Ohio PERS health care

Ohio PERS Health Care Program

Your Partner in Securing Health Care for the Future

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Ohio Public Employees Retirement System

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OPERS

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Ongoing Preservation Efforts – Funding and providing health care coverage

Historically, OPERS has taken a proactive approach to funding health care benefits. These efforts have yielded tangible results as reported in the New York Times, "Ohio is one of a few states to set aside significant amounts. Its public employee retirement system has been building a health care trust fund for years, so it has money today to cover at least part of its promises." Since 1974, when OPERS first offered health care coverage, the System has conscientiously worked to pre-fund coverage. OPERS is one of only a few systems that set aside funds to pay for this intended purpose. In 2005, OPERS' Health Care fund assets were segregated from the pension portfolio for investment purposes. These assets are invested in a separate mix of investments designed to facilitate steady growth and minimize volatility. The OPERS health care fund now stands at $12.8 billion.

Continuing to provide health care coverage, and generating the necessary funding, was a major initiative in 2006. OPERS envisions this initiative to require significant effort in the future. The OPERS Board of Trustees recognizes that providing health care coverage is an important element in planning for any retiree's future. However, factors beyond the control of any retirement system, such as skyrocketing health care costs, increased longevity and the retirement of baby-boomers, have placed significant strains on health care funds. Similar to managing pensions, OPERS' plan to manage the health care fund so that coverage can be preserved into the future involves a multi-faceted approach aimed at controlling expenditures through active management, evaluating plan design to preserve intergenerational equity, implementing a wellness program, and maximizing revenue through investment returns and System funding. Interdepartmental efforts, proactive planning, active management and strong investment returns have yielded a net increase of $992 million to the $12.8 billion retiree health care fund in 2006.

Preliminary estimates for 2007 indicate the solvency period may increase from 18 to 22 years.

OPERS evaluates the progress of the health care plan using a measure referred to as the solvency period. Simply put, the solvency period measures how long the current health care funds will last given the expected level of expenditures. In 2005, the health care fund had an expected solvency period of 17 years. In 2006, the solvency period improved to 18 years. Preliminary estimates for 2007 indicates the solvency period may increase to 22 years.

One of the specific initiatives completed in 2006 was preparation for the implementation of the Health Care Preservation Plan (HCPP). Meeting the HCPP target implementation date of Jan. 1, 2007 required intensive, interdepartmental efforts and member education throughout 2006. The first incremental increase in retirement contributions became effective in 2006 for public employers and members; the technology infrastructure was established and tested in 2005 and 2006. With ongoing communications, including seminars, printed materials and web site content, retirees, members and employers were introduced to the health care plan changes and were knowledgeable when the changes became effective in 2007.

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** **ORS hospital payor initiative** **Wellness survey** **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** **Ohio Quit Line Partnership** OPERS first plan sponsor
	2006	**OPERS selected to lead Central Ohio Hospital Quality Initiative** **First Prilosec OTC® promotion with Ohio pharmacies** **Contribution changes** **Medicare D subsidy** **Comprehensive Wellness Program developed** **68 new drugs added to formulary**
Health Care Preservation Plan implemented **Board approved increase in target solvency range from 15 – 25 years to 20 – 40 year range** **Health Care Preservation Plan "2.0" approved** **OPERS co-leads Rx Purchasing Pool**	**2007**	

A long tradition of health care coverage for 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 the premium 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 saw 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 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. Medical Mutual of Ohio, as it was known at that time, brought the strength of its Blue Cross Blue Shield affiliation. 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 wellness. Coverage was provided for flu and pneumonia vaccines, and several enhancements were made to our 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. Wellness benefits were raised from 80 percent to 100 percent coverage.

In 2000, prescription medication co-pays for mail order were raised from $0/$2/$8 to $4.50/$9/$12. Communications began showing the portion paid by OPERS in addition to the retiree's cost, thereby increasing member awareness of the true cost of health care. The lifetime maximum benefit payable increased to $2.5 million.

Fiscal year 2003 saw the introduction of the Choices Plan, effective for newly hired employees only. Choices introduced a service-based approach to providing health care coverage, replacing the 10-year cliff method. Our first comprehensive disease management program was also introduced.

Until 2004, OPERS had relied on its pharmacy benefit management company to help maximize drug rebates by switching members to preferred drugs. However, 2004 saw OPERS' first use of formulary/non-formulary co-pays in its drug plan. This shift in strategy helped to engage consumers in the solution. Medical plan deductibles increased by $50, out-of-pocket limits increased $250 and office co-pays increased from $10 to $15.

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 wellness theme, OPERS' partnership with the Ohio QuitLine smoking cessation program was established. OPERS realized a $12M savings with the Prilosec OTC program with community pharmacists and saved an additional $20M in generic medications, adding to the $5M in Aetna's new physician network.

In the fall of 2006, the OPERS Board dedicated two days to attending a retreat entitled "Examining Viable Solutions to Sustain Health Care" where recognized experts, consultants and staff discussed various options to continue to finance and deliver the OPERS Health Care program.

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 receive 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 are placed in an account and held for the retiree's future medical expenses. Likewise, if a retiree's selections exceed his or her monthly allowance (such as an employee with limited years of service selecting the more expensive health care plan), the retiree will pay the difference in the form of a monthly premium.

In April 2007, the OPERS Board issued the challenge of increasing the solvency target from the 15 – 25 year range to 20 – 40 year range.

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 is reviewing a updated long-range, strategic proposal consistent with the principles of the HCPP.

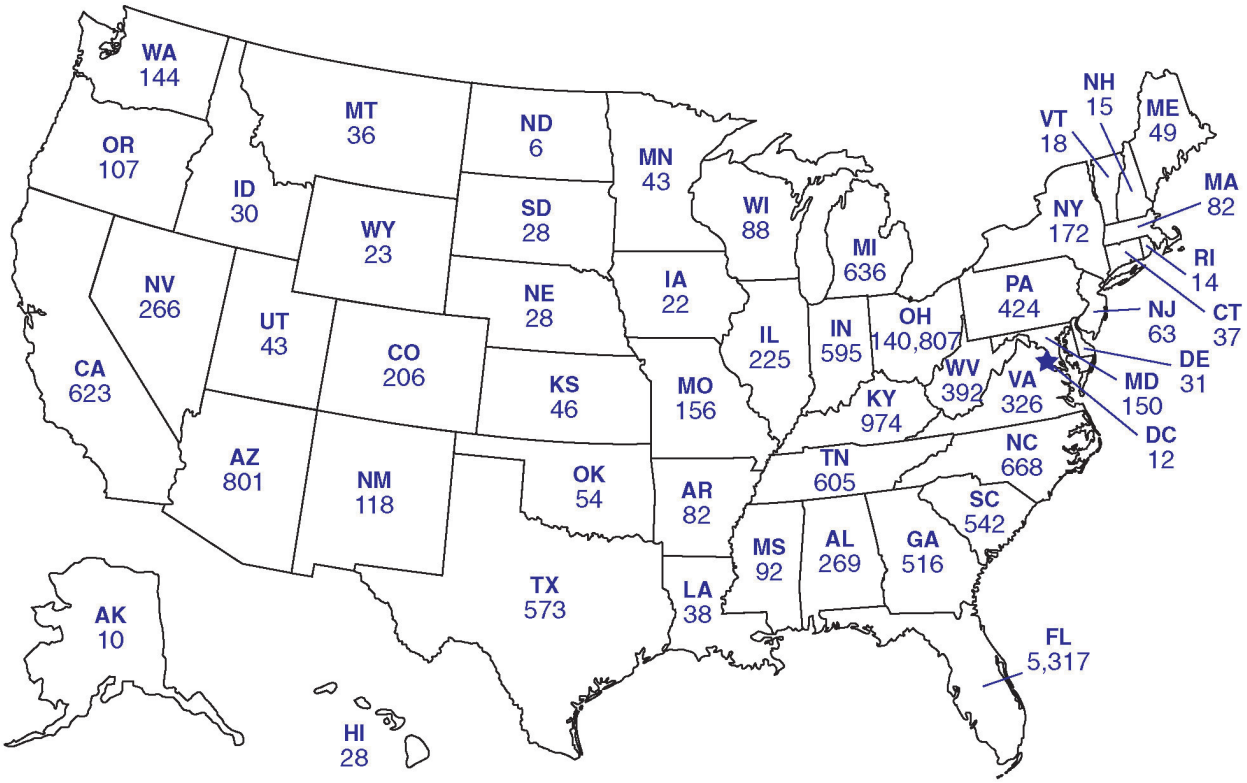
Economic Impact of Ohio PERS Health Benefit

For many OPERS retirees, their pension (averaging $19,000 annually) is their only source of income. Since retirees may be paying a greater share of health care coverage costs under the HCPP, finding solutions for financing health care remains a demanding yet worthy challenge for OPERS. If successful, the Ohio economy and public programs, such as Medicaid, would be less burdened. The following table, a snapshot of a random month's cash outflow of benefit payments, reveals approximately $200M for pension benefits and an additional $100M for health care. This comparison reveals a startling finding: while OPERS is not required to provide health care coverage, the economic impact of eliminating this coverage on physicians, hospitals and the greater health care sector would be substantial as retirees would need to spend as much as one-half of their pension checks on health care.

