OPERS

2016 Health Care Report

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Executive Summary

Transition to the OPERS Medicare Connector

In 2016, Ohio Public Employees Retirement System (System) worked to ensure that all qualified retirees enrolled in an individual Medicare plan via the OPERS Medicare Connector (Connector) and had access to a health reimbursement arrangement (HRA). This followed the enrollment of close to 131,000 OPERS retirees, spouses and dependents into plans via the Connector at the end of 2015.

The Connector was implemented with the goal to "leave no retiree behind." This focus remained in 2016. OPERS reached out to eligible retirees who had yet to enroll through a letter, phone call or home visit. We are grateful for the help of our partners, including Ohio Retirement Study Council, Public Employee Retirees, Inc., American Federation of State, County and Municipal Employees, Ohio Municipal League, the Ohio Legislature and various state and regionally located federal agencies that helped us deliver the message and ensure retirees had access to the coverage they needed.

Under the new Connector model, eligible retirees receive an allowance they may use to reimburse themselves for the premiums for individual medical and prescription plans, as well as, other qualified medical expenses through an HRA. This is a completely new process. As with all changes this significant, the implementation was not without a few bumps in the road. OPERS continues to advocate for our retirees, providing resources and education, and working with the Connector administrator to resolve issues.

Health Care Preservation Plan implementation

The System focused on the continued implementation of ongoing and incremental changes to the OPERS health care program adopted in 2012. These changes included the implementation of the Connector, the continued phasing-out of premium support for spouses and the final year of partial reimbursement for Medicare Part B premiums. We recognize the need to continually monitor funding for both pension and health care as we work to make a health care program available to both current and future retirees. The program must balance long-term sustainability with equitable coverage between generations.

The results from the health care changes are evident in our financial results for 2016. Overall, health care costs significantly reduced from approximately $1.8 billion to approximately $1.2 billion.

OPERS health care coverage is neither mandated nor guaranteed—yet we continue to work toward the preservation of this coverage because access to health care for our retirees is an important aspect of a secure retirement.

Health Care Trust transfer

The 115 Health Care Trust (115 Trust) was established in 2014 to provide a viable way to fund the HRA and consolidate the funding of all health care plans sponsored by OPERS. Prior to the establishment of the 115 Trust, OPERS had two other health care related trusts.

Executive Summary

The 401(h) Health Care Trust (401(h) Trust) had been in existence since OPERS began funding health care in the mid-1970s. This trust, established under Internal Revenue Service (IRS) rules, had limitations that necessitated the establishment of the 115 Trust. OPERS also had the Voluntary Employees Beneficiary Association (VEBA) Trust that provided health care funding for Member-Directed Plan participants. With the establishment of the 115 Trust, OPERS sought IRS approval to consolidate the 401(h) Trust and the VEBA Trust into the new 115 Trust. As a result, the 401(h) Trust and VEBA Trust closed June 30, 2016, and the net positions transferred to the 115 Trust effective July 1, 2016. The 115 Trust now provides funding for all the OPERS health care plans: the self-insured health care plan for the non-Medicare retirees, re-employed retiree plans, Member-Directed retiree medical accounts, wellness retiree medical accounts and Connector HRAs.

ADVOCACY WORK

Biosimilar and generic drugs

OPERS, working with the Public Sector Healthcare Roundtable and the Association for Accessible Medicines, shared with the U.S. Food and Drug Administration, the U.S. Department of Health and Human Services and legislators the importance of biosimilar and generic drug competition. OPERS created a series of informative videos and infographics about biosimilar drugs and overall increasing drug costs.

Cadillac tax

Although the Affordable Care Act's (ACA) excise tax, otherwise known as the "Cadillac tax," has been delayed until 2020, OPERS continues to advocate for a complete repeal or, in the alternative, an exemption for retiree-only health plans.

Medicare Part B premium hike

OPERS used a variety of communication tools to mobilize retirees to reach out to members of Congress and oppose a 20% Medicare Part B premium increase in 2017. November 10, 2016, the projected 20% increase in Medicare Part B premiums was reduced to an approximate 10% increase.

Re-employed retiree plans

OPERS retirees who are receiving a pension and have returned to work for an OPERS-covered employer are not eligible to participate in the HRA because HRAs are incompatible with active OPERS-covered employment under the ACA. However, if eligible, re-employed retirees still receive a subsidy toward the cost of an OPERS group health care plan. This subsidy functions in the same manner as the OPERS retiree health plans prior to the implementation of the Connector and HRA.

To accommodate re-employed retirees who are eligible for access to OPERS health care coverage during public employment, OPERS introduced two health plans exclusively for re-employed retirees in 2016.

Re-employed retirees are required to enroll in their employer's health plan if the employer offers coverage to other employees in similar positions. If a retiree's employer does not offer health care coverage, OPERS provides the following options – the Medical Mutual Interim Plan, for non-Medicare re-employed retirees, and the Humana Interim Plan, for re-employed retirees who are eligible for Medicare.

OPERS Medicare Connector implementation

Work on the OPERS Medicare Connector (Connector) did not end with the enrollment of close to 131,000 OPERS retirees, spouses and dependents into plans via the Connector. In 2016, OPERS embarked on a concentrated communications effort to reach any eligible retiree who had not enrolled in a plan through the Connector by the end of 2015. All attempts were made to ensure OPERS retirees had the health care coverage they needed and gaps in coverage were avoided.

Retirees enrolled in Medicare Part B, but not eligible for premium-free Medicare Part A, were enrolled in a plan via the Connector on a different schedule than the rest of the OPERS retiree population. These retirees were provided alternative coverage under the Humana Interim Plan while they successfully applied for Medicare Part A coverage, and reimbursement for Part A premiums was arranged with OPERS. OPERS worked closely with the Social Security Administration to ensure enrollment in Medicare Part A was simple and efficient. This group enrolled in a plan via the Connector effective July 1, 2016.

In order to ease the transition to the Connector, OPERS provided enrolled retirees with an additional $300 deposit in their HRA in 2016. This additional deposit is to be provided again in 2017 and 2018 and re-evaluated by the OPERS Board of Trustees for the years following.

