State Teachers Retirement System
2022 ORSC Health Care Report
(For period July 1, 2021-June 30, 2022)

(Submitted to ORSC December 19, 2022)

As Required by Section 3307.51, Ohio Revised Code

Year in Review-2022

The State Teachers Retirement Board is permitted by law to offer a cost-sharing, multiple-employer health care plan. STRS Ohio provides access to health care coverage to eligible retirees who participated in the defined benefit or combined plan and their eligible dependents.

Coverage under the current program includes hospital inpatient and outpatient services, physicians' services, outpatient services, prescription drugs and partial reimbursement of monthly Medicare Part B premiums. The State Teachers Retirement Board has discretionary authority over how much, if any, of the associated health care costs will be absorbed by the plan. Benefit recipients pay a portion of the health care cost in the form of a monthly premium. STRS Ohio has established a health care assistance program for low income career teachers that provides health care coverage at no cost to the benefit recipient.

The Retirement Board has established a Health Care Fund within the Employers' Trust Fund from which health care benefits are paid. For the fiscal year ended June 30, 2022, the Board continued to allocate 0% of covered payroll to the Health Care Fund. Assets in the Health Care Fund are reported at fair value, and investment earnings are credited at the market rates of return earned by the total pool of STRS Ohio investments.

In December 2018, the Retirement Board adopted a health care plan management policy. The policy states the board's objectives for the health care plan and lays out clear criteria for making decisions regarding changes to benefits, as well as when those changes should be considered by the board. The policy indicates the goal is to provide a sustainable long-term health care program and to make benefit adjustments as conditions allow or are necessary.

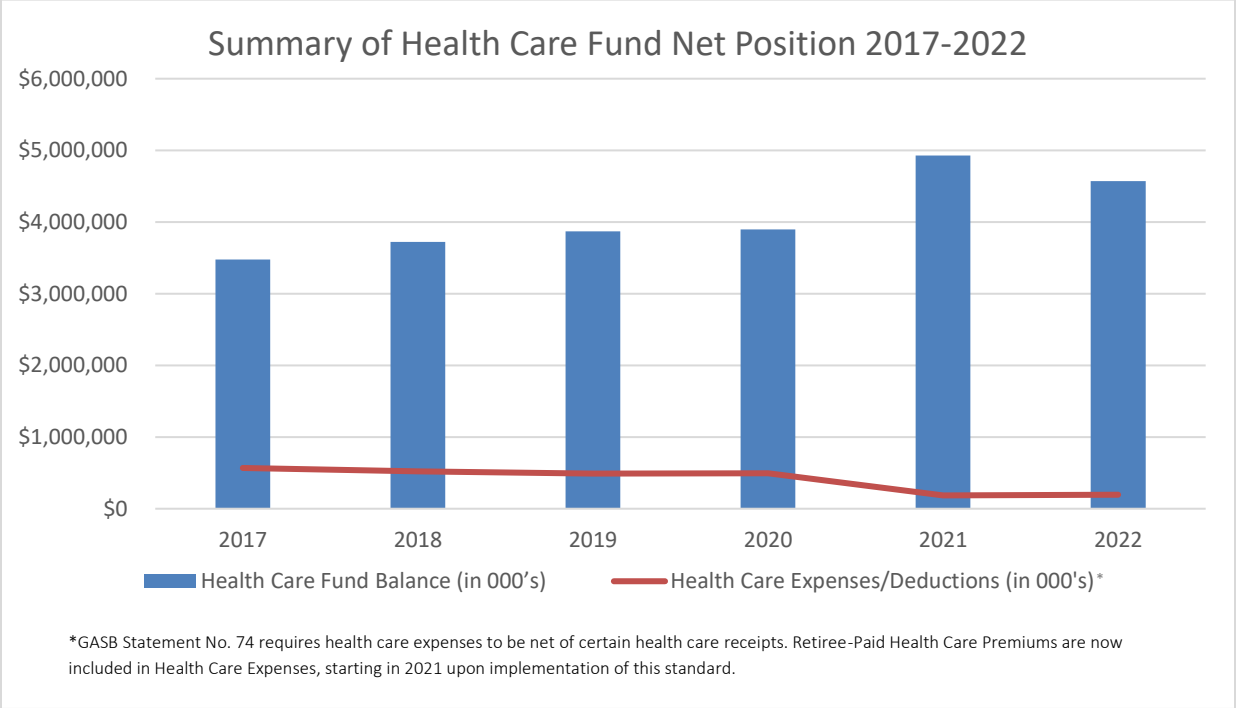
The Health Care Fund net position decreased to $4.6 billion in fiscal 2022 from $4.9 billion in fiscal 2021 primarily as a result of net investment losses in fiscal year 2022. Total payments for health care claims and provider administrative fees, net of health care premiums, totaled $193.6 million in fiscal 2022, an increase of $10.2 million or 5.6% from the previous fiscal year of $183.4 million. This is primarily attributed to a decrease in health care premiums and a larger premium rebate provided to members. Health care premiums received were $258.4 million in fiscal year 2022 compared to $282.9 million in fiscal year 2021. Premium rebate paid to members was $33.9 million in fiscal year 2022 compared to $28.9 million in fiscal year 2021. Health care payments and provider administrative fees totaled $418.1 million in fiscal year 2022, down from $437.4 million in fiscal year 2021.