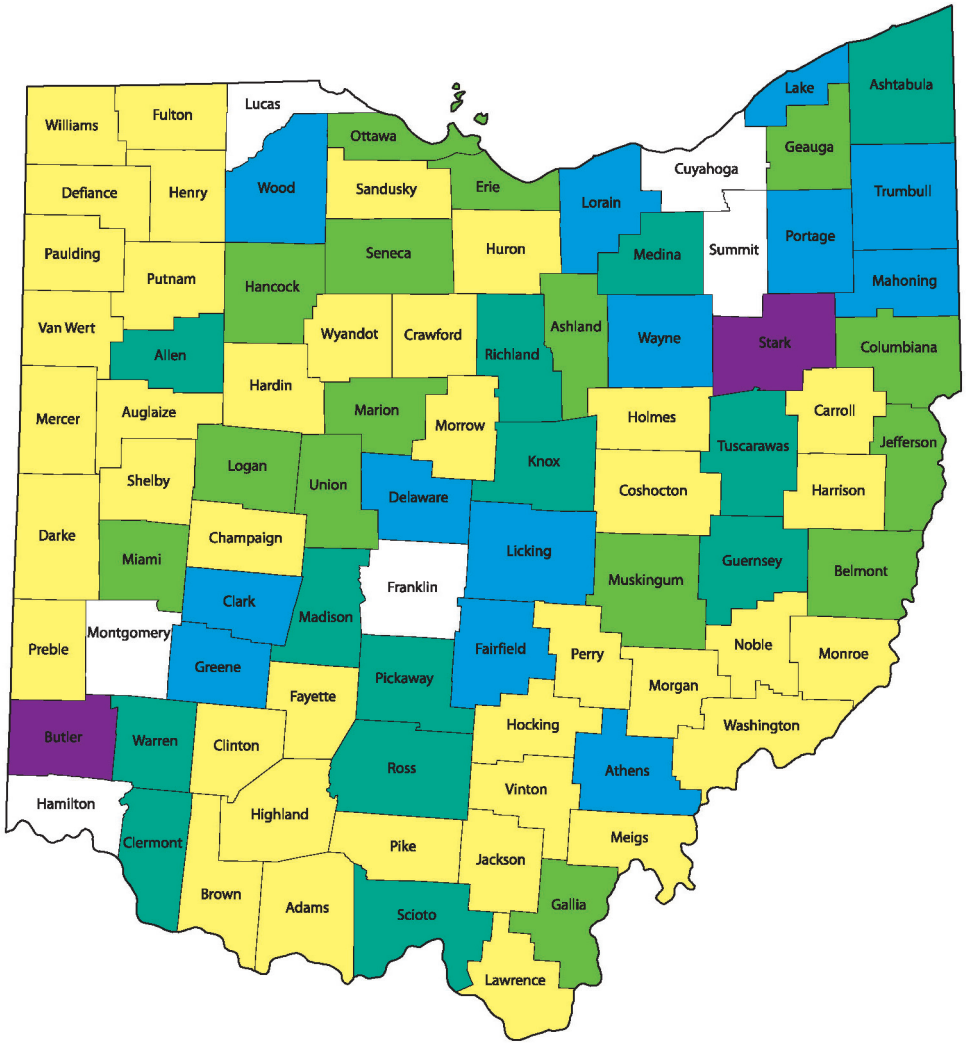
The maps that follow on the next two pages show the distribution of retirees and beneficiaries across the US and the concentrations in Ohio. Based on OPERS actuarial data, 99 percent of the retirees and beneficiaries in Ohio participate in the OPERS health care plan and subsequently redirect their benefit dollars into the respective health care economy.

AUGUST 2006 – SNAPSHOT STATISTICS	
158,000 Pension Benefits Payouts =	**$211M Pensions**
Plus Health Care Usage	**$105M Health Care**
This amount includes:	
• 157,000 Physician Visits	• 86,702 MedicarePremiums
• 3,300 Hospital Admissions	• 413,600 Prescriptions

OHIO PENSION BENEFIT RECIPIENTS



OPERS FINANCIAL IMPACT, BY COUNTY

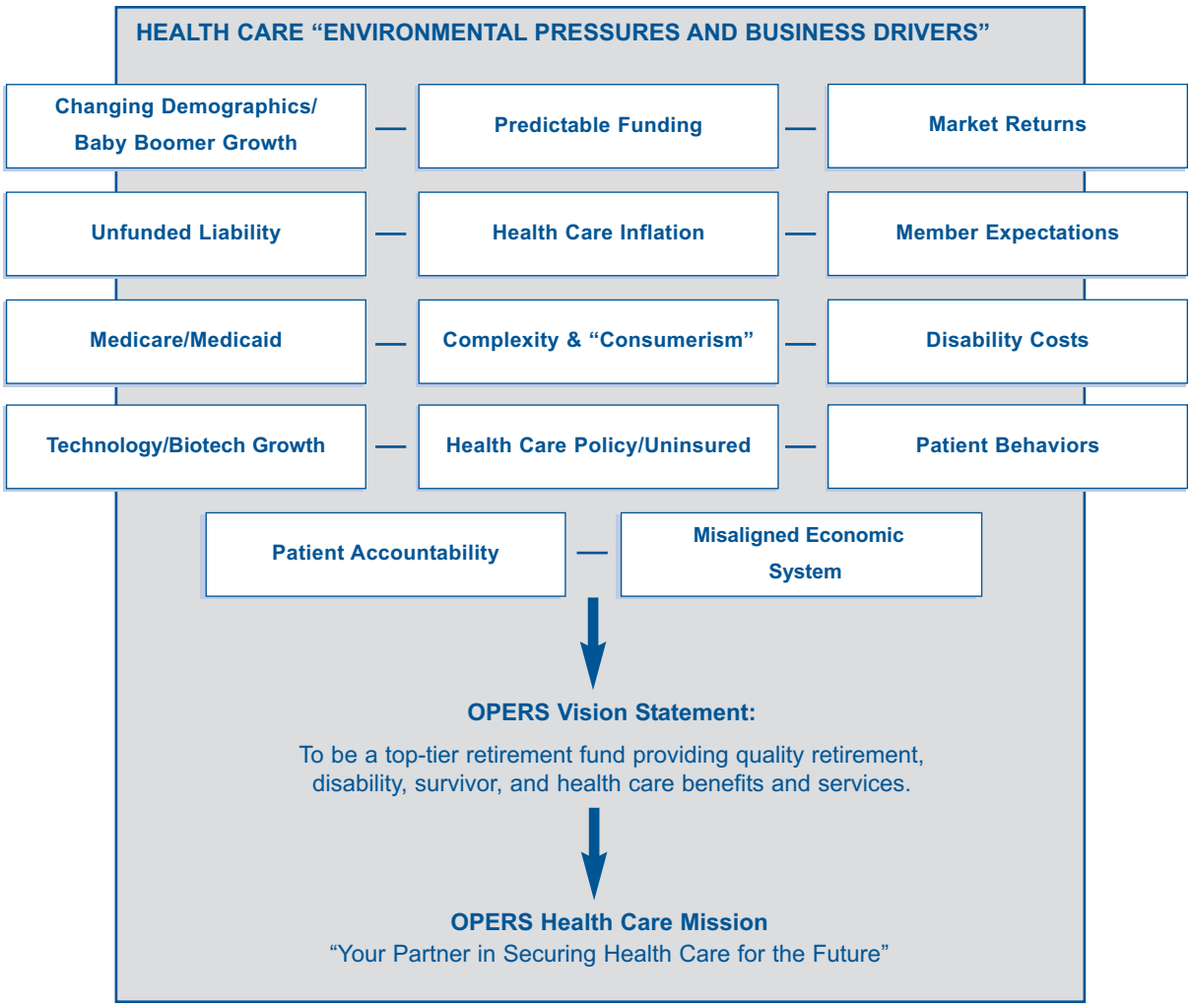


Color Key

$0 – $10 million	
$10 – $15 million	
$15 – $25 million	
$25 – $50 million	
$50 – $100 million	
$100 million	

Of the 156,745 retirees and beneficiaries in the OPERS' system, 140,807, or 89.8%, remain Ohio residents. Pension benefit payments approaching $2.6 billion this year are distributed throughout Ohio, representing OPERS' impact on the state's economy. This does not include health care impact.

OPERS health care vision and subsequent strategy reflects and reacts to a broad range of environmental and business drivers below:



The long-term vision is to accomplish a core set of strategic imperatives, listed on next page, while achieving a specific long-range financial objective of maintaining health care solvency target of 20-40 years. The mission of OPERS health care can be described as continually creating innovative ways to partner with our retirees, other payers, employers, the broader health care provider community and legislative communities to secure retiree health care for the future.

Health Care Vision – OPERS will lead, implement or manage:

1. Maintain solvency within a targeted range of 20 – 40 years
2. Effective member communication and operational reliability to maintain member engagement and trust
3. Maximize revenue via diversified approach of investments and contributions
4. Promote outcomes, efficient and quality-driven health care delivery systems
5. Promotion of evidence based/personalized medicine to optimize care
6. Instill a “culture of wellness” – from employment through retirement
7. Leverage purchasing power to support economic alignment
8. Provider transparency on cost and quality
9. Active management to maintain solvency and enhance value
10. Increase efficiency and quality with interoperable technology systems

Securing health care coverage now and in the future

OPERS has a long history of providing a dependable array of retirement benefits including a sound retiree health care coverage plan. 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 over the past decades to secure a $12-plus billion health care trust fund to prefund health care through investments and employer contributions, the System has also exercised the same disciplines and thoughtful leadership to control spending in an effort to provide a solid health care plan while preserving health care coverage for the future.

