Ohio Public Employees Retirement System

OpersHealthCareReport 2014

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Executive Summary

While health care coverage is not required by law, the Ohio Public Employees Retirement System recognizes the important role it plays as part of a secure retirement for its members.

OPERS first offered health care coverage to retirees in 1962. The plan was not subsidized by the System with the retiree paying the entire premium. In 1974, OPERS began pre-funding health care for its retirees in a 401(h) trust, providing health care coverage and subsidizing monthly premiums. In 2014, OPERS established the 115 Health Care Trust (115 Trust) under Section 115 of the Internal Revenue Code. As a result, the OPERS Health Care Fund now consists of two health care trusts. As of December 31, 2014, the total health care fund, 401(h) and 115 Trust, totaled $12.8 billion in net assets.

The need for change —
Offering retirees access to quality health care coverage has become increasingly difficult in recent years. Retiree demographics are changing. People are living longer and spending more years in retirement than in previous decades. Issues including technological advances and pharmaceutical inflation are driving health care costs up at an alarming rate. Without change, the OPERS health care plan would have exhausted the health care fund in a matter of years.

A Plan to Preserve Health Care for the Future —
In 2012, to preserve our ability to provide retiree health care coverage, OPERS embarked on a comprehensive evaluation of all aspects of health care. As a result, the OPERS Board of Trustees adopted a set of essential changes to the health care plan to be implemented over the next several years.

The following is a list of health plan elements that were changed in order to create the new plan. A complete explanation of each change is available beginning on page 8.

- **Retiree eligibility**
- **Participant cost share**
- **Spouse coverage**
- **Child coverage**
- **Qualifying service credit**
- **Medicare Part B premium reimbursement**
- **Delayed enrollment**
- **Voluntary termination**
- **Minimum earnings requirement**
- **Income-based discount program**
- **Plan sponsorship**

The changes OPERS has made to the health care plan combine providing protection for those already retired and recognizing career employees. We designed a plan that allows for health care coverage within a budget. We've done this by offering retirees an allowance based on years of service and age at retirement. The allowance tables are designed to provide the greatest allowance for individuals who work 32 or more years and are at least age 65.

OPERS is confident its changes to the health care plan present positive, long-term solvency solutions given the challenges that retirement system health care plans face across the country Although the new health care plan will affect current and future retirees, it will allow us to honor our commitment to offer access to coverage for the foreseeable future.

Health Care Utilization and Cost Trends—Three-fourths of OPERS' health care costs are used to treat chronic conditions such as heart disease, stroke, cancer, diabetes and arthritis, mirroring a national trend. Most of these conditions are linked to modifiable risk factors, such as poor eating habits, physical inactivity and smoking. OPERS provides a variety of resources to help participants prevent illness, manage their health and improve the quality of their lives.

We closely monitor pharmacy trends to ensure appropriate usage and pricing.

Strategies for Addressing Health Care Trends—OPERS has developed a strategy for facilitating the transition of plan participants from passive patients to informed consumers of health care. In 2013, OPERS evaluated the health care resources available to retirees as individuals and as a population.

In 2014, OPERS took advantage of proven community-based resources to address retirees' personal health-management needs and gaps in care. Non-Medicare participants and their caregivers had the opportunity to enroll in the Ohio Department of Aging's Chronic Disease Self-Management Program.

OPERS, along with partners such as the Public Sector Healthcare Roundtable and Generic Pharmaceutical Association, engaged the U.S. Food and Drug Administration as well as legislators on the importance of biosimilar and generic drug competition. OPERS will continue these efforts in 2015.

In 2014, OPERS submitted five comments on a variety of issues, including four letters to the FDA and a letter to the U.S. Senate Committee. Copies of these letters are available on the OPERS website, www.opers.org.

In 2014, Medical Mutual of Ohio implemented a cancer clinical pathways program, a more comprehensive approach to addressing the growing cost and trends in cancer care. Steeped in evidence-based guidelines, cancer clinical pathways are the next evolution in the management of cancer.

Eye on Quality—OPERS continues to focus on maximizing quality. In 2014, OPERS conducted its third annual Participant Experience Survey to assess respondents' self-reported health status, their participation in OPERS health and wellness programs, and their impact. Also in 2014, the Clinical Quality Improvement Committee turned its attention toward identifying areas of potential savings in OPERS health care spending including, for example, costs associated with duplicative medical testing and care provided that is not consistent with evidence-based guidelines.