The annual health care actuarial valuation showed that benefit payments for the 12-month period ending June 30, 2022, totaled $418.1 million. The funded ratio of the plan is 230.7% and assuming the fund earns 7.00% in all future years and all other plan experience matches assumptions, the fund is projected to remain solvent for all current members. However, the health care program remains susceptible to volatility from investment returns, government reimbursement changes, enrollment fluctuations and health care inflation.

Financial Information

Fiscal Year 2022 (in 000's)

Additions	Deductions	Fund Balance	Solvency Period[1]	Employer Allocation
($163,787)	$195,912	$4,570,040	Solvent for all current members	0%



Health Care Fund Balance (as graphed above)		
	Health Care Fund Balance (in 000's)	**Health Care Expenses/Deductions (in 000's)***
2017	$3,475,779	$568,459
2018	$3,721,349	$519,897
2019	$3,872,158	$491,521
2020	$3,897,296	$492,817
2021	$4,929,739	$185,734
2022	$4,570,040	$195,912

[1]Solvency period based on each system's individual valuation and underlining assumptions.

*GASB Statement No. 74 requires health care expenses to be net of certain health care receipts. Retiree-Paid Health Care Premiums are now included in Health Care Expenses, starting in 2021 upon implementation of this standard.

Average Cost Per Participant Paid by State Teachers Retirement System
Fiscal Year 2022

Non-Medicare Recipients	Medicare Recipients
$658	$210

Non-Medicare recipients includes all benefit recipients who are not eligible for Medicare.

Medicare recipients includes all benefit recipients who are eligible for Medicare Part A and/or Part B. The enrollee premiums are based on pooling Medicare-eligible individuals together; therefore, the above STRS Ohio subsidies reflect costs averaged across enrollees with Medicare Parts A&B and Medicare Part B-only. Without this pooling, the actual cost for enrollees with Medicare Part B-only would be two and a half times higher than the combined cost.

Population of Benefit Recipients
As of June 30, 2022

Age and Service	Disability	All Others (Survivors, Beneficiaries, etc.)	Total Recipients	Percent Medicare A&B	Percent Medicare B-only	Percent Non-Medicare
91,294	3,055	4,143	98,492	81%	10%	9%

Aetna Basic (Non-Medicare)

	In-Network & Indemnity[1]	Out-of-Network[1]
Deductible[2]	$2,500 per enrollee	$5,000 per enrollee
Out-of-Pocket Limit[2]	$6,500 per enrollee (includes deductible, coinsurance and primary care physician copayments)	$13,000 per enrollee (includes deductible and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	Plan pays 50%
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 For services deemed medically necessary by the plan administrator, indemnity and out-of-network payments are based on allowed amounts determined by the prevailing geographical area fee schedule. If nonparticipating providers charge in excess of these amounts, the enrollee may be responsible for the excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

