health care

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

OPERS 2009 Health Care Report

Presented to:
Ohio Retirement Study Council
June 2010

Ohio Public Employees Retirement System

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OPERS 1935 75 Years 2010

OPERS is providing the 2009 health care report to the Ohio Retirement Study Council (ORSC) required by Section 145.22 of the Ohio Revised Code. The OPERS Board of Trustees recognizes that providing access to quality health care coverage is an important element in providing retirement security for our retirees and their dependents.

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

Events in 2009 pertaining to the OPERS retiree health care plan include the following:

- OPERS released a Request for Proposal (RFP) allowing vendors to bid on the opportunity to administer the medical portion of our retiree health care plan. In 2009, OPERS continued the process to select a vendor(s) to administer the medical coverage portion of our retiree health care plan. The selected vendor(s) began administering the medical portion of the OPERS health care plan on Jan. 1, 2010.

- OPERS selected The Prudential Insurance Company of America (Prudential) to replace the Group Long Term Care Insurance plan that had been provided by Aetna Life Insurance Company (Aetna). Prudential's Long Term Care Insurance plan became effective September 1, 2009.

- Calendar year 2009 will long be remembered as the year that the US financial system recovered from serious market turmoil. The sub-prime mortgage crisis that started the financial crisis caused an $11 trillion decline in equity markets ending in March 2009. The US government responded with an $8 trillion stimulus program to stabilize the banks and the financial markets. The Federal Reserve moved the target rate for over-night loans between banks to near zero. Before year end 2009, the equity markets would rebound with $6 trillion in gains. The year ended with uncertainty on when the economy, employment and prosperity would recover and reach pre-2008 levels.

- Following a -25.8 percent return in 2008, the health care fund returned 24.8 percent during 2009 and outperformed its customized benchmark of 24.1 percent for the year by 70 basis points largely due to manager outperformance and asset allocation activities.

- Despite the excellent return in 2009, the health care fund remained nearly $1.9 billion below its highest value in December 2007. This is due to multiple factors including the impact of the market decline of 2008, increases in health care expenses, and a reduction in the portion of the employer contribution rate being directed to fund health care.

- Health care expenses reached $1.5 billion in 2009 while the number of retirees, eligible dependents and beneficiaries increased 3.3 percent. Health care expenses increased by 8.1 percent over 2008.

The OPERS Board of Trustees and staff are aware of the significant challenges ahead in the form of rising health care costs, health care reform implementation, increased longevity, volatile markets and a growing retiree population due to the retirement of the baby boomer generation. In this environment, we continue to search for answers to meet these challenges that will allow us to continue to provide access to health care coverage for our retirees.

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

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

Mail order prescription services were first offered in 1981. Using National Rx as a business partner, a 90-day supply could be obtained initially for a $1 co-pay. OPERS also began the formal introduction of case management as a cost containment measure.

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

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

In 1999, OPERS made significant strides in its attention to preventive services and wellness. Coverage was provided for flu and pneumonia vaccines, and several enhancements were made to coverage of preventive services and screenings. OPERS continued on that path in 2001; coverage for routine physical exams, EKGs and diabetes and cholesterol screenings were added. Coverage for preventive services was raised from 80 percent to 100 percent.

In 2000, prescription medication co-pays for mail order were raised from $0/$2/$8 to $4.50/$9/$12. The lifetime maximum under the health care plan increased to $2.5 million.

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

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

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

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

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

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

2007 preventive services coverage included the addition of bone density testing and the shingles vaccine, covered at 100 percent without a deductible.

In January 2008, OPERS began offering the Aetna Medicare Open Plan to Medicare-eligible retirees and their covered, Medicare-eligible spouses. The Aetna Medicare Open Plan was a private-fee-for-service (PFFS) Medicare plan designed exclusively for OPERS by Aetna and the Centers for Medicare and Medicaid Services (CMS).

In April 2008 Express Scripts, Inc. began serving as the pharmacy benefit manager (PBM) for the OPERS health care plan. Medco had provided pharmacy benefit management for the OPERS health care plan since 1981. OPERS made this change as the result of a competitive bidding process in collaboration with other Ohio retirement systems and The Ohio State University.

In 2009, OPERS conducted a Request for Proposal (RFP) process to select an administrator(s) for the medical coverage portion of the OPERS health care plan.

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

OPERS offers retirees access to a Long-Term Care Plan to help pay for the costs of care in a nursing home, rehabilitation center or assisted-living facility. In 2009, OPERS secured a contract with Prudential to administer this plan.

Also in 2009, OPERS worked to implement Senate Bill 267, which took effect on March 24, 2009. SB 267 established the monthly reimbursement by OPERS for Medicare Part B premiums at an amount, determined by the OPERS Board of Trustees, that is not less than $96.40. The bill also requires the recipient of the reimbursement to report to OPERS the amount paid for the coverage. The reimbursement cannot exceed the amount paid for coverage. In November 2009, the OPERS Board voted to cap the Medicare B reimbursement rate at $96.40 for 2010.

In September 2009, OPERS, in conjunction with Express Scripts, conducted a marketing campaign aimed at increasing our retirees' use of the Express Scripts Select Home Delivery Program. This program, along with others within Express Scripts' home delivery package, saved OPERS nearly $1 million in 2009.

OPERS HEALTH CARE CHRONOLOGY OF PROGRESS

Health care coverage begins Group Rates – 0% subsidy	**1962**	
	1974	**OPERS pays premium** **OPERS begins funding health care trust**
OPERS offers Kaiser HMO	**1975**	
	1981	**OPERS/ORS secure mail pharmacy in Columbus**
Eligibility increases from 5 to 10 years of service	**1986**	
	1993	**PPO model replaces indemnity** 2 health plan choices
Preventive services expand flu vaccines, physical, etc.	**1999**	
	2000	**Rx co-pay increases** OPERS consumerism model begins
Eligibility is tied to years of service **OPERS introduces Disease Management**	**2003**	
	2004	**OPERS introduces Incentive formulary** deductibles, co-pays and out-of-pockets **Manages prescription drug costs below national average**
OPERS introduces active management of health care program leveraged OTC medications, cost-effective alternatives **OPERS helps create National Public Sector Health Care Coalition**	**2005**	**Investments contribute $900 million to health care fund** **$33M in generic savings** **$20 M in additional rebates**
	2006	**Contributions change** **Medicare D subsidy begins** **OPERS develops comprehensive wellness program**
OPERS implements Health Care Preservation Plan **Approves Health Care Preservation Plan "2.0"** **Implements wellness program** **Develops incentive structure and Medicare Advantage Plan strategy**	**2007**	
	2008	**OPERS introduces the Aetna Medicare Open Plan** **Express Scripts becomes the pharmacy benefit manager for the OPERS health care plan**
OPERS releases a Request for Proposal to select a medical coverage administrator(s) **Initiates implementation of Senate Bill 267** **Changes administrator of**	**2009**	**OPERS increases lifetime health care coverage maximum to $3 million** **Express Scripts Select Home Delivery Program is focus of marketing campaign**

