2017 Health Care Report

Presented to the Ohio Retirement Study Council

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Karen Carraher,
Executive Director

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A Letter from Karen Carraher

Dear members of the Ohio Retirement Study Council:

The Ohio Public Employees Retirement System (OPERS or System) proudly submits the 2017 OPERS Health Care Report. OPERS provides a comprehensive retirement package for Ohio public employees. With over $101.4 billion in total assets, OPERS is the largest public pension fund in Ohio and the 12th largest in the United States. Established in 1935 to provide retirement, disability and survivor benefits for public employees, OPERS serves more than 1 million members. Of that, approximately 200,000 participants are actively participating in OPERS health care. Although not mandated, for more than one-half of our history, OPERS has provided access to health care coverage for retirees, which we believe is an important part of retirement security.

OPERS HEALTH CARE PLANS

In 2016, OPERS moved to a private exchange model for its Medicare-eligible health care participants. Retirees enrolled in Medicare used the OPERS Medicare Connector (Connector) to enroll in an individual Medicare plan and were provided a reimbursement allowance under the OPERS health reimbursement arrangement (HRA) plan to be used for qualifying medical expenses. The Connector was implemented with the goal to "leave no retiree behind." Once all eligible retirees were successfully enrolled, we turned our attention to ensuring participants were using their HRA accounts properly and being reimbursed for qualifying medical expenses. OPERS made significant efforts in 2017 to further educate retirees on the HRA reimbursement process by conducting group seminars, one-on-one counseling and increasing communications.

We continued to implement annual adjustments to plan design and premiums for the OPERS pre-Medicare plan to keep pace with continually rising costs and increasing numbers of participants with chronic or complex conditions.

Significant plan changes introduced in 2012 have been fully implemented and the financial impact of these changes continues to be evident in cost savings. In alignment with national trends, the total retiree population continues to grow and have longer life expectancies than ever before. Also, our per retiree health care expenses will continue to increase as a result of health care cost inflation and our retiree population spending more years in retirement than previous program participants. Our health care program may again require incremental changes to support adequate funding for future retirees.

2017 FINANCIAL PERFORMANCE

Financial markets performed well in 2017 and these positive results are reflected in the performance of our funds. Strong results enable us to continue progress toward our long term-goals. As a team, we remain focused on keeping the System strong today and well into the future. Knowing that all years will not be as positive as 2017, OPERS remains dedicated to a long-term focus.

Respectfully submitted,

Karen E. Carraher

Karen E. Carraher
Executive Director

2017 Year In Review

HEALTH CARE PRESERVATION PLAN

To continue to offer retirees access to health care coverage, in 2012 OPERS adopted significant changes to the health care program, which were fully phased-in as of January 1, 2018. Throughout 2017, OPERS prepared participants for the complete phasing-out of premium support for spouses. To prepare both Medicare and non-Medicare participants to either pay the full cost for spouse coverage or find comparable coverage elsewhere, OPERS furnished a variety of state and federal resources. These resources served to direct participants toward alternate coverage if the full cost to cover a spouse on the OPERS plan became more than they could comfortably afford.

TRANSITION TO THE CONNECTOR

In 2017, the System worked to ensure all eligible participants enrolled into individual Medicare plans via the OPERS Medicare Connector were successfully using their HRA accounts. After an initial adjustment period in 2016, OPERS saw a large increase in retirees successfully submitting HRA claims for reimbursement in 2017.

To further increase retirees' proficiency using the HRA, OPERS offers both a How to Use Your Health Reimbursement Arrangement account seminar presented live in Columbus and around the state and a hands-on, 30-minute workshop designed to provide assistance with claims paperwork at the OPERS office in Columbus. Both offerings have been well-received and participants report an increased understanding of the process after attending.

In addition, OPERS extended personal outreach to those retirees identified as not having used their HRA account or having an unusually high balance. These retirees received one-on-one counseling to increase their understanding of the reimbursement process so they can utilize their HRA account in a manner that best suits their individual retirement health care plan.

OPERS HEALTH CARE PROGRAM

OPERS continued to implement annual adjustments to plan design and premiums for the OPERS pre-Medicare plan to keep pace with rising costs. While participant cost share increased in 2017, OPERS continues to pay the majority of the cost of coverage — 83% of pre-Medicare retirees receive at least a 75% allowance from OPERS toward monthly premiums.

The System extended its agreements with the following health plan administrators – Medical Mutual (Medical), Aetna (Vision) and MetLife (Dental).

As of December 31, 2017, OPERS terminated the Humana Interim Plan for participants enrolled in Medicare but not eligible to enroll into an individual Medicare plan through the Connector. Humana Interim Plan participants were automatically transitioned to the Medicare Re-employed Plan administered by Medical Mutual.

ADVOCACY WORK

Biosimilar drugs

OPERS continued to advocate at the federal level with the goal of increasing the speed in which biosimilar drugs, a cost-effective alternative to specialty drugs, are introduced to the market. As a member of the Public Sector Healthcare Roundtable, OPERS supports regulatory efforts to establish and sustain greater competition in the pharmaceutical, and especially the biopharmaceutical, marketplace.

The end-goal is the implementation of a clear, efficient regulatory pathway to rapidly bring lower-cost biosimilar medications to market.

Increasing the speed of which biosimilar drugs are introduced to the market is important because specialty drugs account for 41.3% of OPERS' total gross cost for retiree prescription drugs. Although specialty drugs account for a large percentage of the total cost, only 4.4% of participants utilized a specialty drug in 2017 and only 0.9% of prescriptions filled are specialty drugs.

Cadillac tax

Although the Affordable Care Act's (ACA) excise tax, otherwise known as the "Cadillac tax," has been delayed until 2022, OPERS continues to advocate for a complete repeal or, in the alternative, an exemption for retiree-only health plans. OPERS opposes the excise tax because it disproportionately impacts retiree-only health care plans and could force OPERS to reduce benefits and shift additional health care costs to OPERS retirees.

STEPS TO STRENGTHEN PENSION FUNDING

As fiduciaries to all members and retirees, one of the duties of the OPERS Board of Trustees (Board) is to assure that the pension plan is well funded. OPERS must adapt to a variety of issues as time passes, such as volatile financial markets and the changing demographics of members.

As of January 1, 2018, OPERS no longer allocates member or employer contributions to the funding of retiree health care coverage. One hundred percent of contributions go toward funding pensions. In 2017, OPERS pursued changes to strengthen pension funding including tying the cost-of-living adjustment to the CPI with a cap and modifying survivor benefits. Strengthening pension funding now could positively impact health care funding in the future.