Medical Mutual Basic (Non-Medicare)

	In-Network & Indemnity[1]	Out-of-Network[1]
Deductible[2]	$2,500 per enrollee	$5,000 per enrollee
Out-of-Pocket Limit[2]	$6,500 per enrollee (includes deductible, coinsurance and primary care physician copayments)	$13,000 per enrollee (includes deductible and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	Plan pays 50%
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 For services deemed medically necessary by the plan administrator, indemnity and out-of-network payments are based on allowed amounts determined by the prevailing geographical area fee schedule. If nonparticipating providers charge in excess of these amounts, the enrollee may be responsible for the excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

AultCare PPO (Non-Medicare)

	In-Network	Out-of-Network[1]
Deductible[2]	$2,500 per enrollee	$5,000 per enrollee
Out-of-Pocket Limit[2]	$6,500 per enrollee; includes deductible, copayments and coinsurance	$13,000 per enrollee; includes deductible, copayments and coinsurance
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	Plan pays 50%
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 Out-of-network payments are based on allowed amounts determined by the prevailing fee schedule in the geographical area where medically necessary services are performed as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

Paramount Health Care (Non-Medicare)

	In-Network[1]	Out-of-Network[1]
Deductible[2]	$2,000 per enrollee	Not applicable
Out-of-Pocket Limit[2]	$4,000 per enrollee; includes deductible, copayments and coinsurance	Not applicable
Lifetime Maximum	Unlimited	Not applicable
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	No coverage
Mental Health	Inpatient: Plan pays 80% Outpatient: Enrollee pays $20	No coverage
Surgery	Plan pays 80%	No coverage
Emergency Services		
Emergency Room	Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	No coverage
Flu Vaccines	Enrollee pays 0% (no deductible)	No coverage
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	No coverage

1 Enrollee must use HMO network providers. Out-of-network benefits do not apply, except for emergency and medically necessary acute onset urgent care services.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted.

Medical Mutual Health Care Assistance Plan (Non-Medicare)

	In-Network & Indemnity[1]	Out-of-Network[1]
Deductible[2]	$300 per enrollee	$300 per enrollee
Out-of-Pocket Limit[2]	$1,100 per enrollee (includes deductible and coinsurance)	$3,300 per enrollee (includes deductible and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%	Plan pays 50%
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 For services deemed medically necessary by the plan administrator, indemnity and out-of-network payments are based on allowed amounts determined by the prevailing geographical area fee schedule. If nonparticipating providers charge in excess of these amounts, the enrollee may be responsible for the excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

Aetna Medicare Plan (Medicare)

	In-Network or Extended Service Area[1]	Out-of-Network[1]
Deductible[2]	$150 per enrollee	$500 per enrollee
Out-of-Pocket Limit[2]	$1,500 per enrollee; includes deductible, copayments and coinsurance	$2,500 per enrollee; includes deductible, copayments and coinsurance
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 96%	Plan pays 92%
Mental Health	Inpatient: Plan pays 96% Outpatient: Enrollee pays $25 (no deductible)	Inpatient: Plan pays 92% Outpatient: Enrollee pays $55 after deductible
Surgery	Plan pays 96%	Plan pays 92%
Emergency Services		
Emergency Room	Enrollee pays $75 (no deductible); waived if admitted	
Urgent Care	Enrollee pays $40 (no deductible)	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 If providers do not accept Medicare assignment or charge in excess of Medicare payments, the enrollee is responsible for excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are combined.