Securing health care coverage now and in the future

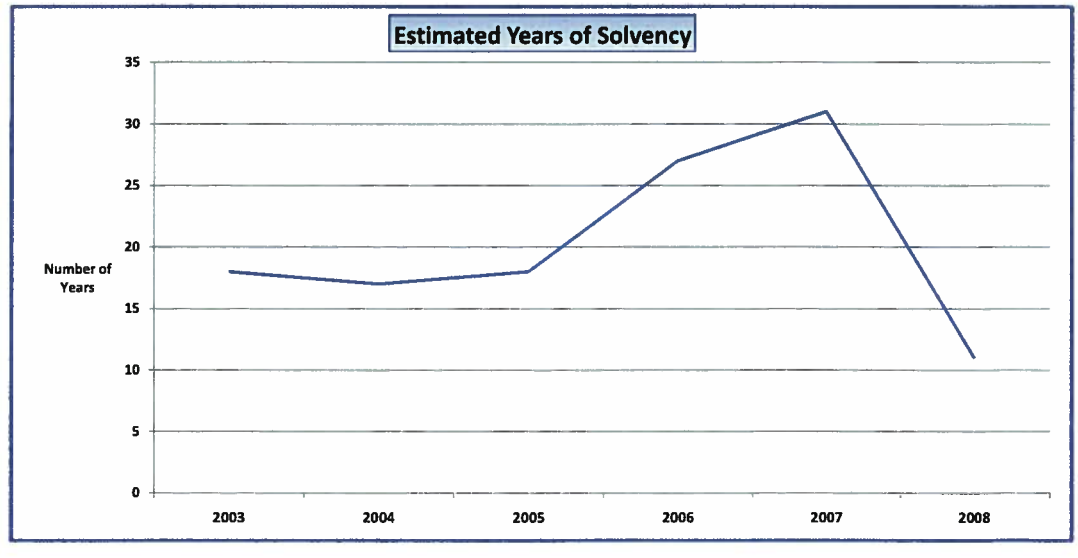
OPERS has a long history of providing dependable retirement benefits including retiree health care coverage. But, like other payors of health care from the federal government to private industry, OPERS has experienced significant inflationary pressures resulting in increased annual expenditures. While OPERS had the foresight and discipline with favorable financial results over the past decades to establish a $11.4 billion health care fund to prefund health care. Through investments and employer contributions, the System has also exercised the same discipline and thoughtful leadership to control spending to provide access to health care coverage for as long as possible.

A realistic plan and a commitment to solvency

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

To help secure health care coverage for the future, OPERS has embraced a philosophy of "active management" where challenges such as escalating drug costs are tackled head-on using proactive strategies. The Board and staff have regularly reacted to marketplace developments in order to capitalize on cost saving opportunities. Based on current funding levels, OPERS' actuaries estimate that every $50 million in savings adds an additional year of solvency. The results are paying off. As of Dec. 31, 2009, HCPP and HCPP 2.0 cumulatively added approximately $1.8 billion to the OPERS health care fund.

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



Source: 2009 Comprehensive Annual Financial Report

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

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

A) Demographics – the average length of retirement has increased as a result of longer life spans. Life expectancy at age 60 has increased 8.16 years in the last 54 years. Source: US Dept of Health, Education and Welfare, IRS

B) Expected retiree population growth – OPERS currently serves nearly 214,000 covered lives. Our population is expected to swell to 400,000 in less than 20 years underscoring the need to provide access to health care coverage for future retirees, and help secure retirees' finances.

C) Estimated future health care cost projections – the peak of future health care cost projections is estimated to occur near 2046. One goal of the HCPP is to encourage our contributing members, or the active work force, to consider working longer to help pay for access to health care coverage and draw benefits at a later age.

The Health Care Preservation Plan 2.0

HCPP 2.0 consists of a multi-disciplinary and strategic set of changes to the OPERS health care plan purposely designed to extend solvency, reduce unfunded liability and improve funding. HCPP 2.0 utilizes a balanced approach with responsibilities distributed among OPERS, retirees, employer groups, the greater health care community and business partners. It is not simply a "cost shift" to the retiree or a reliance on increased contributions, and remains consistent with the original HCPP guiding principles.

HCPP 2.0 summary start dates and status:

1. **Wellness Programs** (2007/2008)
   Status *– Continue to provide wellness programs through Aetna and Gordian*

2. **Medicare Advantage Plan** (2008)
   Status *– Continue to provide medical coverage through Aetna Medicare Open Plan*

3. **Prescription Drug Program RFP** (2007)
   Status *– Continue to provide pharmacy coverage through new PBM, Express Scripts*

4. **Member Cost Share Policy 10-20 percent** (2008-2012)
   Status *– Current cost share – Medicare 21.08 percent of the cost not paid by Medicare, Non-Medicare 16.37 percent*

5. **Eligibility – Spousal Eligibility at 55 years of age** (2011)
   Status *- Began communication plan with targeted letters, news articles and web presence with a target implementation date of January 1, 2011.*

6. **Legislative Initiatives**
   a. OPERS Board Authority to set Medicare B reimbursement level (2009)
   Status *- Board now has authority to set reimbursement level*

7. **Disability Management enhancements/update** (2009/2010)
   Status *- OPERS Board approved legislative action*

8. **Cost-effective group health plan development (medical and pharmacy)** (2008-2010)
   Status *– Worked with other Ohio retirement systems throughout the medical RFP process*

9. **Asset Reallocation to Improve Investment Return Assumption** (2007)
   Status *– OPERS Board approved a reallocation plan in October 2009, effective January 2010*

10. **Increase Contribution Allocation to Health Care** (2008)
    Status *– Re-evaluated ability to increase employer contributions for health care*

Wellness and disease prevention

As a nation dealing with obesity, smoking and lack of exercise, the realities of unhealthy lifestyle choices are taking a financial toll on the economy and individuals alike.

The cost of unhealthy choices in the United States and in Ohio

Unhealthy lifestyle choices can result in a lower quality of life and higher health care expenses for individuals and their families. For example, according to the Center for Disease Control, smoking harms nearly every organ in the body, causing many diseases and reducing the health of smokers in general. Adverse health effects from cigarette smoking account for nearly 1 of every 5 deaths each year in the United States. Obesity increases the risk of many diseases including high blood pressure, osteoarthritis, type 2 diabetes, coronary heart disease, stroke, gall bladder disease and some cancers (i.e. endometrial, breast and colon).