FUTURE OPPORTUNITIES

As retirees live longer, that increased longevity comes at a price. Retirees often are living with one or more chronic conditions which can be expensive to treat. In order to help us to control future costs, we encourage the OPERS retiree population to make smart choices and take charge of their health now. They can do this by understanding how their coverage works, saving for future health care costs, taking advantage of available wellness resources and programs and talking with their doctors about different options for treating their condition. Encouraging retirees to make smart choices now may affect not only their health status but also their bank account and the overall health of the population OPERS is providing with health care coverage.

An example of the System's commitment to a healthier retiree population is the diabetes prevention program for pre-Medicare retirees administered by Medical Mutual. The yearlong program focuses on healthy eating and physical activity and is offered through local YMCAs.

2017 FINANCIAL HIGHLIGHTS

The year 2017 was good for financial markets and the positive results we have garnered reflect that. Good years with strong results enable us to continue progress toward our long term-goals. The OPERS team—staff, management and Board—remains dedicated to keeping the System strong today and well into the future. We know all years will not be as strong—OPERS is dedicated to a long-term focus.

Funded status

Health care coverage is not statutorily guaranteed, and can only be funded if pension funding is adequate. OPERS has historically pre-funded health care costs.

However, analysis of past trends and modeling of future projects indicate that without significant future market improvement, OPERS may need to further decrease the long-term earnings expectations for pensions. As of January 1, 2018, all funding is dedicated to fund pension and, thus, there is no funding to health care. That said, retirees continue to inform us of the importance of meaningful access to health care. We will continue to evaluate plan and product designs to encourage sustainability.

Funded status measures the progress of accumulating the funds necessary to meet future obligations. While initially a pension measure, since OPERS pre-funds health care, we also apply the measure to our health care trust. This measure is helpful, but it is important to remember that health care can and will be modified to be sustainable within the financial resources. As of the December 31, 2016 health care actuarial valuation (the date of the most recent actuarial valuation), OPERS was 60.7% funded. In the absence of employer contributions, and given rising health care costs, the health care fund is expected to become insolvent after 12 years.

The System dedication to maintaining access to meaningful health care has become increasingly expensive as health care expenses continue to increase significantly faster than inflation. Because we anticipate that health care expenses will continue to grow as the number and life expectancy of our retirees continues to grow, we again look to the future to determine how to make incremental changes to provide adequate funding for future retirees.

Investment results

The results of our investment efforts are always a focus for this organization. Because investment returns fund approximately two-thirds of a retiree's ultimate pension, the results of each and every year are important. As always, throughout 2017, we remained steadfast to the proven principles of asset allocation and diversification.

The growing retiree base, retirees living longer in retirement than ever before, and the escalating costs in health care all create unprecedented drains on the income generated from investments. The OPERS long-term investment goal is to attain targeted results to help secure retirement benefits for our members. This sustained performance goal means we focus on the long-term market view—but understand that year-to-year market fluctuations and corrections will occur. When corrections occur, we work to ensure the System can absorb the losses by having the resources and safeguards in place to sustain the foundation.

Globally, the 2017 market delivered strong returns—and OPERS was well-positioned to enjoy the success of the rising markets. The Health Care portfolio returned 15.25% in 2017, compared to the benchmark return of 14.31% and the anticipated actuarial funding plan rate of 6.50%. Overall, we recognize the importance of adhering to our policies and remaining focused on achieving the targeted rate of return. We invest thoughtfully and strategically.

Funding Retiree Health Care

Although health care is neither mandated nor guaranteed, the Board, management and staff, recognize the importance to our members of providing access to meaningful health care as it is an important piece of a secure retirement. The $12.8 billion 115 Health Care Trust has no additional funding and is currently enhanced solely by investment returns. Excess in investment returns and the Health Care Stabilization Fund provide a source of funds to offset years in which the 4.0% allocation of the employer contribution cannot be contributed or in which the fund does not earn the expected 4.0% investment earnings.

Maintaining access to meaningful health care has become increasingly expensive as OPERS retirees, similar to national trends, have increased in number, have longer life expectancies, and have encountered health care costs increasing significantly faster than inflation. Because we anticipate that health care expenses will continue to grow as the number—and life expectancies—of our retirees continues to grow, we again look to the future to determine how to make incremental changes to ensure adequate funding exists for future retirees.

EMPLOYER CONTRIBUTIONS

OPERS is dedicated to the funding objective to meet long-term pension benefit obligations and, to the extent possible, fund post-employment health care. Reduced expectations for lower long-term expected rates of return for the defined benefit pension investments leads to lower funded status and increased amortization periods over time. As a result, the required portion of the employer contribution rate must increase and the corresponding allocation to health care decrease.

With the assistance of the System's actuary and Board approval, a portion of each employer's contribution to OPERS may be set aside for the funding of post-employment health care coverage. The portion of Traditional Pension Plan and Combined Plan employer contributions allocated to health care was 1.0% in 2017. The 2018 allocation is expected to be 0% for health care funding, and is expected to continue thereafter. The employer contribution as a percent of covered payroll deposited for the Member-Directed Plan participant health care accounts for 2017 was 4.0%.

INVESTMENT RETURNS ON THE HEALTH CARE PORTFOLIO

During 2017, OPERS managed investments in three investment portfolios: the Defined Benefit portfolio, the Health Care portfolio and the Defined Contribution portfolio. The Health Care portfolio includes the assets for health care expenses for the Traditional Pension Plan, Combined Plan and Member-Directed eligible members.

The Health Care portfolio returned 15.25% in 2017, compared with the health care policy benchmark return of 14.31%. Total combined health care net assets were $12.8 billion as of December 31, 2017.

115 HEALTH CARE TRUST

The 115 Heath Care Trust (115 Trust) was established in 2014. The 401(h) Health Care Trust and Voluntary Employees' Beneficiary Association Trust were closed as of June 30, 2016 and the net positions transferred to the 115 Trust on July 1, 2016. From 2016 forward, the 115 Trust pre-funds and holds the portion of employer contributions of the Traditional Pension, Combined and Member-Directed plans set aside for funding retiree health care. The 115 Trust provides the funding for health care coverage paid for non-Medicare eligible retirees and eligible dependents of deceased members and monthly deposits to the HRA for Medicare-eligible retirees and eligible dependents of deceased members under the Connector program.

