149)**	**(8,853,297)**
Net Capital Assets	**$26,625,770**	**$26,945,871**	**$26,862,896**	**$27,377,310**	**$26,203,570**	**$26,606,207**
TOTAL ASSETS	**$13,141,841,647**	**$12,391,348,308**	**$14,612,596,299**	**$12,022,386,723**	**$12,101,399,513**	**$15,558,158,060**
Liabilities:						
Undistributed Deposits	69,659	62,273	80,073	52,974	52,974	8,385
Medical Benefits Payable	100,495,333	118,529,285	142,952,643	134,007,772	131,776,992	142,701,327
Investment Commitments Payable	194,165,994	294,572,622	253,257,695	163,153,464	69,811,443	57,017,727
Accounts Payable and Other Liabilities	-					569,998
Accounts Payable RMA Claims	18,485,339	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
TOTAL LIABILITIES	**$313,216,325**	**$432,347,997**	**$1,929,983,877**	**$607,191,449**	**$2,505,317,436**	**$2,275,210,578**
Net Position Held in Trust for Post-employment Health Care, as Restated	**$12,828,625,322**	**$11,959,000,311**	**$12,682,612,422**	**$11,415,195,274**	**$9,596,082,077**	**$13,282,947,482**

Source: *2012 Comprehensive Annual Financial Report*

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

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

	2012	2011*	2010**	2009	2008	2007
Additions:						
Members' Contributions	$159,614,898	$148,370,246	$111,638,313	$94,370,543	$82,695,255	$79,198,959
Employers' Contributions	494,048,415	503,458,216	628,685,237	740,817,891	891,561,073	695,967,837
Contract and Other Receipts	94,730,390	89,087,996	83,572,868	58,649,547	66,343,542	45,534,017
Federal Subsidies	182,579,917	192,118,407	142,658,293	69,132,772	63,310,194	59,075,120
Other Income, Net	11,774,199	10,915,043	7,163,609	654,031	614,989	70,498
Total Non-Investment Income	**$942,747,819**	**$943,949,908**	**$973,718,320**	**$963,624,784**	**$1,104,525,053**	**$879,846,431**
Income/(Loss) from Investing Activities:						
Net Appreciation/(Depreciation) in Fair Value	1,183,656,950	(401,560,941)	1,240,024,373	2,081,098,064	(3,734,049,668)	479,748,239
Bond Interest	201,317,018	202,859,266	137,927,458	152,358,418	182,944,355	211,556,481
Dividends	183,422,898	134,235,895	134,809,505	134,487,014	139,099,121	160,715,579
International Income/(Loss)	10,894	(92,053)	48,675	52,944	552,901	9,981
Other Investment Income/(Loss)	10,861,876	3,671,640	3,778,346	661,628	147,998	13,229,442
External Asset Management Fees	(24,118,062)	(13,648,040)	(10,904,604)	(7,709,148)	(8,674,498)	(10,491,258)
Net Investment Income/(Loss)	1,555,151,574	(74,534,233)	1,505,683,753	2,360,948,920	(3,419,979,791)	854,768,464
From Securities Lending Activity:						
Security Lending Income	-	-	14,236,338	2,336,740	103,004,243	120,699,574
Security Lending Expenses	-	-	(4,259,969)	(562,862)	(79,967,808)	(113,044,477)
Net Securities Lending Income	-	-	9,976,369	1,773,878	23,036,435	7,655,097
Unrealized Loss	-	-		(2,396,132)		
Net Income/(Loss) from Securities Lending	**-**	**-**	**9,976,369**	**(622,254)**	**23,036,435**	**7,655,097**
Less: Investment Administrative Expenses	(5,180,680)	(4,389,394)	(4,495,158)	(3,771,803)	(3,703,986)	(3,809,128)
Net Income/(Loss) from Investing Activity	**1,549,970,894**	**(78,923,627)**	**1,511,164,964**	**2,356,554,863**	**(3,400,647,342)**	**858,614,433**
TOTAL ADDITIONS	**$2,492,718,713**	**$865,026,281**	**$2,484,883,284**	**$3,320,179,647**	**($2,296,122,289)**	**$1,738,460,864**
Deductions:						
Health Care	1,607,921,528	1,575,561,578	1,567,551,611	1,488,032,855	1,377,146,173	1,282,776,044
Administrative Expenses	15,172,174	13,076,814	12,782,968	13,033,595	13,596,943	10,796,417
TOTAL DEDUCTIONS	**$1,623,093,702**	**$1,588,638,392**	**$1,580,334,579**	**$1,501,066,450**	**$1,390,743,116**	**$1,293,572,461**
Net Increase/ (Decrease)	869,625,011	(723,612,111)	904,548,705	1,819,113,197	(3,686,865,405)	444,888,403
Net Position Held in Trust for Post-employment Health Care Balance, Beginning of Year, as Restated	$11,959,000,311	12,682,612,422	11,415,195,274	9,596,082,077	13,282,947,482	12,838,059,079
BALANCE, END OF YEAR	**$12,828,625,322**	**$11,959,000,311**	**$12,319,743,979**	**$11,415,195,274**	**$9,596,082,077**	**$13,282,947,482**

Source: *2012 Comprehensive Annual Financial Report*

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

** 2010 restated for reclassification of Early Retirement Reinsurance Program from Contracts and Other Receipts to Federal Subsidies and the reclassification of the Pending Medical Claims adjustment from Health Care 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.

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 retirees); 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. For a current listing of the OPERS Board of Trustees, please visit **www.opers.org**

OPERS

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