2014 - The Year in Review

In 2012, to preserve our ability to provide retiree health care coverage, OPERS embarked on a comprehensive evaluation of all aspects of health care. As a result, the OPERS Board of Trustees adopted a set of essential changes to the health care plan to be implemented over the next several years.

In 2014, we continued our focus on implementing essential changes the Board approved in 2012 and continuing to communicate and educate our members on these changes. The implementation of these changes is a monumental turning point in the OPERS health care program. As a result of these changes, OPERS has secured the ability to provide retirees with access to meaningful retiree health care coverage well into the future.

The new health care plan allows for safe and consistent funding and provides safeguards for potential investment market volatility. Our investment strategy for the health care fund is different from the pension fund because the liabilities and funding horizon are different. This can translate into lower returns, but also less volatility. Much like a household budget, we've created a plan where the health care expenditures are equal to the money coming in to fund the plan. This allows us to rely on the long-term sustainability of our health care fund.
The new health care plan is equitable, providing coverage for all retirees, both Medicare-eligible and non-Medicare, but also requiring some sacrifice and a shared partnership and responsibility across the retiree and active member populations. Retirees now have more options than ever before and the ability to plan ahead for future health care expenses. Acting as informed health care consumers, plan participants have more choices than ever before and an increased ability to create a plan that suits their individual needs.

In 2016, for the first time, OPERS will introduce the OPERS Medicare Connector. Beginning in 2013, OPERS embarked on an extensive process to procure a Medicare Connector company. Major phases of the procurement process included a rigorous Request for Proposal (RFP) development process, defining requirements, vendor candidate presentations and site visits.

OPERS selected OneExchange to assist Medicare-eligible retirees in evaluating, selecting and enrolling in an individual Medicare plan that best fits their needs and lifestyles. The contract was signed in September 2014; implementation began in October 2014.

OneExchange is the largest and oldest private Medicare exchange company with experience serving over 1.1 million individuals. They are a resource, providing access to a wide assortment of plans from over 90 of the largest and most popular national and regional health insurance companies.

Advantages of providing Medicare-eligible retirees access to a Medicare Connector include:

- Maximizing health care plan choice, affordability and flexibility
- Offering health care plan(s) that meet retirees' individual needs and budgets
- Supporting active consumerism by Medicare-eligible retirees

The OPERS Medicare Connector represents the most significant change to the OPERS health care plan since its inception. Understanding that health care coverage can be an emotional topic and change is almost always challenging, we have embarked on an unprecedented communication and education effort. We have worked over the last two years to prepare retirees for this change and lessen the interruption to their daily lives as much as possible. OPERS has done this by providing consistent education across all mediums. We have distributed an increased amount of print communications, added pages to our website, posted monthly videos to opers.org, increased the number of blog posts addressing health care change and increased the number of in-person education seminars we conduct annually.

Several of the key elements of the new health care plan came to fruition in 2014. It is rewarding to see the financial benefits of the plan adjustments and know that because of our efforts, OPERS retirees can count on meaningful health care coverage for the foreseeable future.

A Plan to Preserve Health Care for the Future

Key changes to the OPERS health care plan, as adopted by the OPERS Board of Trustees in 2012, have provided the foundation for a sustainable plan which recognizes the needs of retirees while providing financial stability within the health care fund. The pension fund continues to meet statutory requirements, and the health care fund is one of the strongest in the nation at 61% funded as of December 31, 2013, the most recent actuarial valuation. Although the adopted changes will have a direct impact on current and future retirees, our funded status will allow us to achieve our goal of offering access to health care coverage well into the future.

Challenges

Offering retirees access to quality health care coverage has become increasingly difficult in recent years. These challenges, including those listed here, made it impossible for OPERS to continue providing coverage at the pre-2012 level. Without change, the health care plan would have exhausted the health care fund in a matter of years.

- **Health Care Coverage is Discretionary—** OPERS is required by law to fund and provide pension benefits, while health care coverage is not mandated. Only after we meet our pension obligations can OPERS use some of the employer contributions to fund health care coverage. OPERS cannot use employee contributions to fund health care.

