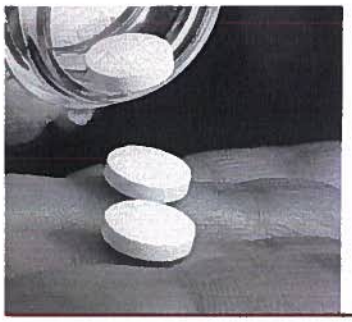


health care

Your Partner in Securing Health Care for the Future

OPERS 2008 Health Care Report

Presented to:
Ohio Retirement Study Council
June 2009

Ohio Public Employees Retirement System

Chris DeRose
Chief Executive Officer

Blake W. Sherry
Chief Operating Officer

Randy Hoffman

OPERS is providing the 2008 health care report required by Section 145.22 of the Ohio Revised Code. The OPERS Board of Trustees recognizes that providing quality, affordable, health care coverage is an important element in providing retirement security for our retirees.

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

Events in 2008 pertaining to the OPERS retiree health care plan include the following:

- As of Jan. 1, 2008, OPERS began offering the Aetna Medicare Open Plan to Medicare-eligible retirees and their covered, Medicare-eligible spouses. The Aetna Medicare Open Plan is a private-fee-for-service (PFFS) Medicare plan that has been designed exclusively for OPERS by Aetna and the Center for Medicare and Medicaid Services (CMS).

- On April 1, 2008 Express Scripts, Inc. began serving as the pharmacy benefit manager (PBM) for the OPERS health care plan.This was the first change in PBM in 27 years. Medco had provided pharmacy benefit management for the OPERS health care plan since 1981. OPERS made this change as the result of a bidding process in collaboration with other Ohio retirement systems and The Ohio State University.

- The challenges of the investment market in 2008 had a significant impact on OPERS resulting in the fund realizing its first decline in five years. Total assets in the OPERS health care trust fund decreased to $9.6 billion in 2008 from $13.3 billion in 2007.

- Market losses in 2008 and the subsequent reduction of the portion of the employer contribution rate used to fund health care are expected to reduce the solvency years of the health care fund from 31 years as of Dec. 31, 2007, to approximately 10 to 15 years as of Dec. 31, 2008. The solvency period measures the length of time the current health care funds would last given the current level of expenditures.

The OPERS Board of Trustees and staff are aware of the significant challenges ahead in the form of rising health care costs, uncertainty of federal funding/programs, increased longevity, and a growing retiree population due to the retirement of the baby boom generation. Despite these challenges, we are confident that we have a plan in place to meet these challenges and continue to provide quality, affordable 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.

To diversify its offering while encouraging retirees to take advantage of expanded services, 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. We also began the formal introduction of case management as a cost containment measure. Aetna provided the service and, at the time, was our sole medical third-party administrator.

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. Adding a second plan administrator offered retirees another set of network providers from which to choose.

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. We 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 providing access to health care coverage, replacing the automatic 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 consumers in keeping prescription drugs affordable.

Dependent eligibility definitions became more restrictive in 2005. Over-the-counter medicines and non-sedating antihistamines were eliminated from coverage, and erectile dysfunction drug coverage was reduced and eventually discontinued.

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 or allowance to be applied toward their selection of one of the three medical/prescription plan offerings and optional dental and vision coverage. Monthly allowance amounts not used toward health care plan choices were placed in an account and held for the retiree's future medical expenses. Likewise, if a retiree's selections exceeded his or her monthly allowance (such as an employee with limited years of service selecting the more expensive health care plan), the retiree paid the difference in the form of a monthly premium.

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% without a deductible.

As of Jan. 1, 2008, OPERS began offering the Aetna Medicare Open Plan to Medicare-eligible retirees and their covered, Medicare-eligible spouses. The Aetna Medicare Open Plan is a private-fee-for-service (PFFS) Medicare plan that has been designed exclusively for OPERS by Aetna and the Center for Medicare and Medicaid Services (CMS). This plan also featured a wellness program.

On April 1, 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 bidding process in collaboration with other Ohio retirement systems and The Ohio State University.

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**
Kaiser HMO offered	**1975**	
	1981	**OPERS/ORS secure mail pharmacy in Columbus**
Eligibility increase from 5 to 10 years of service	**1986**	
	1993	**PPO model replaces indemnity** 2 health plan choices
Preventive services expanded flu vaccines, physicals, etc.	**1999**	
	2000	**Rx co-pay increased** OPERS consumerism model starts
Eligibility tied to years of service **Disease Management introduced**	**2003**	
	2004	**Incentive formulary introduced** deductibles, co-pays and out-of-pockets **Prescription drug costs managed below national average.**
Active management of health care program introduced leveraged OTC medications, cost-effective alternatives **Plan design and subsidy levels changed** **OPERS helps create National Public Sector Health Care Coalition**	**2005**	**Investments contribute $900 million to health care fund** **Prescription drug costs managed below national average.** **$33M in generic savings** **$20M in additional rebates**
	2006	**Contribution changes** **Medicare D subsidy** **Comprehensive wellness program developed**
Health Care Preservation Plan implemented **Health Care Preservation Plan "2.0" approved** **Wellness program implemented** **Incentive Structure and Medicare Advantage Plan Strategy Developed**	**2007**	
	2008	**OPERS introduces the Aetna Medicare Open Plan** **Express Scripts becomes the pharmacy benefit manager for the OPERS health care plan**

Securing health care coverage now and in the future

OPERS has a long history of providing dependable retirement benefits including sound 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 discipline and favorable financial results over the past decades to establish a $9.6 billion health care trust 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 a solid health care plan while preserving health care coverage for the future.