Medical Mutual Basic (Medicare)

	In-Network & Indemnity[1,3]	Out-of-Network[1,3]
Deductible[2]	$2,500 per enrollee	$5,000 per enrollee
Out-of-Pocket Limit[2]	$6,500 per enrollee; includes deductible, coinsurance and primary care physician copayments	$13,000 per enrollee; includes deductible and coinsurance
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%[4]	Plan pays 50%[4]
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient: Plan pays 50% Outpatient: Plan pays 80%
Surgery	Plan pays 80%	
Emergency Services		
Emergency Room	Enrollee pays $150, then 20% after deductible; copayment waived if admitted	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 For services deemed medically necessary by the plan administrator, indemnity and out-of-network payments are based on allowed amounts determined by the prevailing geographical area fee schedule. If nonparticipating providers charge in excess of these amounts, the enrollee may be responsible for the excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out-of-network accumulations are separate.

3 Benefits are payable after Medicare payments.

4 Enrollees with Medicare Part B-only must use in-network providers for hospital services to receive maximum claims payment.

AultCare PrimeTime Health Plan (Medicare)

	In-Network	Out-of-Network[1]
Deductible[2]	$150 per enrollee	$500 per enrollee
Out-of-Pocket Limit[2]	$1,500 per enrollee; includes deductible, copayments and coinsurance	$2,500 per enrollee; includes deductible, copayments and coinsurance
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 96%	Plan pays 92%
Mental Health	Inpatient: Plan pays 96% Outpatient: Enrollee pays $25	Inpatient: Plan pays 92% Outpatient: Enrollee pays $55
Surgery	Plan pays 96%	Plan pays 92%
Emergency Services		
Emergency Room	Enrollee pays $75 (no deductible); waived if admitted	
Urgent Care	Enrollee pays $40 (no deductible)	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 Out-of-network payments are based on allowed amounts determined by the prevailing fee schedule in the geographical area where medically necessary services are performed as established by the plan administrator. If nonparticipating providers charge in excess of these amounts, the enrollee is responsible for excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out- of-network accumulations are combined.

Paramount Elite (Medicare)

	In-Network[1]	Out-of-Network[1]
Deductible[2]	$150 per enrollee	Not applicable
Out-of-Pocket Limit[2]	$1,500 per enrollee; includes deductible, copayments and coinsurance	Not applicable
Lifetime Maximum	Unlimited	Not applicable
Medical Services (% covered by plan)		
Outpatient	Plan pays 96%	No coverage
Mental Health	Inpatient: Plan pays 96% Outpatient: Enrollee pays $20	No coverage
Surgery	Plan pays 96%	No coverage
Emergency Services		
Emergency Room	Enrollee pays $75 (no deductible); waived if admitted	
Urgent Care	Enrollee pays $40 (no deductible)	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	No coverage
Flu Vaccines	Enrollee pays 0% (no deductible)	No coverage
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	No coverage

1 Enrollee must use HMO network providers. Out-of-network benefits do not apply, except for emergency and medically necessary acute onset urgent care services.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted.

Medical Mutual Health Care Assistance Plan (Medicare)

	In-Network & Indemnity[1]	Out-of-Network[1]
Deductible[2]	$300 per enrollee	$300 per enrollee
Out-of-Pocket Limit[2]	$1,100 per enrollee (includes deductible and coinsurance)	$3,300 per enrollee (includes deductible and coinsurance)
Lifetime Maximum	Unlimited	
Medical Services (% covered by plan)		
Outpatient	Plan pays 80%[3]	Plan pays 50%[3]
Mental Health	Inpatient and Outpatient: Plan pays 80%	Inpatient and Outpatient: Plan pays 50%
Surgery	Plan pays 80%	Plan pays 50%
Emergency Services		
Emergency Room	Enrollee pays $150; waived if admitted	
Urgent Care	Enrollee pays $40, then 20% after deductible	
Preventive Services		
Annual Physical	Enrollee pays 0% (no deductible); limit one per calendar year	
Flu Vaccines	Enrollee pays 0% (no deductible)	
EKG, Cholesterol, Blood Sugar, Lipid, Colonoscopy, Sigmoidoscopy, Bone Density Testing	Enrollee pays 0% (no deductible); limited designated services; frequency/age/gender limitations apply based on U.S. Preventive Services Task Force recommendations	

1 For services deemed medically necessary by the plan administrator, indemnity and out-of-network payments are based on allowed amounts determined by the prevailing geographical area fee schedule. If nonparticipating providers charge in excess of these amounts, the enrollee may be responsible for the excess charges.

