277 East Town Street

Columbus, Ohio 43215-4642

Public Employees Retirement System of Ohio
(614) 466-2085 • 1-800-222-PERS (7377)
www.opers.org

June 27, 2000

Aristotle Hutras
Director
Ohio Retirement Study Council
88 E. Broad Street, Suite 1175
Columbus, Ohio 43215

Re: R.C. § 145.22 (E)

Dear Aris:

Enclosed is a copy of the health care report from PERS, which is being submitted pursuant to Ohio Revised Code § 145.22 (E). If you have any additional questions, please feel free to contact us.

Yours very truly,

William Damsel

William Damsel
Defined Contribution Plan Coordinator

Enclosure

WD/clk

PUBLIC EMPLOYEES RETIREMENT SYSTEM OF OHIO
277 East Town Street, Columbus, Ohio 43215

June 27, 2000

MEMORANDUM

TO: Ohio Retirement Study Commission
Ohio House Health, Retirement and Aging Committee
Ohio Senate Ways and Means Committee

FROM: Laurie Fiori Hacking, Executive Director Laurie Fiori Hacking

RE: Reporting requirements under ORC Section 145.22(E)

The following document fulfills the requirements of the Public Employees Retirement System of Ohio (PERS) as provided in Ohio Revised Code (ORC) Section 145.22 (E). The relevant sections of the code and PERS' responses follow:

"(E) ~~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 Section 145.325 (Medicare benefits for members of public employees retirement system), and ORC section 145.58 (Group hospitalization coverage; ineligible individuals; service credit; alternative use of HMO).

"(2) A summary of the benefits;"

PERS Response – Health Care Benefits

The following is an outline of the current PERS health care benefits:

The PERS health care plan includes preferred provider organizations, which make up a network. A health care network is a partnership between doctors, hospitals, PERS and its plan administrators, and our benefit recipients as patients. Once a recipient is eligible for Medicare, the PERS health care plan becomes secondary to Medicare coverage and network provisions will not apply.

The PERS health care plan network benefits include the following: 80 percent of reasonable and customary fees for medical services, and 100 percent hospital

coverage; a deductible of $100 per individual, with a maximum of $200 per account; and a lifetime maximum benefit of $2,500,000. Persons served by a preferred provider network may choose a provider outside of the network with reduced benefits (70 percent of reasonable and customary fees and $150 deductible).

Prescription Drug Programs: A drug benefit card and a mail order prescription drug program are available for qualified recipients. The prescription drug program is available to participants in the PERS plan and the optional HMOs.

Alternative Health Care Plans: Alternative health care coverage, HMOs, is available to PERS benefit recipients who reside in an HMO area. An HMO offers hospital and medical services through participating physicians and health care facilities. Coverage under an HMO program is comprehensive and many services are paid in full. The primary benefit recipient is responsible for the cost difference in HMO coverage if that cost is more than the basic cost of the PERS health care plan. The cost for dependent coverage also is the responsibility of the primary benefit recipient.

Medicare Effects on PERS Health Care Coverage: If a PERS benefit recipient is eligible for Medicare Part A (hospital) at no cost, enrollment in that plan through the Social Security Administration is necessary. All persons who are 65 and older and who are not eligible for Medicare Part A must submit proof of this fact and substitute coverage will be provided by PERS. If a recipient is eligible for health care coverage, enrollment in Medicare Part B (medical) is necessary when eligibility is reached. Proof of enrollment must be submitted to PERS.

Unless covered by an HMO, a benefit recipient enrolled in Medicare Part B (medical) may use Medicare direct, in which the health care provider submits the recipient's itemized bill to the Medicare paying agency, which then can submit the medical bills directly to the appropriate claims administrator.

If a benefit recipient is not being reimbursed for Medicare Part B from another source, PERS needs proof that they are enrolled in Medicare Part B. PERS then reimburses the recipient for the basic premium cost of the coverage as long as the recipient is enrolled. The cost is added to the recipient's monthly benefit amount. If a benefit recipient must pay the Medicare Part B premium to the Medicare Payment Center, the premium may be deducted from the monthly benefit check with PERS sending direct payment to the Medicare Payment Center on behalf of the recipient.