This additional deposit is intended to cover out-of-pocket expenses incurred early in the year as retirees transition to new health care plans and reimbursement arrangements are established. The $300 deposit is also intended to reimburse retirees for pharmacy expenses while the Medicare "doughnut hole" closes.

During the initial year of our transition, we were keenly aware of some of the challenges retirees faced with the health reimbursement arrangement (HRA) process. We remain committed to helping our retirees through this transition and worked throughout 2016 to provide resources and information - making certain the Connector administrator resolved service issues.

Health care plan design for non-Medicare retirees

It is important to OPERS that our health care programs have a positive effect on participants. In 2015, OPERS conducted a study to measure the effectiveness of the Medical Mutual Disease Management program. The results showed that overall the program did not improve how participants manage their chronic conditions. OPERS decided to end the disease management program, including no-cost diabetic supplies, as of January 1, 2016.

Finally, in 2016, participation in the Healthy U program was added to the list of activities that earn non-Medicare participants a $50 wellness retiree medical account deposit.

Health Care Horizons forum

Nearly 60 OPERS employers participated in Health Care Horizons, a value-based health care forum held June 6, 2016. The purpose of the forum was to bring together industry leaders and experts to educate employers on value-based health care. Employers also had the opportunity to hear directly from their peers and learn from their real-life, value-based delivery models the ways in which they could maximize their employees' health care dollars.

2016 Financial highlights

OPERS remains strong; 2016 was a good year for the System with positive results and, more importantly, continued progress toward our long-term goals. The OPERS team--staff, management and Board--remain dedicated to keeping this System strong today and well into the future.

Funded status

OPERS is not required to pre-fund retiree health care coverage. However, OPERS has historically pre-funded this expense. The combined actions of our conservative approach to pre-funding and the changes to health care have yielded favorable results.

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 means provided. The December 31, 2015 (the date of the latest health care evaluation) shows a funded status of 64.5%. The current assets are expected to be sufficient to fund future health care needs.

Investment results

Our dedication to providing members with a secure retirement remains the cornerstone of our perspective toward issues, initiatives, projects and activities. This dedication is especially important as investment markets have become increasingly complex and market volatility, even within a single year, can be remarkable. Because investment returns provide approximately two-thirds of the pension funding, the inconsistent markets dictate that we must be diligent in adhering to the proven principles of asset allocation and diversification to produce solid results.

Eventful certainly describes the 2016 investment market. The market had a very slow start; in fact, 2016 saw the worst-ever, five-day start. However, by year-end, the market was well over the 19,000 mark. The OPERS long-term investment goal is to achieve sustained performance to help secure retirement benefits for our members. This sustained performance goal means we focus on the long-term market view, understanding that year-to-year market fluctuations and corrections will occur.

2016 Year In Review

The 2016 investment results were favorable and showed consistent, steady growth. The total health care assets return, combining the health care portfolios for the year, is 7.55%, compared to a combined benchmark return of 7.75% and the actuarial rate anticipated for funding of health care of 5.00%. Because of the structural change of the health care trusts in 2016, health care investment activity is reflected in two different health care trust portfolios (401(h) Health Care Trust portfolio and 115 Health Care Trust portfolio) through June 30, 2016. Effective July 1, 2016, all health care activity is within the 115 Health Care Trust portfolio as the assets transferred from the 401(h) Health Care Trust portfolio to the 115 Health Care Trust portfolio.

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.

Periodically, the System engages in a more comprehensive study that examines the nature of the liabilities we will ultimately pay, the characteristics of the asset allocation projections and associated level of risk, referred to as an asset liability study. OPERS, in conjunction with its investment consultants, completed such a study in 2016 and, as a result, modified the asset allocation slightly, but not substantively. The study was a good reinforcement that our current strategy remains the most appropriate for the long-term results we want to achieve. We continue to be diligent in systematic funding and following established asset allocation strategies. Our methods have reaped results and have allowed the System to grow steadily—with the ability to absorb both peaks and valleys. OPERS has one of the largest health care funds in the United States with a balance of $11.9 billion as of December 31, 2016.

Funding Retiree Health Care

To continue to offer viable access to health care, in 2012 OPERS adopted significant changes to the health care program. These changes are being phased-in with complete implementation by 2018. In January 2016, after extensive outreach, one of the most significant changes, the OPERS Medicare Connector (Connector) was fully implemented. By year-end, the Connector provided over 143,000 Medicare-eligible OPERS retirees and dependents with access to an individual Medicare Advantage or Medigap plan, and a prescription drug plan. In conjunction with the Connector, OPERS provided allowances to eligible members in the form of a health reimbursement arrangement (HRA). Analysis shows the Connector provides our Medicare-eligible retirees with access to better and more affordable health care coverage than any group program OPERS could provide. Additionally, the OPERS 2016 financial results also show significant savings in health care costs due to the changes in the health care program. Total health care expenses decreased by 34.3% to $1.2 billion in 2016, compared to $1.8 billion in 2015.

OPERS carefully monitors the funding streams for both pension and health care. OPERS has one of the largest pre-funded health care funds in the U.S. with a balance of $11.9 billion as of December 31, 2016. Prior to July 2016, OPERS maintained three health care trusts. OPERS sought Internal Revenue Service approval to consolidate the 401(h) Health Care Trust (401(h) Trust) and the Voluntary Employees' Beneficiary Association (VEBA) Trust into the 115 Health Care Trust (115 Trust). As a result, on June 30, 2016, OPERS closed the 401(h) Trust and the VEBA Trust and transferred the assets to the 115 Trust on July 1, 2016. This change will provide streamlined reporting and the flexibility needed to administer different types of health care plans.