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 HCPP 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. OPERS' actuaries estimate that every $50 million in savings adds an additional year of solvency. The results are paying off. As of Dec. 31, 2008, HCPP and HCPP 2.0 cumulatively added approximately $1 billion to the OPERS health care fund.

In 2007, the OPERS Board approved a policy to improve the funding and necessary cost controls to expand our 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 209,000 health care benefit recipients and our population is expected to swell to 400,000 in less than 20 years underscoring the need to provide cost-effective health care coverage for future retirees, help secure retirees' finances and responsibly contribute to the state's economy.

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 active work force, to consider working longer to generate a larger health care allowance from OPERS to help pay their premiums.

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, the legislature, 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:

1. Wellness Programs (2007/2008)
2. Medicare Advantage Plan (2008)
3. Prescription Drug Program RFP (2007)
4. Member Cost Share Policy 10-20% (2008-2012)
5. Eligibility – Spousal Eligibility at 55 years of age (2011)
6. Legislative Initiatives
   a. OPERS board authority to set Medicare B reimbursement level (2009)
   b. OPERS secondary for re-employed retirees
7. Disability Management enhancements/update (2009/2010)
8. Medical health plan development/Health plan/pharmacy plan purchasing pool (2008-2010)
9. Asset reallocation to improve investment return assumption (2007)
10. Increased contribution allocation to health care (2008)

Disease Prevention

Wellness and disease prevention – Statements and statistics that tell a story

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.

Overweight people and obesity increase the risk of many diseases including high blood pressure, osteoarthritis, type 2 diabetes, coronary heart disease, stroke, gall bladder disease and some cancers (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:

A retiree's choices affect his or her health, whether in the short term, the long term, or both.

- 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 3,632 retirees enrolled in the program during the first year.

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. In late 2008, Aetna expanded the network of fitness centers where retirees can obtain a free membership.

OPERS provides two Disease Management programs. Those enrolled in the Aetna Medicare Open Plan have access, based on need, to a disease management program through the medical plan. During 2008, 12,151 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 2008, a total of 33,853 retirees and spouses were enrolled. Approximately 5400 were enrolled in the High Severity Program, about 11,500 were enrolled in the Moderate Severity Program and 16,900 were participating in the Low Severity Program.

Legislative Priorities

OPERS is pursuing changes to state law to authorize the OPERS Board to determine the percentage of the amount of the Medicare Part A equivalent coverage to be paid by OPERS for a spouse, widow, or widower of a retired member. Currently, state law requires that 50 percent of the coverage be subsidized by OPERS and, under the Health Care Preservation Plan, spouses may receive a 25 percent subsidy.

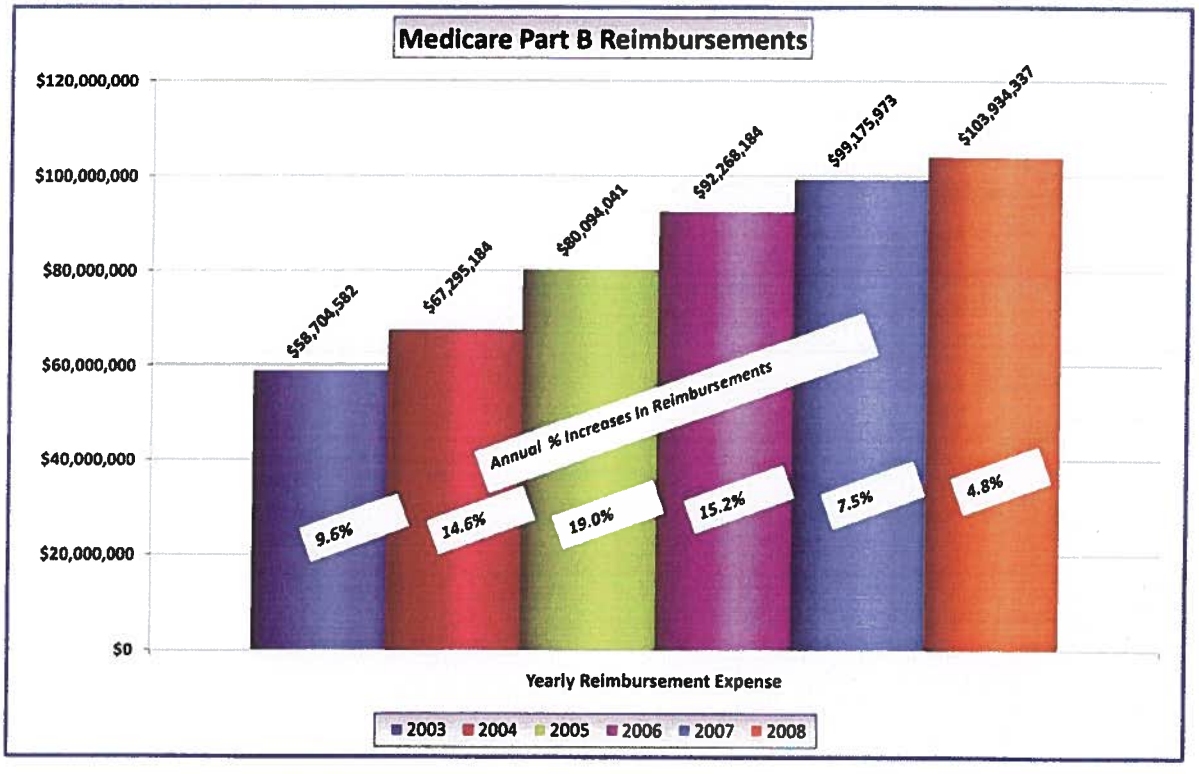
Current law requires OPERS retirees who are reemployed in the public sector to use the employer's health care coverage as primary and OPERS provides secondary coverage. OPERS is pursuing legislative changes to these coordination of benefits provisions to apply to OPERS retirees employed in the private sector and to disability and survivor benefit recipients who are employed and have access to coverage.