A realistic plan and a commitment to solvency

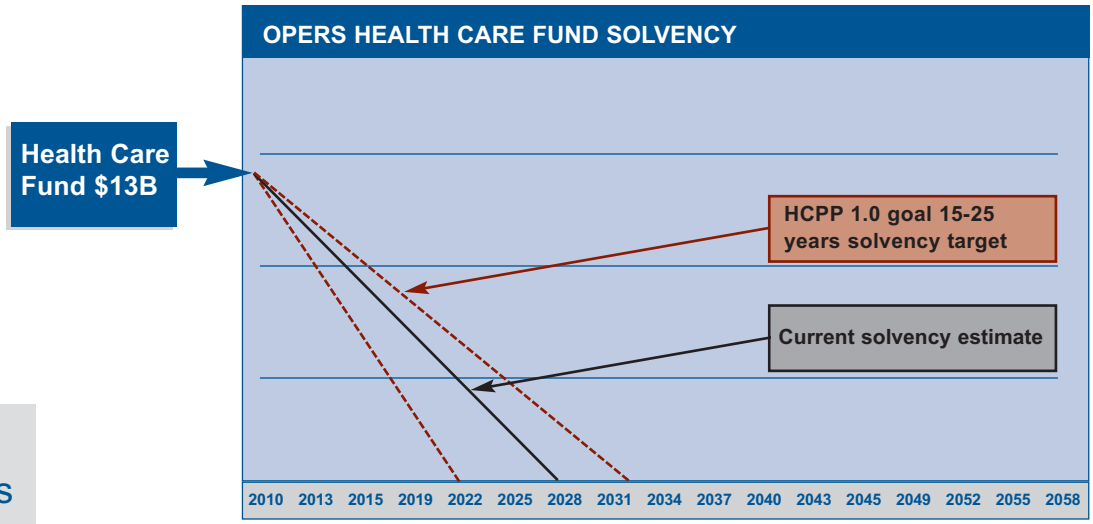
In 2004, the OPERS Board and staff had the foresight to create the Health Care Preservation Plan. The HCPP is a multi-faceted collaborative effort originally aimed at achieving an average of 15 to 25 years of solvency for the health care fund. The HCPP charged staff to implement a multi-platform plan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

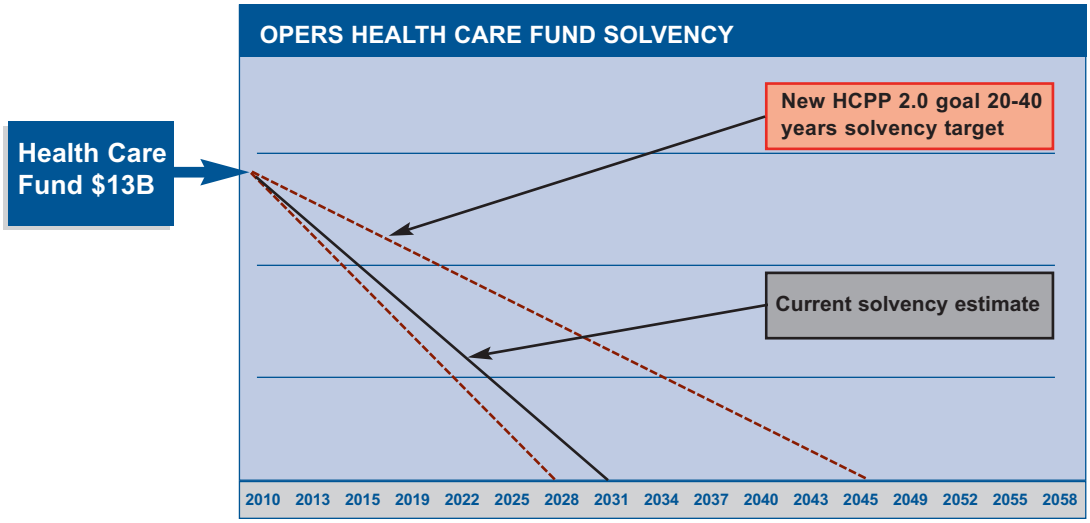
OPERS' 2006 health care expenditures were below actuarial projections.

To help secure health care coverage, OPERS has also 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. For example, encouraging our retirees and beneficiaries to choose generic or OTC brand medications saved the OPERS health care fund over $30 million dollars last year. These savings stretch the health care dollar beyond the normal annual plan design changes. OPERS' actuaries report that every $50 million in savings adds an additional year of solvency. The results are paying off. OPERS' 2006 health care expenditures were below actuarial projections and compared favorably with national statistics of active employee populations.

As previously stated, while OPERS has had success in stabilizing and extending health care solvency, the board recently 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.

Current solvency estimate – 22 years





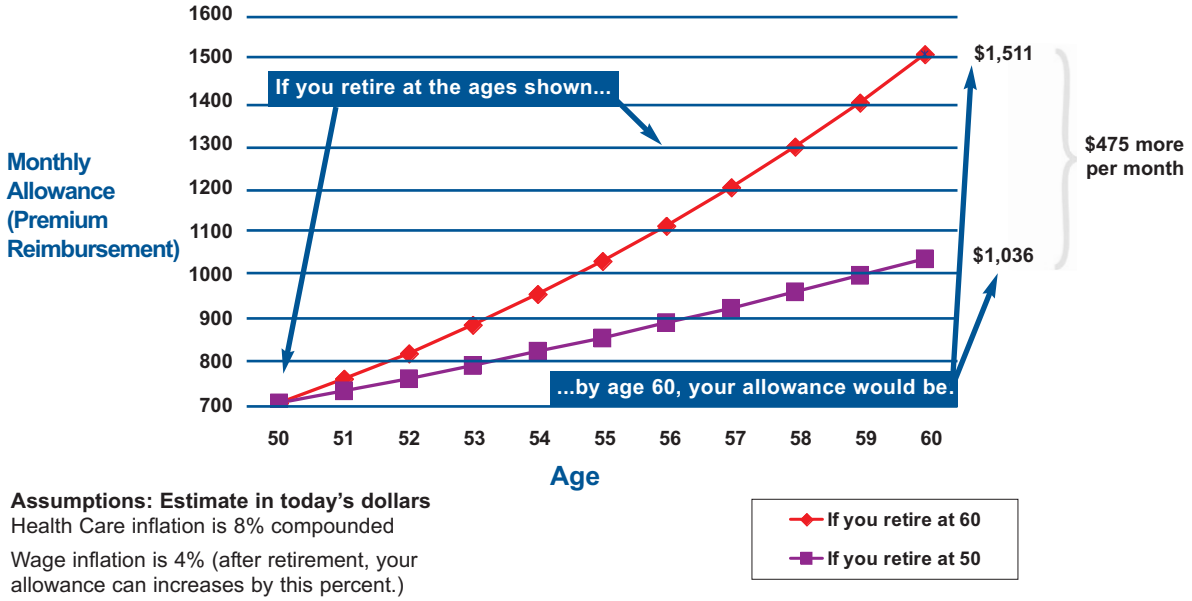
The board approved this increase in the targeted solvency period for multiple reasons, including:

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, a 48% increase. Source: US Dept of Health, Education and Welfare, IRS

B) Expected retiree population growth - OPERS currently serves 200,000 health care benefit recipients and our population is expected to swell to 400,000 in less than 20 years underscoring the need to provide health care coverage for future retirees, help secure retirees' finances and, as stated before, 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 2040. Although unclear at this time, the HCPP may encourage our contributing members, or active work force, to consider working longer to generate a larger health care allowance from OPERS to pay their premiums as seen in the following chart.

ESTIMATED EFFECT OF DELAYING RETIREMENT ON HEALTH CARE ALLOWANCE



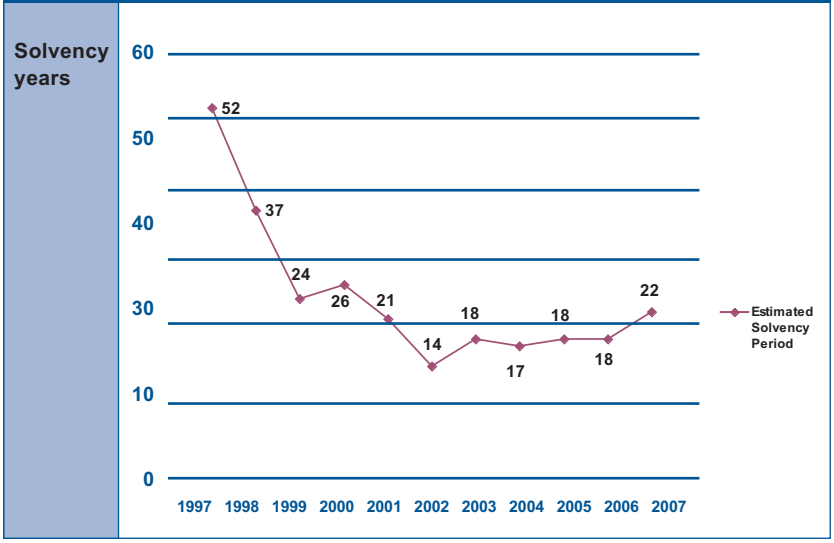
Assumptions: Estimate in today's dollars
Health Care inflation is 8% compounded

Wage inflation is 4% (after retirement, your allowance can increases by this percent.)