OPERS' funding plan is based on actuarial valuation assumptions that represent projected long-term expectations of demographic and economic activity impacting the System. Both state law and best practices indicate pension systems should review assumptions used in actuarial valuations every five years. In 2016, the OPERS Board of Trustees' (Board) actuarial consultants conducted an experience study for the period 2011 through 2015, comparing assumptions to actual results. The experience study incorporates both a historic review and forward-looking projections to determine the appropriate set of assumptions to keep the plan on the path toward full funding. As is typical after the conclusion of these studies, OPERS modified some of the assumptions used for the pension valuation. The expected investment rate for the health care investments remained unchanged at 5.0%.

Employer contributions and investment returns are the two main sources of health care funding and designed to support the long-range funding stability. OPERS employer contributions provide a more predictable flow of funding while a conservative investment philosophy for the health care portfolios provides less risk and recognizes a shorter funding period than with pension assets.

Funding Retiree Health Care

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. The OPERS Board approved changes to pension funding requiring more of the employer contributions to be allocated to pension funding, thereby reducing the amount available to support health care funding. For 2016, the employer contribution rate allocation to pension funding was 12% and to health care funding was 2%. The Board approved a new allocation schedule starting in 2017 with 13% allocated to pension funding and 1% allocated to health care funding; and, the 2018 allocation is expected to shift again with the full 14% employer allocation going to pension funding and 0% allocated to health care funding, to continue each year thereafter until pension funding improves. It is important to note that while the Board approved a plan for future allocations of employer contributions, the Board formally approves the contribution rate allocation annually and may adjust the schedule for the next year based on actual investment results. Current projections indicate the changes to the allocation will reduce the health care fund solvency, but will still allow for sufficient funding for health care at this time.

Investment returns on the health care portfolios

Since 1974, OPERS has been pre-funding health care for its retirees, providing health care plans and paying a large portion of monthly premiums. The 401(h) Trust portfolio returned 4.73% in 2016 and the 115 Health Care Trust portfolio returned 5.11%. The combined return for both health care portfolios was 7.55%, compared with the combined benchmark return of 7.75%. Total combined health care net assets were $11.9 billion as of December 31, 2016.

401(h) Health Care Trust

The 401(h) Trust, established under Section 401(h) of the Internal Revenue Code (IRC), provided coverage to eligible OPERS retirees. This trust was pre-funded and held the portion of employer contributions from the Traditional Pension and Combined plans that were set aside for funding retiree health care. Employer contributions to this trust ceased in September 2014 upon the establishment of the 115 Trust. Health care coverage previously funded through the 401(h) Trust terminated as of December 31, 2015 and the 115 Trust began funding all health care coverage previously funded through the 401(h) Trust. In March 2016, OPERS received two favorable rulings from the Internal Revenue Service (IRS) allowing OPERS to consolidate all health care assets into the 115 Trust. Transition to the new health care trust structure was completed as of July 1, 2016 with the transfer of the 401(h) Trust assets to the 115 Trust.

Funding Retiree Health Care

115 Health Care Trust

As OPERS prepared to change the manner of funding health care for Medicare-eligible retirees, it needed a permissible trust that could fund an HRA. In 2014, OPERS established the 115 Trust under Section 115 of the IRC to support an HRA plan, since the 401(h) Trust was not permissible for the HRA. Beginning in 2016, the 115 Trust is the sole funding vehicle for all OPERS-sponsored health care plans as a result of the favorable IRS rulings allowing the consolidation of all health care assets into the 115 Trust. This trust, similar to the 401(h) Trust, provides reimbursement for eligible health care expenses of retirees in the Traditional Pension and Combined plans, now funding the self-insured health care plans for the non-Medicare retirees, re-employed retiree plans, wellness retiree medical accounts (RMA) and the Connector HRAs. Not including the HRA, all these plans were previously funded through the 401(h) Trust through December 31, 2015. Additionally, the 115 Trust is the funding vehicle for the RMAs for participants of the Member-Directed Plan beginning July 1, 2016. Refer to the next paragraph for additional information.

Voluntary Employees' Beneficiary Association (VEBA) Trust

Member-Directed Plan participants are provided with a RMA. The funding vehicle of the RMAs, prior to July 1, 2016, was the VEBA Trust established under Section 501(c)(9) of the IRC. The VEBA Trust held the portion of employer contributions of the Member-Directed Plan participants that were set aside for funding retiree health care. As previously discussed, the IRS approved the consolidation of OPERS health care assets into the 115 Trust. As of July 1, 2016, the funding vehicle of the Member-Directed RMAs is the 115 Trust.

Sources of income

Additions to the health care trusts are comprised primarily of employer contributions and investment returns. Retiree-paid health care premiums, federal subsidies and vendor rebates provide additional funding support for the health care trusts. Retiree-paid health care premiums are the portion of plan premiums paid by a retiree and dependents for health care coverage. Federal subsidies include funds provided by the federal government for participation in programs like Retiree Drug Subsidy, Medicare Part D rebates and previous programs like the Early Retiree Reinsurance Program.

Future Challenges and Opportunities

Promoting chronic disease prevention and management

The prevalence of preventable chronic conditions among OPERS health care participants supports the continued need for wellness efforts aimed at conditions such as diabetes and heart disease. In 2016, OPERS worked with the YMCA of the USA to make the evidence-based Diabetes Prevention Program available to non-Medicare participants in early 2017.

Medical Homes

OPERS continues to support the availability of Medical Homes for retirees through plan design and participant education. A Medical Home is a team of health care professionals led by a primary care provider, all working together to give retirees comprehensive and coordinated care. Providing comprehensive primary care from wellness to end of life, the model promotes improvements in how care is delivered and paid for, recognizing the importance of coordinated care and performance-based reimbursements. The model is showing evidence of improved quality, better medication adherence and decreases in total health care costs as a result of less demand for costly hospital inpatient and emergency departments care.

OPERS continues to educate retirees, via newsletters and other communication tools, on the value of Medical Homes and encourage their utilization of Medical Homes. These efforts are coupled with a plan design offering a reduced office visit co-pay to non-Medicare enrollees when care is provided by a Medical Home. Popularity of the Medical Home model continues to grow among OPERS participants. In 2016, more than 10,500, or 17.9%, of OPERS non-Medicare participants residing in Ohio sought care from a Medical Home. This is an increase from 14.7% in 2015.