Funding Retiree Health Care

SOURCES OF INCOME

Additions to the health care trusts are comprised primarily of employer contributions and investment returns. In 2017, OPERS implemented Governmental Accounting Standards Board Statement No. 74 (GASB 74), Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans. GASB 74 requires that certain health care receipts be netted with health care expenses reported in Health Care Expenses in the Statement of Changes in Fiduciary Net Position. The presentation of Retiree-Paid Health Care Premiums, Federal Subsidy, and formulary rebates, rebates previously reported in Contract and Other Receipts, has been revised and these health care receipts are now included in health care expenses.

Statutory Requirements

Pursuant to Sections 145.58 and 145.584 of the Ohio Revised Code (ORC), the OPERS Board of Trustees (Board) is required to prepare annually a report giving a full accounting of the revenues and costs relating to the provision of health coverage. The report must be as of December 31. Section 10 of ORC 145.22 (E) requires OPERS to submit the report by June 30 of the following year to the Ohio Retirement Study Council, director of Budget and Management, and the standing committees of the Ohio House of Representatives and Ohio Senate.

The following information fulfills the requirements of OPERS as outlined in ORC Section 145.22(E). The requirements and the System's responses follow:

1. A description of the statutory authority for the benefits provided

Appendixes A and B are copies of ORC Section 145.58 (group hospitalization coverage; ineligible individuals; service credit; alternate use of Health Maintenance Organization) and ORC Section 145.584 (Medicare-equivalent benefits for members ineligible for Medicare), as they existed during the majority of 2017. Both sections were amended by Substitute Senate Bill 343, effective January 7, 2013.

2. A summary of coverage for 2017

The following is an outline of OPERS health care coverage in 2017:

THE 2017 OPERS RETIREE HEALTH PLAN FOR PRE-MEDICARE PARTICIPANTS

The 2017 OPERS health care plan administrator, Medical Mutual, utilized a Preferred Provider Organization (PPO) for our pre-Medicare participants. Doctors and medical facilities that belong to the PPO network agree to perform services at agreed-upon contract rates. While participants were able to choose any provider and still receive coverage, they had lower out-of-pocket costs if they chose a network provider. Pre-Medicare, re-employed retirees were in a separate plan with identical coverage.

OPERS Retiree Health Plan administered by Medical Mutual PPO/Medical Mutual Interim Plan

2017 OPERS Retiree Health Plan	2017
Deductible (in-network)	$1,000
Total (in-network) out-of-pocket maximum	$4,900
Deductible (out-of-network)	$2,000
Total (out-of-network) out-of-pocket maximum	$7,000
Office visit copay (medical home)	$15
Office visit copay (primary care physician or PCP)	$25
Office visit copay (specialist)	$40
Inpatient copay	$150
Emergency room	$150 (emergency) $250 (non-emergency)
Preventive services	100%
Skilled nursing/hospice	100%
Other medical services	25% co-insurance

Statutory Requirements

Prescription drug coverage – Retirees enrolled in the OPERS retiree health care plan (Medical Mutual) or the Humana Interim Plan received prescription drug coverage through Express Scripts.

OPERS non-Medicare prescription drug coverage – In 2017, plan participants could receive up to a 30-day supply of medication, plus refills, as prescribed by their physician at a retail pharmacy. Plan participants could receive up to a 90-day supply of medication, plus refills, as prescribed by their physician, through the Express Scripts home delivery program. Cost-share for prescriptions differs based on the delivery method, whether a drug is a generic or a name brand and its formulary status. In 2017, Medication Therapy Management continued to be available for eligible participants.

2017 Non-Medicare Prescription Drug Plan	2017
Retail pharmacy network	55,000 pharmacies
Annual deductible(s)	$100 (generics) $200 (brands)
Formulary	High performance
Generics	20% co-insurance $4 min/$8 max retail $10 min/$20 max mail
Formulary brand	30% co-insurance $30 min/$60 max retail $75 min/$150 max mail
Non-formulary brand	NOT COVERED
Specialty drugs - Brand	40% co-insurance $150 max
Specialty drugs - Biosimilar/Generic	40% co-insurance $100 max
Value-based insurance design (VBID) - Generics for chronic conditions including asthma, COPD, heart disease, hypertension, high cholesterol, depression and diabetes	$0
Generic PPIs - Medications treating acid-reflux and heartburn	50% co-insurance $25 retail min $62.50 mail min
Annual out-of-pocket maximum	$1,950 (per ACA limits)

Statutory Requirements

WELLNESS RETIREE MEDICAL ACCOUNT (RMA)

In prior plan years, the non-Medicare plans also had the opportunity to earn modest wellness incentives that were deposited in a wellness RMA. The wellness RMA also housed excess retiree health care premium allowances earned in prior plan years. The wellness RMA can be used to reimburse the retiree's qualified medical expenses. Wellness incentives are no longer awarded starting with the 2017 plan year.

MEMBER-DIRECTED RMA

Upon separation or retirement, a Member-Directed Plan participant may use the vested funds in their Member-Directed RMA to reimburse qualified health care expenses. Vesting requirements for the Member-Directed RMA have changed over the life of the plan. The Member-Directed RMA originally required 10 years of participation to fully vest in the contributions and interest earned on the account. Effective January 1, 2009, contributions and interest vested with the participant over a five-year period. Effective July 1, 2015, new participants to the Member-Directed RMA are required to participate for 15 years to become fully vested.

OPERS MEDICARE CONNECTOR HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

During 2017, Medicare-eligible retirees selected an individual medical or prescription drug plan (or both) through the Connector. They were also eligible for a monthly allowance, deposited into an HRA account, to be used for reimbursement of qualifying medical expenses.

The allowance can be used toward the reimbursement of the premium of an individual Medicare plan. Any remaining allowance can be used to reimburse the cost of any of the following:

- Medicare Part B premium,
- Vision and dental premiums,
- Deductibles, co-insurance and other out-of-pocket medical expenses,
- Medical expenses for a spouse,
- Saved for future health care expenses, including premium increases as the member ages.

The Internal Revenue Service defines qualifying medical expenses. Claims filed through the HRA are reimbursed for qualifying medical expenses retirees and their dependents incur. Reimbursements of qualifying medical expenses are not taxable income and are not reported on any tax form. The amount of the HRA monthly allowance depends on years of qualifying service and age when first enrolled in the OPERS health care plan. HRA account balances roll over from month-to-month and year-to-year.