In addition to coverage available through employment, OPERS is pursuing changes to state law to coordinate health care coverage with any other health care coverage available to a retiree's spouse or dependent. OPERS would continue to provide primary health care coverage for its retired members and OPERS would be secondary if a member's spouse or dependent has access to primary health care coverage for any other source.

Senate Bill 267

Amended Sub. SB 267 passed both the Ohio House and Senate and was signed by the Governor on Dec. 23, 2008 and the Act took effect on March 24, 2009.

SB 267 establishes 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 reimbursement cannot exceed the amount paid for coverage. The bill requires the recipient of the reimbursement to report to OPERS the amount paid for the coverage. OPERS is currently working toward the implementation of this new statute.



Source: 2008 Comprehensive Annual Financial Report

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) is not a guaranteed benefit. As of December 31, 2007, the date of the latest actuarial valuation, OPERS' estimated liability for health care coverage was $29.8 billion and the System had accumulated assets (on an actuarial funding basis) of $12.8 billion for that obligation. Although OPERS had an unfunded actuarial liability of $17.0 billion, this represented a reduction of $1.7 billion from the valuation as of December 31, 2006, and an improvement in the funding ratio from 39 percent to 43 percent. OPERS is one of only a handful of retirement systems around the country that pre-funds any portion of health care, as 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 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 are expected to reduce the solvency years of the health care fund from 31 years as of December 31, 2007, to approximately 10-15 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.

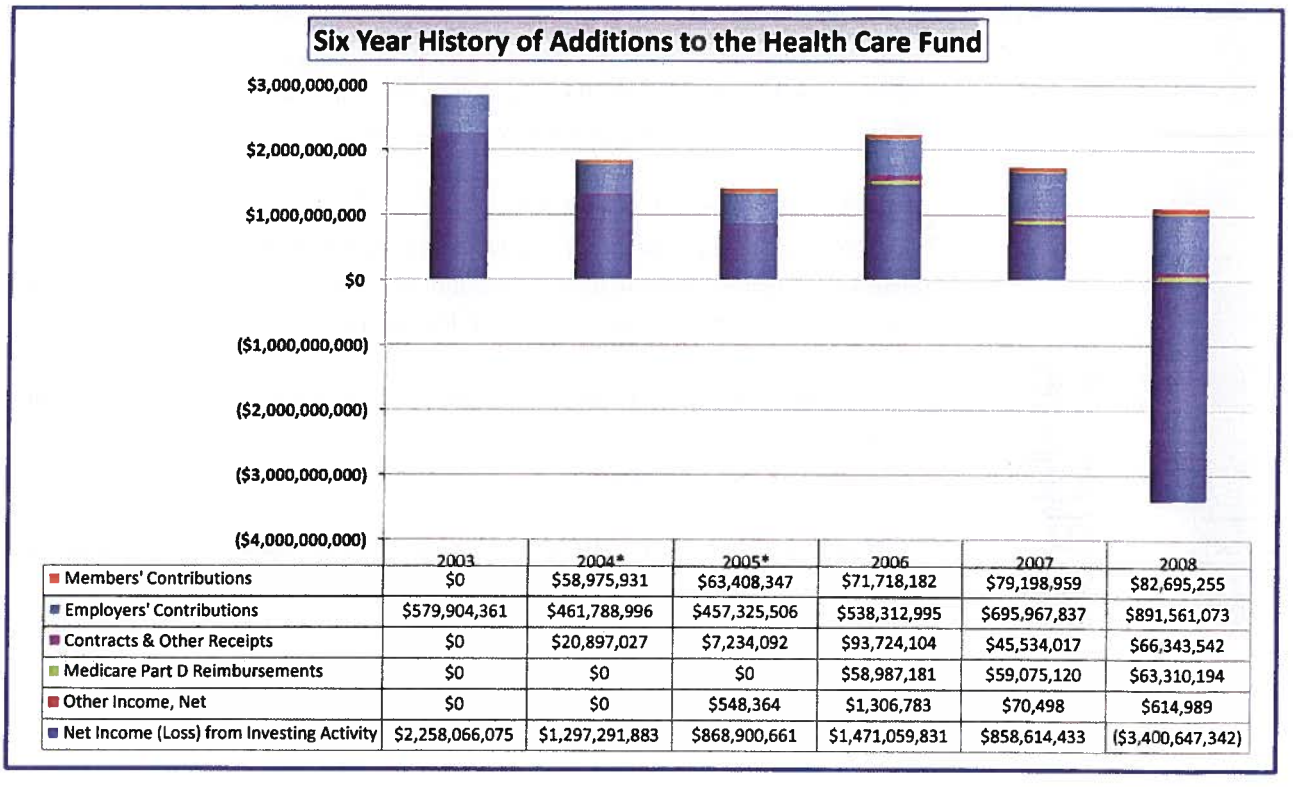
1. Investment Income – The health care portfolio reported a loss of 25.8 percent for the year ended December 31, 2008, compared to a positive return of 6.9 percent in 2007, resulting in a $3.4 billion loss in plan assets.