The OPERS Healthy Living Healthy Retirement Plan

The OPERS wellness plan, *Healthy Living Healthy Retirement*, is administered by Gordian Health Solutions, Inc. The program rewards OPERS retirees and their covered spouses with up to $100 per year for actively participating. Enrollment in the plan is voluntary and is tailored to each retiree's situation. Retirees not eligible for Medicare receive either wellness or disease prevention counseling on a regular basis, provided by a health coach or nurse. Retirees who are Medicare eligible have the choice to receive these services through the Aetna Medicare Open Plan.

Healthy Living Healthy Retirement is based on the following principles:

- Anything that affects the health of our retirees also affects how fast we spend health care dollars.
- Any steps we take to maintain or improve the health of our retirees will improve their quality of life and also improve the solvency of the OPERS health care fund.

Healthy Living Healthy Retirement began for non-Medicare eligible retirees in September 2007. A total of 2,068 retirees enrolled in the program through 2009.

The Aetna Medicare Open Plan was made available to retirees beginning Jan. 1, 2008. This program offers wellness and condition management coaching as well as a fitness gym network to retirees who enroll. As of the end of 2009, 11,902 retirees participated in the condition management program and 1,416 participated in a wellness coaching program.

Disease Management

OPERS provides two Disease Management programs. Those enrolled in the Aetna Medicare Open Plan had access, based on need, to a disease management program through the medical plan. During 2009, 2,903 retirees and spouses were actively working with a nurse in this program. An additional 15,828 were being actively monitored without nurse engagement.

LifeMasters provides OPERS Disease Management program for those not yet eligible for Medicare. During 2009, a total of 39,334 retirees and spouses were enrolled. Those enrolled are split into three categories or severity programs based on the state of their disease and their level of need for interventions and care. 12,134 participants were enrolled in the High Severity Program, 9,502 were enrolled in the Moderate Severity Program and 17,698 were participating in the Low Severity Program.

Legislation

On Nov. 18, 2009, the OPERS Board of Trustees approved seeking legislation from the Ohio General Assembly containing a set of changes to OPERS pension benefit plan design. The OPERS Board and staff researched and proposed the plan design change in response to a request by the Ohio Retirement Study Council (ORSC). The ORSC asked all five of Ohio's public pension systems to examine changes to a number of benefit plan elements with the goal of ensuring the long-term fiscal strength of the systems. The board had been considering plan design changes for more than a year prior to the ORSC request.

The recommended changes include:

1. Adding two years to age and service retirement eligibility, as well as a minimum retirement age of 55;
2. Modifying the benefit formula;
3. Tying the Cost of Living Adjustment (COLA) to the Consumer Price Index; and
4. Extending the final average salary calculation from three to five years.

These changes will require enactment by the Ohio General Assembly. OPERS will work with the ORSC and the Ohio General Assembly as they review the various plans from the five Ohio public pension systems. While the plans have certain similarities, there are also significant differences depending on each system's current funded status, member demographics and current plan design.

If approved by the state legislature, the recommended changes will build on past actions by the OPERS Board to keep pensions secure and provide access to health care coverage for as long as possible. OPERS currently plans to reduce the portion of employer contributions directed to fund health care until 2015, when 0 percent of employer contributions will be allocated to the health care fund. If these pension plan changes are enacted, OPERS will be able to restore health care funding to 4 percent of employer contributions.

Funding:

Beginning in fiscal 2006, the Government Accounting Standards Board (GASB) required retirement systems to estimate their liability for health care coverage similar to the manner in which pension liabilities are estimated. However, unlike pensions, the health care coverage OPERS provides (with the exception of Medicare B reimbursements and coverage for members not eligible for free Medicare Part A) is not a guaranteed benefit. As of December 31, 2008, the date of the latest actuarial valuation, OPERS' liability for health care coverage was $29.6 billion and the System had accumulated assets (on an actuarial funding basis) for that obligation of $10.7 billion. OPERS had an unfunded actuarial liability of $18.9 billion, representing an increase of $1.9 billion from the December 31, 2007 valuation. While the funding ratio declined from 43% in 2007 to 36% in 2008, OPERS remains one of only a handful of retirement systems around the country that pre-funds any portion of health care (the accounting requirements do not mandate pre-funding health care coverage).

As noted above, health care coverage is not a statutorily guaranteed benefit (with the exception of Medicare Part B reimbursements and coverage for members not eligible for free Medicare Part A) and may be changed to ensure the long-term solvency of the fund and OPERS' ability to provide future coverage. The funding progress of the health care plan is measured in terms of solvency years, or the number of years that funds are projected to be available to pay health care coverage under the current plan structure. The market losses of 2008 reduced the solvency years of the health care fund from 31 years as of December 31, 2007, to 11 years as of December 31, 2008.

Additions to the health care fund:

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

1. Investment Income – The health care portfolio earned an investment return of 24.8 percent for the year ended December 31, 2009, compared to a return of -25.8 percent in 2008, resulting in a nearly $2.4 billion gain in plan assets.

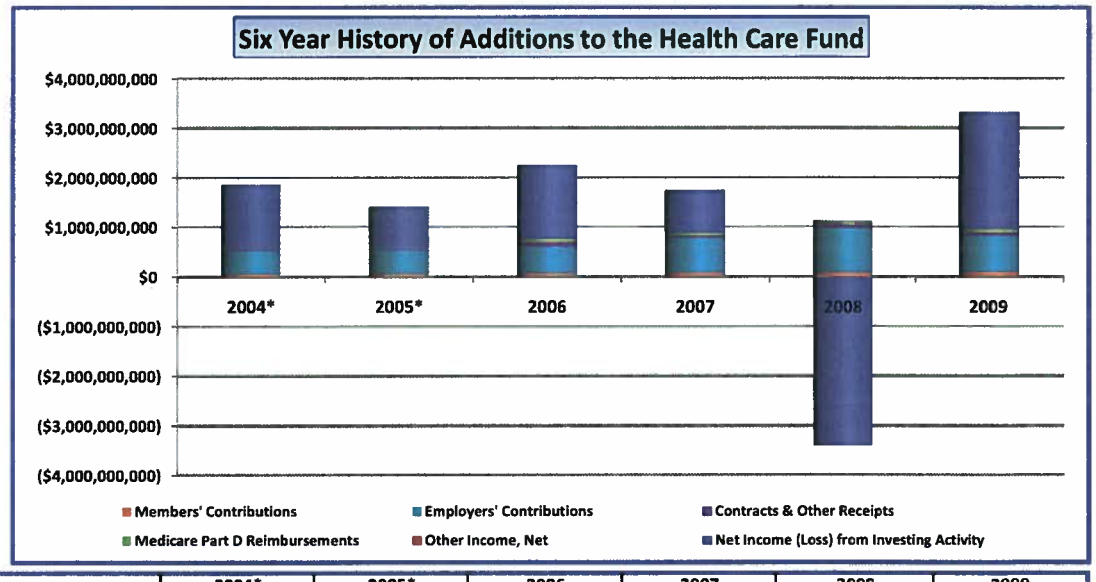
2. Employer Contributions – Employer contributions as a percent of active member payrolls added $741 million to the fund in 2009 – a decrease of 17 percent over 2008 revenue. Due to the market losses of 2008, OPERS reduced the portion of the employer contribution rate directed to fund health care in 2009 to an average of 5.88 percent from 7 percent in 2008. Under the funding plan adopted by the OPERS Board of Trustees at the end of 2008, OPERS will reduce the portion of employer contributions directed to fund health care until 2015, when 0% of employer contributions will be allocated to the health care fund. The Board has approved a series of plan design changes that, if enacted by the Ohio legislature, would allow OPERS to restore health care funding to 4% of employer contributions.