Dental Plan: A plan for dental coverage is available to all PERS benefit recipients regardless of health care coverage. It is intended to help defray the costs of dental treatment, including oral examinations, diagnostic services, extractions, crowns, bridges and dentures. If a recipient chooses coverage under the dental plan, a premium is deducted from each monthly benefit check.

Dependents also may be enrolled if the recipient chooses coverage. PERS subsidizes 25 percent of the premium cost for the benefit recipient only.

Vision Plan: A plan for vision coverage is available to all PERS benefit recipients regardless of health care coverage. This plan includes some coverage for services provided by an ophthalmologist, optometrist, or an optician for examinations, frames and lenses. A premium payment is deducted from each monthly benefit check for those recipients who choose to participate. Dependents also may be enrolled if the recipient chooses coverage. PERS subsidizes 25 percent of the premium cost for the benefit recipient only.

Long Term Care Plan: This is a program in which any PERS benefit recipient, regardless of health care coverage, and their spouse may apply for protection from the expense of long term care. This plan was designed specifically to cover those long term care expenses not covered by the basic hospital/medical coverage. It is intended 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:"

PERS Response – Health Care Eligibility

The following are the current eligibility requirements for the PERS health care plan:

When applying for age and service retirement, a member must have 10 years of Ohio service credit to qualify for the PERS 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. If a member retires, chooses a joint and survivor annuity plan of payment (Plan A, C or D) and dies, the beneficiary will be entitled to health care coverage if the deceased retiree was eligible for health care coverage. If an individual is receiving a disability benefit, health care coverage is provided regardless of years of service credit.

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

Eligible dependents may be covered. These include the member's spouse; unmarried child(ren) under age 18, or under age 22 if attending school and dependent on the benefit recipient's support; and a dependent child, regardless of age, who has a physical or mental handicap, is unable to earn a living, and became incapacitated prior to age 18 (or 22 if attending school).

"(4) A statement of the number of participants eligible for the benefits;"

PERS Response – Eligible Participants

As of December 31, 1999, there were 118,062 benefit recipients receiving PERS health care coverage. The number of eligible dependents cannot be determined, but as of December 31, 1999, 43,485 dependents were covered by a PERS health care plan.

"(5) A description of the accounting, asset valuation, and funding method used to provide the benefits;"

PERS Response – Financial Methods

PERS 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, PERS estimates health care claims which have been incurred at year-end, but which are not yet known to the retirement system.

Plan investments are carried 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." Short-term investments are reported at amortized cost, which approximates fair value. All other investments are valued at market value with the exception of real estate, which is based on estimated current values and independent appraisals.

Since 1997 the Retirement Board has directed that employer contributions equal to 4.2% of the covered payroll be used to fund health care costs. These contributions along with investment income on the assets allocated to health care and periodic adjustments in health care provisions are expected to sustain the program indefinitely.

"(6) A statement of the net assets available for the provision of the benefits as of the last day of the fiscal year;"

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;"

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;"

See Attachment C, "Statements of 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 (D) of section 145.58 of the Revised Code."

$43,954,994 for 1999

Sec. 145.325 Medicare benefits for members of public employees retirement system

(A) Except as otherwise provided in division (B) of this section, the board of the public employees retirement system shall make available to each retirant 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 retirant 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 retirant 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 sections 145.48, 145.49, and 145.50 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.

(ENACTED: HB 402, Eff. 12/14/67; HB 1, Eff. 6/13/75; HB 1, Eff. 8/26/77; HB 126, Eff. 6/13/81; SB 346, Eff. 7/29/92)

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

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

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

(2) The spouse of the former member;

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

(B) The public employees retirement board may enter into agreements with insurance companies, health insuring corporations, or government agencies authorized to do business in the state for issuance of a policy or contract of health, medical, hospital, or surgical benefits, or any combination thereof, for those individuals receiving age and service retirement, or a disability or survivor benefit subscribing to the plan, or for PERS retirants employed under section 145.38 of the Revised Code, for coverage of benefits in accordance with division (D)(4)(b) of section 145.38 of the Revised Code. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children and for any of the individual's sponsored dependents as the board determines appropriate. If all or any portion of the policy or contract premium is to be paid by any individual receiving age and service retirement or a disability or survivor benefit, the individual shall, by written authorization, instruct the board to deduct the premium agreed to be paid by the individual to the company, corporation, or agency.