Value-based insurance design (VBID)

In light of rising health care costs, many plan sponsors across the country are focusing on the quality of health care coverage more than ever before. In addition, it is also important to ensure plan participants have easy access to provider care.

In 2016, OPERS continued to offer important VBID features, including free generic medications for certain chronic conditions and coverage maximums for certain lab tests, to maximize the value of our health care fund and retirees' out-of-pocket costs, as well as, support participants' efforts to improve their health and quality of life.

Aligning active employee and retiree health and wellness efforts

Recognizing that current active employees will become future OPERS retirees, a significant opportunity exists to promote the health of current active employees by aligning OPERS' wellness initiatives with those undertaken by Ohio's public employers. In support of this effort, in 2016, we held the Health Care Horizons Forum, an OPERS employer forum where we collaborated with public employers to determine best practices in wellness initiatives and to better align programs between public employers and the OPERS retiree health plans.

Helping retirees to take charge of their own health

Anticipated transformations in care delivery and payment methods create a unique opportunity to assist our participants in taking an active role in their wellness and health care decision-making. For example, OPERS implemented coverage maximums for our medical plan for non-Medicare participants.

Future Challenges and Opportunities

A coverage maximum is the maximum amount the plan will pay for a given laboratory test. Effective January 1, 2016, we applied coverage maximums to 40 lab tests. Retirees can minimize out-of-pocket costs by using Medical Mutual's online tool, MyCareCompare, to search for lab providers whose charges are less than the coverage maximum.

New generics to the marketplace

OPERS' traditional drug trend and overall drug trend were positively influenced by continued growth in the use of generic drugs. In 2016, 91.5% of OPERS prescriptions were filled using generic drugs, providing millions of dollars in savings. With new generic drugs becoming available in the market, OPERS communications efforts and OPERS VBID programs have helped drive generic drug growth.

OPERS' biosimilar and generic drug efforts

OPERS, along with partners such as the Public Sector Healthcare Roundtable and the Association for Accessible Medicines, engaged the U.S. Food and Drug Administration, the U.S. Department of Health and Human Services and legislators on the importance of biosimilar and generic drug competition. OPERS will continue these efforts in 2017. OPERS could save $134 million if 11 biosimilar products come to the U.S. marketplace over the next 10 years.

Despite delay, Cadillac tax remains a concern

Although the Affordable Care Act's (ACA) excise tax, otherwise known as the "Cadillac tax," has been delayed until 2020, OPERS continues to advocate for a complete repeal or, if necessary, an exemption for retiree-only plans, like OPERS. If implemented, the Cadillac tax would be assessed to health care plan providers when their coverage value exceeds certain thresholds. For OPERS, the tax, in its current form, could have significant consequences on retiree health care costs.

Continuing to monitor legislative activity during a changing environment

The future of federal health care policy is uncertain. However, OPERS continues to educate elected officials at the state and federal levels about our retiree health care program. We anticipate additional efforts to repeal and replace at least portions of the ACA in 2017. We will continue to monitor legislative proposals relating to our retirees' health care coverage and continue to advocate the need for accessible and affordable retiree health care.

Complying with new accounting standards

In 2015, the Governmental Accounting Standards Board (GASB) approved additional reporting requirements for other post-employment benefits (OPEB), such as health care (Statements No. 74 and 75). These new standards for health care require systems to allocate the unfunded health care liability, or net OPEB liability, to all contributing employers. OPERS will continue to work proactively with employers to ensure smooth implementation of these new GASB standards. The statements require OPERS to implement the new standards in 2017 and employers to implement, generally, in 2018. Similar to the pension liability reporting (Statements No. 67 and 68), the new OPEB standards have no impact on funding and are a reporting requirement only.

Statutory Requirements

The OPERS Board of Trustees (Board) shall have prepared annually a report giving a full accounting of the revenues and costs relating to the provision of health coverage under Sections 145.58 and 145.584 of the Ohio Revised Code (ORC). The report shall be made as of December 31, 1997 and the thirty-first day of December of each year thereafter. Article 10 of ORC 145.22 (E) requires OPERS to submit the report by June 30 of the following year.

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 2016. Both sections were amended by Substitute Senate Bill, effective January 7, 2013.

2. A summary of coverage for 2016

The following is an outline of OPERS health care coverage in 2016:

The 2016 OPERS Retiree Health Plan for non-Medicare participants

The 2016 OPERS health care plan administrator, Medical Mutual, utilized a Preferred Provider Organization (PPO) for our non-Medicare benefit recipients. 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. Non-Medicare, re-employed retirees were in a separate plan with identical coverage.

2016 Medical Mutual PPO and Medical Mutual Interim Plan features

Deductible (In-network)	$1,000
Total (In-network) out-of-pocket max	$4,900
Deductible (out-of-network)	$2,000
Total (out-of-network) out-of-pocket max	$7,000
Office visit copay (medical home)	$15
Office visit copay (primary care physician or PCP)	$25
Office visit copay (specialist)	$40
Office visit copay (chronic conditions)	Discontinued
Inpatient deductible	$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 receive prescription drug coverage through Express Scripts.

OPERS non-Medicare prescription drug coverage – In 2016, 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 2016, Medication Therapy Management continues to be available for eligible participants.

2016 Prescription Drug Plan features

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	40% co-insurance $150 max
Value-based insurance design (VBID) - Generics for chronic conditions	$0
Over-the-counter (OTC)/generic proton pump inhibitors (PPI) (heartburn meds)	No OTCs, generic: 50% co-insurance ($25 retail/$62.50 mail min)
Brand PPIs	NOT COVERED
Maximum out-of-pocket	$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 (Connector) health reimbursement arrangement (HRA)

Beginning with January 2016 premiums, Medicare-eligible retirees could select an individual medical or prescription drug plan through the Connector, and may be eligible for a monthly allowance deposited into an HRA to be used for reimbursement of eligible health care expenses. During 2017, retirees and spouses may receive an HRA allowance (deposited in the same account); however, in 2018 and beyond, spouses (including surviving spouses, with a low-income exception approved by the Board in 2017) will not receive an allowance. Many retirees will have dollars remaining in the HRA and these remaining allowance dollars can be used to cover dependent costs.