3. Member Contributions (Premiums) – Member contributions represent amounts paid by retirees toward the cost of OPERS provided health care for themselves, their spouse and dependents. In 2009 these contributions totaled $94.4 million, compared to $82.7 million in 2008, or a 14.1%

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

This increase reflects the rising cost of health care coverage, an increase in the retiree population, and program design changes that are intended to gradually increase the retiree cost share to approximately 20%. The number of retirees in 2009 increased 3.3% over 2008, with a corresponding increase of 2.6% in the number of dependent pension recipients eligible for health care coverage. By comparison, the number of benefit recipients in 2008 increased by a total of 3.2% over 2007 levels.

4. Contract and other receipts include vendor receipts (rebates, performance guarantee penalties, etc.) and revenue due from other Ohio retirement systems. OPERS retirees and/or their spouses who are receiving retirement benefits from other systems previously chose which system provided their health care coverage. Funds are transferred to the system providing the coverage based on the value of coverage that would have been provided to the member by the other system (known as health care waivers). Effective January 1, 2007, this election was changed to require retirees and their spouses who qualify for retirement under another Ohio retirement system to elect coverage under that system's health care plan. OPERS health care may only be elected as secondary coverage. In 2008, OPERS recorded accrued revenues for historical amounts due from other systems for health care waivers not yet received as of December 31, 2008. This accrual increased revenues from other systems to nearly $18.8 million in 2008 compared to $0.9 million in 2007. In 2009, these revenues were $5.2 million and 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.

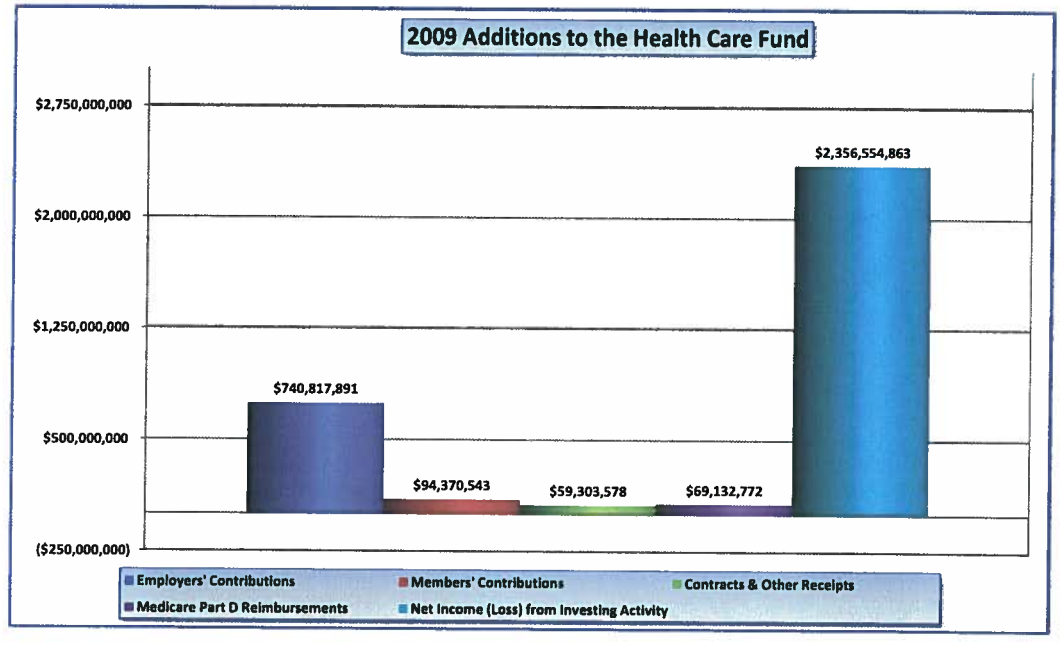


	2004*	2005*	2006	2007	2008	2009
Members' Contributions	$58,975,931	$63,408,347	$71,718,182	$79,198,959	$82,695,255	$94,370,543
Employers' Contributions	$461,788,996	$457,325,506	$538,312,995	$695,967,837	$891,561,073	$740,817,891
Contracts & Other Receipts	$20,897,027	$7,234,092	$93,724,104	$45,534,017	$66,343,542	$58,649,547
Medicare Part D Reimbursements	$0	$0	$58,987,181	$59,075,120	$63,310,194	$69,132,772
Other Income, Net	$0	$548,364	$1,306,783	$70,498	$614,989	$654,031
Net Income (Loss) from Investing Activity	$1,297,291,883	$868,900,661	$1,471,059,831	$858,614,433	($3,400,647,342)	$2,356,554,863

Source: 2009 Comprehensive Annual Financial Report
Notes:

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

5. Medicare Part D Reimbursements - Fiscal year 2009 marked the fourth year that Medicare law permitted a federal subsidy for employers that offer a high-quality prescription drug program for retirees and their dependents. The subsidy, which reflects a reimbursement of approximately 25-28% of eligible retiree prescription drug costs, represented over $69 million in revenue for OPERS in 2009, compared to $63 million in 2008 and $59 million in both 2007 and 2006.