30 year service credit for both retirement ages.

D) The unpredictability of market returns and volatility of health care inflation affect the solvency of our health care fund. Solvency is dependent on several variables including: market returns, employer contributions and health care inflation to name a few.

VOLATILITY OF SOLVENCY



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:

Health Care Preservation Plan "Guiding Principles"

1. Preserve access to quality health care coverage for all eligible members and their dependents.

2. Commit to a long-term solvency period.

3. Balance health care changes between current and future retirees.

4. Consider career service, membership status and affordability in determining health care premiums.

5. Balance OPERS responsibilities with the personal accountability and consumerism of our members to preserve benefits for the long-term.

6. Manage the program using sound business practices consistent with industry norms and marketplace developments.

7. Review annual program adjustments to keep pace with increasing health care and pharmacy cost trends, which allow for a phased-in approach to benefit changes.

8. Support health and disease management activities that assist benefit recipients and hold vendors accountable for results.

9. Pursue health care public policy changes and related advocacy activities.

10. Maintain affordability of health care for members through multiple plan designs while maximizing group purchasing power.

11. Educate and communicate with all interested parties as early as possible and on an ongoing basis about all aspects of the OPERS health care program.

HCPP 2.0 summary and projected start dates:

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

1. Disease Prevention

Wellness and disease prevention – Statements and statistics that tell a story
Encouraging wellness has become a multi-billion-dollar business opportunity in America. As a nation all too often known for obesity, smoking and lack of exercise, the realities are taking a financial toll on the economy and individuals alike.

The cost of unhealthy choices in the United States and in Ohio
The annual health care costs for obesity-related diseases in the United States increased from $39 billion in 1993 to $117 billion in 2000 (Martin LF, 1998)

With current overweight and obesity trends affecting all age groups, urgent preventative measures are required to reduce disease, disability and cost containment (Daviglus, 2005)

In excess of $75 billion dollars are spent annually for health care costs directly attributable to tobacco use with another $82 billion in indirect expenditures (Fiore MC et al, 2000)

It is estimated that annual health care costs related to smoking exceed $4 billion in Ohio alone.

The cost of unhealthy choices to OPERS
OPERS spends over $750 million dollars annually in nine disease categories representing over 75 percent of OPERS' health care costs. Preventive services are estimated to make up only 5 percent of these expenditures. The top three categories, including cardiovascular, diabetes and musculoskeletal, accounted for over $400 million in health care expenditures. To further illustrate this magnitude, OPERS spends nearly $500,000 per day on cardiovascular care alone.

Healthy living – healthy retirement

What we know about the health of our current retiree population

Based on a study conducted by OPERS, approximately 70 percent of our retirees can be classified as overweight or obese, and between 10 and 12 percent admit to smoking. This is important, as studies have repeatedly linked obesity, sedentary lifestyle, tobacco use and poor nutrition to a higher likelihood of developing serious diseases later in life.

The OPERS wellness incentive program is formulated

"The late 50s and early 60s are a crucial time to focus on disease prevention."

– *(Dr. Julie Gerberding, Director of the Centers for Disease Control and Prevention in Atlanta, Newsweek, Dec. 8, 2005)*

During 2006, OPERS staff worked with consultants and The Ohio State University to formulate a comprehensive wellness and prevention program. The program borrows many of the same components used by private-sector health plan sponsors including Fortune 100 companies while tailoring to the unique needs of Ohio's retired public employees.

The idea is simple – encourage every retiree and beneficiary to become a fully engaged health care consumer and provide the tools to prevent, reduce or optimally treat diseases. The objective is to find a solution that improves a retiree's health while reducing OPERS health costs or risks. OPERS' wellness incentive program will utilize health risk assessments, health coaches, and financial incentives to reward behaviors and results that benefit both the retiree and OPERS.

The OPERS Healthy Living Healthy Retirement Plan

THE INITIAL PROGRAM STRUCTURE IS AS FOLLOWS:

The OPERS wellness plan, Healthy Living Healthy Retirement, will reward OPERS retirees and their covered spouses with up to $100 per year for actively participating and achieving individualized goals. Enrollment in the plan is voluntary and will be tailored to each person's situation. Persons not eligible for Medicare will receive either wellness or disease specific counseling on a regular basis, provided by a health coach or nurse. Persons who are Medicare eligible will have the choice to receive these services through a Medicare Advantage plan.

Healthy Living Healthy Retirement is based on the following principals:

A person'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 works to assist participants with certain risk factors including obesity, smoking, borderline high blood pressure, early diabetes, lack of exercise, and early osteoporosis (weakened bones). Retirees and their covered spouses with certain chronic or advanced conditions will be offered one-on-one counseling by a dedicated registered nurse. Disease Management, a chronic disease program, already exists, but will be rolled into the *Healthy Living Healthy Retirement program* – offering incentives to those who participate.

OPERS views the *Healthy Living Healthy Retirement* program as an opportunity for both program participants and the OPERS health plan to receive positive outcomes. Encouraging retirees and their covered spouses to enroll in this program (and to stay enrolled) is the key to both improving their quality of life and having a positive impact on the OPERS health care fund.

Long-term Wellness Strategy

Ultimately, Ohio is in need of an aligned model and OPERS, as a retirement system would benefit from an integrated and coordinated approach to improve health and reduce risk factors during employment as the following chart illustrates:

Health status here...

Affects health status later

CULTURE OF HEALTH – RISK REDUCTION		
Life stage	**Age**	**Health factors**
Preschool	**0-5**	Parental involvement Public health/health access Healthy habits
School-age	**6 – 18**	Parental involvement Influence of school system Healthy habits Public health/health access
Adult/Employment	**18 – retirement**	Healthy habits/lifestyle Public health/providers Work environment Benefits/access
Retirement **OPERS responsibility**	**OPERS** **48 – 65**	Access to affordable, quality care Healthy habits Public health
	65+	Medicare coordination Access to affordable, quality care Healthy habits

OPERS WELLNESS INITIATIVE OBJECTIVES

- Determine a baseline risk factor in the first year, then measure improvements each following year
- Reduce obesity, smoking rates and sedentary behaviors. Also focus on other key risk factors (cardiac, diabetes, cholesterol, blood pressure)
- Obtain a positive ROI after one year of full participation
- Communicate a clear and effective message
- Reduce overall healthcare costs of participants
- Reward members who have adopted a healthy lifestyle or are actively taking steps to improve their health

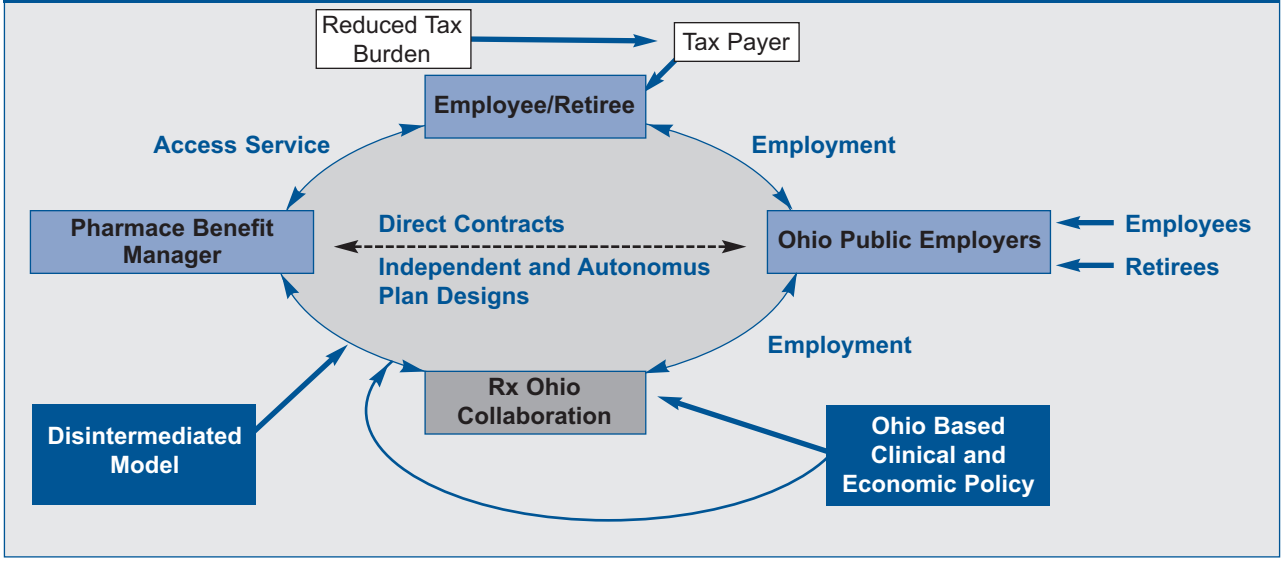
For every $1 Invested, $1.30-$1.50 Return Expected

2. **Medicare Advantage –** OPERS is in the final stage of securing an estimated $25M in 2008 by taking advantage of Medicare funding and using alternative health plan models.