The HRA 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 Parts A and B premiums
- Medical and prescription plan premiums
- Vision and dental plan premiums
- A spouse or child's premiums
- Other qualified out-of-pocket medical expenses – examples include doctor and prescription copays.

The Internal Revenue Service defines qualifying expenses. Claims filed through the HRA are reimbursed for qualified medical expenses retirees and their dependents have already incurred. Reimbursements of qualified 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 will roll over from month-to-month and year-to-year.

Humana Interim Plan

The Humana Interim 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 and Medicare–eligible retirees under age 65 with end-stage renal disease. Retirees enrolled in Medicare Part B and not eligible for premium-free Medicare Part A were eligible to be enrolled in the Humana Interim Plan from January 1, 2016 through June 30, 2016, at which time they were required to move to the Connector.

2016 Humana Interim Plan features

Annual deductible	**$500**
Total out-of-pocket maximum	**$850**
Office visit copay (primary)	**4%**
Office visit copay (specialist)	**8%**
Emergency room/urgent care	**$50**
Preventive services	**100%**
Skilled nursing/hospice	**100%/95%**
Other medical services	**4%**

Medicare Part B reimbursement

If an OPERS retiree was enrolled in OPERS health care or a medical plan through the Connector, and was not being reimbursed from another source for their Medicare Part B premium, they were eligible for reimbursement of a portion of the Medicare B premium from OPERS. In order to receive this reimbursement, the retiree was required to send a copy of their Medicare card, showing enrollment in Part B. As long as the participant remained enrolled in Part B coverage, the allowable reimbursement was added to the recipient's monthly retirement benefit payment. Enrolled spouses are not eligible for this reimbursement. As part of program changes approved by the Board in 2012, the Medicare Part B reimbursement is being phased out over a three-year period with no reimbursements beginning January 1, 2017.

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 2016, 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 chose to participate. OPERS does not subsidize this plan.

3. A summary of the eligibility requirements for health care coverage in 2016:

Listed here are the eligibility requirements for OPERS health care plans in 2016.

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 2016, 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 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 is 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.

Statutory Requirements

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.

Coverage for surviving spouses

For survivor benefit effective dates prior to January 1, 2015 – If a member retired, chose a joint life or multiple life annuity plan of payment and passes away , the surviving spouse was eligible for health care coverage if the deceased retiree was eligible.

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

For survivor benefit effective dates January 1, 2015 or after – If a member retired, chose a joint life or multiple life annuity plan of payment and passed away, the surviving spouse was eligible for health care coverage if the deceased retiree met the OPERS health care eligibility requirements.

If a member passes away before retirement, health care coverage may be available to their survivors receiving monthly benefits if the deceased retiree met the OPERS health care eligibility requirements of age 60 and 20 years of qualifying health care service credit, or 30 years of qualifying health care service credit at any age, under Group A, 31 years at any age under Group B and 32 years at any age under Group C.

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 2016, 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 2016, OPERS offered medical and pharmacy plans for recipients yet to enroll in Medicare. Monthly allowances are used to offset the monthly premium for the coverage provided.

Effective January 1 2016, OPERS ceased offering a medical and pharmacy group plan to Medicare-eligible retirees. Instead, Traditional Pension Plan and Combined Plan retirees enrolled in Medicare Parts A and B received an allowance credited to an HRA to be used to reimburse the cost of coverage selected through the Connector 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 beginning in 2015, spouses began transitioning from their original monthly allowance to zero. Spouses not yet eligible for Medicare have access to OPERS coverage at full cost until 2020 and that may be extended. If the retiree is living, the retiree may use their HRA to reimburse the cost of a spouse's coverage. Spouses eligible for Medicare have access to the Connector beginning in 2016. 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. Beginning January 1, 2017, interest on the RMA will accrue 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, 2016, there were 176,195 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. Under this method, 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 reimbursements are recognized when they become measurable and due to OPERS based on contractual requirements. Therefore, health care reimbursements contain estimates based on information received from health care vendors and other sources. Investment purchases and sales are recorded as of their trade date.

Investments are reported at fair value. Fair value is the amount that a plan can reasonably expect to receive for an investment in a current sale between a willing buyer and a willing seller, that is, other than in a forced 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 2% of covered payroll were credited to the 115 Health Care Trust (115 Trust) for the period of January 1, 2016 through December 31, 2016. Retiree-paid health care premiums (amounts paid by retirees toward the cost of OPERS-provided health care for the retiree, their spouse and dependents), federal subsidies, contract and other receipts and other miscellaneous income comprise the balance of health care additions.

OPERS has consistently pre-funded the retiree health care. The 401(h) Health Care Trust (401(h) Trust) was established under Section 401(h) of the IRC. This trust was pre-funded and held the portion of the employer contributions of the Traditional Pension Plan and the Combined Plan that were set aside for funding retiree health care. Employer contributions to this trust ceased in September 2014 upon the establishment of the 115 Trust.

As OPERS prepared to change the manner of delivery of health care to Medicare-eligible retirees, it needed a permissible trust that could fund an HRA. In 2014, OPERS established the 115 Trust under Section 115 of the IRC to support an HRA, since the 401(h) Trust was not permissible for an HRA.

Member-Directed Plan participants are provided with Member-Directed RMAs. The funding vehicle of the Member-Directed RMAs, prior to July 1, 2016, was the Voluntary Employees' Beneficiary Association (VEBA) Trust established under Section 501(C)(9) of the IRC. The VEBA Trust held the portion of the employer contributions of the Member-Directed Plan that were set aside for funding retiree health care. Beginning July 1, 2016, the Member-Directed RMAs are funded through the 115 Trust.