2 Annual deductible must be met before plan begins making payments, unless otherwise noted. In-network and out- of-network accumulations are separate.

3 Enrollees with Medicare Part B-only must use in-network providers for hospital services to receive maximum claims payment.

Express Scripts Prescription Plan (Non-Medicare)

For Medical Mutual Basic, Aetna Basic, AultCare PPO and Paramount Health Care

	Retail Preferred/Home Delivery	Retail Non-Preferred
Annual Deductible	$275 per enrollee for covered brand-name drugs, including brand-name specialty drugs	
Generic	**Retail:** Enrollee pays $10 **Home Delivery:** Enrollee pays $9 for Low- Cost Generic Drug Program medications; $25 for all other generic medications	Enrollee pays the copayment/coinsurance charged at a preferred pharmacy, plus a $10 fee per fill
Formulary Preferred Brand-Name	**Retail:** Enrollee pays $30 after deductible **Home Delivery:** Enrollee pays $75 after deductible	
Formulary Non-Preferred Brand-Name	**Retail:** Enrollee pays $75 after deductible **Home Delivery:** Enrollee pays $187.50 after deductible	
Nonformulary Brand-Name	Not covered	
Specialty Drugs	Enrollee pays the lesser of 8% of the cost **or** $450 for supply of 1–31 days, $900 for supply of 32–60 days and $1,350 for supply of 61–90 days (after deductible)	
Maximum Annual Expense	If an enrollee pays a total of $5,100 out of pocket in copayments/coinsurance/deductible for covered medications, that enrollee pays nothing for covered medications for the remainder of the year.	

Express Scripts Prescription Plan (Non-Medicare)

For Health Care Assistance Program

	Retail Preferred/Home Delivery Retail Non-Preferred
Annual Deductible	Not applicable
Generic	**Retail:** Enrollee pays $5 **Home Delivery:** Enrollee pays $9 for Low-Cost Generic Drug Program medications; $10 for all other generic medications
Formulary Preferred Brand-Name	**Retail:** Enrollee pays $20 **Home Delivery:** Enrollee pays $40
Formulary Non-Preferred Brand-Name	**Retail:** Enrollee pays $50 **Home Delivery:** Enrollee pays $100
Nonformulary Brand-Name	Not covered
Specialty Drugs	**Retail:** Enrollee pays $20 **Home Delivery:** Enrollee pays $40
Maximum Annual Expense	If an enrollee pays a total of $500 out of pocket in copayments for covered medications, that enrollee pays nothing for covered medications for the remainder of the year.

Express Scripts Medicare Part D Prescription Plan (Medicare)

For Aetna Medicare Plan, Medical Mutual Basic, AultCare PrimeTime Health Plan and Paramount Elite

	Retail Preferred/Home Delivery	Retail Non-Preferred
Annual Deductible	$275 per enrollee for covered brand-name drugs, including brand-name specialty drugs	
Generic	**Retail:** Enrollee pays $10 **Home Delivery:** Enrollee pays $9 for Low-Cost Generic Drug Program medications; $25 for all other generic medications	Enrollee pays the copayment/coinsurance charged at a preferred pharmacy, plus a $10 fee per fill
Formulary Preferred Brand-Name	**Retail:** Enrollee pays $30 after deductible **Home Delivery:** Enrollee pays $75 after deductible	
Formulary Non-Preferred Brand-Name	**Retail:** Enrollee pays $75 after deductible **Home Delivery:** Enrollee pays $187.50 after deductible	
Nonformulary Brand-Name	Not covered	
Specialty Drugs	Enrollee pays the lesser of 8% of the cost **or** $450 for supply of 1–31 days, $900 for supply of 32–60 days and $1,350 for supply of 61–90 days (after deductible)	
Maximum Annual Expense	If an enrollee pays a total of $5,100 out of pocket in copayments/coinsurance/deductible for covered medications, that enrollee pays nothing for covered medications for the remainder of the year.	