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

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

(C) If the board provides health, medical, hospital, or surgical benefits through any means other than a health insuring corporation, it shall offer to each individual eligible for the benefits the alternative of receiving benefits through enrollment in a health insuring corporation, if all of the following apply:

(1) The health insuring corporation provides services in the geographical area in which the individual lives;

(2) The eligible individual was receiving health care benefits through a health maintenance organization or a health insuring corporation before retirement;

(3) The rate and coverage provided by the health insuring corporation to eligible

individuals is comparable to that currently provided by the board under division (B) of this section. If the rate or coverage provided by the health insuring corporation is not comparable to that currently provided by the board under division (B) of this section, the board may deduct the additional cost from the eligible individual's monthly benefit.

The health insuring corporation shall accept as an enrollee any eligible individual who requests enrollment.

The board shall permit each eligible individual to change from one plan to another at least once a year at a time determined by the board.

(D) 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.

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

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

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

Attachment C

STATEMENTS OF PLAN NET ASSETS
HEALTH CARE

	1999	1998	1997	1996	1995	1994
Assets						
Cash and Short Term Investment	$193,521,934	$471,335,326	$487,746,980	$499,169,867	$353,600,557	$542,600,044
Receivables:						
Employers'	$27,145,428	$29,510,057	$21,388,190	$24,240,915	$24,624,841	$23,659,125
Retirement Incentive Plan	$2,777,067	$2,964,960	$3,829,808	$3,527,193	$1,706,491	$1,345,457
Investment Sales Proceeds	$117,162	$86,793,714	$46,184,481	$1,971,383	$10,817,145	
Accrued Interest and Dividends	$46,415,084	$52,727,381	$51,018,811	$46,742,776	$60,681,581	$61,424,582
Total Receivables	$76,454,741	$171,996,112	$122,421,290	$76,482,267	$97,830,058	$86,429,164
Investments, at fair value:						
Bonds	$2,162,313,014	$2,795,959,387	$3,031,100,715	$3,035,272,679	$3,789,626,044	$3,400,706,772
Mortgage & Mortgage Backed	$1,429,145,862	$1,413,860,311	$1,115,901,122	$1,025,311,866	$759,843,916	$853,676,132
Stocks	$3,911,196,263	$3,805,758,533	$2,580,763,906	$2,059,686,377	$1,712,462,199	$1,040,228,479
Real Estate	$1,118,361,190	$930,135,999	$609,166,124	$518,242,690	$483,534,455	$406,770,132
Venture Capital	$18,111,104	$8,565,060	$6,485,887	$4,977,458	$5,411,920	$3,378,445
International Securities	$2,287,215,780	$477,774,232	$207,407,199	$160,034,275	$44,731,309	$6,540,762
Collateral on Loaned Securities		$1,135,559,244	$944,925,686	$2,013,574,900	$1,557,133,046	$2,025,404,461
Total Investments	$10,926,343,213	$10,567,612,766	$8,495,750,639	$8,817,100,245	$8,352,742,889	$7,736,705,183
Collateral on Loaned Securities	$865,608,588					
Fixed Assets:						
Land	$724,575	$723,204	$307,514	$316,739	$336,898	$356,495
Building and Building Improvements	$3,868,237	$3,657,787	$3,282,978	$3,366,657	$3,484,318	$3,636,156
Furniture, Fixtures, and Equipment	$4,428,341	$3,784,916	$2,953,821	$2,803,422	$2,782,978	$2,609,631
	$9,021,153	$8,165,907	$6,544,313	$6,486,818	$6,604,194	$6,602,282
Accumulated Depreciation	($3,384,156)	($3,014,820)	($2,438,487)	($2,153,523)	($2,058,796)	($1,858,991)
Total Fixed Assets	$5,636,997	$5,151,087	$4,105,826	$4,333,295	$4,545,398	$4,743,291
Prepaid Expenses and Other	$15,985,801	$14,580,242	$12,714,410	$600,084	$521,589	$463,160
TOTAL ASSETS	$12,083,551,274	$11,230,675,533	$9,122,739,145	$9,397,685,758	$8,809,240,491	$8,370,940,842
Liabilities:						
Undistributed Deposits	$251,682	$110,336	$689,534	$1,175,971	$1,248,435	$818,504
Medical Benefits Payable	$53,846,033	$46,398,790	$44,621,490	$49,130,163	$49,190,177	$41,355,923
Investment Commitments Payable		$36,238,584	$7,962,109	$1,685,348	$5,915,470	$7,124,451
Accrued Administrative Expenses	$631,714	$528,321	$1,148,310	$996,534	$880,932	$842,692
Obligations Under Securities Lending	$865,608,588	$1,135,559,244	$944,925,686	$2,013,574,900	$1,557,133,046	$2,025,404,461
TOTAL LIABILITIES	$920,338,017	$1,218,835,275	$999,347,129	$2,066,562,916	$1,614,368,060	$2,075,546,031
Net assets held in trust for pension and post-employment health care benefits	$11,163,213,257	$10,011,840,228	$8,123,392,016	$7,331,122,842	$7,194,872,431	$6,295,394,811

