Ohio PERS health care

Ohio PERS Health Care Report 2005

Presented to:
Ohio Retirement Study Council

June 30, 2006

Ohio Public Employees Retirement System

Blake W. Sherry
Interim Executive Director

Scott E. Streator
Director of Health Care

OPERS

TABLE OF CONTENTS

Securing health care coverage now and in the future

The Ohio Public Employees Retirement System (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 billion Health Care Trust Fund to prefund health care through investments and employer contributions, the System is now exercising the same disciplines and thoughtful leadership to control spending in an effort to preserve health care into the future while providing a solid health care coverage plan.

A realistic plan and a commitment to solvency

In 2004, the OPERS Retirement Board and staff had the foresight to create the Health Care Preservation Plan (HCPP). The HCPP is a multi-faceted collaborative effort that charges staff to implement a multi-platform plan design by Jan. 1, 2007. The HCPP encompasses more than a straightforward plan design change. The Board also has charged OPERS with achieving an average of 15 to 25 years of solvency for the health care fund.

OPERS' actuaries report that every $50 million in savings adds an additional year of solvency.

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 retired members to choose generic drugs when possible saved the OPERS health care fund $33 million 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' 2005 health care expenditures were below actuarial projections and in line with national statistics. Several examples are contained in this report.

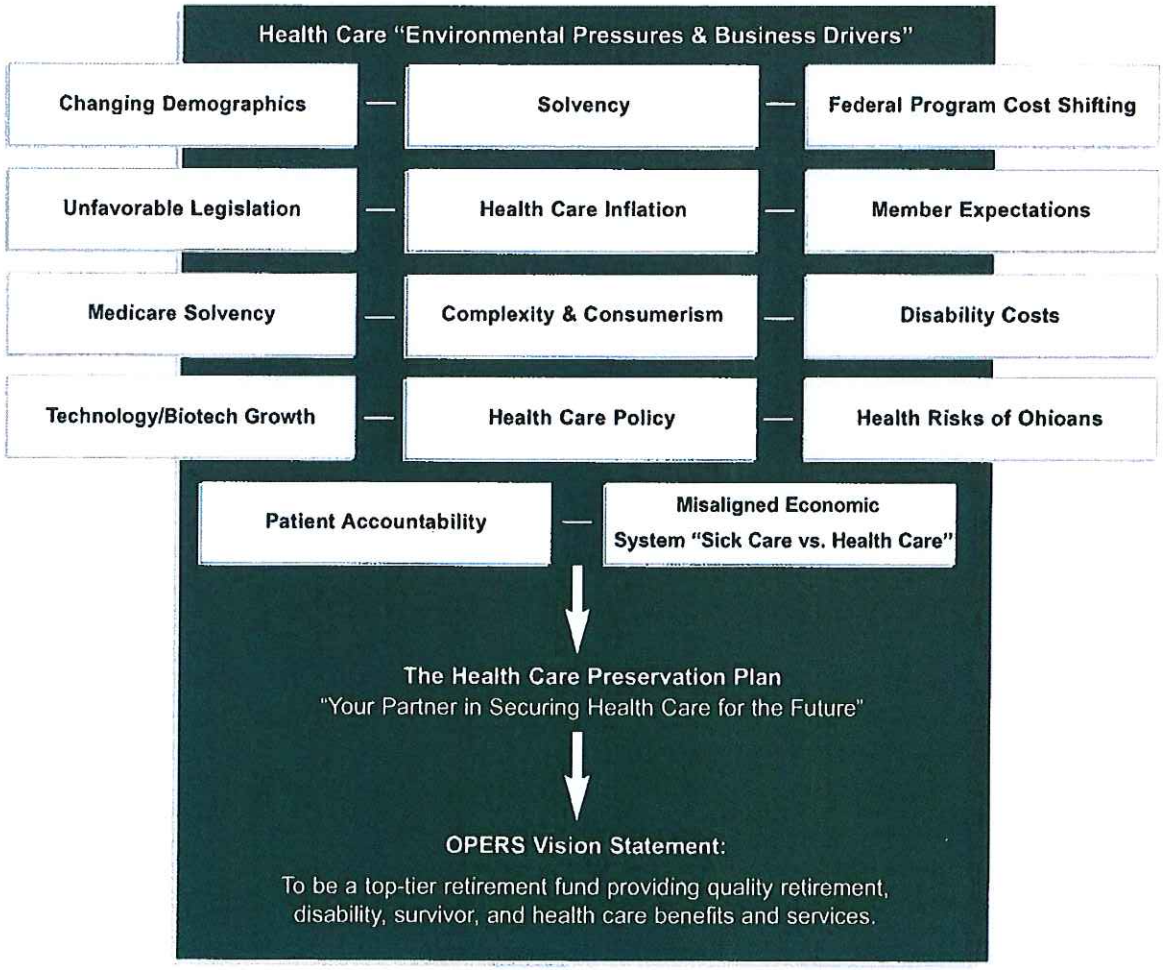
Advocacy at the federal, state and local levels

As part of the HCPP, OPERS has been active at the federal, state and local levels to advocate for improvements throughout the health care system to improve safety, quality and impose cost containment solutions. OPERS intends to form partnerships when appropriate to leverage our collective influence with drug companies, health service providers and others on which our retirees depend for quality health care services.

EXECUTIVE SUMMARY *(continued from page 1)*

There is significant work to be done and many more solutions to be developed in order for us to maintain a meaningful health care coverage package for our growing membership. Our current health care solvency projections indicate OPERS has 17 years before retiree health care coverage would need to become a strictly pay-as-you-go benefit. This would drastically reduce the investment earnings available to help fund health care coverage with investment earnings. Coupled with the new Government Accounting Standards Board (GASB) requiring financial disclosures next year of unfunded health care liability, OPERS will continue to identify tangible and creative strategies that fulfill the Health Care Preservation Plan's Guiding Principles and secure a health benefit for the future.

OPERS HEALTH CARE STRATEGY



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 took another huge step affecting member choice and cost containment by adding 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. OPERS continues to use this dual-partner configuration today, ensuring choice for our retirees while enjoying the benefits of a healthy competition between providers.