- **Increase In Retiree Population—**Baby boomers are retiring. OPERS expects its retiree population will increase by 40% in the next 10 years.

- **Life Expectancy—**Retirees are living longer. The average OPERS member retires at age 57.6; using a 78.7 year average life expectancy, a retiree would have access to OPERS health care coverage for more than 21 years. This is far more than anticipated when the plan was established in 1974.

- **Health Care Fund—**The OPERS Health Care Fund was $12.8 billion at the end of 2014. However, when OPERS finalized plan changes in 2012, we were facing the depletion of the fund within 10 years if we had not adopted significant changes to the health care plan.

- **Health Care Inflation—**Technological advances as well as medical and pharmaceutical inflation are driving health care costs up at a much higher rate than the Consumer Price Index (CPI). In 2014, the rate of health care inflation was 3.0% while the CPI was 1.6%.

- **Chronic Condition Prevalence–**Not only are conditions such as high blood pressure, high cholesterol, heart disease and diabetes highly prevalent among OPERS retirees, many participants have multiple chronic conditions. The costs associated with chronic conditions have far-reaching implications for the OPERS health care plan and the health care system at large.

Guiding Principles

The OPERS Board adopted and referred to these guiding principles for direction during the creation of the new health care plan:

1. Preserve access to quality health care coverage, with or without a health care allowance, for all eligible retirees and their eligible dependents.
2. Commit to a long-term solvency period.
3. Strive to balance health care changes between current and future retirees.
4. Encourage health care participants to share responsibility for prudent personal health management and medical expenditures.
5. Consider career service, membership status, and affordability in determining health care premiums.
6. Manage the health care program using sound business practices consistent with industry norms and marketplace developments.
7. Support short and long-term health management initiatives for both active and retiree groups.
8. Review the program, at a minimum, annually to evaluate health care delivery, legislation, and program trends.
9. Consider member needs and program costs in the design of the health care program.
10. Influence health care public policy changes and related advocacy activities.
11. Communicate with and educate all stakeholders as early as possible.

Health Care Plan Design

The new health care plan adjusts three main components to achieve optimal savings and plan longevity—eligibility, participant cost (allowance) and plan sponsorship (in the form of a Medicare Connector). The following is a summary of the key changes comprising the new plan:

- **Retiree Eligibility—**To be eligible for OPERS retiree health care coverage, members with a retirement effective date on or after January 1, 2015 must retire with 20 or more years of qualifying service and be age 60, or retire with 30 years of qualifying service at any age.
- **Participant Cost—**Beginning January 1, 2015, the amount OPERS pays toward the total monthly cost of coverage (allowance) will be based on the retiree's years of qualifying service and age at first enrollment in the OPERS health care plan using a revised allowance table. The table provides a range of allowances from 51% to 90%.
- **Spouse Coverage—**Spouses not yet eligible for Medicare will have access to the OPERS retiree health plan through 2020 through an eligible OPERS retiree or disability benefit recipient. OPERS will begin phasing out premium allowances for spouses in 2016, leading to a $0 allowance in 2018. Beginning in 2016, spouses over age 65 and enrolled in Medicare Parts A and B can use the OPERS Medicare Connector and will receive an allowance in 2016 and 2017. By 2018, OPERS will phase the allowance to $0. However, the Medicare Connector will offer plans with a $0 premium which can be selected as a minimum level of coverage. Additionally, most retirees will have allowance dollars available after their plan selection and payment to apply toward the cost of spousal health care. Beginning in 2018, after the spousal allowance is phased out, members will receive the same amount, regardless of whether they have a spouse or not.

- **Child Coverage—**Dependent children of members and benefit recipients with 20 years or more of service will receive an allowance equal to 50% of the retiree's allowance percentage. Children of benefit recipients with less than 20 years of service credit will be phased out and ineligible at the end of 2017.

- **Qualifying Service Credit—**The following types of service credit will apply toward health care eligibility and allowance effective January 1, 2014: contributing service, Ohio retirement system service, USERRA (military service that interrupts public employment), unreported time and restored (refunded) service. In order to earn service credit applicable to health care coverage eligibility, an OPERS member must earn a minimum of $1,000 per month.