2. Employer Contributions – Employer contributions as a percent of active member payrolls added $892 million to the fund in 2008 – an increase of 28 percent over 2007 revenue. The majority of this increase is due to an increase in the employer contributions directed to health care vs. pensions. During 2008, OPERS was able to increase the portion of the employer contribution rate used to fund health care from an average of 5.5 percent in 2007 to 7 percent in 2008 as a result of favorable market returns in prior years. However, the market losses of 2008 resulted in the portion of the employer contribution rate allocated to fund health care being reduced to 5.5 percent in 2009.

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

3. Member Contributions – Member contributions represent amounts paid by retirees toward the cost of OPERS provided health care for themselves, their spouse and dependents. In 2008, these contributions totaled $82.7 million, compared to $79.2 million in 2007, or a 4.4% increase. This increase reflects both the rising cost of health care coverage and an increase in the retiree population. The number of retirees increased 3.3 percent over 2007, with a corresponding increase in the number of recipients eligible for health care coverage. By comparison, the number of benefit recipients in 2007 increased by 2.9 percent over 2006 levels.

4. Contract & Other Receipts – 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 coverage from other systems may choose which system will provide their health care coverage. Funds are transferred to the system providing the benefit based on the value of coverage that would have been provided to the member by the other system. In 2008, OPERS recorded accrued revenues for historical amounts due from other systems not yet received as of Dec. 31, 2008.

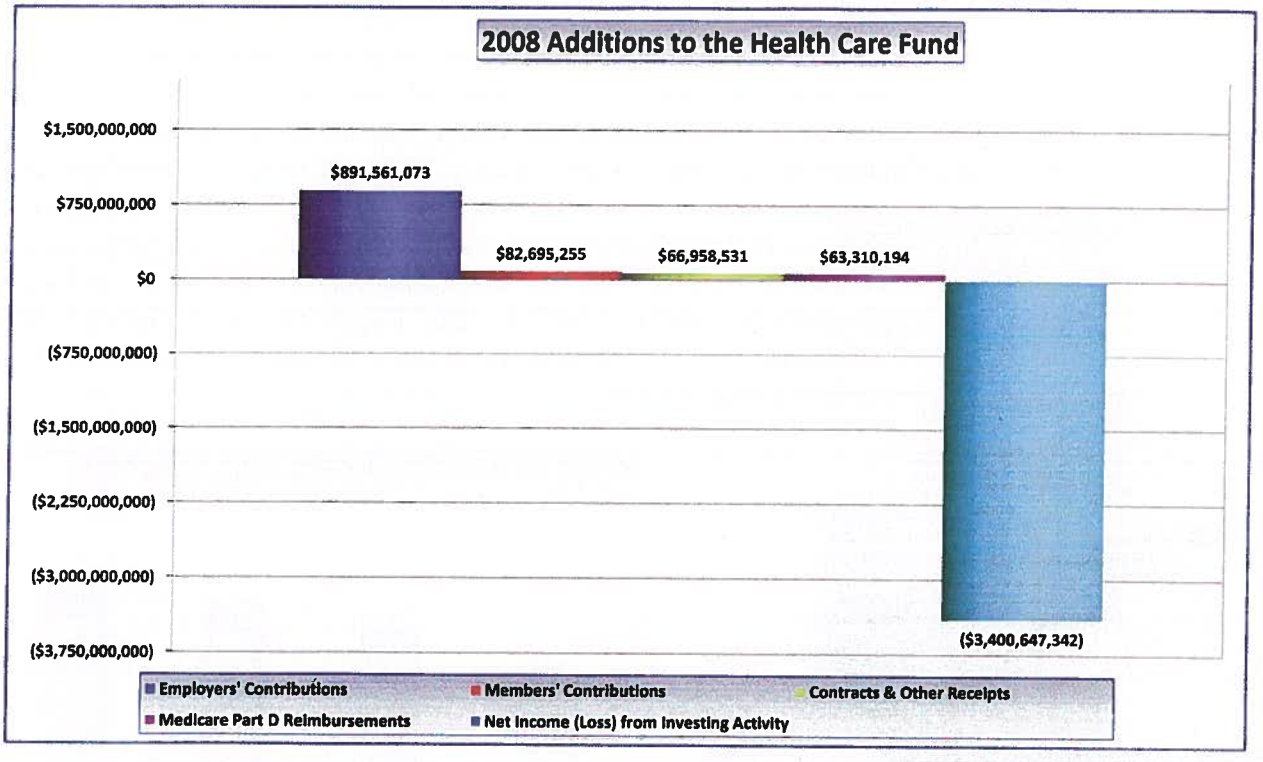


	2003	2004*	2005*	2006	2007	2008
Members' Contributions	$0	$58,975,931	$63,408,347	$71,718,182	$79,198,959	$82,695,255
Employers' Contributions	$579,904,361	$461,788,996	$457,325,506	$538,312,995	$695,967,837	$891,561,073
Contracts & Other Receipts	$0	$20,897,027	$7,234,092	$93,724,104	$45,534,017	$66,343,542
Medicare Part D Reimbursements	$0	$0	$0	$58,987,181	$59,075,120	$63,310,194
Other Income, Net	$0	$0	$548,364	$1,306,783	$70,498	$614,989
Net Income (Loss) from Investing Activity	$2,258,066,075	$1,297,291,883	$868,900,661	$1,471,059,831	$858,614,433	($3,400,647,342)