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 up to 100 percent coverage.

In 2000, prescription medication co-pays for mail order were raised from $0/$2/$8 to $4.50/$9/$12. Benefit 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.

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.

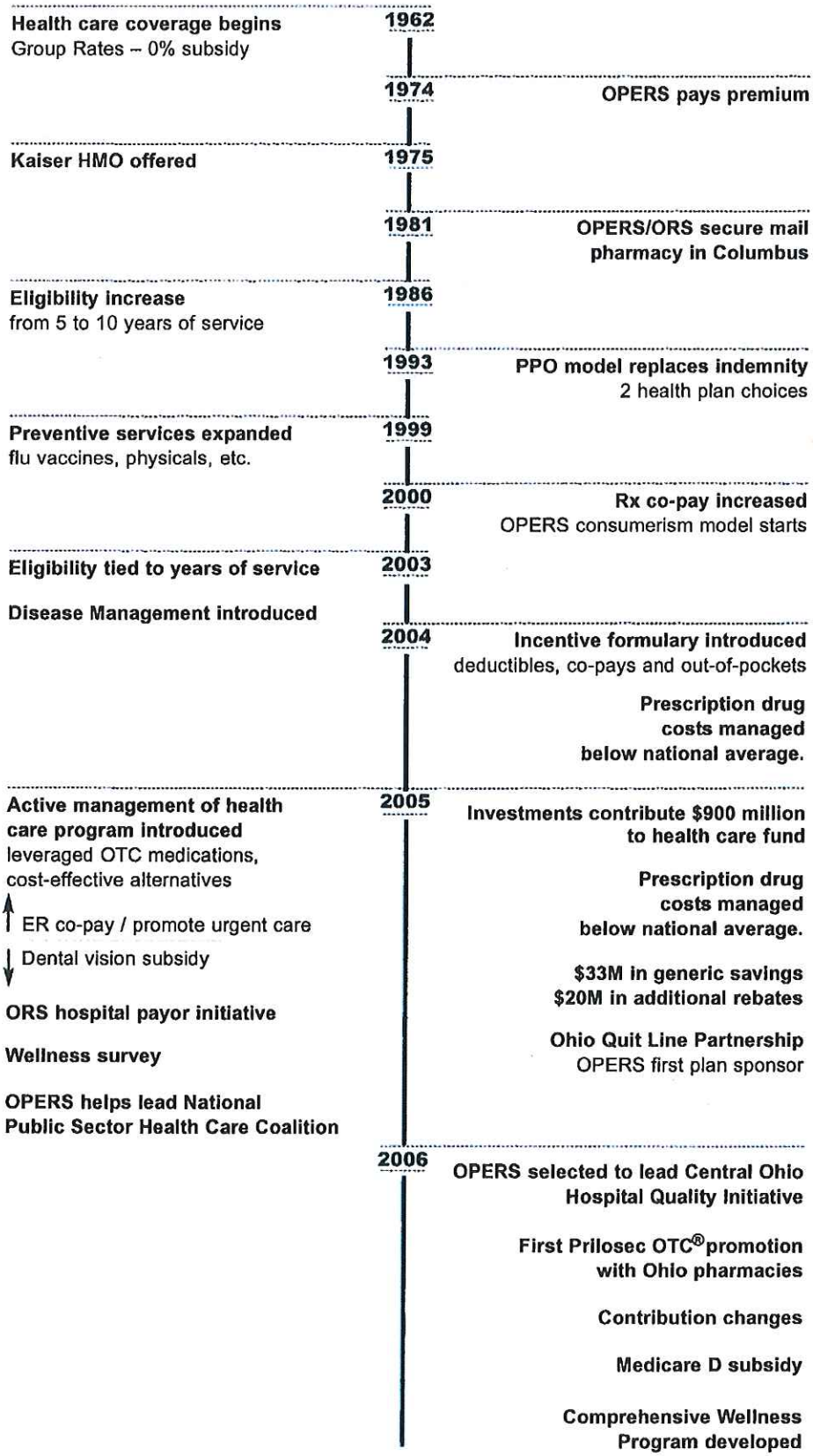
Dependent eligibility definitions became more restrictive in 2005. Over-the-counter medicines and non-sedating antihistamines were eliminated from coverage, and erectile dysfunction drug coverage was reduced and eventually discontinued.

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.

The HCPP establishes three groups of retirees, each with eligibility standards based on length of service and start date.

As 2007 approaches, we are preparing for the Health Care Preservation Plan to take effect. The HCPP establishes three groups of retirees, each with eligibility standards based on length of service and start date. It also adds two additional plan designs for health care coverage. Retirees will 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 will be 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 (as would happen in the case of an employee with relatively shorter service selecting the more expensive health care plan) the difference would be paid by the individual as a premium.

OPERS HEALTH CARE CHRONOLOGY OF PROGRESS: *intensity and complexity increase with time*



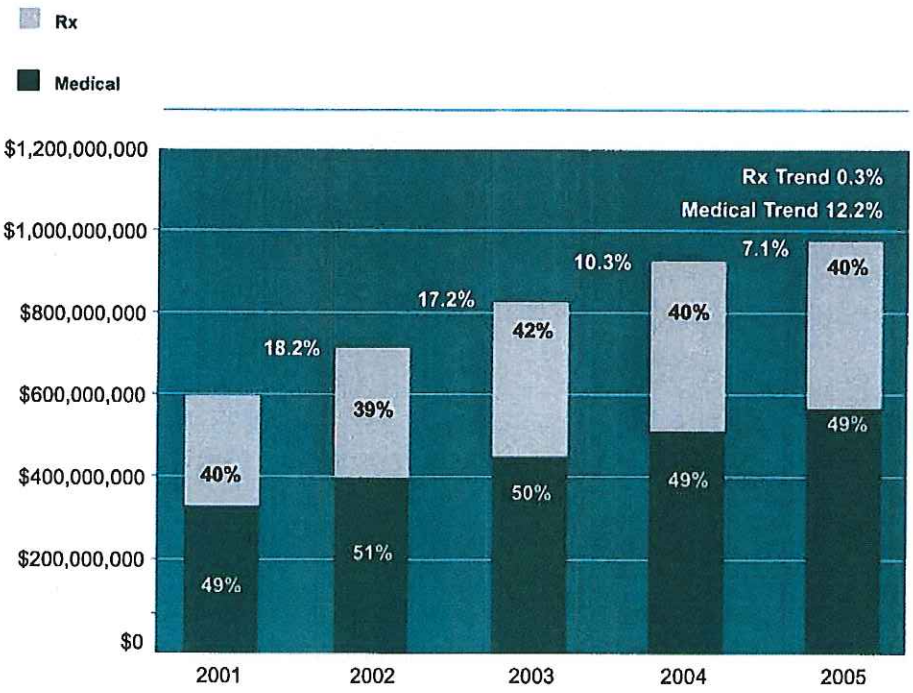
Indeed, a core guiding principle is to maintain solvency long-term for an average of 15-25 years.