In March 2016, OPERS received two favorable rulings from the IRS allowing OPERS to consolidate all health care assets into the 115 Trust. The 401(h) Trust and the VEBA Trust were closed as of June 30, 2016, and the net positions transferred to the 115 Trust on July 1, 2016. Beginning in 2016, the 115 Trust is the funding source for all health care plans.

The funded status of health care as of December 31, 2015, the most recent actuarial valuation, was 64.5%. 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. Health care is solvent for an indefinite period under actuarial terms as of December 31, 2015. An indefinite solvency period indicates that health care assets are expected to be sufficient to fund future health care needs.

Statutory Requirements

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."

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

In March 2016, OPERS received two favorable rulings from the Internal Revenue Service allowing OPERS to consolidate all health care assets into the 115 Trust. Transition to the new health care trust structure was completed as of July 1, 2016. The OPERS Combining Statements of Changes in Fiduciary Net Position for the year ended December 31, 2016 reflects a partial year of activity in the 401(h) Trust and VEBA Trust prior to the termination of these trusts, on June 30, 2016, and the assets and liabilities, or net position, of these trusts being consolidated into the 115 Health Care Trust, on July 1, 2016. The OPERS Statements of Fiduciary Net Position reflects all health care assets in the 115 Trust as of December 31, 2016.

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

OPERS paid approximately $50.5 million in Medicare Part B premiums to benefit recipients in 2016.

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.

Appendix A – Ohio Revised Code Sec. 145.58

(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 Medicare-equivalent benefits for members ineligible for 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

	2016	2015	2014
115 Health Care Trust*			
Assets			
Cash and Short-Term Investments	**$874,632,840**	**$228,930,728**	**$7,797,254**
Receivables			
Members and Employers	28,954,270	31,146,407	20,597,780
Vendor and Other	67,090,996	140,747,042	175,326,214
Investment Sales Proceeds	70,760,106	744,048	988,589
Accrued Interest and Dividends	41,092,533	1,246,089	728,607
Total Receivables	**207,897,905**	**173,883,586**	**197,641,190**
Investments, at fair value			
Fixed Income	4,087,785,698	296,365,386	66,380,103
Domestic Equities	3,071,759,733	82,245,096	50,172,724
International Equities	2,265,107,975	58,142,626	41,687,272
Other Investments	1,534,240,696	48,222,156	24,508,856
Total Investments	**10,958,894,102**	**484,975,264**	**182,748,955**
Capital Assets			
Land	942,728		
Building and Building Improvements	28,004,098		
Furniture and Equipment	32,759,796	1,441,984	
Total Capital Assets	61,706,622	1,441,984	
Accumulated Depreciation	(33,678,510)		
Net Capital Assets	**28,028,112**	**1,441,984**	
TOTAL ASSETS	**12,069,452,959**	**889,231,562**	**388,187,399**
Liabilities			
Undistributed Deposits	287,413	10,021	
Benefits Payable	109,142,271	1,634,811	
Investment Commitments Payable	79,535,412	1,789,658	1,803,774
Accounts Payable and Other Liabilities		44,685,032	303,453
TOTAL LIABILITIES	**188,965,096**	**48,119,522**	**2,107,227**
Net Position Held in Trust for Post-employment Health Care	**$11,880,487,863**	**$841,112,040**	**$386,080,172**

Source: 2014 - 2016 Comprehensive Annual Financial Reports

*Based on Internal Revenue Service guidance received in 2016, OPERS transferred health care assets from the 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association Trust into the 115 Health Care Trust on July 1, 2016. All health care assets, liabilities and net position are reflected in the 115 Health Care Trust statement as of December 31, 2016.

Appendix C – Statements of Fiduciary Net Position—Health Care

	2016*	2015	2014	2013	2012	2011**
401(h) Health Care Trust						
Assets						
Cash and Short-Term Investments		**$437,888,805**	**$503,893,407**	**$491,371,340**	**$446,851,345**	**$516,841,401**
Receivables						
Members and Employers			12,096,566	19,417,032	43,429,976	51,989,914
Early Retirement Incentive Plan			6,062	64,600	177,884	773,991
Vendor and Other		677,725	1,309,906	147,929,032	147,616,824	67,535,218
Investment Sales Proceeds		43,193,263	64,470,004	75,148,940	261,962,739	185,275,974
Accrued Interest and Dividends		39,359,404	47,590,193	47,924,681	47,650,966	49,585,342
Total Receivables		**83,230,392**	**125,472,731**	**290,484,285**	**500,838,389**	**355,160,439**
Investments, at fair value						
Fixed Income		3,733,008,136	4,434,483,598	4,313,177,166	4,731,050,357	4,349,713,914
Domestic Equities		2,969,522,823	3,296,381,497	3,594,242,223	3,293,138,146	3,642,820,108
Private Equity				110,263,964	73,443,686	54,927,514
International Equities		2,221,451,642	2,661,469,316	3,333,565,455	3,506,799,272	3,310,599,792
Other Investments		1,390,445,167	1,615,807,236	1,159,221,629	563,094,682	134,339,269
Total Investments		**10,314,427,768**	**12,008,141,647**	**12,510,470,437**	**12,167,526,143**	**11,492,400,597**
Capital Assets						
Land		916,220	916,220	729,981	729,981	665,394
Building and Building Improvements		27,256,121	27,261,277	21,476,205	21,737,564	19,627,154
Furniture and Equipment		29,358,536	28,536,399	26,907,290	24,688,709	24,809,991
Total Capital Assets		57,530,877	56,713,896	49,113,476	47,156,254	45,102,539
Accumulated Depreciation		(30,510,198)	(28,082,475)	(24,246,817)	(20,530,484)	(18,156,668)
Net Capital Assets		**27,020,679**	**28,631,421**	**24,866,659**	**26,625,770**	**26,945,871**
TOTAL ASSETS		**10,862,567,644**	**12,666,139,206**	**13,317,192,721**	**13,141,841,647**	**12,391,348,308**
Liabilities						
Undistributed Deposits		243,005	183,002	146,606	69,659	62,273
Benefits Payable		91,451,759	99,279,185	90,019,865	100,495,333	118,529,285
Investment Commitments Payable		76,923,764	113,120,724	99,797,215	194,165,994	294,572,622
Accounts Payable and Other Liabilities		22,880,935	13,033,505	15,544,228	18,485,339	19,183,817
Obligations Under Securities Lending						
TOTAL LIABILITIES		**191,499,463**	**225,616,416**	**205,507,914**	**313,216,325**	**432,347,997**
Net Position Held in Trust for Post-employment Health Care, as Restated		**$10,671,068,181**	**$12,440,522,790**	**$13,111,684,807**	**$12,828,625,322**	**$11,959,000,311**