Source: 2008 Comprehensive Annual Financial Report
Notes:
* Additions were restated to delineate contracts and other receipts. Years prior to 2004 are not restated.
Medicare Part D Reimbursements effective in 2006.
Beginning in 2007, OPERS began recording estimated accruals for vendor performance guarantees, rebates, Medicare Part D, and ORS receipts.

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

5. Medicare Part D Reimbursements - Fiscal year 2006 marked the first year the new 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 $63 million in revenue for OPERS in 2008, compared to $59 million in both 2007 and 2006.

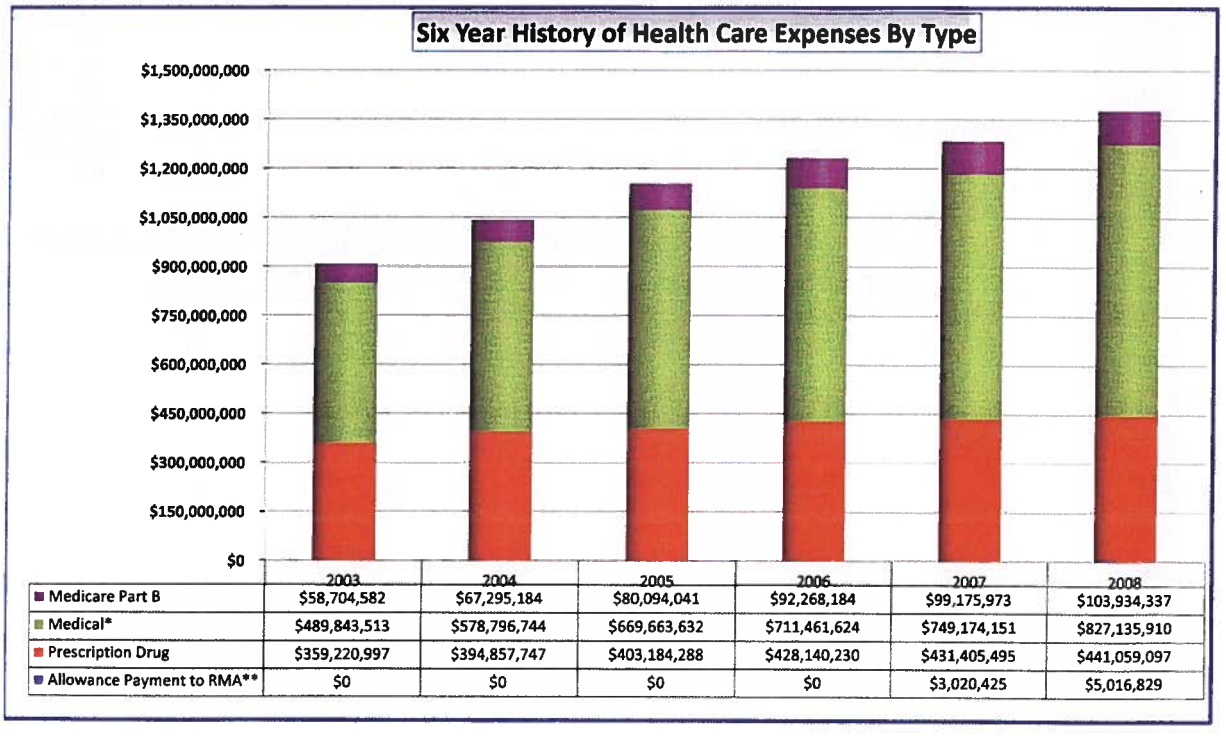


Source: 2008 Comprehensive Annual Financial Report

Health Care Expenses:

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.

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 2008 also reflect the impact of the combination of significant plan design changes, cost-sharing changes and extensive cost containment efforts. As mentioned previously, 2008 represents the second 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. Based on the relatively low growth in the health care expenses in 2007 and 2008, the plan has been successful. Health care expenses have risen at a consistent rate from $1.2 billion in 2006 to $1.3 billion in 2007 and to almost $1.4 billion in 2008.