The Health Care Preservation Plan (HCPP) was adopted by the OPERS Retirement Board in 2004 for full implementation by Jan. 1, 2007. The HCPP is not a stagnate plan design change, but provides OPERS a strategic framework to responsibly react and plan for current and future health care needs. As explained later, at the core of this comprehensive plan is a set of guiding principles that help determine overall strategies. These strategies are designed to react to the various business drivers that OPERS faces as a large Ohio health care benefit payor along with other public and private plan sponsors.

Our members, both retired and active, have entrusted OPERS to provide meaningful health care coverage both now and in the long term. Therefore, OPERS realigned the organization in 2004 to dedicate a group of health care staff and professionals to fulfill the challenge of preserving health care. Indeed, a core guiding principle is to maintain solvency long-term – a 15-25 year average.

In 2005, our 50-year actuarial projection forecasted our long-term solvency to be within this range while providing a benefit package designed to improve or maintain our retiree's health.

Five-Year Health Cost Trends *(Claim costs only)*



As reported in the statement of plan net assets, OPERS has nearly $12 billion in a separate health care trust fund. This fund is managed and diversified in investment instruments to achieve maximum earnings to meet solvency assumptions and liquidity needs.

Investment earnings provided nearly $900 million in 2005 towards health care

The unique position of managing $12 billion in assets dedicated for health care stems from the careful and disciplined approach by the Board during the 1980s and 1990s. Investment earnings provided nearly $900 million in 2005 towards health care while employer contributions added another $460 million.

As part of the HCPP, OPERS is increasing employee and employer contributions to the maximum statutory levels. The increases are being phased in to continue to build adequate assets while giving ample notice to members and employers. OPERS is in an enviable position to have prefunded health care. Without the $12 billion, health care would be funded on a "pay-as-you-go" basis whereby only employer contributions would be available to fund the annual expenditures (2005) of over $1 billion.

HEALTH CARE PRESERVATION PLAN "GUIDING PRINCIPLES"

As part of the HCPP, the Board approved a set of "Guiding Principles" to provide a strategic framework to meet long-term demands in a balanced and pragmatic approach.

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.

ADVOCACY EFFORTS ARE AN IMPORTANT COMPONENT OF "ACTIVE MANAGEMENT"

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

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. 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 is leading efforts aimed at formulating group purchasing arrangements for prescription medications. OPERS recently hosted a meeting with the senior research and development management team from the nation's largest drug manufacturer to discuss pricing concerns and collective needs. In addition, OPERS is pursuing a number of legislative changes at the state level that, if enacted, will help to preserve the OPERS health care plan as well as others.

Working to control costs at the federal level

At the federal level, OPERS is working 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 the formation of the first and only national public sector health care coalition called the National Health Care Roundtable with other Ohio retirement systems. For more information on various national policy endeavors, visit www.healthcareroundtable.org.

OPERS helped lead the formation of the first and only national public sector health care coalition.

THE CHANGES PROPOSED IN HB 272 CAN HAVE A POSITIVE IMPACT

The OPERS Board is also recommending a number of statutory changes aimed at improving pension funding status and protecting the long-term solvency of the OPERS retiree health care program. These changes are contained in HB 272 which was introduced by Representative Schneider (R-Cin.) and is currently pending in the House Financial Institutions, Real Estate and Securities committee.

With regard to its retiree health care program, the OPERS Board is seeking statutory changes giving it authority to set the amount paid to retirees for Medicare Part B coverage, which is now determined annually by the federal government. The bill also specifies statutory changes authorizing the OPERS Board to establish the amount paid for Medicare Part A equivalent coverage to spouses of retirees who are ineligible for Medicare. Currently the level of reimbursement is set in statute. The OPERS Board is requesting the changes to these provisions so that it has the ability to determine the portion of the cost that OPERS will pay for these two benefits. The changes would make these provisions consistent with the Board's current authority to establish the cost of coverage under the OPERS health care program.

It is important for our active members to begin saving for the cost of retiree health care.

In addition, the OPERS Board is seeking statutory authority to establish a medical savings account program under which members can voluntarily contribute to a retiree medical savings account and do so by payroll deduction. It is important for our active members to begin saving for the cost of retiree health care, and this program would provide a method by which members can set aside funds to help pay the cost of qualified medical expenses after retirement.

The OPERS Board is asking the Ohio General Assembly to enact the incremental changes contained in HB 272 to reduce the need to make more drastic changes to the OPERS retiree health care program in the future.

The OPERS Board is asking the Ohio General Assembly to enact the incremental changes contained in HB 272 to reduce the need to make more drastic changes to the OPERS retiree health care program in the future.

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 direct health care costs attributable to tobacco with another $82 billion in indirect expenditures (Fiore MC et al, 2000)
- It is estimated the 2005 smoking related health costs exceed $4 billion in Ohio alone.

To further illustrate this magnitude, OPERS spends nearly $500,000 per day on cardiovascular care 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. Of these expenditures only 5 percent is estimated to be spent on preventive services. The top three categories, including cardiovascular, diabetes and musculoskeletal, accounted for over $400 million in health care expenditures in 2005. To further illustrate this magnitude, OPERS spends nearly $500,000 per day on cardiovascular care alone.