HUMANA INTERIM MEDICARE PLAN

The Humana Interim Medicare Plan is the plan OPERS provides for Medicare-eligible retirees who are not eligible to participate in the HRA during re-employment. These retirees included Medicare-eligible, re-employed retirees and their eligible Medicare dependents as well as Medicare–eligible retirees under age 65 with end-stage renal disease. At the close of 2017, the Humana Interim Medicare Plan ceased and plan participants were moved to the Medical Mutual Medicare Plan.

MEDICARE PART A REIMBURSEMENT

Ohio law allows OPERS to provide premium reimbursement to those who are not eligible for premium-free Medicare Part A. Medicare-eligible OPERS retirees are required to enroll in, and pay, the monthly premium for Medicare Part A coverage through the Centers for Medicare and Medicaid Services. OPERS provides a monthly reimbursement for the Medicare Part A premium cost and provides a 50% Medicare Part A premium reimbursement to eligible spouses. With enrollment in both Medicare Parts A and B, retirees and eligible spouses have the opportunity to make a plan selection through the Connector and may receive an HRA allowance.

THE DENTAL PLAN

During 2017, voluntary dental coverage was available to all OPERS retirees, and their eligible dependents, regardless of their participation in OPERS health care. The dental plan, administered by MetLife, is intended to help defray the costs of dental care, including oral examinations, diagnostic services and extractions, as well as crowns, bridges and dentures. If a retiree choses coverage under the dental plan, a premium payment is deducted from each monthly benefit payment. OPERS does not subsidize this plan.

THE VISION PLAN

Voluntary vision coverage is offered to all OPERS retirees and their eligible dependents, regardless of their participation in OPERS health care. The vision plan, administered by Aetna, covers services provided by ophthalmologists, optometrists or opticians for examinations, frames and lenses. A premium payment is deducted from each monthly benefit payment for those recipients who choose to participate. OPERS does not subsidize this plan.

3. A summary of the eligibility requirements for health care coverage in 2017:

Listed here are the eligibility requirements for OPERS health care plans in 2017.

AGE-AND-SERVICE RETIREMENT

All OPERS members are in one of three retirement groups: Group A, Group B or Group C. The retirement group determines pension eligibility and benefit calculation. The group also affects when members will be eligible for health care coverage through OPERS. In 2017, a benefit recipient must have attained age 60 and have 20 years of qualifying health care service credit or have 30 years of qualifying health care service credit at any age under Group A; 32 years of qualifying health care service credit at any age or 31 years of service and minimum age 52 under Group B; and 32 years and age 55 under Group C to be eligible for OPERS retiree health care.

For retirement benefits effective on and after January 1, 2014, OPERS limited the types of service credit counted toward health care eligibility to the following:

- Contributing service
- Service transfers from other Ohio retirement systems
- Service purchased under USERRA (military service that interrupts public service)
- Restored service credit
- Unreported service

Once a retiree voluntarily withdraws from OPERS health care on or after January 1, 2014, they cannot re-enroll absent proof of creditable coverage or a recent involuntary termination under another plan.

As of January 1, 2014, contributing service credit for health care accumulated only if the member's earnable salary was at least $1,000 per month. Partial health care credit was not granted for months in which earnable salary is less than $1,000. Credit earned prior to January 2014 is not affected by this requirement.

DISABILITY BENEFIT RECIPIENTS

Recipients of disability benefits prior to January 1, 2014, have continued access to health care coverage while the disability benefit continues and will not be subject to the five-year rule described below. The allowance will be determined in the same way as an age-and-service retiree. If the recipient does not meet minimum age-and-service requirements, the minimum allowance will be used. Recipients with an initial disability effective date on or after January 1, 2014, will have coverage during the first five years of disability benefits. After five years, the recipient must meet minimum age-and-service health care eligibility requirements or be enrolled in Medicare due to disability status to remain enrolled in OPERS health care. If enrolled, the allowance will be determined in the same way as an age-and-service retiree.

Statutory Requirements

COVERAGE FOR SURVIVING SPOUSES

If a member retired, chose a joint life or multiple life annuity plan of payment and passes away, their surviving spouse will have access to the OPERS health care plans. Surviving spouses do not receive an allowance and are responsible for the full cost of coverage. However, OPERS does provide limited funding to surviving spouses meeting a minimum income requirement.

ELIGIBLE DEPENDENTS

In accordance with Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code (IRC), retirees receiving a monthly age-and-service or disability benefit may enroll their legal spouse and any eligible children under the age of 26.

The member or retiree's eligible children are a biological or legally adopted child or minor grandchild if the grandchild is born to an unmarried, un-emancipated minor child and ordered by the court to provide coverage pursuant to Ohio Revised Code Section 3109.19.

In order for a child to be eligible for coverage, the child must be under the age of 26 (regardless of enrollment as a full-time student or marital status). Coverage may be extended if the child is permanently and totally disabled prior to age 22. This means that the child is not able to work in any substantial gainful activity because of a physical or mental impairment which has lasted or is expected to last for at least 12 months. Evidence of the incapacity is required and is subject to approval by OPERS.

Participants in OPERS health care receiving a monthly benefit as the surviving spouse or beneficiary of a deceased retiree or deceased member may only enroll those dependents that would have been eligible dependents of the deceased retiree or member as defined on this page.

COVERAGE OPTIONS

In 2017, OPERS continued to provide monthly allowances for health care coverage for Traditional Pension Plan and Combined Plan retirees and their eligible dependents in various OPERS-sponsored plans. For those retiring on or after January 1, 2015, the allowance (subsidy) provided by OPERS is based on age and years of qualifying service credit when a recipient first enrolls in OPERS health care.

In 2017, OPERS offered medical and pharmacy plans for recipients yet to enroll in Medicare. Monthly allowances were used to offset the monthly premium for the coverage provided.

Traditional Pension Plan and Combined Plan retirees enrolled in Medicare Parts A and B received an allowance credited to an HRA account to be used to reimburse qualifying medical expenses associated with the coverage in which the retiree is enrolled through the Connector. The Connector is administered by a vendor selected by OPERS. The vendor assists retirees, spouses and dependents with selecting a medical and pharmacy plan.

Over a three-year period that began in 2015, spouses started transitioning from their original monthly allowance to zero. If the retiree is living, the retiree may use their HRA to reimburse the cost of a spouse's coverage. Spouses eligible for Medicare began to have access to the Connector in 2016; spouses not yet eligible for Medicare have access to OPERS coverage at full cost until 2020 and that may be extended. Spouses of deceased members no longer assume the retiree's health care allowance (low-income exception approved by the Board in 2017). If the retiree has at least 20 years of qualifying service and is enrolled in OPERS health care, children (up to age 26) receive half of the retiree's allowance percentage. If the recipient has less than 20 years of qualifying service, children (up to age 26) transition from the original allowance to zero over three years (2015-2017), but have access to OPERS coverage at the full cost until 2020.