Source: 2011 - 2016 Comprehensive Annual Financial Reports

*Based on Internal Revenue Service guidance received in 2016, OPERS transferred health care assets from the 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association Trust into the 115 Health Care Trust on July 1, 2016. All health care assets, liabilities and net position are reflected in the 115 Health Care Trust statement as of December 31, 2016. See page 26 for the 115 Health Care Trust statements.

** Net Position by Plan was restated to correct the allocation of investment income as of December 31, 2010, with the restatement rolled forward through 2011 and 2012. The adjustment is reflected in the Cash and Short-Term Investments line and has no impact on the total net position of the System.

Appendix C – Statements of Fiduciary Net Position—Health Care

	2016*	2015	2014	2013	2012	2011**
Voluntary Employees' Beneficiary Association Trust						
Assets						
Cash and Short-Term Investments		**$4,675,584**	**$4,148,957**	**$5,707,117**	**$2,355,351**	**$1,838,812**
Receivables						
Members and Employers		13,932,389	11,647,166	7,953,038	1,573,325	1,717,956
Investment Sales Proceeds		532,305	628,545	610,262	2,104,651	997,981
Accrued Interest and Dividends		437,722	465,050	405,596	361,199	288,278
Total Receivables		**14,902,416**	**12,740,761**	**8,968,896**	**4,039,175**	**3,004,215**
Investments, at fair value						
Fixed Income		37,189,326	38,408,780	33,339,330	31,937,847	24,133,945
Domestic Equities		27,429,090	28,230,500	28,196,827	23,579,831	22,849,059
Real Estate		17,627,759	16,410,600	14,791,023	12,281,837	8,891,222
Private Equity		19,309,205	19,895,505	15,746,087	12,285,901	7,717,274
International Equities		28,135,488	31,447,388	32,934,729	28,205,829	22,672,643
Other Investments		23,392,047	24,639,714	13,488,024	5,687,375	1,208,097
Total Investments		**153,082,915**	**159,032,487**	**138,496,020**	**113,978,620**	**87,472,240**
Collateral on Loaned Securities		**18,887,694**	**17,067,184**	**13,199,734**	**10,986,106**	**13,766,599**
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	1,800,555
Total Capital Assets		3,011,981	2,987,214	2,785,324	2,628,153	1,800,555
Accumulated Depreciation		(2,180,336)	(2,101,775)	(1,989,331)	(1,767,867)	(1,736,914)
Net Capital Assets		**831,645**	**885,439**	**795,993**	**860,286**	**63,641**
TOTAL ASSETS		**192,380,254**	**193,874,828**	**167,167,760**	**132,219,538**	**106,145,507**
Liabilities						
Benefits Payable		208,449	254,216	16,688	11,171	422
Investment Commitments Payable		843,360	1,017,665	876,994	1,623,282	1,670,566
Due to Other Plans		5,992,744				
Obligations Under Securities Lending		18,888,895	17,063,783	13,189,782	10,969,210	13,778,387
TOTAL LIABILITIES		**25,933,448**	**18,335,664**	**14,083,464**	**12,603,663**	**15,449,375**
Net Position Held in Trust for Post-employment Health Care, as Restated		**$166,446,806**	**$175,539,164**	**$153,084,296**	**$119,615,875**	**$90,696,132**

Source: 2011 - 2016 Comprehensive Annual Financial Reports

*Based on Internal Revenue Service guidance received in 2016, OPERS transferred health care assets from the 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association Trust into the 115 Health Care Trust on July 1, 2016. All health care assets, liabilities and net position are reflected in the 115 Health Care Trust statement as of December 31, 2016. See page 26 for the 115 Health Care Trust statements.

**Net Position by Plan was restated to correct the allocation of investment income as of December 31, 2010, with the restatement rolled forward through 2011 and 2012. The adjustment is reflected in the Cash and Short-Term Investments line and has no impact on the total net position of the System.

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

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

Source: 2014 - 2016 Comprehensive Annual Financial Reports

*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 transferred to the 115 Health Care Trust on July 1, 2016. The Special Item Interplan Activity-Trust Closures line represents this interplan activity. All health care plans are funded through the 115 Health Care Trust as of July 1, 2016.