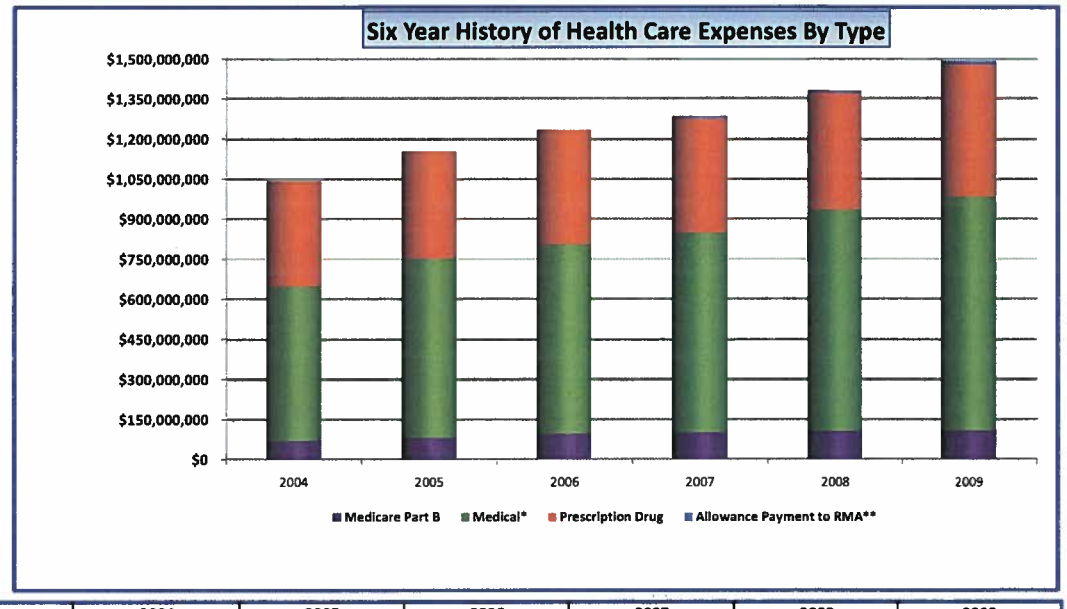
Source: 2009 Comprehensive Annual Financial Report

Health Care Expenses:

The increase in health care expenses reflects the expanding retiree population and the nation-wide trend in health care inflation that continues to be well in excess of general inflation. However, the expenses incurred by OPERS in 2009 also reflect the impact of the combination of significant plan design changes, cost-sharing changes and extensive cost containment efforts. As mentioned previously, 2009 represents the third year of implementation for the Health Care Preservation Plan (HCPP). The goal of HCPP was to extend the period of time the health care assets were expected to last (the plan solvency years).

The 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 and the Medicare Advantage program. In addition, wellness programs were initiated that provide retirees with financial incentives for healthy lifestyles and participation in programs such as smoking cessation. Based on the relatively low growth in health care expense since plan inception in 2006, the plan has been successful. Health care expenses have risen at a fairly consistent rate from $1.3 billion in 2007 to $1.4 billion in 2008 and to $1.5 billion in 2009. At the same time, the number of retirees and eligible dependents and beneficiaries increased by 2.9% in 2007, 3.2% in 2008, and 3.3% in 2009.

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



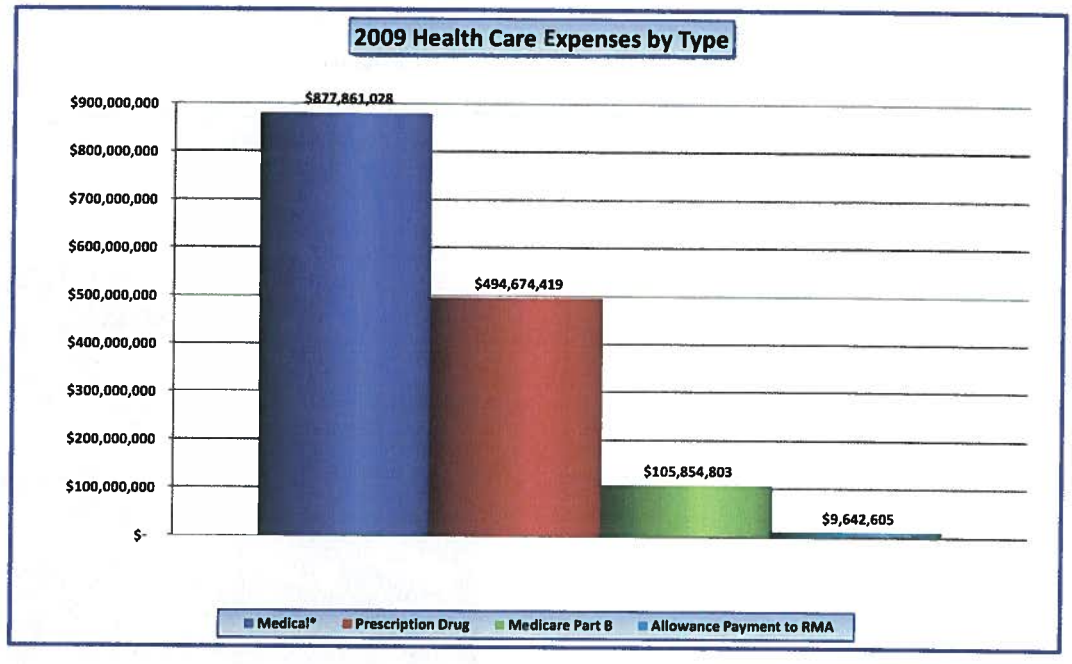
	2004	2005	2006	2007	2008	2009
Medicare Part B	$67,295,184	$80,094,041	$92,268,184	$99,175,973	$103,934,337	$105,854,803
Medical*	$578,796,744	$669,663,632	$711,461,624	$749,174,151	$827,135,910	$877,861,028
Prescription Drug	$394,857,747	$403,184,288	$428,140,230	$431,405,495	$441,059,097	$494,674,419
Allowance Payment to RMA**	$0	$0	$0	$3,020,425	$5,016,829	$9,642,605

Source: 2009 Comprehensive Annual Financial Report

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

Health Care Expenses *(continued)*:

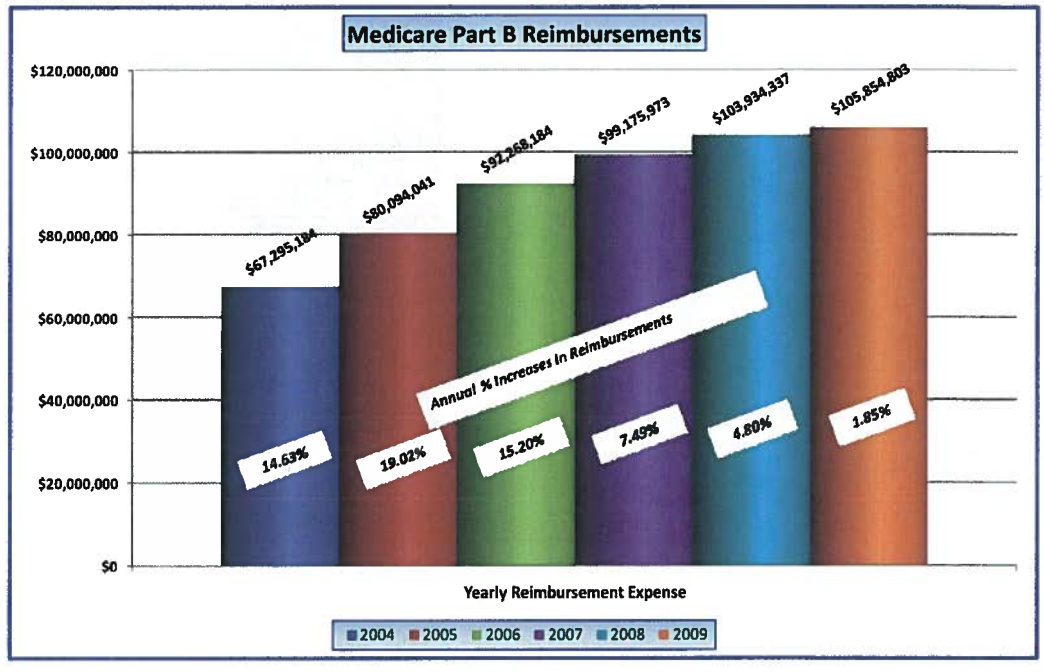
The majority of health care expenses are comprised of medical and prescription drug costs, and reimbursements to retirees for Medicare Part B premiums. These expenses increased by $106.3 million in 2009. Medical expenses increased by $50.7 million or 6.1%, and prescription drug costs rose by $53.6 million in 2009 or 12.2% over the 2008 levels. Statutorily required Medicare Part B reimbursements increased by $1.9 million.



Source: 2009 Comprehensive Annual Financial Report
*Includes Medical, Disease Management, Wellness, Dental and Vision (OPERS receives member contributions for Dental and Vision).

Health Care Expenses *(continued)*:

Legislative changes that became effective in 2009 permit the Board to determine the value of Medicare Part B reimbursements above a base threshold. This change effectively permits the Board to establish a cap on these reimbursements, which limited the increases in these expenses to 1.8% over the 2008 levels. By comparison, Medicare Part B reimbursements in 2008 were 4.8% higher than in 2007, as the federal premiums continued to rise. The overall breakdown of health care expenses for 2008 and 2007 reflect similar distributions, with medical expenses averaging approximately 59% of the total, followed by prescription drugs (33%) and Medicare Part B reimbursements and other expenses (8%).



Source: 2009 Comprehensive Annual Financial Report

The future holds many challenges and opportunities

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

- **Health care funding** - Following the investment experiences of 2008 and early 2009, the OPERS Investment Division worked closely with the Board's consultant, Mercer, on a review of the asset allocations for the Health Care Fund. The result of the effort is a revised Health Care asset allocation and investment policy. These changes are designed to improve the projected level of future returns at acceptable levels of risk to better meet future health care coverage needs. Staff will be implementing the new allocations throughout 2010 and beyond.

- **OPERS baby boomer population retiring** – The retiree population is expected to double in less than 20 years, which will require multiple approaches and increased demand for health care education and communications. The OPERS Strategic Plan provides direction to help us prepare for an increased retiree population.

- **Moving our population into a culture of wellness and disease prevention** – From employment, through retirement, the Health Care Preservation Plan contains disease prevention and wellness initiatives for all plan participants.

- **Retiree accountability and consumerism** – OPERS has made a commitment to provide consumerism education and encourage OPERS health care plan participants to make prudent health care choices and use their coverage wisely. The goal is to make plan participants more accountable for their own health care decisions.

- **Federal legislation and health care policy** – Both the House and Senate passed a health care reform bill prior to the end of 2009. Changes brought about as a result of this legislation could have an impact on how OPERS administers the OPERS health care plan in the future.

- **Ongoing health care inflation management**
  - Biotechnology and medical technology growth, including the challenge of finding a way to pay for the wave of new specialty drugs.
  - Demand for measurable improvements in the value of health care, necessitating quality and transparent pricing. OPERS works with our health care vendors to ensure that we are maximizing cost containment strategies for our members' benefit.

- **Retiree education** – In 2009, OPERS provided health care education to retirees by including health care focused articles in every issue of *Ohio PERS NEWS for Retirees* and also providing retiree organizations with educational articles for their member publications. We also increased educational opportunities on the OPERS website by adding videos of the retiree and open enrollment seminars. The OPERS health care education team delivered educational presentations to nearly 19,000 participants in 2009. Health care educators also delivered presentations to more than 70 OPERS retiree and employer organizations.
  - In 2009, the OPERS health care educators presented 60 seminars to retirees and active members.
  - The health care education team also increased the number of open enrollment seminars to 90 during our open enrollment period in October. During 2009, the seminars were targeted to

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

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

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

2. A summary of coverage

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

The 2009 OPERS Health Care Plan

The 2009 OPERS health care plan, administered by Aetna and 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. Because these providers of service provide a cost savings to OPERS, the 2009 plan design 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. Once a recipient became eligible for Medicare, he or she was able to choose any provider of service, regardless of network status, without a decrease in coverage. The OPERS health care plan is secondary to Medicare. All states in the US were within the PPO network. Participants living outside of the United States were able to choose any provider of services (regardless of Medicare status) without a decrease in coverage.

Alternate Health Care Coverage

Alternate health care coverage was available in 2009 to OPERS health care plan participants who resided in certain counties in Ohio (and a few border counties in Indiana, Kentucky and Michigan). These products included Kaiser Permanente HMP and AultCare PPO. HMO products offered hospital and medical services through participating physicians and facilities.

Plan participants were responsible for the cost difference in HMO coverage if that cost was more than the cost of the OPERS health care plan.

Medicare

The following requirements regarding Medicare were in effect for 2009:

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

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

When a plan participant or covered spouse reached the age of 65, OPERS requested a copy of the Medicare card. If the covered individual was not eligible for free Medicare 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 A.

Medicare Direct

OPERS health care plan participants who were enrolled in Medicare B (medical) and who were enrolled in the OPERS health plan (not an alternate plan) were eligible to use Medicare Direct.

The Medicare Direct program covered Medicare B charges only. The Medicare Direct program allowed the health care provider of services to mail a claim to the Medicare paying agency. The agency made a payment and forwarded the remainder of the bill (along with a Medicare explanation of benefits) to the OPERS health plan administrator.