Express Scripts Medicare Part D Prescription Plan (Medicare)

For Health Care Assistance Program

	Retail Preferred/Home Delivery	Retail Non-Preferred
Annual Deductible	Not applicable	
Generic	**Retail:** Enrollee pays $5 **Home Delivery:** Enrollee pays $9 for Low-Cost Generic Drug Program medications; $10 for all other generic medications	
Formulary Preferred Brand-Name	**Retail:** Enrollee pays $20 **Home Delivery:** Enrollee pays $40	
Formulary Non-Preferred Brand-Name	**Retail:** Enrollee pays $50 **Home Delivery:** Enrollee pays $100	
Nonformulary Brand	Not covered	
Specialty Drugs	**Retail:** Enrollee pays $20 **Home Delivery:** Enrollee pays $40	
Maximum Annual Expense	If an enrollee pays a total of $500 out of pocket in copayments for covered medications, that enrollee pays nothing for covered medications for the remainder of the year.	

Health Care Future – Fiscal Year 2022

The STRS Ohio Health Care Program remains in solid financial position even with the reduction to the expected rate of investment return from 7.45% to 7.00%, which was done in 2021. As of June 30, 2022, the program is 230.7%, funded, meaning there is, if all actuarial assumptions are met, long-term solvency for all current retirees and STRS Ohio members upon retirement. The current subsidy strategy calls for pre-Medicare subsidies to be frozen at the increased 2023 levels and for Medicare subsidy increases to be capped at the lesser of 6% or the actual trend. In addition, benefit recipients enrolled in a Medicare plan in the STRS Ohio Health Care Program receive a $30 per month premium credit as partial reimbursement for Medicare Part B premiums.

Due to the strong funding level, the Retirement Board will continue evaluating possible changes to the program for implementation Jan. 1, 2024. For 2023, the Board voted to increase the 2023 non-Medicare subsidy levels. Premiums were also reduced for Medicare enrollees to reflect the positive experience in the Aetna Medicare Plan.

A significant contributor to the solid funding status has been the continuing strong consistent levels of federal government reimbursements resulting from operating a Medicare Advantage and self-insured Prescription Part D (MAPD) program and the increasing formulary drug rebates. STRS Ohio recognizes these payments are not guaranteed and are subject to significant volatility. Additionally, the system recognizes the investment return volatility associated with the current asset mix. It is also important to note that employer contributions to the Health Care Fund ceased beginning July 1, 2014. As a result of potential funding volatility and lack of employer contributions, benefit changes are likely to be gradually introduced.
An upcoming eligibility change for the STRS Ohio Health Care Program will occur next August. Members who retire on or after Aug. 1, 2023, must have at least 20 years of total service credit to access coverage. Members who retire before Aug. 1, 2023, will be grandfathered under their current requirements. This change was first announced ten years ago and has been continually communicated since then.

Supplementary Statutory Requirements

The following is provided in accordance with the requirements of Revised Code section 3307.51(E)

(1) A description of the statutory authority for the benefits provided:

Ohio Revised Code, section 3307.39, states:

> The State Teachers Retirement Board may enter into an agreement 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 coverage, or any combination thereof, for those individuals receiving, under the STRS defined benefit plan, service retirement or a disability or survivor benefit who subscribe to the plan. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children as the board considers appropriate.
>
> 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 state teachers retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by section 3307.28 of the Revised Code.

Ohio Revised Code section 3307.39, also states "the board may make a monthly payment to each recipient of service retirement, or a disability or survivor benefit under the STRS defined benefit plan who is enrolled in coverage under part B of the Medicare program established under Title XVIII of "The Social Security Amendments of 1965," 79 Stat. 301 (1965), 42 U.S.C.A. 1395j, as amended."