MEMBER-DIRECTED RETIREE MEDICAL ACCOUNT (RMA)

Member-Directed Plan participants are provided with a Member-Directed RMA. The plan holds the portion of employer contributions of the Member-Directed Plan participants that are set aside for funding retiree health care. Upon separation or retirement, the participant may use the vested funds in their Member-Directed RMA to reimburse qualified health care expenses. Members with an account prior to July 1, 2015, become vested in the account at a rate of 20% for each year of participation until the member is fully vested at the end of five years. For members establishing accounts on or after July 1, 2015, the member is fully vested after 15 years at a rate of 10% for each year starting in the sixth year of participation. The account earns a fixed annual interest rate established by the Board. Interest on the RMA accrues only if the investment portfolio containing the RMA assets earns a return greater than zero in the prior year.

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

As of December 31, 2017, there were 191,241 OPERS retirees and primary beneficiaries eligible to participate in OPERS health care. In addition to a retiree, a primary benefit recipient could be a survivor of a deceased retiree continuing to receive coverage on the retiree's account, which is representative of the OPERS contributing membership.

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

OPERS financial statements are prepared using the accrual basis of accounting under which deductions are recorded when the liability is incurred and revenues are recognized when earned. Health care payments are considered a liability and recognized when a present obligation exists. Therefore, OPERS estimates health care claims which have been incurred at year-end, but which have not yet been reported to the System as of fiscal year end. Health care receipts are recognized when they become measurable and due to OPERS based on contractual requirements. Therefore, health care receipts contain estimates based on information received from health care vendors and other sources.

Investment purchases and sales are recorded as of the trade date. Investments are generally reported at fair value. Fair value is the amount that a plan can reasonably expect to receive for an investment in a current sale between a willing buyer and a willing seller, that is, other than in a forced or liquidation sale. All investments, with the exception of real estate, private equity and hedge funds are valued based on closing market prices or broker quotes. Securities not having a quoted market price have been valued based on yields currently available on comparable securities of issuers with similar credit ratings. The fair value of real estate investments is based on estimated current values and independent appraisals. The fair value of private equity is based on management's valuation of estimates and assumptions from information and representations provided by the respective general partners, in the absence of readily ascertainable market values.

The fair value of hedge funds is based on a net asset value, which is established by the fund or by the fund's third-party administrator.

Employer contributions and investment earnings are used to fund health care expenses. Employer contributions of 1 percent of covered payroll were credited to the 115 Health Care Trust (115 Trust) for the year ended December 31, 2017. In 2017, OPERS implemented Governmental Accounting Standards Board Statement No. 74 (GASB 74), Financial Reporting for Post employment Benefit Plans Other Than Pension Plans. GASB 74 requires that certain health care receipts be netted with health care expenses reported in the Health Care Expenses category in the Statement of Changes in Fiduciary Net Position. The presentation of Retiree-Paid Health Care Premiums, Federal Subsidy, and formulary rebates, rebates previously reported in Contract and Other Receipts, has been revised and these health care receipts are now included in health care expenses.

The 115 Trust was established in 2014. The 401(h) Health Care Trust and Voluntary Employees' Beneficiary Association Trust were closed as of June 30, 2016 and the net positions transferred to the 115 Trust on July 1, 2016. From 2016 forward, the 115 Trust pre-funds and holds the portion of employer contributions of the Traditional Pension, Combined and Member-Directed plans set aside for funding retiree health care.

The funded status of health care as of December 31, 2016, the most recent actuarial valuation, was 60.7 percent. The funding progress of health care is measured in terms of solvency years, or the number of years that funds are projected to be available to pay health care expenses under the current plan design before health care would be reduced to a pay-as-you-go basis. The fund is expected to become insolvent after 12 years as of the December 31, 2016 valuation.

The health care stabilization fund is intended to somewhat mitigate this risk. Excess in investment returns and the health care stabilization fund provide a source of funds to offset years in which the 4.0 percent allocation of the employer contributions cannot be contributed or investment returns do not meet the 4.0 percent expected return. The funding source for the stabilization fund is any investment earnings on the health care core fund in excess of 4.0 percent.

6. A statement of the fiduciary net position (or net assets) available for the provision of the coverage as of the last day of the fiscal year.

Please see Appendix C, "Statements of Fiduciary Net Position - Health Care."

7. A statement of any changes in the net position (or net assets) available for the provision of health care coverage, including participant and employer contributions, net investment income, administrative expenses and benefits provided to participants, as of the last day of the fiscal year.

Please see Appendix D, "Statements of Changes in Fiduciary Net Position - Health Care."

8. For the last six consecutive fiscal years, a schedule of the net position (or net assets) available for health care coverage, the annual cost of health care, administrative expenses incurred and annual employer contributions allocated for the provision of coverage.

Please see Appendix D, "Statements of Changes in Fiduciary Net Position - Health Care."

Statutory Requirements

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

In conjunction with the implementation of Governmental Accounting Standards Board Statement No. 74 (GASB 74), Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans, in 2017, health care receipts, or payments, from retirees and health care vendors to OPERS are required to offset the related health care expenses incurred by OPERS during the year. As a result, health care expenses were reduced by $242.7 million for retiree-paid health care premiums, prescription rebates and federal subsidies, causing the activity in 2017 to decrease to $1.0 billion from $1.2 billion in 2016, as there was no netting of health care receipts in 2016.

10. A statement of the amount paid under division (C) of section 145.58 of the Revised Code.

OPERS discontinued reimbursement of Medicare Part B premiums as of December 31, 2016. However, in accordance with section 145.584 of the Revised Code, OPERS reimburses retirees who do not have premium-free Medicare Part A for their Part A premiums as well as any applicable surcharges (late-enrollment fees).

Appendix A – Ohio Revised Code Sec. 145.58

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

(A) The public employees retirement board shall adopt rules establishing eligibility for any coverage provided under this section. The rules shall base eligibility on years and types of service credit earned by members. Eligibility determinations shall be made in accordance with the rules, except that an individual who, as a result of making a false statement in an attempt to secure a benefit under this section, is convicted of violating section 2921.13 of the Revised Code is ineligible for coverage.