3. **The Rx Ohio Collaborative (ROC)** – Staying true to our original guiding principles, OPERS is leveraging our purchasing power and collaborating with other public sector prescription drug payers to form an Rx purchasing pool that not only fulfills due diligence in contracting with vendors, but increases discounts and provides a structure and vision that could ultimately reduce health care costs for any of our 3,400 employer groups from townships, municipalities, counties, etc.

OPERS, with other Ohio Retirement Systems and prominent active employer groups have joined efforts, under the name Rx Ohio Collaboration (ROC), to explore and implement innovative, cost-effective approaches to maximize their collective value of over $1B in prescription drug expenditures and improve the health of the nearly 400,000 retirees and active employees.

A RX POOLED PURCHASING VISION – ECONOMIC ALIGNMENT



4. **Cost Sharing** – Consistent with our HCPP guiding principles listed previously, the board has approved a reasonable average cost sharing target of 10 to 20 percent when members use the health care system. The board approved increasing health care plan cost sharing to 20 percent over 5 years in a phased in approach, but will have the yearly option to adjust the cost share annually within the targeted range.

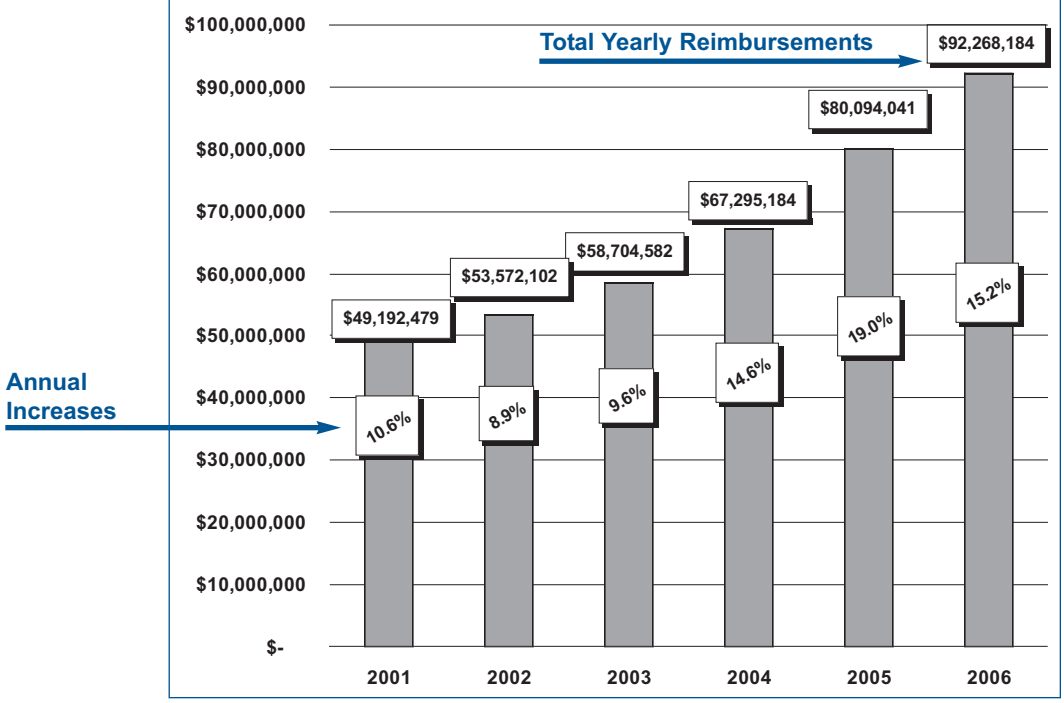
   Keep in mind, OPERS pays secondary to Medicare for our Medicare-eligible retirees, a natural enhancement for benefit recipients as they age. This coordination of benefits is designed to reduce out of pocket costs for those who are 65 and older as they will pay 20 percent of what Medicare does not pay, resulting in lower out-of-pocket costs.

5. **Spousal Eligibility** – As the retirement population continues to increase, the board approved eligibility changes to allow spouses that are age 55 and older to continue to have health care coverage while spouses that are under age 55 will continue to have access to health care coverage, but will be required to pay 100 percent of the premium. This change would not affect spouses of disabled retirees.

6. **Legislative Needs –** First, OPERS would benefit by updating current state law to authorize the Board to determine Medicare B reimbursement. The Federal government determines the rates for the Medicare B premium yearly based on their risk pool – not OPERS' risk pool. As seen in the chart below, the increases and total expenditures have been significant and are outside of OPERS' control.

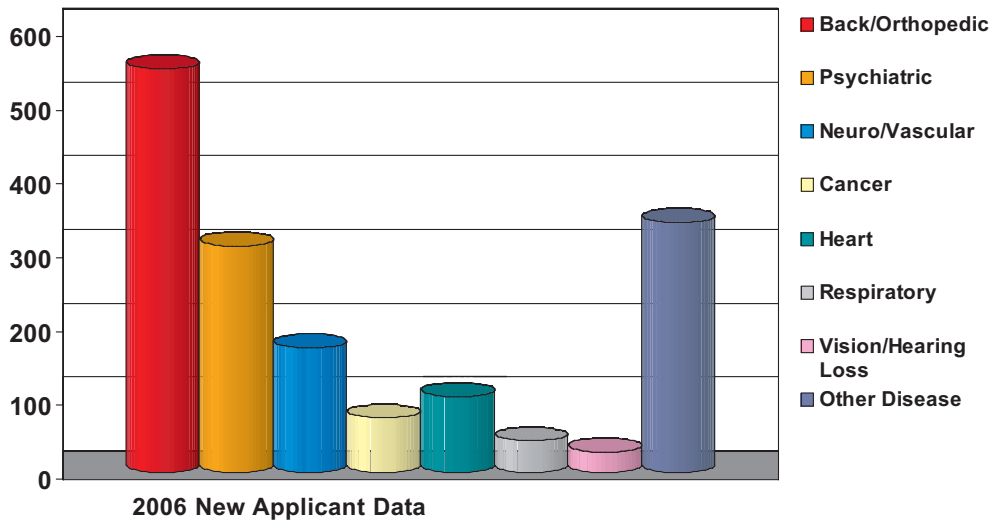
   Second, similar to Medicare Policy, if re-employed retirees and eligible dependents have access to health care coverage through another employer, the OPERS board believes this is an equitable arrangement and helps preserve health care for all.

MEDICARE PART B REIMBURSEMENTS



7. **Disability program updates –** The disability benefit is important and statistics indicate while approximately 14 percent of our membership has retired on a disability benefit, they represent a disproportionate share (30 percent) of OPERS health care costs. Therefore, a disability task force has been created to identify opportunities where OPERS could examine and possibly revise disability retirement policies. The task force will also research successful clinical programs that have demonstrated the ability to improve disabled retirees' quality of life and have helped a portion of these retirees to return to the work force.

DISABILITY BY DIAGNOSIS



8. Development of new health care delivery models – The last objective of HCPP 2.0 is to expand on the Rx Ohio Collaboration by leveraging OPERS' purchasing size by exploring a purchasing pool or alternative delivery model for medical care. This may not require true risk pooling but instead identification and creation of market place developments that improve the delivery of health care from a productivity-based model to a performance-based model. Measurements on quality, efficiency and outcomes would be prioritized in a performance-based model.

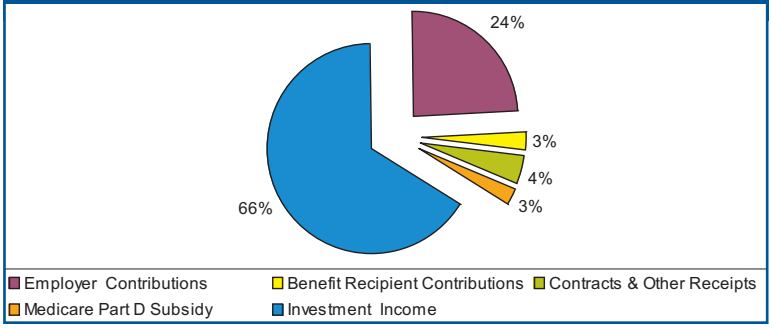
Funding

As shown below, OPERS health care is funded from two main sources:

1. Investment earnings - the $12.8 billion dollar health care trust fund provided an additional $1.5 billion dollars from investment earnings in 2006. While investment earnings on the health care fund allowed us to increase solvency in 2006, a year of market decline would likely decrease the solvency of the fund.

2. Employer contributions – employer contributions provided another $500 million dollars to the health care fund in 2006. Health care funding in 2006 increased from 4.0% to 4.5%

2006 HEALTH CARE REVENUE SOURCES



OPERS Health Care Financial Performance and Objectives

HEALTH CARE FUND STATEMENT

	2006	2005
Balance, beginning of year additions:	$11,845,713,012	$11,609,113,358
Retirees' contributions	$71,718,182	$63,408,347
Employers' contributions	$539,496,748	$457,805,155
Contract and other receipts	$92,540,351	$6,754,443
Medicare Part D receipts	$58,987,181	NA
Investment income	$1,471,059,831	$868,900,661
Other income	$1,306,783	$548,364
	$2,235,109,076	$1,397,416,970
Deductions:		
Benefits	**$1,231,870,038**	$1,152,941,961
OPERS administrative expenses	$10,892,971	$7,875,355
	$1,242,763,009	$1,160,817,316
Balance, end of year	**$12,838,059,079**	**$11,845,713,012**

Health Care Planning Continues

Clearly, progress has been made regarding health care solvency. However, more needs to be done for OPERS to continually maintain the board-established target solvency period of a rolling 20-40 years. OPERS' advocacy efforts were instrumental in ensuring that public pension systems could be enrolled in the Medicare D subsidy program. As a result, savings to the System's health care plan exceeded $50 million for 2006. As stated, cost saving measures being contemplated to improve the health care fund's solvency include: ongoing work with physicians and retirees to encourage the use of generic drugs and lower-cost pharmaceuticals, implementation of wellness programs beginning while a member is still working and further plan design changes.