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

	2016*	2015	2014	2013	2012	2011**
401(h) Health Care Trust						
Additions						
Employer Contributions			$135,522,351	$120,056,440	$494,048,415	$503,458,216
Contract and Other Receipts		$9,435	10,950,386	126,941,889	94,730,390	89,087,996
Retiree-Paid Health Care Premiums+		248,601,375	238,406,380	178,140,822	159,614,898	148,370,246
Federal Subsidy			44,715,641	105,965,762	182,579,917	192,118,407
Other Income/(Expense), net			7,601,841	13,483,861	11,774,199	10,915,043
Total Non-investment Income		**248,610,810**	**437,196,599**	**544,588,774**	**942,747,819**	**943,949,908**
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	(401,560,941)
Bond Interest	(60,085,563)	157,207,141	284,087,239	116,748,678	201,317,018	202,859,266
Dividends	131,736,664	105,609,193	186,495,341	206,180,289	183,422,898	134,235,895
International Income/(Loss)	3,751	(11,506)	18,941	(4,659)	10,894	(92,053)
Other Investment Income	14,158	652,343	4,302,396	13,183,549	10,861,876	3,671,640
External Asset Management Fees	(7,012,448)	(27,988,205)	(30,811,500)	(40,036,389)	(24,118,062)	(13,648,040)
Net Investment Income/(Loss)	**493,289,087**	**(218,108,781)**	**653,819,162**	**1,402,756,532**	**1,555,151,574**	**(74,534,233)**
Investment Administrative Expenses	(3,080,517)	(5,355,603)	(5,252,268)	(5,407,709)	(5,180,680)	(4,389,394)
Net Income/(Loss) from Investing Activity	**490,208,570**	**(223,464,384)**	**648,566,894**	**1,397,348,823**	**1,549,970,894**	**(78,923,627)**
TOTAL ADDITIONS	**490,208,570**	**25,146,426**	**1,085,763,493**	**1,941,937,597**	**2,492,718,713**	**865,026,281**
Deductions						
Health Care Expenses		1,774,989,836	1,738,596,173	1,642,525,598	1,607,921,528	1,575,561,578
Administrative Expenses		19,611,199	18,329,337	16,352,514	15,172,174	13,076,814
TOTAL DEDUCTIONS		**1,794,601,035**	**1,756,925,510**	**1,658,878,112**	**1,623,093,702**	**1,588,638,392**
Special Item						
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	(723,612,111)
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	12,682,612,422
Balance, End of Year	**$0**	**$10,671,068,181**	**$12,440,522,790**	**$13,111,684,807**	**$12,828,625,322**	**$11,959,000,311**

Source: 2011 - 2016 Comprehensive Annual Financial Reports

*Health care coverage provided through the 401(h) Health Care Trust (401(h) Trust) was terminated as of December 31, 2015. Therefore, there are no deductions in the 401(h) Trust for 2016 as health care was funded through the 115 Health Care Trust (115 Trust) in 2016. The 401(h) Trust and the Voluntary Employees' Beneficiary Association (VEBA) Trust were closed as of June 30, 2016 and the net positions transferred to the 115 Trust on July 1, 2016. Activity included in this 2016 column is for the six-month period ended June 30, 2016. The Special Item Interplan Activity-Trust Closures line represents the interplan activity as a result of these closures and transfer of net positions to the 115 Trust. The 401(h) Trust net position transferred to the 115 Trust was $11,161,276,751.

**Net Position by Plan was restated to correct the allocation of investment income as of December 31, 2010, with the restatement rolled forward through 2011 and 2012. The adjustment is reflected in the Cash and Short-Term Investments line and has no impact on the total net position of the System.

+ Beginning in 2015, Retiree-Paid Health Care Premiums was reported separately and not included in a Member Contributions line item. For comparability, this activity has been 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	2011**
Voluntary Employees' Beneficiary Association Trust						
Additions						
Employer Contributions***	$10,483,804		$14,702,198	$18,256,171	$16,883,868	$15,982,848
Contract and Other Receipts	22,722		20,484	3,061	9,233	9,082
Interplan Activity					63,641	
Total Non-investment Income	**10,506,526**		**14,722,682**	**18,259,232**	**16,956,742**	**15,991,930**
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	(2,877,126)
Bond Interest	1,222,858	1,902,518	1,625,463	1,635,744	1,271,636	947,608
Dividends	1,738,911	826,237	2,547,764	2,062,309	1,351,077	790,885
Real Estate Operating Income, net	1,026,057	2,959,962	3,017,022	2,028,598	1,288,261	914,755
International Income/(Loss)	79	371	240	(43)	81	(562)
Other Investment Income	517,933	1,724,353	3,584,241	2,210,914	1,785,191	810,818
External Asset Management Fees	(92,819)	(907,438)	(692,565)	(645,737)	(386,839)	(236,503)
Net Investment Income/(Loss)	**6,690,778**	**622,538**	**11,040,970**	**17,933,705**	**14,028,197**	**349,875**
From Securities Lending Activity						
Security Lending Income	92,902	106,312	77,985	83,192	98,909	72,422
Security Lending Expenses	(41,106)	(23,811)	(6,747)	(11,881)	(25,735)	(17,305)
Net Security Lending Income	51,796	82,501	71,238	71,311	73,174	55,117
Unrealized Gains/(Losses)	4,152	(1,202)	3,401	9,952	16,896	(11,788)
Net Income from Securities Lending	**55,948**	**81,299**	**74,639**	**81,263**	**90,070**	**43,329**
Investment Administrative Expenses	(40,192)	(75,920)	(71,081)	(60,287)	(68,480)	(81,707)
Net Income/(Loss) from Investing Activity	**6,706,534**	**627,917**	**11,044,528**	**17,954,681**	**14,049,787**	**311,497**
TOTAL ADDITIONS	**17,213,060**	**627,917**	**25,767,210**	**36,213,913**	**31,006,529**	**16,303,427**
Deductions						
Health Care Expenses	1,417,445	2,396,972	2,217,933	1,719,043	1,236,169	895,574
Administrative Expenses	629,201	1,330,559	1,094,409	1,026,449	850,617	914,578
Interplan Activity	727,192	5,992,744				28,172
TOTAL DEDUCTIONS	**2,773,838**	**9,720,275**	**3,312,342**	**2,745,492**	**2,086,786**	**1,838,324**
Special Item						
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	14,465,103
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	76,231,029
Balance, End of Year	**$0**	**$166,446,806**	**$175,539,164**	**$153,084,296**	**$119,615,875**	**$90,696,132**

Source: 2011 - 2016 Comprehensive Annual Financial Reports

*The Voluntary Employees' Beneficiary Association (VEBA) Trust was terminated as of June 30, 2016 and the net position transferred to the 115 Health Care Trust on July 1, 2016. Activity included in this 2016 column is for the six-month period ended June 30, 2016. The Special Item Interplan Activity-Trust Closures line represents the interplan activity as a result of this closure and transfer of net position to the 115 Health Care Trust. The VEBA Trust net position transferred was $180,886,028.

**Net Position by Plan was restated to adjust the allocation of investment income as of December 31, 2010, with the restatement shown in the beginning net position of 2011. The restatement by plan does not impact the total net position of the System.

***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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