What we know about the health of our current retiree population

In 2005, OPERS completed an extensive survey of both retired and active members to determine the overall health of its membership. The data, unfortunately, mirrors Ohio and much of the Midwest in terms of risk factors that lead to debilitating and costly diseases.

Approximately 70 percent of OPERS' membership is overweight or obese, and between 10 percent and 12 percent admit to smoking while most surveys reveal over 25 percent of all Ohioans use tobacco. More importantly, insightful information was gained by confirming most of the membership was willing to make strides for health improvement.

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 2005, OPERS staff consulted nationally renowned wellness experts and worked locally with staff from The Ohio State University Medical Center 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 retired and active member to become a fully engaged health care consumer and provide the tools to prevent, reduce or optimally treat diseases.

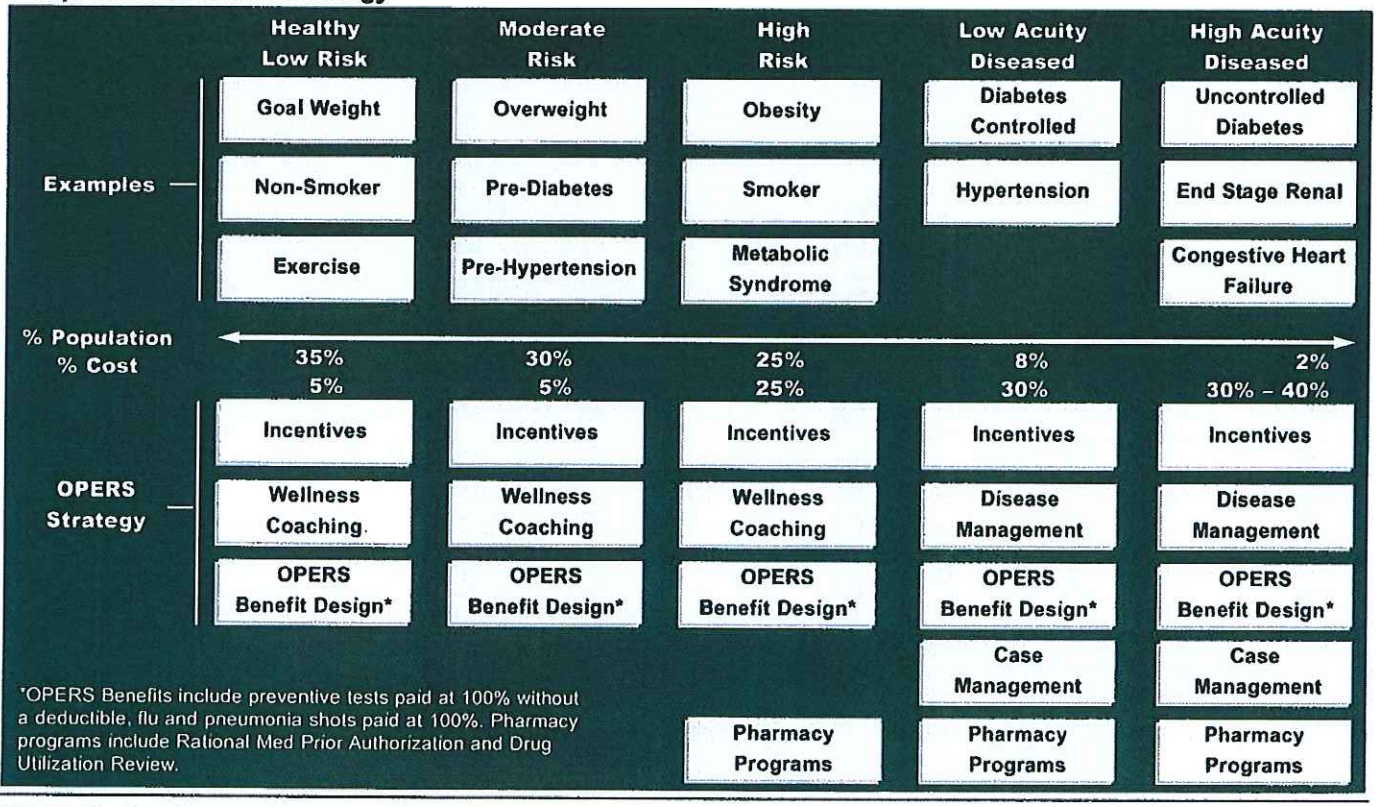
The idea is simple: Encourage every retired member to become a fully engaged health care consumer and provide the tools to prevent, reduce or optimally treat diseases. The objective is to find a solution that improves a member's health while reducing OPERS health costs or risks. OPERS' wellness incentive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