(B) The 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 coverage, or any combination thereof, for eligible 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 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 eligible 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 individuals who are not eligible under the rules adopted under division (A) of this section 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 145.584 of the Revised Code for any such 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 coverage 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 coverage under part B of the medicare program established under Title XVIII of "The Social Security Act Amendments of 1965," 79 Stat. 301 (1965), 42 U.S.C.A. 1395j, as amended, an amount determined by the board for such coverage, except that the board shall make no such payment to any individual who is not eligible for coverage under the rules adopted under division (A) of this section or pay an amount that exceeds the amount paid by the recipient for the coverage.

At the request of the board, the recipient shall certify to the retirement system the amount paid by the recipient for coverage described in this division.

(D) The board shall establish by rule requirements for the coordination of any coverage or payment provided under this section or section 145.584 of the Revised Code with any similar coverage or payment 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. Amended by 130th General Assembly File No. TBD, SB 42, §1, eff. 3/23/2015.

Amended by 129th General Assembly File No.148, SB 343, §1, eff. 1/7/2013.

Effective Date: 10-01-2002; 2008 SB267 03-24-2009

Appendix B – Ohio Revised Code Sec. 145.584

145.584 Benefits equivalent to Medicare

(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 without payment of premiums, one of the following:

(1) 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;

(2) An amount, determined by the board, to reimburse the retirant or disability benefit recipient for payment of premiums for federal hospital insurance benefits described in this division, which amount shall not exceed the premiums paid.

This coverage or amount 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 without payment of premiums. The widow or widower of a retirant or disability benefit recipient shall be eligible for such coverage or amount only if he or she is the recipient of a monthly allowance or benefit from this system. A portion of the cost of the premium or amount for the spouse may be paid from the appropriate funds of the system. The remainder of the cost shall be paid by the recipient of the allowance or benefit.

The cost of such coverage or amount, 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 may contract for such coverage as provided in section 145.58 of the Revised Code.

At the request of the board, the recipient of reimbursement under this section shall certify to the retirement system the premium paid for the federal insurance benefits described in division (A) of this section. Payment of the amount described in division (A)(2) of this section shall begin for the first month that the recipient is participating in both the federal hospital insurance benefits and a health care arrangement offered by the system.

(B) The board need not make the hospital insurance coverage or amount 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.

Amended by 130th General Assembly File No. TBD, SB 42, §1, eff. 3/23/2015.

Renumbered from §145.325 and amended by 129th General Assembly File No.148, SB 343, §1, eff. 1/7/2013.

Appendix C – Statements of Fiduciary Net Position—Health Care

	2017	2016	2015	2014
115 Health Care Trust[1]				
Assets				
Cash and Cash Equivalents	**$823,866,242**	**$874,632,840**	**$228,930,728**	**$7,797,254**
Receivables				
Members and Employers	17,310,993	28,954,270	31,146,407	20,597,780
Vendor and Other	10,325,432	67,090,996	140,747,042	175,326,214
Investment Sales Proceeds	58,028,023	70,760,106	744,048	988,589
Accrued Interest and Dividends	44,801,284	41,092,533	1,246,089	728,607
Total Receivables	**130,465,732**	**207,897,905**	**173,883,586**	**197,641,190**
Investments, at fair value				
Fixed Income	4,348,639,837	4,087,785,698	296,365,386	66,380,103
Domestic Equities	3,403,242,732	3,071,759,733	82,245,096	50,172,724
International Equities	2,645,509,612	2,265,107,975	58,142,626	41,687,272
Other Investments	1,654,750,270	1,534,240,696	48,222,156	24,508,856
Total Investments	**12,052,142,451**	**10,958,894,102**	**484,975,264**	**182,748,955**
Capital Assets				
Land	942,728	942,728		
Building and Building Improvements	27,998,673	28,004,098		
Furniture and Equipment	33,676,485	32,759,796	1,441,984	
Total Capital Assets	62,617,886	61,706,622	1,441,984	
Accumulated Depreciation	(36,873,343)	(33,678,510)		
Net Capital Assets	**25,744,543**	**28,028,112**	**1,441,984**	
TOTAL ASSETS	**13,032,218,968**	**12,069,452,959**	**889,231,562**	**388,187,399**
Liabilities				
Undistributed Deposits	230,367	287,413	10,021	
Benefits Payable	114,643,770	109,142,271	1,634,811	
Investment Commitments Payable	98,511,166	79,535,412	1,789,658	1,803,774
Accounts Payable and Other Liabilities			44,685,032	303,453
TOTAL LIABILITIES	**213,385,303**	**188,965,096**	**48,119,522**	**2,107,227**
Net Position Held in Trust for Post-employment Health Care	**$12,818,833,665**	**$11,880,487,863**	**$841,112,040**	**$386,080,172**

Source: 2014 - 2017 Comprehensive Annual Financial Reports

[1]The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016.

Appendix C – Statements of Fiduciary Net Position—Health Care

	2015	2014	2013	2012
401(h) Health Care Trust[1]				
Assets				
Cash and Cash Equivalents	**$437,888,805**	**$503,893,407**	**$491,371,340**	**$446,851,345**
Receivables				
Members and Employers		12,096,566	19,417,032	43,429,976
Early Retirement Incentive Plan		6,062	64,600	177,884
Vendor and Other	677,725	1,309,906	147,929,032	147,616,824
Investment Sales Proceeds	43,193,263	64,470,004	75,148,940	261,962,739
Accrued Interest and Dividends	39,359,404	47,590,193	47,924,681	47,650,966
Total Receivables	**83,230,392**	**125,472,731**	**290,484,285**	**500,838,389**
Investments, at fair value				
Fixed Income	3,733,008,136	4,434,483,598	4,313,177,166	4,731,050,357
Domestic Equities	2,969,522,823	3,296,381,497	3,594,242,223	3,293,138,146
Private Equity			110,263,964	73,443,686
International Equities	2,221,451,642	2,661,469,316	3,333,565,455	3,506,799,272
Other Investments	1,390,445,167	1,615,807,236	1,159,221,629	563,094,682
Total Investments	**10,314,427,768**	**12,008,141,647**	**12,510,470,437**	**12,167,526,143**
Capital Assets				
Land	916,220	916,220	729,981	729,981
Building and Building Improvements	27,256,121	27,261,277	21,476,205	21,737,564
Furniture and Equipment	29,358,536	28,536,399	26,907,290	24,688,709
Total Capital Assets	57,530,877	56,713,896	49,113,476	47,156,254
Accumulated Depreciation	(30,510,198)	(28,082,475)	(24,246,817)	(20,530,484)
Net Capital Assets	**27,020,679**	**28,631,421**	**24,866,659**	**26,625,770**
TOTAL ASSETS	**10,862,567,644**	**12,666,139,206**	**13,317,192,721**	**13,141,841,647**
Liabilities				
Undistributed Deposits	243,005	183,002	146,606	69,659
Benefits Payable	91,451,759	99,279,185	90,019,865	100,495,333
Investment Commitments Payable	76,923,764	113,120,724	99,797,215	194,165,994
Accounts Payable and Other Liabilities	22,880,935	13,033,505	15,544,228	18,485,339
TOTAL LIABILITIES	**191,499,463**	**225,616,416**	**205,507,914**	**313,216,325**
Net Position Held in Trust for Post-employment Health Care	**$10,671,068,181**	**$12,440,522,790**	**$13,111,684,807**	**$12,828,625,322**

Source: 2012 - 2015 Comprehensive Annual Financial Reports

[1] The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. No activity exists for 2016 and 2017.