The positive impact of the planning centered on health care coverage has already become evident. In 2006, OPERS realized a 6.8 percent increase in gross costs for total health care, which is on par with the national average increase of 6.8 percent to 7.0 percent. However, when factoring in revenue components of rebates from pharmaceutical companies and a federal subsidy for participating in the Medicare Part D program, the net health care expenses ***decreased by 5.7 percent*** from 2005 to 2006.

Financing Structural Enhancements – Incremental Rate Increase

As part of the HCPP, and to help defray the cost of providing health care coverage, incremental increases in the retirement contribution rates became effective Jan. 1, 2006. Prior to this increase, the contribution rates had not changed in 27 years and OPERS was the only statewide pension system in Ohio with a contribution rate less than the statutory maximum. Beginning in 2006, member contribution rates increased by 0.5 percent and will continue to increase at that rate per year for three years. Similarly, employer contribution rates will increase on an incremental basis up to the statutory maximum of 14 percent in 2008. The contribution rate for employers in the law enforcement division will increase incrementally up to the statutory maximum of 18.1 percent in 2011.

Monitoring The Structure's Strength – GASB and Other Post-employment Benefits

The Government Accounting Standards Board (GASB) issued new accounting rules for reporting health care benefits or other post-employment benefits (OPEB). The new OPEB standards became effective for OPERS as of year-end 2006.

The GASB standards require OPERS to calculate and disclose the estimated liability for all current and future retirees for the entire amount of health care subsidy OPERS will provide. This essentially requires health care benefits to be measured in the same manner pensions are measured. As stated previously, post-employment health care benefits are neither mandated nor guaranteed, yet OPERS has managed to continue to provide an excellent plan - a goal that remains a priority within prudent financial standards.

As noted previously, OPERS uses a measure of solvency period to track the progress of the health care fund. As required by the GASB, the new accounting requirement will be used for reporting in our financial statements. At the same time, however, OPERS will continue to use solvency as an internal measure.

As retirement systems implement the new accounting requirement, there will be liabilities of varying sizes reported, based on the size of the plan, the specific benefits offered and assumptions used. It is important to note that the new accounting standard does not require health care liabilities to be funded, however, OPERS has chosen to set aside funds. As of Dec. 31, 2005 (the date of the last actuarial valuation), OPERS had assets of $11.1 billion and had a positive funded ratio of 35%. As stated previously, the fund is estimated at $12.8 billion for 2006. While OPERS may not strive to be 100% funded, our strategy is to make incremental changes in the health care plan that are not too dramatic, and implement these changes in a manner designed to allow individuals time to plan and make decisions accordingly. OPERS' goal is to make these changes in a manner such that we will always have 20-40 years of health care liabilities pre-funded.

2006 Summary

Total OPERS health care claims costs increased 7.6 percent for 2006.

Over half of the 7.6% increase was attributable to new retirees (baby boom affect and living longer).

Expected trend for 2006 was 7.0 percent overall,	**VS**	***Actual trend of 3.6%***

TOTAL CLAIMS EXPERIENCE

	2005	2006	Overall OPERS Change	Self-Funded Employers*
Medical	$579,320,328	$626,258,765	8.1%	
Prescription Drug	$357,938,385	$382,526,208	6.9%	
Total	**$937,258,713**	**$1,008,784,973**	**7.6%**	**7.6%**

Less rebates for RX – Bear Stearns June 2007 OPERS Investment Forum

PER CAPITA TREND

	2005	2006	Actual Trend	Trend Assumption	Solvency Projection
Medical	$255.88	$266.10	4.0%	7.5%	
Prescription Drug	$154.85	$159.55	3.0%	6.0%	
Total	**$410.72**	**$425.65**	**3.6%**	**7%**	**5.0%**

*approx. blend

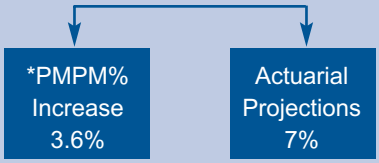
HEALTH CARE FUND STATEMENT

	2005	2006	$ change	% change
Claim costs	$937.3M	$1,009.4M	$71.5M	7.6%

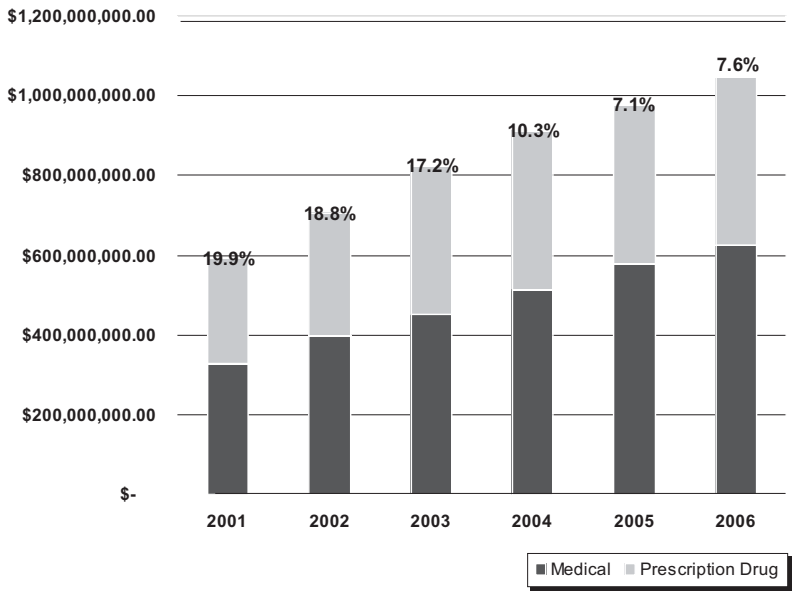
PMPM: Per member per month

Claim costs: Medical and Rx

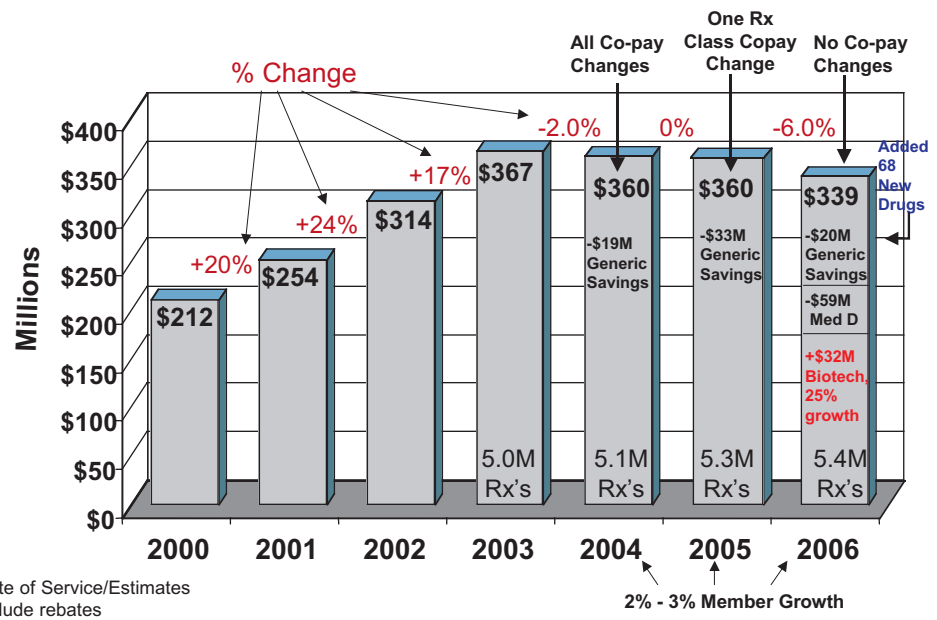
(Medicare Part D, HMO, admin. fees, disease mgmt. fees excluded)
With rebates (allocated in the year earned vs. received) and Medicare Part D netted in the above totals, the change in claims costs from 2005 to 2006 is approximately 1.3%



SIX-YEAR HEALTH COST TRENDS (CLAIM COSTS ONLY)



OHIO PERS: ACTIVE MANAGEMENT FOR RX CHALLENGES



The above chart reflects both successes and challenges. While there has been consistent improvement in the usage of lower cost and equally effective generic and OTC pharmaceuticals, the "biotech surge" is growing at 25 percent. While these products exemplify innovation, until the FDA supports generic competition, consumers will grapple with adequate funding as these products average $8000 per year for OPERS. Moreover, with over 800 new biotech drugs in the FDA pipeline, it is predicted that the majority of future pharmacy costs will be comprised of these specialized and valuable medications, some costing up to $1,500 per month.