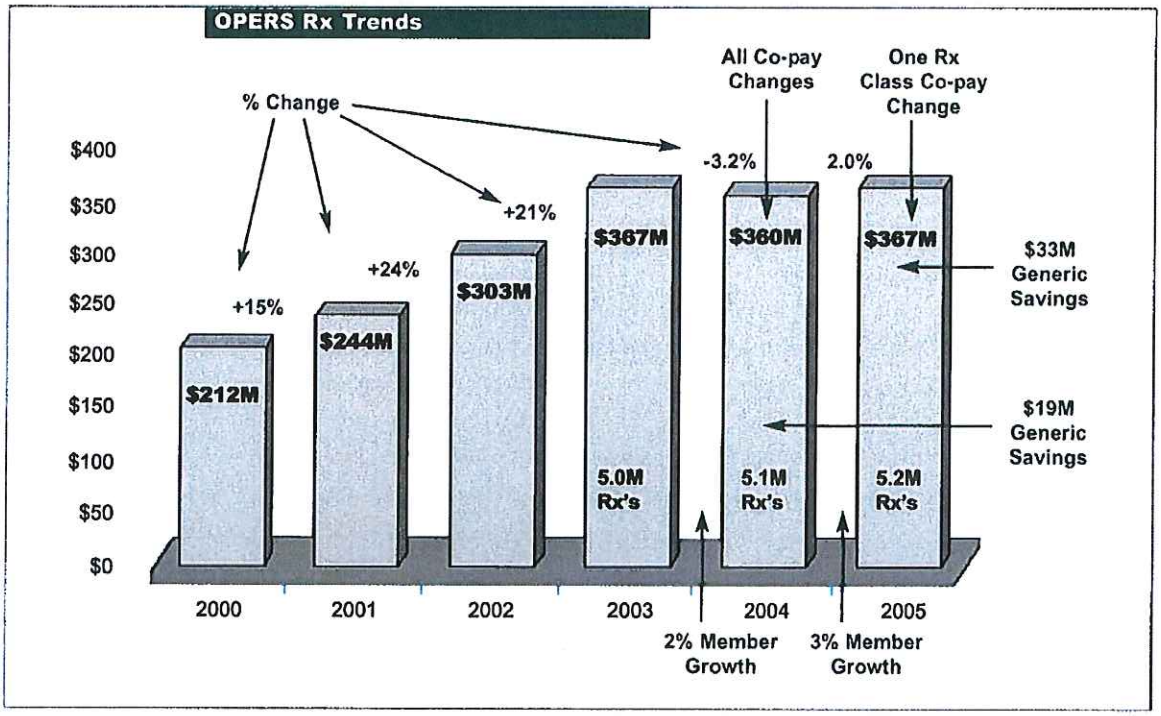
Proposed reward structure and projected return on investment

The proposed plan will reward non-Medicare members $50 per year for maintaining (or attaining) a healthy weight. Similarly, $50 will be provided for avoidance of tobacco or completion of a smoking cessation program. Moreover, another $100 will be available for obtaining tailored goals for each individual who voluntarily participates. Medicare eligible retirees will also be offered a unique program that will take advantage of incentives and senior sensitive programming.

Consultants have projected that OPERS will save $1.30 to $1.50 return on each $1 spent in the first year alone. The Board approved this innovative initiative, and staff will use a team of experts to monitor results after the pilot two-year program has been completed.

Comprehensive Health Strategy





OPERS has been recognized internationally for developing and applying creative techniques in controlling prescription drug costs. Per member, per month costs have been negative the past two years, and additional management techniques will be employed due to ongoing inflation, biotechnology costs and utilization patterns.

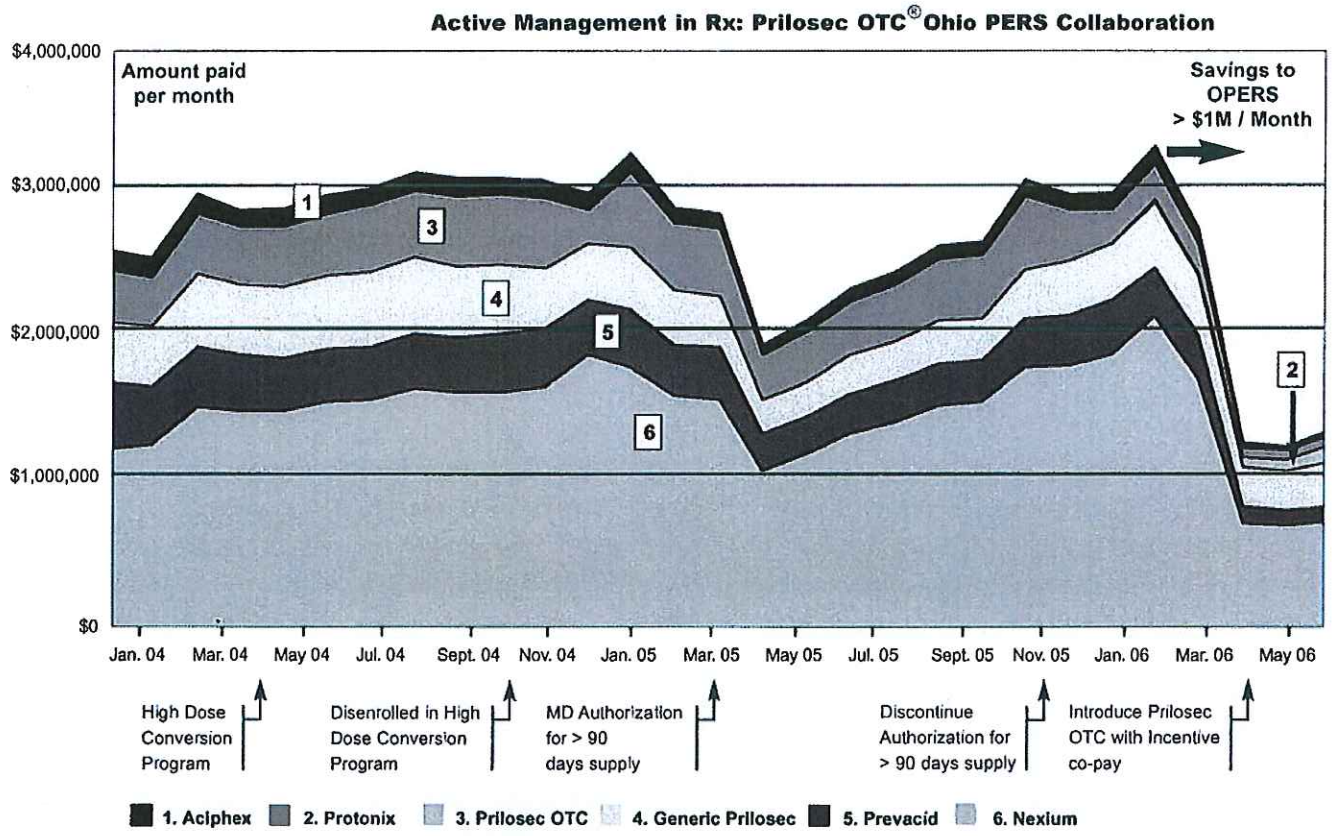
In early 2006, OPERS pioneered a partnership with Ohio pharmacies resulting in over $3 million in savings for one medication class using lower cost OTC alternatives