- **Medicare Part B Premium Reimbursement—**The monthly Medicare Part B premium reimbursement provided to retirees enrolled in Medicare Part B will be eliminated over a three-year period, beginning in 2015 (2015—reimbursement reduced to $63.62, 2016—reimbursement reduced to $31.81, 2017—reimbursement reduced to $0).

- **Delayed Enrollment—**Retirees may delay entry into the OPERS health care plan. Effective January 1, 2015, a retiree's allowance will be determined based on their years of qualifying service at retirement and age when first enrolled in the OPERS health care plan. Retirees between the ages of 60 and 65 can increase their allowance by 3% for every year of age attained while not enrolled in the OPERS health care plan.

- **Voluntary Termination—**Effective January 1, 2014, once a retiree voluntarily terminates from the OPERS health care plan, he or she can only re-enroll if OPERS receives proof of creditable coverage. This voluntary termination provision does not apply to retirees who become re-employed in an OPERS-covered position.

- **Minimum Earnings Requirement—**Effective January 1, 2014, in order to earn a full year of service credit applicable to health care coverage eligibility, an OPERS member must earn a minimum of $1,000 per month. OPERS will not prorate earnings below $1,000 per month and they will not qualify toward health care coverage eligibility.

- **Income-Based Discount Program—**Beginning January 1, 2015, an increased income-based discount will be provided for retirees who have a household income at or below 200% of the federal poverty level (FPL) and at least 20 years of qualifying service. Eligible retirees will receive a 30% discount on their monthly premiums for the OPERS group health care plan.

- **Plan Sponsorship—**Beginning in 2016, health care coverage for retirees and spouses enrolled in Medicare Parts A and B will be available for purchase via the OPERS Medicare Connector. Health care coverage for retirees and spouses under age 65 will be provided through an OPERS-sponsored plan.

Medicare Connector

OPERS retirees enrolled in Medicare Parts A and B will choose an individual Medicare plan through the OPERS Medicare Connector in the fall of 2015 for a plan year effective date of January 1, 2016. Eligible OPERS retirees will receive an allowance to fund the costs of the individual Medicare plan. The monthly allowance will be notionally deposited into a Health Reimbursement Arrangement (HRA) and available for reimbursement of eligible health care expenses. After paying the premium for their choice of Medicare plan, retirees will have the discretion to determine how they use any remaining allowance dollars. Funds can be directed toward IRS allowable medical expenses such as coverage for their spouse, Medicare Part B premiums, out-of-pocket costs or savings for future health care expenses.

In 2014, after an extensive procurement and contract negotiation process, OPERS established a partnership with OneExchange, a Medicare Connector organization to help retirees and dependents eligible for Medicare Parts A and B select an individual Medicare Supplement or Medicare Advantage Plan.

OneExchange is the largest and oldest private Medicare exchange company with experience serving over 1.1 million individuals. They are a resource, providing access to a wide assortment of plans from over 90 of the largest and most popular national and regional health insurance companies.

OneExchange offers experience, choice, credentials and ease of use of Health Reimbursement Arrangements for our retirees:

Experience - Facilitated more than 500 implementations.

Choice - Offers a robust list of carrier and plan options for retirees.

Credentials - Licensed Benefit Advisors are required to go through an extensive six-week training course prior to helping Medicare-eligible retirees enroll in a plan. Licensed Benefit Advisors and Customer Service staff also participate in continuous training sessions throughout the year.

Ease of Use of the Health Reimbursement Arrangement - Offers a variety of ways retirees are able to receive reimbursement.

The Connector will provide an initial enrollment process for each eligible retiree. A Licensed Benefit Advisor will assist retirees in choosing a plan that best meets their needs. Retirees will use their monthly allowance amount from OPERS to purchase this plan. Depending on their selection, the Medicare Connector should increase participants' purchasing power and is expected to offset some of the other changes OPERS has made to preserve the health care fund.

Connector Implementation and Communications

The new OPERS health care plan has been designed to allow retirees and active members time to plan and prepare, especially the Medicare population. A concerted effort to educate the Medicare population about the different aspects of Medicare including enrollment, plan selection, qualified Medicare expense reimbursement processes and guaranteed issue has been and will continue to be a major portion of our ongoing strategic communication plan. OPERS has embarked on an unprecedented communication campaign addressing each facet of the key changes with specific communications methods and techniques to ensure the appropriate audience is reached and concerns and issues are addressed.