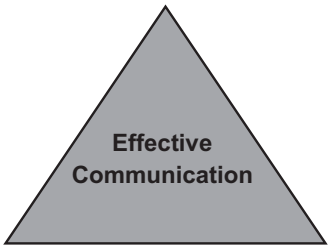
The balanced scorecard below was purposely developed to align the OPERS health care division's objectives with OPERS' overall organizational objectives of being a top-tier pension fund and maintaining quality member service. The delicate balance of member satisfaction in the face of relentless health care inflation and critical cost management imperatives supports the necessity of extracting the greatest value of the health care dollar.

OPERS believes member trust is as big an asset as the $13 billion health care fund.

2007 OPERS HEALTH CARE SCORECARD

Member Satisfaction

- Member satisfaction with OPERS
- Vendor management satisfaction



Financial Performance

- Manage trend below yearly actuarial projections
- Identify feasible savings opportunities to achieve 20 – 40 year solvency with corresponding liability reduction

Clinical/Value

- Preventive services
- Wellness enrollment
- Disease management ROI
- Rx purchasing pool

Advocacy efforts are an important component of "Active Management"

OPERS continues to be actively involved at all levels of health care policy development and administration not only advocate on behalf of our retirees, but to truly seek improved value in health care.

As an advocate for health care reform, OPERS is active at the local, state and federal levels.

Helping central Ohio citizens find quality health care

In the greater Columbus area, OPERS leads an initiative to encourage hospitals to report on key quality and safety practices implemented to prevent medical errors. OPERS partnered with the nationally recognized LeapFrog Group to make improvements in safety, quality, and health care affordability. After only one year, OPERS has been successful in leading many area hospitals to participate by reporting their clinical outcomes to LeapFrog. The results of this reporting will be available online to aid consumers in assessing the quality of local hospitals.

Implementing group purchasing and pursuing legislative change

At the state level, OPERS helped create and lead one of the most significant effort ever aimed at formulating group purchasing arrangements for prescription medications. The Rx Ohio Collaborative will complete its RFP during 2007, with the intended outcome of providing a new approach to accessing prescription drug benefits for Ohio's public sector employers.

Working to control costs at the federal level

At the federal level, OPERS has worked with Medicare, the FTC (Federal Trade Commission), the FDA (Food and Drug Administration) and other agencies to help control escalating health care costs. OPERS helped lead and actively participates in the National Health Care Roundtable with other Ohio retirement systems. For more information on various national policy endeavors, visit www.healthcareroundtable.org.

The future holds many challenges and opportunities

While a few creative and successful strategies have been recognized, the remaining challenges are significant:

- **OPERS Baby Boomer population retiring –** retiree population is expected to double by 2035.

- **Moving our population into a culture of wellness and disease prevention throughout government –** from childhood to employment, through retirement.

- **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.

- **GASB 43/OPEB –** OPERS and other governmental plan sponsors are required to report any unfunded post-employment benefits effective for the year ending Dec. 31, 2006. GASB 43 is another measurement that simply estimates the unfunded liability but does not reflect any future plan designs, Medicare subsidizations or health improvements of our population. Though it does have limitations, it is likely to elevate the concern of funding health care for government plan sponsors even though the federal government is not required to report their unfunded liabilities.

- The continual need for retiree understanding and engagement not only in their own health, but in how to navigate the complex health care system from claims payments to formulary medications and plan designs.

- Advocating and measuring the concept of " value for money" in the health care sector.

- Identify broadly supported processes and tools to measure health care improvement from information technology and administrative functions to quality of care, return on investment and quality of life, to name a few.

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
   Attachments 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; alternative use of HMO).

2. A summary of benefits

The Following is an outline of the current OPERS health care benefits:

The 2006 OPERS Health Care Plan

The 2006 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 2006 plan design encouraged the use of these providers. While benefit recipients were able to choose any provider and still receive benefits, 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 benefits. The OPERS health plan is secondary to Medicare.

The 2006 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 benefits.

How 2006 Benefits Were Paid

For benefit recipients eligible for Medicare, those living outside of the United States and those who lived in a network area and used network providers of service, the following benefits were available in 2006 (subject to medical necessity and the reasonable and customary rate):

Most Medical Benefits	80%
Certain Preventative Benefits	100% No deductible
Inpatient Hospital Benefits	100%

In 2006 the calendar year deductible was $150 per person and $300 for a family.

The maximum out-of-pocket amount (the amount after which the plan paid at 100 percent% for the remainder of the calendar year) was $750 for an individual and $1500 for a family.

The lifetime maximum benefit was $2,500,000 per covered person.

Benefit recipients who lived in a network area and who were not eligible for Medicare received the following benefits if they did not use network providers of service (subject to medical necessity and the reasonable and customary rate):

Most Medical Benefits	60%
Certain Preventative Benefits	100% No deductible
Inpatient Hospital Benefits (For elective admissions)	70%

An in-network calendar year deductible of $150 per individual or $300 per family applied. The maximum out of pocket amount (after which the plan paid at 100 percent for the remainder of the calendar year) was $750 for an individual and $1500 for a family. The lifetime maximum benefit was $2,500,000 regardless of network usage.

Alternate Health Care Coverage

Alternative health coverage was available to 2006 OPERS benefit recipients who resided in certain counties in Ohio (and a few border counties in Indiana, Kentucky and Michigan). HMO products included Kaiser Permanente, Paramount and United Health Care. HMO products offered hospital and medical services through participating physicians and facilities.

In general, coverage under an HMO program was more comprehensive than coverage provided by PPO plans. 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.

In addition to the HMOs, AultCare was offered as an alternative preferred provider organization. It was made available to qualifying benefit recipients who lived in Stark and surrounding counties in Ohio.

Prescription Drug Coverage

For 2006, prescription drug coverage was available for all benefit recipients eligible for OPERS health care and their covered dependents. When covered persons used retail pharmacies, they were able to receive a 34-day supply of medication. When benefit recipients chose the mail service plan, they were able to receive up to 90 days of medication at one time.

2006 co-payments were designed to encourage use of generic products, formulary products and the mail service. The following co-payments applied to a 34-day supply at retail:

$5.00	Generic Medication
$10.00	Single Source Brand (formulary drug)
$25.00	Single Source Brand (non-formulary drug)

When a brand was chosen even though a generic was available, the retiree paid the difference in cost up to $100, plus the generic co-pay.

The following co-payments applied to a 90-day supply at mail:

$10.00	Generic Medication
$20.00	Single Source Brand (formulary drug)
$50.00	Single Source Brand (non-formulary drug)

When a brand was chosen even though a generic was available, the retiree paid the difference in cost up to $100, plus the generic co-pay.

Medicare

The following requirements regarding Medicare were in effect for 2006:

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 (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 HMOs) 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 Reimbursement

If our benefit recipient was enrolled in OPERS health care and was not being reimbursed 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.

The Dental Plan

During 2006, dental coverage was made available to all OPERS benefit recipients and their eligible dependents regardless of whether or not they were covered by 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 recipient chose to be covered under the dental plan, a premium payment was deducted from each monthly benefit check. OPERS subsidized 12.5 percent of the benefit recipient’s cost of dental coverage.

The Vision Plan

Vision coverage was offered to all OPERS benefit recipients and their eligible dependents regardless of whether or not they were covered by the OPERS health 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 subsidized 12.5 percent of the benefit recipient’s cost of vision coverage.

The Long Term Care Plan

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

This plan was designed to cover those long-term care expenses not covered by the basic hospital/medical coverage (e.g. custodial care), including Medicare. Its intent was 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 the benefits

Following are the eligibility requirements for the OPERS health care plan. These requirements were in effect during 2006:

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 was provided regardless of years of service credit.

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

If a member died before retirement, health care coverage may have been available to their survivors receiving monthly benefits regardless of the member's years of service credit.

Eligible Dependents
Eligible dependents included the member's spouse; unmarried child(ren) under age 18, or under age 22 if attending school (on at least a two-thirds full time basis) and dependent on the benefit recipient's support. Also eligible were dependent children, regardless of age, who had physical or mental handicaps, were unable to earn their living, and who became incapacitated prior to age 18 (or 22 if attending school).

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

As of Dec. 31, 2006, there were benefit recipients 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 expenses are recorded when the liability is incurred and revenues 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 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 expenses. Under this method, employer contributions equal to 4.5 percent of covered payroll were used to fund health care liabilities in 2006. Based upon our most recent actuarial projections, these contributions along with investment income on allocated assets and periodic adjustments in health care provisions are expected to be sufficient to sustain the program through approximately 2022 using an intermediate health care inflation assumption. This also assumes that OPERS continues to earn its actuarial assumption rate of 6.5 percent on investment assets, and the percent of employer contributions allocated toward health care funding increases from 4 percent to 5.5 percent over the three year period from 2006 through 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 Attachment 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 Attachment 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 Attachment 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 $92 million in Medicare Part B premiums to its benefit recipients in 2006.

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.

145.58. Group hospitalization coverage for retired persons and survivors; ineligible individuals.

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 [145.33.1], 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 [145.29.7] or 145.298 [145.29.8] of the Revised Code, credit obtained after January 29, 1981, pursuant to section 145.293 [145.29.3] or 145.301 [145.30.1] 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 OPERS retirees 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 [145.32.5] 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 equal to the basic premium for such coverage, except that the board shall make no such payment to any ineligible individual.

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 [145.32.5] 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.