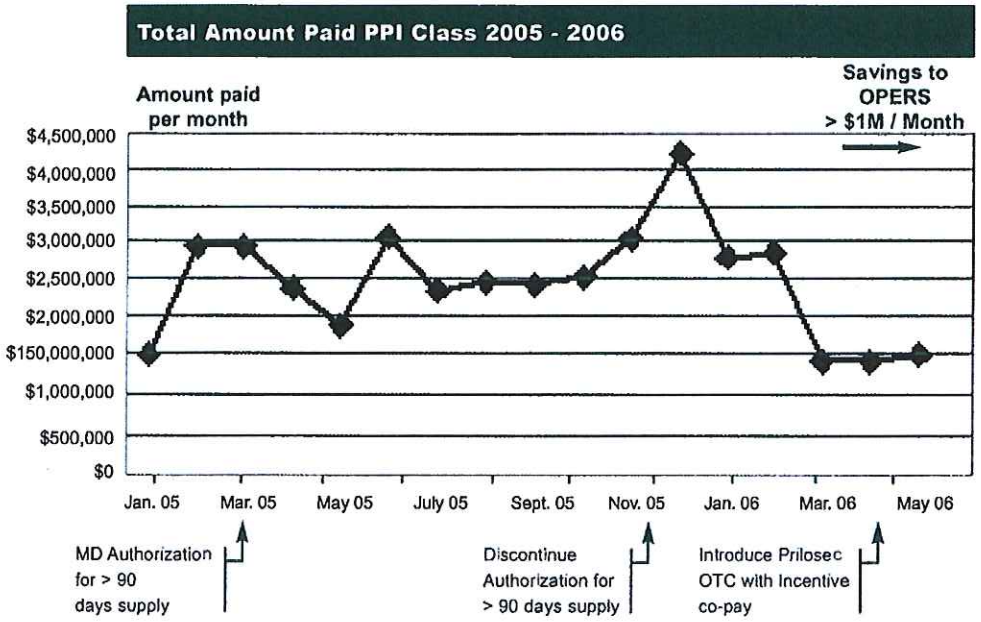
One achievement is related to structuring transparent pharmacy benefit management techniques along with several other Ohio retirement systems. In 2005, OPERS saved $33 million in generics alone and increased rebates by $20 million. In early 2006, OPERS pioneered a partnership with Ohio pharmacies to educate members about effective and lower cost over-the-counter alternatives for digestive disorders. To date, OPERS has reduced the average daily cost of medications within the costly Proton Pump Inhibitor (PPI) drug class by 50 percent through efforts to promote Proctor & Gamble's Prilosec OTC®over the more expensive Nexium®and similar products. This alone has saved over $3 million in the first three months (see charts).

OPERS has made cost-saving changes to the coverage of drugs within the PPI class while still providing retirees and providers with choice and avoiding burdensome prior authorizations. This system of aligning the co-payments to reflect the true costs of pharmaceuticals deemed clinically equivalent may provide a strategy that could be applied to other product classes. Indeed, these principles now are being studied for application to other pharmaceutical and medical coverage possibilities for long-term cost containment and sound policy as consistent with the HCPP.

OPERS is working directly with Centers of Medicaid and Medicare Services (CMS) for future projects. The Medicare D benefit is expecting to yield over $50 million in subsidies directly back to OPERS.

INNOVATIVE STRATEGIES TO SUCCESSFULLY CONTAIN RISING PRESCRIPTION DRUG COSTS *(continued from page 13)*





THE FUTURE HOLDS MANY CHALLENGES AND OPPORTUNITIES

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

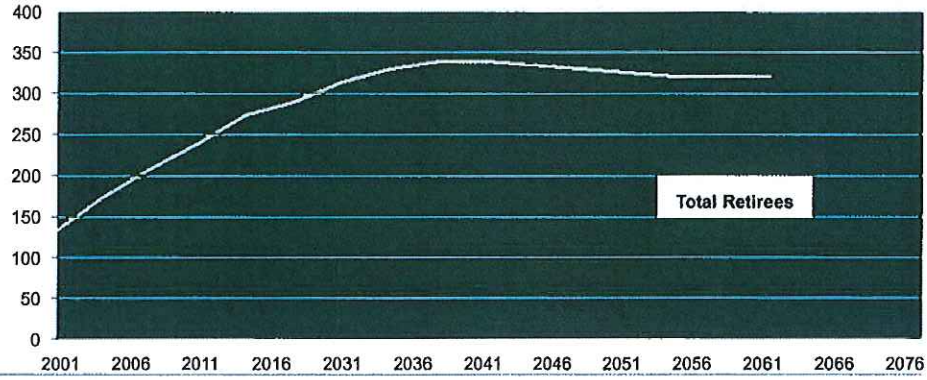
GASB 43 is likely to elevate the concern of funding health care for government plan sponsors.

- OPERS Baby Boomer population retiring – retiree membership expected to double by 2035.
- Need to establish culture of wellness and disease prevention throughout government – from childhood, employment, through retirement.
- Biotechnology and medical technology growth.
- Quality of care. OPERS is leading the national "Leapfrog" Hospital Quality Improvement Initiative for Central Ohio Hospitals and provided support for HB 197 to increase transparency of publishing hospital quality data. This is only the beginning as the average health consumer will demand greater value as the cost of health care is shifted to the individual from private and public plan sponsors.
- GASB 43/OPEB – OPERS and other governmental plan sponsors will be required to report any unfunded post-employment benefits effective for the year ending Dec. 31, 2006. Fortunately, OPERS has been using solvency, as a means to measure financial health of the benefit. 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. Fortunately, OPERS has implemented a solid preservation plan, and the Board is in the planning stages of another full-day health care retreat in 2006 to evaluate new opportunities.
- Worker/Retiree ratio expected to decrease
- Healthcare Inflation -- Last year OPERS realized $38 million in increased costs with $18 million due to prescription drugs that are rising nearly three times CPI.