To date, Connector communications include:

874	**Seminars**
22	**Retiree and member newsletter articles**
45	**Blogs**
19	**Videos**

- Launched Connector Readiness opers.org Web pages
- Developed two Connector focused publications, the 2016 Preview Guide and the Connector Readiness Kit.
- Created Learn, Plan, Act campaign designed to provide members with information and tools to make an informed decision about retirement and health care coverage.

Connector Advisory Panel

In creating a comprehensive Connector communication strategy, OPERS sought detailed and consistent retiree input. OPERS formed a Connector Advisory Panel comprised of approximately a dozen retirees. Participants were chosen to serve as a representation of the overall retiree population. The panel was a diverse group representing various ages and economic backgrounds and from different locations within Ohio and even out-of-state.

The Connector Advisory Panel met beginning in late 2014 and well into 2015. The group spent their time reviewing and providing feedback on print communications, website content, social media content, videos and educational seminar content. In terms of Connector communications, the panel helped OPERS understand the retiree perspective and to focus communications through the eyes of a variety of retirees, all with different learning styles. The feedback provided by the panel helped to shape the overall Connector communication campaign.

Changes for retirees without premium-free Medicare Part A

Beginning in 2016, OPERS will reimburse retirees without premium-free Medicare Part A for their Part A premiums, as well as any applicable late-enrollment fees. Although current law requires OPERS to provide a Medicare Part A-equivalent level of health care coverage to retirees who are not eligible for premium-free Medicare Part A, changes in federal law meant that these individuals could not receive Medicare Part A-equivalent coverage from OPERS and also participate in the OPERS Medicare Connector.

Prompted by retiree feedback, OPERS sought a change to the law (enacted in Substitute Senate Bill 42, effective March 23, 2015) that would allow retirees without premium-free Medicare Part A to enroll in Medicare Part A and in turn, select medical and prescription drug coverage through the OPERS Medicare Connector. OPERS will also reimburse 50% of the Medicare Part A premium and applicable surcharges for eligible spouses of OPERS retirees.

Changes beyond 2015

By January 2016 OPERS will have established new group health care plans for non-Medicare and Medicare retirees who choose to return to work in an OPERS-covered position. The non-Medicare plan will be similar to our existing plan for non-Medicare retirees. Our Medicare plan will work as a supplement plan with Original Medicare.

Funding Retiree Health Care

The revised OPERS health care plan includes changing eligibility requirements, modifying allowance allocations and adapting to new health care plan delivery models to maintain a solvent health care fund. The implementation of these changes is beginning to show measurable results. Employer contributions and investment returns are the two main sources of OPERS funding and are designed to support long-range funding stability. OPERS employer contributions provide a more predictable flow of funding while a conservative investment philosophy with the health care fund provides less risk and allows for more accurate forecasting of returns.

Employer Contributions—OPERS has the discretion to set the percentage of employer contributions allocated to the health care fund each year. With the pension fund meeting the statutory requirement of a 30-year amortization period, employer contributions allocated the health care fund can begin to move toward the funding goal of 4%. One of the essential keys to using the employer contribution rate was the pension reform changes. Without these changes, the employer contribution rate would not have been available to fund health care. In 2014, 2% of employer contributions were allocated to fund retiree health care. After review of the pension funding status, OPERS will evaluate opportunities to increase health care funding with the goal of moving toward a full 4% allocation.

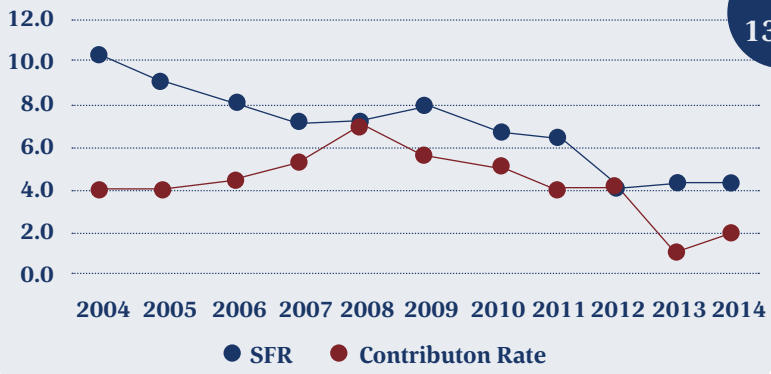
Investment returns on the health care portfolio— Since 1974, OPERS has been pre-funding health care for its retirees, providing health care plans and paying a large portion of monthly premiums. The 401 (h) health care portfolio had a positive investment return of 5.28% in 2014 and the 115 Trust portfolio experienced a loss of 0.03%. Total health care net assets declined by $0.3 billion to $12.8 billion as of December 31, 2014. As of December 31, 2013, the total net assets were $13.1 billion.