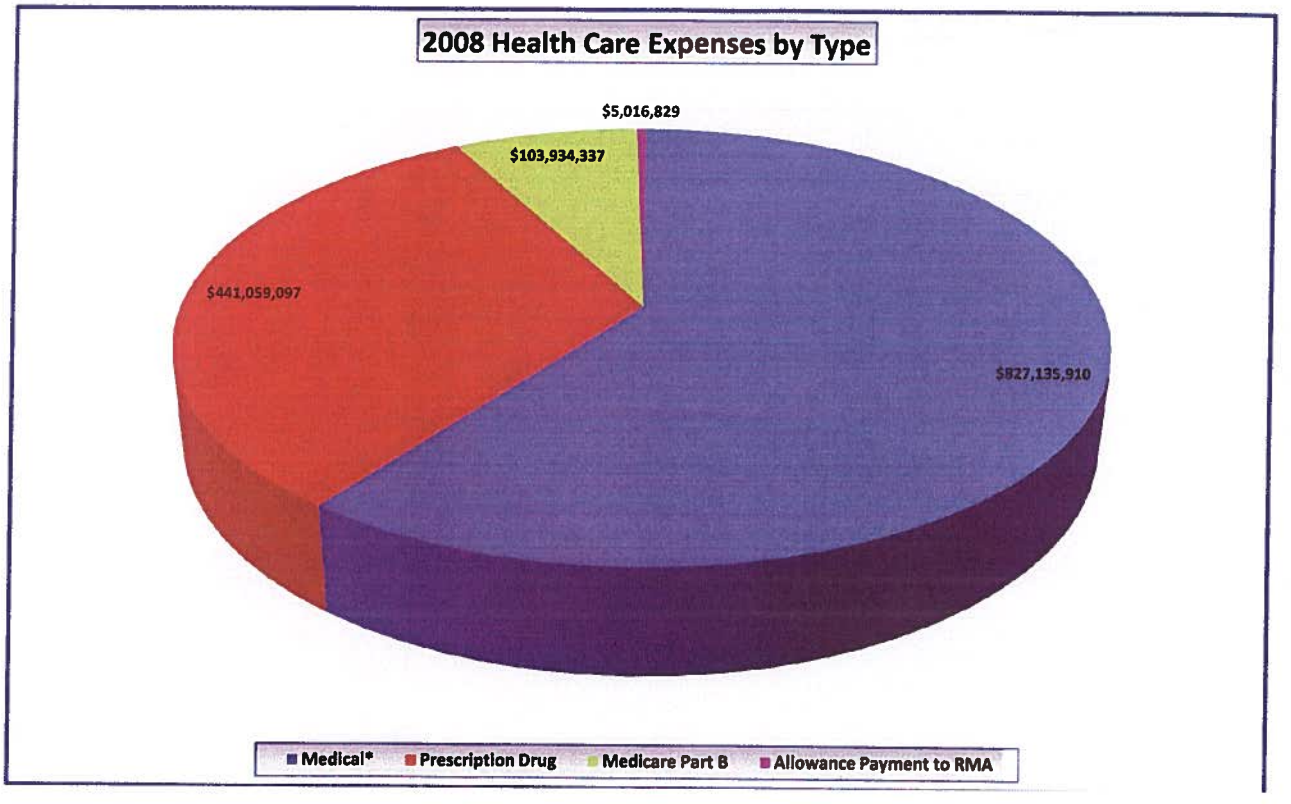


	2003	2004	2005	2006	2007	2008
Medicare Part B	$58,704,582	$67,295,184	$80,094,041	$92,268,184	$99,175,973	$103,934,337
Medical*	$489,843,513	$578,796,744	$669,663,632	$711,461,624	$749,174,151	$827,135,910
Prescription Drug	$359,220,997	$394,857,747	$403,184,288	$428,140,230	$431,405,495	$441,059,097
Allowance Payment to RMA**	$0	$0	$0	$0	$3,020,425	$5,016,829

Source: 2008 Comprehensive Annual Financial Report
*Includes Medical, Disease Management, Wellness, Dental and Vision (OPERS receives member contributions for Dental and Vision).
**Retiree Medical Account (RMA) commenced Jan. 1, 2007

Health Care Expenses:

These expenses are comprised of medical and prescription drug costs, as well as reimbursements to retirees for Medicare Part B premiums. The majority of the $94.4 million increase in total health care expenses for 2008 occurred primarily in medical expenses (including claims, administration fees, premiums, and disease management programs), which increased $78.0 million or 10.4 percent. Increases in prescription drug expenses accounted for $9.6 million of the total increase, with statutorily required Medicare Part B reimbursements and deposits to retiree medical accounts comprising the balance of $6.8 million. The overall breakdown of health care expenses for 2007 and 2006 reflects similar distributions, with medical expenses averaging approximately 59 percent of the total, followed by prescription drugs (33 percent) and Medicare Part B reimbursements (7 percent).



Source: 2008 Comprehensive Annual Financial Report
*Includes Medical, Disease Management, Wellness, Dental and Vision (OPERS receives member contributions for Dental and Vision).

The future holds many challenges and opportunities

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

- The downturn in investments that OPERS experienced in 2008 has resulted in a decrease in funding for both health care and pensions. The low return in the investment market have impacted every sector of the economy and are unprecedented for OPERS. However, the system remains strong and stable due to our diversified portfolio, disciplined investment approach and experienced investment staff.

- **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 childhood to employment, through retirement. The Health Care Preservation Plan contains disease prevention and wellness initiatives for our retirees.

- **Federal legislation and health care policy** – changes to Medicare and health care policy being discussed at a federal level could have an impact on how OPERS administers the OPERS health care plan. OPERS monitors federal issues and works with federal counterparts.

- **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 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 member's benefit.