(2) A summary of coverage for 2022:

A summary of the coverage for calendar year 2022 is provided on pages 5 through 18 in the attached ORSC Health Care Report.

(3) A summary of the eligibility requirements for the benefits:

In general, service retirees are required to have 15 years of qualified service credit to be eligible for the STRS Ohio Health Care Program, and eligibility is extended to disability recipients and some survivor annuitants and survivor benefit recipients. Service retirees who retire on or after August 1, 2023 will need 20 years of service to be eligible for the STRS Ohio Health Care Program.

More details on eligibility requirements for the STRS Ohio Health Care Program are provided in Attachment A on pages 25 and 26.

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

As of June 1, 2022, there were 142,028 benefit recipients eligible to participate in the STRS Ohio Health Care Program.

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

The Retirement Board has established a Health Care Fund within the Employers' Trust Fund from which health care benefits are paid. For the fiscal year ended June 30, 2022, the Board continued to allocate 0% of covered payroll to the Health Care Fund. Assets in the Health Care Fund are reported at fair value, and investment earnings are credited at the market rates of return earned by the total pool of STRS Ohio investments.

The Actuarially Determined Contribution (ADC) is calculated as the normal cost determined under the Entry Age Normal Actuarial Cost Method, plus the amortization of the unfunded actuarial liability over a 30-year open level percent of pay, plus anticipated administrative expenses. Currently, the ADC is negative and is projected to remain negative, thus the employer is not expected to make any future contributions to the Health Care Fund.

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

Post-Employment Health Care
Statement of Fiduciary Net Position
As of June 30, 2022
(In Thousands)

Assets:	
Cash and short-term investments	$ 136,560
Receivables:	
Accrued interest and dividends	13,715
Securities sold	26,507
Medical benefits receivable	34,537
Total receivables	74,759
Investments, at fair value:	
Fixed income	785,296
Domestic equities	1,135,813
International Equities	994 ,712
Real estate	615,136
Alternative investments	985,372
Total investments	4,516,329
Invested securities lending collateral	77,206
Total assets	4,804,854
Liabilities:	
Securities purchased and other investment liabilities	21,717
Debt on real estate investments	115,818
Accrued expenses and other liabilities	1,992
Medical benefits payable	18,081
Obligations under securities lending program	77,206
Total liabilities	234,814
Fiduciary net position restricted for post-employment health care coverage:	4,570,040

(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:

Post-Employment Health Care
Statement of Changes in Fiduciary Net Position
As of June 30, 2022
(In Thousands)

Additions:	
Contributions:	
Employer	$ 0
Government reimbursements	97,713
Total contributions	97,713
Investment income from investing activities:	
Net appreciation (depreciation) in fair value of investments	(325,944)
Interest	24,497
Dividends	42,823
Real estate income	12,770
Investment income (loss)	(245,854)
Less internal investment expenses	(2,339)
Less external asset management fees	(13,533)
Net income (loss) from investing activities	(261,726)
Securities lending income	255
Securities lending expenses	(29)
Net income from securities lending activities	226
Net investment income (loss)	(261,500)
Total additions	(163,787)
Deductions:	
Health care	193,572
Administrative expenses	2,340
Total deductions	195,912
Net increase (decrease) in net position	(359,699)
Fiduciary net position restricted for post-employment health care coverage:	
Beginning of year	4,929,739
End of year	4,570,040

(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:

Six-Year History

Fiscal Year Ended (in Thousands)