Medicare Part B Reimbursement

If a plan participant was enrolled in OPERS health care and was not being reimbursed from another source for his or her Medicare B premium, he or she was eligible for OPERS reimbursement. In order to receive this reimbursement, the participant 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.

Medicare Part D

Medicare Part D is prescription drug coverage. OPERS does not recommend that our retirees sign up for Medicare Part D because it may require an additional premium. The OPERS health care plan provides prescription drug coverage that is equivalent to or better than Medicare Part D.

The Aetna Medicare Open Plan

The Aetna Medicare Open Plan is a Medicare Advantage PFFS plan that OPERS began offering to our Medicare-eligible recipients beginning Jan. 1, 2008. This plan features the same deductible and co-insurance amount as the OPERS Enhanced Plan. Those participating in the Aetna Medicare Open Plan are required to use a provider that accepts the terms and conditions of this plan. Claims are submitted directly to Aetna for payment.

The Dental Plan

During 2009, 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 was intended to help defray the costs of dental care, including oral examinations, diagnostic services, and extractions, as well as crowns, bridges, and dentures. If a retiree chose to be covered under the dental plan, a premium payment was deducted from each monthly benefit check. OPERS does not subsidize this plan.

The Vision Plan

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

The Long Term Care Plan

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

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

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

Following are the eligibility requirements for the OPERS health care plan. These requirements were in effect during 2009:

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

Coverage for Surviving Spouses

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

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

Eligible Dependents

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

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

In order for a child to be eligible for coverage, the child must be under 18 and never married or under age 22, never married, and attending an accredited school on a full time basis for at least 5 months of the calendar year. Certain farm training programs qualify as accredited schools. Coverage may be extended if the child is permanently and totally disabled prior to the limiting ages listed above. This means that the child is not able to work in any substantial gainful activity because of a physical or mental impairment, which has lasted or is expected to last for at least 12 months. Evidence of the incapacity is required and is subject to approval by OPERS.

For all children:

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

- The retiree is divorced, legally separated, separated under a written separation agreement, or is living apart at all times during the last 6 months of the calendar year and the retiree is the parent of the child.
- The child is in the custody of the retiree or his/her other parent for more than one-half of the calendar year.
- The retiree provides over one-half of the child's support, subject to the provisions of Section 152 of the Internal Revenue Code regarding multiple support agreements.

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

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

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

As of Dec. 31, 2009, there were 213,220 OPERS retirees and dependents covered under the OPERS health care plan.

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

OPERS utilizes an accrual basis of accounting under which deductions are recorded when the liability is incurred and additions are recorded in the accounting period they are earned and become measurable. Under this method, OPERS estimates health care claims which have been incurred at year end, but which are not yet known to the Retirement System. Investment purchases and sales are recorded as of their trade date. Investment expenses are financed exclusively through investment income.

Plan investments are reported at fair value. Fair value is, "the amount that a plan can reasonably expect to receive for an investment in a current sale between a willing buyer and a willing seller that is, other than in a forced or liquidation sale." All investments, with the exception of private equity, are valued based on closing market prices or broker quotes. The fair value of private equity investments is based on estimated current values and independent appraisals.

Employer contributions and investment earnings are used to fund health care expenses. Under this method, employer contributions equal to on average 5.88 percent of covered payroll were used to fund health care liabilities for the period of Jan. 1, 2009 through Dec. 31, 2009. Additionally, revenues from member contributions (premiums), Medicare Part D reimbursements, and contract and other receipts comprise the balance of health care additions. The market losses of 2008 and subsequent reduction of the portion of employer contribution rate used to fund health care reduced the solvency years of the health care fund from 31 years as of Dec. 31, 2007, to 11 years as of Dec. 31, 2008.

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

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

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

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

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

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

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

   No significant changes affect these reports.

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

    OPERS paid approximately $105.9 million in Medicare Part B premiums to its benefit recipients who were enrolled in the health care plan in 2009.

Sec. 145.325. Medicare equivalent benefits.

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

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

B) The board need not make the hospital insurance coverage described in division (A) of this section available to any person for whom it is prohibited by section 145.58 of the Revised Code from paying or reimbursing the premium cost of such insurance. HISTORY: 132 v H 402 (Eff 12-14-67); 136 v H 1 (Eff 6-13-75); 137 v H 1 (Eff 8-26-77); 139 v H 126 (Eff 6-13-81); 144 v S 346 (Eff 7-29-92); 148 v H 628 (Eff 9-21-2000).

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

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

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

2. The spouse of the former member;

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

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

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

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

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

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

(D) The board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section or section 145.325 of the Revised Code with any similar coverage, payment, or benefit made available to the same individual by the Ohio police and fire pension fund, state teachers retirement system, school employees retirement system, or state highway patrol retirement system.

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

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

	2009	2008	2007	2006	2005	2004
Assets						
Cash and Short-Term Investments	**$82,384,335**	**$214,267,049**	**$166,407,166**	**$322,120,585**	**$250,418,690**	**$194,486,592**
Receivables:						
Members' and Employers'	70,351,872	99,321,334	107,187,056	82,850,806	67,383,947	64,664,924
Retirement Incentive Plan	3,185,825	344,045	676,337	762,533	1,805,631	3,098,433
Vendor and Other	49,921,976	57,775,901	36,025,605	34,882,853		
Investment Sales Proceeds	884,914,266	57,319,401	33,489,810	80,471,902	7,776,993	12,946,973
Accrued Interest and Dividends	37,732,716	46,426,349	64,843,050	67,341,496	51,057,887	30,981,282
Total Receivables	**1,046,106,655**	**261,187,030**	**242,221,858**	**266,309,590**	**128,024,458**	**111,691,612**
Investments, at fair value:						
Global Bonds	3,746,406,051	4,363,406,922	6,581,396,111	6,116,700,706	4,226,384,980	2,600,579,782
Domestic Equities	3,806,887,666	2,731,493,461	4,186,123,350	4,388,937,986	4,623,642,722	5,590,842,559
Real Estate					505,301,728	629,039,656
Private Equity	39,341,186	5,150,008				69,834,553
International Equities	2,974,380,740	2,201,764,403	2,282,909,655	1,973,897,814	2,281,196,185	2,671,029,189
Total Investments	**10,567,015,643**	**9,301,814,794**	**13,050,429,116**	**12,479,536,506**	**11,636,525,615**	**11,561,325,739**
Collateral on Loaned Securities	**299,502,780**	**2,297,927,070**	**2,072,493,713**	**2,015,624,266**	**1,749,802,181**	**1,429,823,432**
Capital Assets:						
Land	665,394	665,394	665,394	665,394	665,394	665,394
Building and Building Improvements	19,660,159	19,663,497	19,852,388	19,679,465	19,096,169	18,624,614
Furniture and Equipment	20,582,082	17,141,828	14,941,722	11,420,812	9,411,311	7,366,060
Total Capital Assets	40,907,635	37,470,719	35,459,504	31,765,671	29,172,874	26,656,068
Accumulated Depreciation	(13,530,325)	(11,267,149)	(8,853,297)	(7,340,277)	(6,266,653)	(5,553,881)
Net Capital Assets	**27,377,310**	**26,203,570**	**26,606,207**	**24,425,394**	**22,906,221**	**21,102,187**
Prepaid Expenses and Other Assets						
TOTAL ASSETS	**$12,022,386,723**	**$12,101,399,513**	**$15,558,158,060**	**$15,108,016,341**	**$13,787,677,165**	**$13,318,429,562**
Liabilities:						
Undistributed Deposits	$52,974	$52,974	$8,385			
Medical Benefits Payable	134,007,772	131,776,992	142,701,327	145,895,911	138,450,016	116,024,321
Investment Commitments Payable	163,153,464	69,811,443	57,017,727	108,410,835	53,711,956	163,468,451
Accounts Payable and Other Liabilities			569,998	26,250		
Accounts Payable RMA Claims	10,474,459	5,748,957	2,419,428			
Obligations Under Securities Lending	299,502,780	2,297,927,070	2,072,493,713	2,015,624,266	1,749,802,181	1,429,823,432
TOTAL LIABILITIES	**$607,191,449**	**$2,505,317,436**	**$2,275,210,578**	**$2,269,957,262**	**$1,941,964,153**	**$1,709,316,204**
Net assets held in trust for pension and post-employment health care benefits	**$11,415,195,274**	**$9,596,082,077**	**$13,282,947,482**	**$12,838,059,079**	**$11,845,713,012**	**$11,609,113,358**