- **Retiree communications** – OPERS health care staff has greatly increased its presence in retiree communities by forming an active partnership with Public Employees Retirees, Inc. (PERI), the Ohio State University Retiree Association (OSURA) and Rapid Transit Authority(RTA). OPERS provides PERI, OSURA and RTA with health care related articles for their monthly and quarterly publications. Also, OPERS health care educators delivered presentations to more than 80 PERI districts and chapters throughout 2008.
  - In 2008, the OPERS health care educators presented 54 seminars to retirees and active members. This is double the amount of seminars presented in 2007.
  - The health care education staff also increased the number of open enrollment seminars to 75 during our open enrollment period in October. During 2008, the seminars were targeted to Medicare and non-Medicare retirees, with an attendance reaching close to 9,000 retirees.
  - January through March 2008, the health care education staff presented 35

The following information fulfills the requirements of the Ohio Public Employees Retirement System as outlined in Ohio Revised Code Section 145.22(E). The section 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 2008 OPERS Health Care Plan

The 2008 OPERS health care plan utilized a Preferred Provider Organization (PPO). PPO networks are based on a partnership between doctors, hospitals, health plan administrators and benefit recipients. 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 2008 plan design encouraged the use of these providers. While benefit recipients 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 plan is secondary to Medicare.

The 2008 OPERS health care plan utilized the PPO networks of Aetna and Medical Mutual, the plan's two administrators. All states in the US were in the OPERS PPO network. Benefit recipients 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 to 2008 to OPERS benefit recipients who resided in certain counties in Ohio (and a few border counties in Indiana, Kentucky and Michigan). These products included Kaiser Permanente and AultCare PPO. HMO products offered hospital and medical services through participating physicians and facilities.

OPERS benefit recipients 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 2008:

If an OPERS benefit recipient 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 benefit recipient without cost, OPERS provided comparable substitute coverage.

Benefit recipients 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 benefit recipient 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

Benefit recipients 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 our benefit recipient 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 benefit recipient was required to send a copy of his or her Medicare card, showing enrollment in Part B. As long as the benefit recipient remained enrolled in part B coverage, the full 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 requires an additional premium. The OPERS health care plan provides prescription drug coverage that is better than Medicare Part D and does not require an additional premium.

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 2008, 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 2008:

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 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 beneficiary 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 Ohio PERS 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, 2008, there were 208,857 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 real estate and private equity, are valued based on closing market prices or broker quotes. The fair value of real estate and private equity investments is based on estimated current values and independent appraisals.

Employer contributions and investment earnings are used to fund health care deductions. Under this method, employer contributions equal to 7 percent of covered payroll were used to fund health care liabilities for the period of Jan. 1, 2008 through Dec. 31, 2008. Additionally, revenues from member contributions, 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 are expected to reduce the solvency years of the health care fund from 31 years as of Dec. 31, 2007, to approximately 10-15 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 $104 million in Medicare Part B premiums to its benefit recipients in 2008.

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)

	2008	2007	2006	2005	2004	2003
Assets						
Cash and Short-Term Investments	**$214,267,049**	**$166,407,166**	**$322,120,585**	**$250,418,690**	**$194,486,592**	**$417,214,283**
Receivables:						
Members' and Employers'	$99,321,334	$107,187,056	$82,850,806	$67,383,947	$64,664,924	$71,464,614
Retirement Incentive Plan	$344,045	$676,337	$762,533	$1,805,631	3,098,433	5,124,584
Vendor and Other	$57,775,901	$36,025,605	$34,882,853			
Investment Sales Proceeds	$57,319,401	$33,489,810	$80,471,902	$7,776,993	$12,946,973	$11,534,818
Accrued Interest and Dividends	$46,426,349	$64,843,050	$67,341,496	$51,057,887	$30,981,282	$29,499,116
Total Receivables	**$261,187,030**	**$242,221,858**	**$266,309,590**	**$128,024,458**	**$111,691,612**	**$117,623,132**
Investments, at fair value:						
Global Bonds	$4,363,406,922	$6,581,396,111	$6,116,700,706	$4,226,384,980	$2,600,579,782	$2,264,268,507
Domestic Equities	$2,731,493,461	$4,186,123,350	$4,388,937,986	$4,623,642,722	$5,590,842,559	$5,112,470,625
Real Estate				$505,301,728	$629,039,656	$644,858,238
Private Equity	$5,150,008				$69,834,553	$57,113,048
International Equities	$2,201,764,403	$2,282,909,655	$1,973,897,814	$2,281,196,185	$2,671,029,189	$2,305,480,202
Total Investments	**$9,301,814,794**	**$13,050,429,116**	**$12,479,536,506**	**$11,636,525,615**	**$11,561,325,739**	**$10,384,190,620**
Collateral on Loaned Securities	**$2,297,927,070**	**$2,072,493,713**	**$2,015,624,266**	**$1,749,802,181**	**$1,429,823,432**	**$960,517,368**
Capital Assets:						
Land	$665,394	$665,394	$665,394	$665,394	$665,394	$1,473,754
Building and Building Improvements	$19,663,497	$19,852,388	$19,679,465	$19,096,169	$18,624,614	$40,554,734
Furniture and Equipment	$17,141,828	$14,941,722	$11,420,812	$9,411,311	$7,366,060	$16,603,845
Total Capital Assets	$37,470,719	$35,459,504	$31,765,671	$29,172,874	$26,656,068	$58,632,333
Accumulated Depreciation	($11,267,149)	($8,853,297)	($7,340,277)	($6,266,653)	($5,553,881)	($10,444,551)
Net Capital Assets	**$26,203,570**	**$26,606,207**	**$24,425,394**	**$22,906,221**	**$21,102,187**	**$48,187,782**
Prepaid Expenses and Other Assets						
TOTAL ASSETS	**$12,101,399,513**	**$15,558,158,060**	**$15,108,016,341**	**$13,787,677,165**	**$13,318,429,562**	**$11,927,733,185**
Liabilities:						
Undistributed Deposits	$52,974	$8,385				
Medical Benefits Payable	$131,776,992	$142,701,327	$145,895,911	$138,450,016	$116,024,321	$114,581,249
Investment Commitments Payable	$69,811,443	$57,017,727	$108,410,835	$53,711,956	$163,468,451	$38,150,816
Accounts Payable and Other Liabilities		$569,998	$26,250			$680,303
Accounts Payable RMA Claims	$5,748,957	$2,419,428				
Obligations Under Securities Lending	$2,297,927,070	$2,072,493,713	$2,015,624,266	$1,749,802,181	$1,429,823,432	$960,517,368
TOTAL LIABILITIES	**$2,505,317,436**	**$2,275,210,578**	**$2,269,957,262**	**$1,941,964,153**	**$1,709,316,204**	**$1,113,929,736**
Net assets held in trust for pension and post-employment health care benefits	**$9,596,082,077**	**$13,282,947,482**	**$12,838,059,079**	**$11,845,713,012**	**$11,609,113,358**	**$10,813,803,449**