Attachment D

STATEMENTS OF CHANGES IN PLAN NET ASSETS
HEALTH CARE

	1999	1998	1997	1996	1995	1994
Additions:						
Contributions:						
Members'						
Employers'	$392,459,727	$379,761,098	$422,152,429	$403,816,027	$381,803,227	$371,768,137
TOTAL CONTRIBUTIONS	$392,459,727	$379,761,098	$422,152,429	$403,816,027	$381,803,227	$371,768,137
Investment Income:						
Net Appreciation in Fair Value of Instruments	$888,386,350	$1,593,731,660	$370,211,565	($223,614,062)	$603,341,894	($335,838,310)
Bond Interest	$254,543,745	$250,812,003	$285,716,854	$250,836,769	$212,206,050	$338,940,321
Dividends	$69,366,846	$49,322,412	$45,080,119	$33,889,761	$29,152,640	$30,278,070
Real Estate Operating Income, net	$71,472,483	$56,358,214	$60,159,183	$41,976,169	$27,318,784	$31,826,019
Securities Lending Income	$29,062,059	$2,476,890	$1,727,809	$1,082,848	$1,404,426	$1,011,109
	$1,312,831,483	$1,952,701,179	$762,895,530	$104,171,485	$873,423,794	$66,217,209
Less: Investment Expenses	($28,561,474)	($1,698,418)	($1,005,080)	($798,761)	($593,144)	($433,624)
Net Investment Income	$1,284,270,009	$1,951,002,761	$761,890,450	$103,372,724	$872,830,650	$65,783,585
TOTAL ADDITIONS	$1,676,729,736	$2,330,763,859	$1,184,042,879	$507,188,751	$1,254,633,877	$437,551,722
Deductions:						
Benefits	$523,599,349	$440,596,663	$389,845,273	$369,213,858	$353,685,547	$327,578,426
Refunds of Contributions						
Administrative Expenses	$1,757,358	$1,718,984	$1,928,432	$1,724,482	$1,470,710	$845,251
TOTAL DEDUCTIONS	$525,356,707	$442,315,647	$391,773,705	$370,938,340	$355,156,257	$328,423,677
Net Increase	$1,151,373,029	$1,888,448,212	$792,269,174	$136,250,411	$899,477,620	$109,128,045
Net assets held in trust for pension and postemployment health care benefits:						
Balance, Beginning of Year (as restated)	$10,011,840,228	$8,123,392,016	$7,331,122,842	$7,194,872,431	$6,295,394,811	$6,186,266,766
BALANCE, END OF YEAR	$11,163,213,257	$10,011,840,228	$8,123,392,016	$7,331,122,842	$7,194,872,431	$6,295,394,811