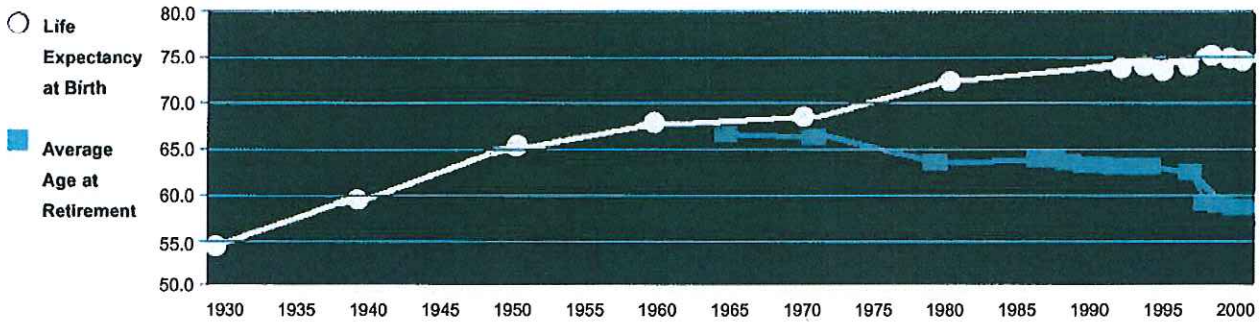
THE FUTURE HOLDS MANY CHALLENGES AND OPPORTUNITIES *(continued from page 14)*

Retiree Population Growth
Past 5 years – increased by 21,000
Next 5 years – will increase 25,000
Next 10 years – will increase 60,000
Next 20 years – will double to 272,000

Active Workers Growth
Past 5 years – increased by 41,000; declined last year



Worker/ Retiree Ratio
2001: 2.6
2006: 2.2
2011: 1.8
2016: 1.5
2021: 1.4



While most governmental health plan sponsors will be faced with the same business pressures OPERS faces, the OPERS strategy is not solely fixed or limited to increased funding. The HCPP allowed OPERS to increase employer and employee contributions to maximum statutory levels. However, increased funding is only part of OPERS health care strategy, and, therefore, our on-going plan to actively manage the benefit to reduce or prevent unnecessary health expenses. It is imperative OPERS continues to work locally, statewide and nationally to improve health care efficiencies and reduce the liability for a long-term benefit.

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

The 2005 OPERS Health Care Plan

The 2005 OPERS health 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 2005 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 2005 OPERS health plan utilized the PPO networks of Aetna and Medical Mutual, the two administrators of the OPERS health plan. All states in the United States 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 2005 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 2005 (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 2005, 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%	

A calendar year deductible of $200 per individual or $400 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 $1500 for an individual and $3000 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 2005 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 2005, 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.

2005 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 2005:

If an OPERS benefit recipient was eligible for Medicare Part A (hospital) at no cost OPERS required enrollment in Medicare coverage (if covered by OPERS health care). 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 was available in certain states and 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.

Medicare Deduction

If a benefit recipient was required to pay the Medicare B premium to the CMS directly, he or she was able to ask OPERS to make a payment to Social Security, rather than having the amount added to his or her pension check. Due to changes in CMS policy, OPERS discontinued paying directly to CMS on the benefit recipient's behalf effective fall 2005.

The Dental Plan

During 2005, 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 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 2005:

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 December 31, 2005, there were 138,329 benefit recipients and 55,713 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 reasonable 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 percent of covered payroll were used to fund health care liabilities in 2005. 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 ½ 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 $79,599,076 in Medicare Part B premiums to its benefit recipients in 2005.

145.325. Medicare equivalent benefits.

A) Except as otherwise provided in division (B) of this section, the board of the public employees retirement system shall make available to each retiree or disability benefit recipient receiving a monthly allowance or benefit on or after January 1, 1968, who has attained the age of 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

	2005	2004	2003	2002	2001	2000	1999
	2005	2004	2003	2002	2001	2000	1999
Assets							
Cash and Short Term Investment	$250,418,690	$194,486,592	$417,214,283	$185,571,147	$152,283,582	$299,551,036	$193,521,934
Receivables:							
Employers Contributions	$67,383,947	$84,664,924	$71,464,614	$46,467,195	$26,975,696	$20,915,187	$27,145,428
Retirement Incentive Plan	$1,605,631	3,098,433	5,124,584	$18,188,956	$6,775,267	$3,721,569	$2,777,067
Investment Sales Proceeds	$7,776,993	12,946,973	11,534,816	$39,388,483	$14,246,185	$26,467,866	$117,162
Accrued Interest and Dividends	$51,057,887	30,981,282	29,499,116	$27,438,280	$29,271,211	$46,815,613	$46,415,084
Total Receivables	**$128,024,458**	**$111,691,612**	**$117,623,132**	**$131,482,914**	**$77,268,359**	**$97,920,255**	**$76,454,741**
Investments, at fair value:							
Bonds	$3,061,221,426	$1,658,033,259	$1,440,534,173	$1,147,148,273	$1,271,358,373	$2,134,491,585	$2,162,313,014
Mortgage & Mortgage Backed	$1,165,163,554	942,546,523	823,734,334	$734,293,155	$757,309,894	$1,493,537,925	$1,429,145,862
Stocks	$4,623,642,722	5,590,842,559	5,112,470,625	$4,129,397,805	$4,750,774,185	$3,650,714,985	$3,911,196,263
Real Estate	$505,301,728	629,039,656	644,858,238	$866,566,452	$967,004,493	$1,046,691,262	$1,118,361,190
Private Equity		69,834,553	57,113,048	$48,181,864	$12,933,389	$16,733,040	$16,111,104
International Securities	$2,281,196,185	2,671,029,189	2,305,480,202	$1,776,052,122	$2,002,672,885	$2,045,814,900	$2,287,215,780
Collateral on Loaned Securities							
Total Investments	**$11,636,525,615**	**$11,561,325,739**	**$10,384,190,620**	**$8,701,639,671**	**$9,762,053,219**	**$10,587,983,697**	**$10,926,343,213**
Collateral on Loaned Securities	$1,749,802,181	$1,429,823,432	$960,517,368	$435,303,084	$593,251,558	$799,148,208	$865,608,588
Capital Assets:							
Land	$665,394	$665,394	$1,473,754	$697,663	$691,687	$717,831	$724,575
Building and Building Improvements	$19,096,169	$18,624,614	$40,554,734	$17,702,101	$12,387,633	$6,016,564	$3,868,237
Furniture, Fixtures, and Equipment	$9,411,311	$7,366,060	$16,603,845	$8,335,682	$7,067,342	$5,357,308	$4,428,341
Total Capital Assets	$29,172,874	$26,656,068	$58,632,333	$26,735,446	$20,146,662	$12,091,703	$9,021,153
Accumulated Depreciation	($8,266,653)	($5,553,881)	($10,444,551)	($4,668,983)	($3,946,684)	($3,644,071)	($3,384,156)
Net Capital Assets	**$22,906,221**	**$21,102,187**	**$48,187,782**	**$22,066,463**	**$16,199,978**	**$8,447,632**	**$5,636,997**
Prepaid Expenses and Other		$0	$0	$22,941,136	$19,931,624	$18,677,709	$15,985,801
TOTAL ASSETS	**$13,787,677,165**	**$13,318,429,562**	**$11,927,733,185**	**$9,499,004,417**	**$10,620,988,520**	**$11,811,728,537**	**$12,083,551,274**
Liabilities:							
Undistributed Deposits		$0	$0	$1,026,008	$6,313,108	$477,657	$251,682
Medical Benefits Payable	$138,450,016	$116,024,321	$114,581,249	$95,374,085	$72,859,185	$41,684,800	$53,846,033
Investment Commitments Payable	$53,711,956	$163,468,451	$38,150,816	$79,530,542	$10,355,578	$4,259,704	
Accrued Administrative Expenses		$0	$680,303	$1,488,612	$1,825,097	$728,799	$631,714
Obligations Under Securities Lending	$1,749,802,181	$1,429,823,432	$960,517,388	$435,303,084	$593,251,558	$799,148,208	$865,608,588
TOTAL LIABILITIES	**$1,941,964,153**	**$1,709,316,204**	**$1,113,929,736**	**$612,722,331**	**$684,604,526**	**$846,299,168**	**$920,338,017**
Net assets held in trust for pension and post-employment health care benefits	$11,845,713,012	$11,609,113,358	$10,813,803,449	$8,886,282,086	$9,936,383,994	$10,965,429,369	$11,163,213,257