Appendix C – Statements of Fiduciary Net Position—Health Care

	2015	2014	2013	2012
Voluntary Employees' Beneficiary Association Trust[1]				
Assets				
Cash and Cash Equivalents	**$4,675,584**	**$4,148,957**	**$5,707,117**	**$2,355,351**
Receivables				
Members and Employers	13,932,389	11,647,166	7,953,038	1,573,325
Investment Sales Proceeds	532,305	628,545	610,262	2,104,651
Accrued Interest and Dividends	437,722	465,050	405,596	361,199
Total Receivables	**14,902,416**	**12,740,761**	**8,968,896**	**4,039,175**
Investments, at fair value				
Fixed Income	37,189,326	38,408,780	33,339,330	31,937,847
Domestic Equities	27,429,090	28,230,500	28,196,827	23,579,831
Real Estate	17,627,759	16,410,600	14,791,023	12,281,837
Private Equity	19,309,205	19,895,505	15,746,087	12,285,901
International Equities	28,135,488	31,447,388	32,934,729	28,205,829
Other Investments	23,392,047	24,639,714	13,488,024	5,687,375
Total Investments	**153,082,915**	**159,032,487**	**138,496,020**	**113,978,620**
Collateral on Loaned Securities	**18,887,694**	**17,067,184**	**13,199,734**	**10,986,106**
Capital Assets				
Land	26,508	26,508	19,731	19,731
Building and Building Improvements	788,568	788,717	617,485	587,546
Furniture and Equipment	2,196,905	2,171,989	2,148,108	2,020,876
Total Capital Assets	3,011,981	2,987,214	2,785,324	2,628,153
Accumulated Depreciation	(2,180,336)	(2,101,775)	(1,989,331)	(1,767,867)
Net Capital Assets	**831,645**	**885,439**	**795,993**	**860,286**
TOTAL ASSETS	**192,380,254**	**193,874,828**	**167,167,760**	**132,219,538**
Liabilities				
Benefits Payable	208,449	254,216	16,688	11,171
Investment Commitments Payable	843,360	1,017,665	876,994	1,623,282
Due to Other Plans	5,992,744			
Obligations Under Securities Lending	18,888,895	17,063,783	13,189,782	10,969,210
TOTAL LIABILITIES	**25,933,448**	**18,335,664**	**14,083,464**	**12,603,663**
Net Position Held in Trust for Post-employment Health Care	**$166,446,806**	**$175,539,164**	**$153,084,296**	**$119,615,875**

Source: 2012 - 2015 Comprehensive Annual Financial Reports

[1] The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. No activity exists for 2016 and 2017.

Appendix D – Statements of Changes in Fiduciary Net Position—Health Care

	2017	2016	2015	2014
115 Health Care Trust[1]				
Additions				
Employer Contributions	$157,417,888	$274,419,455	$253,673,333	$111,561,319
Contract and Other Receipts[2]	857,541	93,306,585	95,860,582	143,813,190
Retiree-Paid Health Care Premiums[2]		184,368,783		
Federal Subsidy[2]		4,065,058	175,930,875	131,904,250
Other Income/(Expense), net	117,882	15,715	10	76,970
Interplan Activity		6,036,782		
Total Non-investment Income	**158,393,311**	**562,212,378**	**525,464,800**	**387,355,729**
Income From Investing Activities				
Net Increase in the Fair Value of Investments	1,303,745,052	160,473,865	(17,539,101)	(2,660,677)
Bond Interest	162,929,606	92,284,043	6,517,201	535,544
Dividends	325,553,345	130,678,719	(9,556,397)	1,019,374
International Income/(Loss)	248,369	(1,998)	(1,178)	223
Other Investment Income	396,299	(282,340)	(43,576)	
External Asset Management Fees	(36,062,800)	(27,669,191)	(2,147,433)	(61,239)
Net Investment Income/(Loss)	**1,756,809,871**	**355,483,098**	**(22,770,484)**	**(1,166,775)**
Investment Administrative Expenses	(5,447,329)	(2,853,560)	(302,871)	(26,581)
Net Income/(Loss) from Investing Activity	**1,751,362,542**	**352,629,538**	**(23,073,355)**	**(1,193,356)**
TOTAL ADDITIONS	**1,909,755,853**	**914,841,916**	**502,391,445**	**386,162,373**
Deductions				
Health Care Expenses[2]	952,001,573	1,195,956,899	45,184,620	
Administrative Expenses	19,408,478	21,693,387	2,174,957	82,201
TOTAL DEDUCTIONS	**971,410,051**	**1,217,650,286**	**47,359,577**	**82,201**
Special Item[1]				
Interplan Activity—Trust Closures		**11,342,184,193**		
Net Increase/(Decrease)	938,345,802	11,039,375,823	455,031,868	386,080,172
Net Position Held in Trust for Post-employment Health Care Balance, Beginning of Year	11,880,487,863	841,112,040	386,080,172	
Balance, End of Year	**$12,818,833,665**	**$11,880,487,863**	**$841,112,040**	**$386,080,172**

Source: 2014 - 2017 Comprehensive Annual Financial Reports

[1]The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association (VEBA) Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. The Special Item represents this interplan activity and nets to zero in consolidation.

[2]Governmental Accounting Standards Board (GASB) Statement No. 74 requires health care expenses be reported net of certain health care receipts. The presentation of Retiree-Paid Health Care Premiums, Federal Subsidy and formulary rebates, rebates included in Contracts and Other Receipts, has been revised and is now included in Health Care Expenses, starting in 2017 upon implementation of this standard.