	2022	2021	2020	2019	2018	2017
Employer contributions	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
Government reimbursements	$ 97,713	$ 96,478	$ 81,876	$ 84,789	$ 107,197	$ 79,357
Retiree-paid health care premiums	$ 0	$ 0	$ 295,779	$ 312,841	$ 329,305	$ 339,056
Net investment income (loss)	$ (261,500)	$ 1,121,699	$ 140,300	$ 244,700	$ 328,965	$ 440,197
Health care expenses	$ 193,572	$ 183,390	$ 490,559	$ 489,169	$ 517,470	$ 565,962
Administrative expenses	$ 2,340	$ 2,344	$ 2,258	$ 2,352	$ 2,427	$ 2,497
Fiduciary net position available for benefits	$ 4,570,040	$ 4,929,739	$ 3,897,296	$ 3,872,158	$ 3,721,349	$ 3,475,779

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

GASB Statement No. 74 requires health care expenses to be net of certain health care receipts. Retiree-Paid Health Care Premiums are now included in Health Care Expenses, starting in 2021 upon implementation of this standard.

(10) A statement of the amount paid under division (B) of section 3307.39 of the Revised Code:

In 2020 and 2021, STRS Ohio reimbursed benefit recipients who were enrolled in an STRS Ohio health care plan and Medicare Part B $29.90 per month toward their total Medicare Part B premium. In 2023, the Medicare Part B premium reimbursement will be moved to a $30 subsidy credit for all benefit recipients who pay Medicare enrollee premiums.

Attachment A – Summary of STRS Ohio Eligibility Requirements for the Benefits

3307:1-11-03 Health care services - medical plan.

(A) Eligibility

The following individuals shall be eligible to participate in a medical plan offered by the retirement system:

(1) A service retiree with an effective benefit date:

(a) Before January 1, 2004; or

(b) Between January 1, 2004 and July 1, 2023 and the benefit is based on fifteen or more years of total service credit; or

(c) After July 1, 2023 and the benefit is based on twenty or more years of total service credit.

(2) A service retiree who began receiving service retirement benefits with no break in monthly benefits following the termination of disability benefits, with a disability effective benefit date:

(a) Before January 1, 2004; or

(b) Between January 1, 2004 and July 1, 2023 and the service retiree benefit is based on fifteen or more years of total service credit; or

(c) After July 1, 2023 and the service retiree benefit is based on twenty or more years of total service credit.

(3) A disability benefit recipient.

(4) A survivor annuitant.

(5) A survivor benefit recipient under division (C)(1) of section 3307.66 of the Revised Code who was eligible for coverage as a dependent at the time of the member's or disability benefit recipient's death where the effective date of survivor benefits or the effective date of disability benefits of the deceased member is:

(a) Before January 1, 2004; or

(b) Between January 1, 2004 and July 1, 2023 provided that the deceased member had fifteen or more years of total service credit at the time of death; or

(c) After July 1, 2023 provided the deceased member had twenty or more years of total service credit at the time of death.

(6) A survivor benefit recipient under division (C)(2) of section 3307.66 of the Revised Code who was eligible for coverage as a dependent at the time of the member's or disability benefit recipient's death.

(7) Dependents, to the extent that a medical plan and/or ancillary plan allows for dependent coverage.

(8) Notwithstanding paragraphs (A)(1) to (A)(7) of this rule, an individual not eligible for medicare coverage is not eligible for primary coverage in a medical plan offered by the retirement system if the individual is employed and has access to an entity's medical plan or if similarly situated, non-retired employees have access to an entity's medical plan, provided the medical plan includes prescription coverage and provides equivalent coverage at a cost no more than what is available to full-time employees as defined by the entity. The retirement board may require each enrollee to annually file a verification of employment statement disclosing the availability for enrollment as an employee in an entity's medical plan.

(a) When an individual is enrolled in an entity's medical plan and a medical plan offered by the retirement system, coverage in the retirement system's medical plan will be limited to secondary coverage applied only to those covered medical expenses not paid by the entity's medical plan.

(b) An employed individual not eligible for Medicare who does not file a verification of employment statement with the retirement system when requested by the retirement system; does not enroll in the entity's medical plan when eligible to enroll, or is excluded from the entity's medical plan based upon being an enrollee is not eligible to enroll or remain enrolled in a medical plan offered by the retirement system.