Source: 2008 Comprehensive Annual Financial Report

	2008	2007	2006	2005*	2004*	2003
Additions:						
Members' Contributions	$82,695,255	$79,198,959	$71,718,182	$63,408,347	$58,975,931	
Employers' Contributions	$891,561,073	$695,967,837	$538,312,995	$457,325,506	$461,788,996	$579,904,361
Contract and Other Receipts	$66,343,542	$45,534,017	$93,724,104	$7,234,092	$20,897,027	
Medicare Part D Reimbursements	$63,310,194	$59,075,120	$58,987,181			
Other Income, Net	$614,989	$70,498	$1,306,783	$548,364		
Total Non-Investment Income	**$1,104,525,053**	**$879,846,431**	**$764,049,245**	**$528,516,309**	**$541,661,954**	**$579,904,361**
Income/ (Loss) from Investing Activities:						
Net Appreciation / (Depreciation) in Fair Value	($3,734,049,668)	$479,748,239	$1,048,846,038	$382,822,937	$856,405,146	$1,880,567,921
Bond Interest	$182,944,355	$211,556,481	$179,769,220	$124,871,047	$122,129,931	$108,848,479
Dividends	$139,099,121	$160,715,579	$106,148,349	$99,647,424	$107,071,190	$90,394,749
Real Estate Operating Income / (Loss), net	$0				$52,299,350	$68,149,246
International Income	$552,901	$9,981	$143,649,645	$262,947,660	$165,266,361	$114,250,161
Other Investment Income / (Loss)	$147,998	$13,229,442	$2,829,179	$6,773,879	$10,401,718	$9,872,674
External Asset Management Fees	($8,674,498)	($10,491,258)	($10,797,650)	($7,188,895)	($13,599,165)	($14,091,697)
Net Investment Income / (Loss)	($3,419,979,791)	$854,768,464	$1,470,444,781	$869,874,052	$1,299,974,531	$2,257,991,533
From Securities Lending Activity:						
Security Lending Income	$103,004,243	$120,699,574	$94,382,644	$34,774,894		
Security Lending Expenses	($79,967,808)	($113,044,477)	($89,727,122)	($31,691,948)		
Net Securities Lending Income	$23,036,435	$7,655,097	$4,655,522	$3,082,946	$1,861,915	$677,601
Less: Investment Administrative Expenses	($3,703,986)	($3,809,128)	($4,040,472)	($4,056,337)	($4,544,563)	($603,059)
Net Income / (Loss) from Investing Activity	**($3,400,647,342)**	**$858,614,433**	**$1,471,059,831**	**$868,900,661**	**$1,297,291,883**	**$2,258,066,075**
TOTAL ADDITIONS	**($2,296,122,289)**	**$1,738,460,864**	**$2,235,109,076**	**$1,397,416,970**	**$1,838,953,837**	**$2,837,970,436**
Deductions:						
Health Care Benefits	$1,377,146,173	$1,282,776,044	$1,231,870,038	$1,152,941,961	$1,040,949,675	$907,769,092
Administrative Expenses	$13,596,943	$10,796,417	$10,892,971	$7,875,355	$2,694,253	$2,679,981
TOTAL DEDUCTIONS	**$1,390,743,116**	**$1,293,572,461**	**$1,242,763,009**	**$1,160,817,316**	**$1,043,643,928**	**$910,449,073**
Net Increase/ (Decrease)	($3,686,865,405)	$444,888,403	$992,346,067	$236,599,654	$795,309,909	$1,927,521,363
Net assets held in trust for pension and Post-employment health care benefits:						
Balance, Beginning of Year	$13,282,947,482	$12,838,059,079	$11,845,713,012	$11,609,113,358	$10,813,803,449	$8,886,282,086
BALANCE, END 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**

Source: 2008 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