Source: 2009 Comprehensive Annual Financial Report

	2009	2008	2007	2006	2005*	2004*
Additions:						
Members' Contributions	$94,370,543	$82,695,255	$79,198,959	$71,718,182	$63,408,347	$58,975,931
Employers' Contributions	740,817,891	891,561,073	695,967,837	538,312,995	457,325,506	461,788,996
Contract and Other Receipts	58,649,547	66,343,542	45,534,017	93,724,104	7,234,092	20,897,027
Medicare Part D Reimbursements	69,132,772	63,310,194	59,075,120	58,987,181		
Other Income, Net	654,031	614,989	70,498	1,306,783	548,364	
Total Non-Investment Income	**963,624,784**	**1,104,525,053**	**879,846,431**	**764,049,245**	**528,516,309**	**541,661,954**
Income/ (Loss) from Investing Activities:						
Net Appreciation / (Depreciation) in Fair Value	2,081,098,064	(3,734,049,668)	479,748,239	1,048,846,038	382,822,937	856,405,146
Bond Interest	152,358,418	182,944,355	211,556,481	179,769,220	124,871,047	122,129,931
Dividends	134,487,014	139,099,121	160,715,579	106,148,349	99,647,424	107,071,190
Real Estate Operating Income / (Loss), net						52,299,350
International Income	52,944	552,901	9,981	143,649,645	262,947,660	165,266,361
Other Investment Income / (Loss)	661,628	147,998	13,229,442	2,829,179	6,773,879	10,401,718
External Asset Management Fees	(7,709,148)	(8,674,498)	(10,491,258)	(10,797,650)	(7,188,895)	(13,599,165)
Net Investment Income / (Loss)	2,360,948,920	(3,419,979,791)	854,768,464	1,470,444,781	869,874,052	1,299,974,531
From Securities Lending Activity:						
Security Lending Income	2,336,740	103,004,243	120,699,574	94,382,644	34,774,894	
Security Lending Expenses	(562,862)	(79,967,808)	(113,044,477)	(89,727,122)	(31,691,948)	
Net Securities Lending Income	1,773,878	23,036,435	7,655,097	4,655,522	3,082,946	1,861,915
Unrealized Loss	(2,396,132)					
Net Income/(Loss) from Securities Lending	**(622,254)**	**23,036,435**	**7,655,097**	**4,655,522**	**3,082,946**	**1,861,915**
Less: Investment Administrative Expenses	(3,771,803)	(3,703,986)	(3,809,128)	(4,040,472)	(4,056,337)	(4,544,563)
Net Income / (Loss) from Investing Activity	**2,356,554,863**	**(3,400,647,342)**	**858,614,433**	**1,471,059,831**	**868,900,661**	**1,297,291,883**
TOTAL ADDITIONS	**$3,320,179,647**	**($2,296,122,289)**	**$1,738,460,864**	**$2,235,109,076**	**$1,397,416,970**	**$1,838,953,837**
Deductions:						
Health Care Benefits	$1,488,032,855	$1,377,146,173	$1,282,776,044	$1,231,870,038	$1,152,941,961	$1,040,949,675
Administrative Expenses	13,033,595	13,596,943	10,796,417	10,892,971	7,875,355	2,694,253
TOTAL DEDUCTIONS	**$1,501,066,450**	**$1,390,743,116**	**$1,293,572,461**	**$1,242,763,009**	**$1,160,817,316**	**$1,043,643,928**
Net Increase/ (Decrease) Net assets held in trust for pension and Post-employment health care benefits	$1,819,113,197	($3,686,865,405)	$444,888,403	$992,346,067	$236,599,654	$795,309,909
Balance, Beginning of Year	9,596,082,077	13,282,947,482	12,838,059,079	11,845,713,012	11,609,113,358	10,813,803,449
BALANCE, END OF YEAR	**$11,415,195,274**	**$9,596,082,077**	**$13,282,947,482**	**$12,838,059,079**	**$11,845,713,012**	**$11,609,113,358**

Source: 2009 Comprehensive Annual Financial Report

*Additions and Health Care Benefits were restated to delineate contracts and other receipts, years prior to 2004 are not restated.

OPERS
Board of Trustees

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

Elected Board Members

Eddie Parks
State Employees

Sharon M. Downs
Retired Members

John W. Maurer
Retired Members

Kimberly Russell
State College and University Employees

Cinthia Sledz
Vice Chair
Miscellaneous Employees

Ken Thomas
Chair
Municipal Employees

Helen Youngblood
County Employees

Statutory Board Member

Hugh Quill
Director, Department of Administrative Services

Appointed Board Members

Lennie Wyatt
Investment Expert
Governor Appointee

Charlie Adkins
Investment Expert
Treasurer of State Appointee

James R. Tilling
Investment Expert
General Assembly Appointee

Chris DeRose
Chief Executive Officer