APPENDIX D – STATEMENTS OF CHANGES IN PLAN NET ASSETS

	2005	2004	2003	2002	2001	2000	1999
Additions:							
Contributions:							
Members'							
Employers'	$460,534,741	$464,096,679	$579,904,361	$573,038,298	$431,103,750	$452,867,242	$392,459,727
TOTAL CONTRIBUTIONS	**$460,534,741**	**$464,096,679**	**$579,904,361**	**$573,038,298**	**$431,103,750**	**$452,867,242**	**$392,459,727**
Investment Income:							
Net Appreciation in Fair Value of Instruments & Other Invest. Inc.	$389,596,816	$868,806,864	$1,888,247,396	($897,847,591)	($1,396,124,511)	($546,918,282)	$888,386,350
Bond Interest	$124,671,047	122,129,931	107,738,517	135,276,183	361,752,777	284,384,050	254,543,745
Dividends	$99,647,424	107,071,190	88,991,564	65,521,483	130,998,068	90,565,240	69,366,846
International	$262,947,660	165,266,361	109,545,453	(189,310,970)			
Real Estate Operating Income, net	$0	52,299,350	63,468,603	45,652,477	137,855,938	82,658,021	71,472,483
Securities Lending Net Income	$3,082,946	1,861,915	677,601	1,104,834	47,293,017	37,326,394	29,062,059
	$880,145,893	$1,315,435,611	$2,258,669,134	($839,603,604)	($718,224,713)	($51,982,577)	$1,312,831,483
Less: Investment Expenses	($11,245,232)	(18,143,728)	(603,059)	(3,462,304)	(45,351,114)	(37,183,505)	(28,561,474)
Net Investment Income	$868,900,661	$1,297,291,883	$2,258,066,075	($843,065,908)	($763,575,827)	($89,166,082)	$1,284,270,009
Other Income, net	$548,364						
TOTAL ADDITIONS	**$1,329,983,766**	**$1,761,388,562**	**$2,837,970,436**	**($270,027,610)**	**($332,472,077)**	**$363,701,160**	**$1,676,729,736**
Deductions:							
Benefits	$1,085,508,757	$963,384,400	$907,769,092	$776,006,852	$693,484,110	$559,606,294	$523,599,349
Refunds of Contributions							
Administrative Expenses	$7,875,355	2,694,253	2,679,981	4,067,446	3,089,188	1,878,754	1,757,358
TOTAL DEDUCTIONS	**$1,093,384,112**	**$966,078,653**	**$910,449,073**	**$780,074,298**	**$696,573,298**	**$561,485,048**	**$525,356,707**
Net Increase	$236,599,654	$795,309,909	$1,927,521,363	($1,050,101,908)	($1,029,045,375)	($197,783,888)	$1,151,373,029
Net assets held in trust for pension and							
Postemployment health care benefits:							
Balance, Beginning of Year (as restated)	$11,609,113,358	$10,813,803,449	$8,886,282,086	$9,936,383,994	$10,965,429,369	$11,163,213,257	$10,011,840,228
BALANCE, END OF YEAR	**$11,845,713,012**	**$11,609,113,358**	**$10,813,803,449**	**$8,886,282,086**	**$9,936,383,994**	**$10,965,429,369**	**$11,163,213,257**

health care

Ohio PERS
Retirement Board
April 2006

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
Chair
State Employees

Sharon M. Downs
Vice Chair
Retired Members

John W. Maurer
Retired Members

Cinthia Sledz
Miscellaneous Employees

Helen Youngblood
County Employees

Ken Thomas
Municipal Employees

Charlie Adkins
State College and
University Employees

Statutory Board Member

Carol Nolan Drake
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

Blake W. Sherry
Interim
Executive Director

OPERS
Ohio Public Employees
Retirement System
277 East Town Street
Columbus, OH 43215-4642