HISTORY: 128 v 308 (Eff 10-14-59); 129 v 1714(1740) (Eff 10-27-61); 131 v 170 (Eff 11-13-65); 135 v H 430 (Eff 11-20-73); 136 v H 268 (Eff 8-20-76); 137 v H 1 (Eff 8-26-77); 139 v H 126 (Eff 6-13-81); 139 v H 236 (Eff 2-2-82); 140 v H 631 (Eff 3-28-85); 141 v H 706 (Eff 12-15-86); 142 v S 124 (Eff 10-1-87); 144 v H 382 (Eff 6-30-91); 144 v H 383 (Eff 5-4-92); 144 v S 346 (Eff 7-29-92); 145 v H 151 (Eff 2-9-94); 146 v S 82 (Eff 3-7-97); 147 v S 67 (Eff 6-4-97); 148 v H 222 (Eff 11-2-99); 148 v H 535 (Eff 4-1-2001); 149 v S 247. Eff 10-1-2002.

APPENDIX C – STATEMENT OF PLAN NET ASSETS

	2006	2005	2004	2003	2002	2001
Assets						
Cash and Short Term Investments	**$322,120,585**	**$250,418,690**	**$194,486,592**	**$417,214,283**	**$185,571,147**	**$152,283,582**
Receivables:						
Members' and Employers' Contributions	$82,850,806	$67,383,947	$64,664,924	$71,464,614	$46,467,195	$26,975,696
Retirement Incentive Plan	$762,533	$1,805,631	3,098,433	5,124,584	$18,188,956	$6,775,267
Contract and Other Receivables	$34,882,853					
Investment Sales Proceeds	$80,471,902	$7,776,993	$12,946,973	$11,534,818	$39,388,483	$14,246,185
Accrued Interest and Dividends	$67,341,496	$51,057,887	$30,981,282	$29,499,116	$27,438,280	$29,271,211
Total Receivables	**$266,309,590**	**$128,024,458**	**$111,691,612**	**$117,623,132**	**$131,482,914**	**$77,268,359**
Investments, at fair value:						
Global Bonds	$6,116,700,706	$4,226,384,980	$2,600,579,782	$2,264,268,507	$1,881,441,428	$2,028,668,267
Equities	$4,388,937,986	$4,623,642,722	$5,590,842,559	$5,112,470,625	$4,129,397,805	$4,750,774,185
Real Estate		$505,301,728	$629,039,656	$644,858,238	$866,566,452	$967,004,493
Private Equity			$69,834,553	$57,113,048	$48,181,864	$12,933,389
International Securities	$1,973,897,814	$2,281,196,185	$2,671,029,189	$2,305,480,202	$1,776,052,122	$2,002,672,885
Total Investments	**$12,479,536,506**	**$11,636,525,615**	**$11,561,325,739**	**$10,384,190,620**	**$8,701,639,671**	**$9,762,053,219**
Collateral on Loaned Securities	**$2,015,624,266**	**$1,749,802,181**	**$1,429,823,432**	**$960,517,368**	**$435,303,084**	**$593,251,558**
Capital Assets:						
Land	$665,394	$665,394	$665,394	$1,473,754	$697,663	$691,687
Building and Building Improvements	$19,679,465	$19,096,169	$18,624,614	$40,554,734	$17,702,101	$12,387,633
Furniture and Equipment	$11,420,812	$9,411,311	$7,366,060	$16,603,845	$8,335,682	$7,067,342
Total Capital Assets	$31,765,671	$29,172,874	$26,656,068	$58,632,333	$26,735,446	$20,146,662
Accumulated Depreciation	($7,340,277)	($6,266,653)	($5,553,881)	($10,444,551)	($4,668,983)	($3,946,684)
Net Capital Assets	**$24,425,394**	**$22,906,221**	**$21,102,187**	**$48,187,782**	**$22,066,463**	**$16,199,978**
Prepaid Expenses and Other					**$22,941,138**	**$19,931,824**
TOTAL ASSETS	**$15,108,016,341**	**$13,787,677,165**	**$13,318,429,562**	**$11,927,733,185**	**$9,499,004,417**	**$10,620,988,520**
Liabilities:						
Undistributed Deposits					$1,026,008	$6,313,108
Medical Benefits Payable	$145,895,911	$138,450,016	$116,024,321	$114,581,249	$95,374,085	$72,859,185
Investment Commitments Payable	$108,410,835	$53,711,956	$163,468,451	$38,150,816	$79,530,542	$10,355,578
Accounts Payable and Other Liabilities	$26,250			$680,303	$1,488,612	$1,825,097
Obligations Under Securities Lending	$2,015,624,266	$1,749,802,181	$1,429,823,432	$960,517,368	$435,303,084	$593,251,558
TOTAL LIABILITIES	**$2,269,957,262**	**$1,941,964,153**	**$1,709,316,204**	**$1,113,929,736**	**$612,722,331**	**$684,604,526**
Net assets held in trust for pension and post-employment health care benefits	**$12,838,059,079**	**$11,845,713,012**	**$11,609,113,358**	**$10,813,803,449**	**$8,886,282,086**	**$9,936,383,994**

	2006	2005*	2004*	2003**	2002**	2001**
Additions:						
Members' Contributions	$71,718,182	$63,408,347	$58,975,931	$38,392,266	$28,628,319	$26,138,574
Employers' Contributions	$539,496,748	$457,805,155	$461,834,411	$579,904,361	$573,038,298	$431,103,750
Contract and Other Receipts	$92,540,351	$6,754,443	$20,851,612	$964,169	$27,341,970	$6,779,205
Medicare Part D Reimbursements	$58,987,181					
Other Income, Net	$1,306,783	$548,364				
Total Non-Investment Income	**$764,049,245**	**$528,516,309**	**$541,661,954**	**$619,260,796**	**$629,008,587**	**$464,021,529**
Income from Investing Activities:						
Net Appreciation in Fair Value	$1,048,846,038	$382,822,937	$856,405,146	$1,880,567,921	($899,648,951)	($1,604,110,433)
Bond Interest	$179,769,220	$124,871,047	$122,129,931	$108,848,479	$135,276,163	$361,752,777
Dividends	$106,148,349	$99,647,424	$107,071,190	$90,394,749	$65,521,483	$130,998,066
Real Estate Operating Income, net			$52,299,350	$68,149,246	$45,652,477	$137,855,938
International Income	$143,649,645	$262,947,660	$165,266,361	$114,250,161	($189,310,970)	207,880,501
Other Investment Income	$2,829,179	$6,773,879	$10,401,718	$9,872,674	$1,801,360	$105,421
External Asset Management Fees***	($10,797,650)	($7,188,895)	($13,599,165)	($14,091,697)		
Net Investment Income	$1,470,444,781	$869,874,052	$1,299,974,531	$2,257,991,533	($840,708,438)	($765,517,730)
From Securities Lending Activity:						
Security Lending Income	$94,382,644	$34,774,894				
Security Lending Expenses	($89,727,122)	($31,691,948)				
Net Securities Lending Income	$4,655,522	$3,082,946	$1,861,915	$677,601	$1,104,834	$4,381,419
Less: Investment Administrative Expenses	($4,040,472)	($4,056,337)	($4,544,563)	($603,059)	($3,462,304)	($2,439,516)
Net Income from Investing Activity	**$1,471,059,831**	**$868,900,661**	**$1,297,291,883**	**$2,258,066,075**	**($843,065,908)**	**($763,575,827)**
TOTAL ADDITIONS	**$2,235,109,076**	**$1,397,416,970**	**$1,838,953,837**	**$2,877,326,871**	**($214,057,321)**	**($299,554,298)**
Deductions:						
Benefits	$1,231,870,038	$1,152,941,961	$1,040,949,675	$947,125,527	$831,977,141	$726,401,889
Administrative Expenses	$10,892,971	$7,875,355	$2,694,253	$2,679,981	$4,067,446	$3,089,188
TOTAL DEDUCTIONS	**$1,242,763,009**	**$1,160,817,316**	**$1,043,643,928**	**$949,805,508**	**$836,044,587**	**$729,491,077**
Net Increase/Decrease	$992,346,067	$236,599,654	$795,309,909	$1,927,521,363	($1,050,101,908)	($1,029,045,375)
Net assets held in trust for pension and Post-employment health care benefits: Balance, Beginning of Year (as restated)	$11,845,713,012	$11,609,113,358	$10,813,803,449	$8,886,282,086	$9,936,383,994	$10,965,429,369
BALANCE, END OF YEAR	**$12,838,059,079**	**$11,845,713,012**	**$11,609,113,358**	**$10,813,803,449**	**$8,886,282,086**	**$9,936,383,994**

*Additions/Benefits were restated in the 2006 Comprehensive Annual Financial Report (CAFR) to delineate contracts and other receipts for years 2004 & 2005.
**For this six year comparison, Additions/Benefits were also re-stated for the years 2001, 2002, 2003. These numbers are not audited.
***Beginning with the 2004 CAFR , External Asset Management Fees were separately identified (for years 2004 and 2003).

Ohio PERS health care

Ohio PERS Retirement Board

January 2007

The 11-member Ohio PERS Retirement Board is responsible for the administration and management of Ohio PERS. 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

Ronald C. Alexander
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

Robert C. Smith
Investment Expert
Governor Appointee

Warren W. Tyler
Investment Expert
Treasurer of State Appointee

James R. Tilling
Investment Expert
General Assembly Appointee

Chris DeRose
Executive Director

OPERS
Ohio Public Employees
Retirement System
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