Appendix D – Statements of Changes in Fiduciary Net Position—Health Care

	2016	2015	2014	2013	2012
401(h) Health Care Trust[1]					
Additions					
Employer Contributions			$135,522,351	$120,056,440	$494,048,415
Contract and Other Receipts		$9,435	10,950,386	126,941,889	94,730,390
Retiree-Paid Health Care Premiums[2]		248,601,375	238,406,380	178,140,822	159,614,898
Federal Subsidy			44,715,641	105,965,762	182,579,917
Other Income/(Expense), net			7,601,841	13,483,861	11,774,199
Total Non-investment Income		**248,610,810**	**437,196,599**	**544,588,774**	**942,747,819**
Income From Investing Activities					
Net Increase in the Fair Value of Investments	$428,632,525	(453,577,747)	209,726,745	1,106,685,064	1,183,656,950
Bond Interest	(60,085,563)	157,207,141	284,087,239	116,748,678	201,317,018
Dividends	131,736,664	105,609,193	186,495,341	206,180,289	183,422,898
International Income/(Loss)	3,751	(11,506)	18,941	(4,659)	10,894
Other Investment Income	14,158	652,343	4,302,396	13,183,549	10,861,876
External Asset Management Fees	(7,012,448)	(27,988,205)	(30,811,500)	(40,036,389)	(24,118,062)
Net Investment Income/(Loss)	**493,289,087**	**(218,108,781)**	**653,819,162**	**1,402,756,532**	**1,555,151,574**
Investment Administrative Expenses	(3,080,517)	(5,355,603)	(5,252,268)	(5,407,709)	(5,180,680)
Net Income/(Loss) from Investing Activity	**490,208,570**	**(223,464,384)**	**648,566,894**	**1,397,348,823**	**1,549,970,894**
TOTAL ADDITIONS	**490,208,570**	**25,146,426**	**1,085,763,493**	**1,941,937,597**	**2,492,718,713**
Deductions					
Health Care Expenses		1,774,989,836	1,738,596,173	1,642,525,598	1,607,921,528
Administrative Expenses		19,611,199	18,329,337	16,352,514	15,172,174
TOTAL DEDUCTIONS		**1,794,601,035**	**1,756,925,510**	**1,658,878,112**	**1,623,093,702**
Special Item[1]					
Interplan Activity—Trust Closures	**(11,161,276,751)**				
Net Increase/(Decrease)	(10,671,068,181)	(1,769,454,609)	(671,162,017)	283,059,485	869,625,011
Net Position Held in Trust for Post-employment Health Care Balance, Beginning of Year	10,671,068,181	12,440,522,790	13,111,684,807	12,828,625,322	11,959,000,311
Balance, End of Year	**$0**	**$10,671,068,181**	**$12,440,522,790**	**$13,111,684,807**	**$12,828,625,322**

Source: 2012 - 2016 Comprehensive Annual Financial Reports

[1] The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. The Special Item represents this interplan activity and nets to zero in consolidation. No activity exists in 2017.

[2] Beginning in 2015, Retiree-Paid Health Care Premiums was reported separately and not included in the Member Contributions line item. For comparability, this activity was reclassified from Member Contributions to Retiree-Paid Health Care Premiums for all prior years presented.

Appendix D – Statements of Changes in Fiduciary Net Position—Health Care

	2016	2015	2014	2013	2012
Voluntary Employees' Beneficiary Association Trust[1]					
Additions					
Employer Contributions[2]	$10,483,804		$14,702,198	$18,256,171	$16,883,868
Contract and Other Receipts	22,722		20,484	3,061	9,233
Interplan Activity					63,641
Total Non-investment Income	**10,506,526**		**14,722,682**	**18,259,232**	**16,956,742**
Income From Investing Activities					
Net Increase in the Fair Value of Investments	2,277,759	($5,883,465)	958,805	10,641,920	8,718,790
Bond Interest	1,222,858	1,902,518	1,625,463	1,635,744	1,271,636
Dividends	1,738,911	826,237	2,547,764	2,062,309	1,351,077
Real Estate Operating Income, net	1,026,057	2,959,962	3,017,022	2,028,598	1,288,261
International Income/(Loss)	79	371	240	(43)	81
Other Investment Income	517,933	1,724,353	3,584,241	2,210,914	1,785,191
External Asset Management Fees	(92,819)	(907,438)	(692,565)	(645,737)	(386,839)
Net Investment Income	**6,690,778**	**622,538**	**11,040,970**	**17,933,705**	**14,028,197**
From Securities Lending Activity					
Securities Lending Income	92,902	106,312	77,985	83,192	98,909
Securities Lending Expenses	(41,106)	(23,811)	(6,747)	(11,881)	(25,735)
Net Securities Lending Income	51,796	82,501	71,238	71,311	73,174
Unrealized Gains/(Losses)	4,152	(1,202)	3,401	9,952	16,896
Net Income from Securities Lending	**55,948**	**81,299**	**74,639**	**81,263**	**90,070**
Investment Administrative Expenses	(40,192)	(75,920)	(71,081)	(60,287)	(68,480)
Net Income from Investing Activity	**6,706,534**	**627,917**	**11,044,528**	**17,954,681**	**14,049,787**
TOTAL ADDITIONS	**17,213,060**	**627,917**	**25,767,210**	**36,213,913**	**31,006,529**
Deductions					
Health Care Expenses	1,417,445	2,396,972	2,217,933	1,719,043	1,236,169
Administrative Expenses	629,201	1,330,559	1,094,409	1,026,449	850,617
Interplan Activity	727,192	5,992,744			
TOTAL DEDUCTIONS	**2,773,838**	**9,720,275**	**3,312,342**	**2,745,492**	**2,086,786**
Special Item[1]					
Interplan Activity—Trust Closures	**(180,886,028)**				
Net Increase/(Decrease)	(166,446,806)	(9,092,358)	22,454,868	33,468,421	28,919,743
Net Position Held in Trust for Post-employment Health Care Balance, Beginning of Year	166,446,806	175,539,164	153,084,296	119,615,875	90,696,132
Balance, End of Year	**$0**	**$166,446,806**	**$175,539,164**	**$153,084,296**	**$119,615,875**

Source: 2012 - 2016 Comprehensive Annual Financial Reports

[1]The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association (VEBA) Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. The Special Item represents this interplan activity and nets to zero in consolidation. No activity exists in 2017.

[2]Beginning in October 2014, the Board approved the funding of the VEBA Trust participant accounts using the reserves in the VEBA Trust rather than the allocation of employer contributions. Instead, employer contributions were allocated to the Member-Directed Plan to repay the original plan start-up and administrative costs.

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