Other Sources of Income

Employer contributions and investment returns constitute approximately 61% of the 2014 funding for health care. Employee contributions, federal subsidies and vendor rebates provide additional funding support for the health care fund. Employee contributions are represented as the portion of plan premiums paid by a retiree for health care coverage for all covered participants. 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.

Self-Funding Rate — The primary indicator for monitoring the health care fund is the self-funding rate (SFR). The SFR is the percentage of the employer contribution rate required to fund health care. Matching health care expenses against revenue is achieved by designing a health care plan with expenditures that match the funding provided. In 2012, the Board approved a health care plan with expenditures that match the funding provided. With this design, health care can accomplish its goal of providing continued access to health care for retirees. The chart illustrates employer contributions in relation to SFR over time.

SFR Contribution Rates (%)



OPERS Health Care Funding—National Comparison— OPERS' commitment to funding health care is evidenced in its ability to adapt to the changing health care landscape and modify key components of plan design and eligibility to maintain the solvency of the health care fund. OPERS has been pre-funding health care since 1974. Most retirement systems across the nation follow a pay-as-you-go model which does not provide the level of control and flexibility experienced by OPERS.

Health Care Utilization and Cost Trends

OPERS' experience mirrors the nation's portion of health care expenses associated with chronic conditions. Approximately 75% of OPERS' health care costs go to treat chronic conditions such as heart disease, stroke, cancer, diabetes and arthritis. For circulatory disorders alone which include common conditions such as heart disease, high cholesterol, and high blood pressure, OPERS spends more than three-quarters of a million dollars per day. Listed below are the top five categories of health conditions and their associated costs.

The majority of the below medical conditions are linked to modifiable risk factors such as poor eating habits, physical inactivity, and smoking. OPERS provides a variety of resources to help participants better manage their health including addressing unhealthy lifestyle behaviors, improve quality of life, and prevent the incidence of multiple chronic conditions. These resources help fight chronic disease including the prevention of complications associated with those conditions and keep overall health costs down.

Category	2014 Costs	Cost Per Day
Cardiovascular & Circulatory	$293,638,000	$804,500
Orthopedic (Musculoskeletal)	$221,211,000	$606,100
Neoplasms (Cancer)	$188,611,000	$516,700
Diabetes & Complications	$156,797,000	$429,600
Respiratory/Pulmonary	$ 87,103,000	$238,600

A Careful Eye on Prescription Drug Costs and Trends

In an effort to provide the most cost effective health care plan for our retirees, OPERS continues to monitor new developments in medication manufacturing and usage within the pharmaceutical industry. The fastest growing contributor to OPERS' annual drug costs are specialty medications – high cost drugs that are typically injected or infused, but sometimes taken by mouth, and usually require special storage and close monitoring.

OPERS' Percentage of Total Pharmacy Costs Associated with Specialty Drugs

Year	Medicare	Non-Medicare
2010	8.4%	14.9%
2011	9.5%	17.2%
2012	13.9%	22.8%
2013	17.5%	25.2%
2014	19.4%	28.0%

A biosimilar is a generic version of a specialty medication that has comparable structure, safety and effectiveness as a brand name specialty drug. Biosimilars are expected to cost considerably less than specialty medications that, on average, cost $3,565 per month in 2014. With significantly higher annual trends projected for specialty drugs in comparison to traditional drugs, it is projected that specialty drugs may account for 50% of all drug costs nationwide by 2018 (Source: Prime Therapeutics, April 2013).

Specialty Drug Trend	Traditional Drug Trend
Actual 2014* 29.8% Medicare 32.9% Non-Medicare	**Actual 2014*** 12.3% Medicare 9.5% Non-Medicare
Projected** 2015—22.6% 2016—22.3% 2017—21.3%	**Projected**** 2015—0.6% 2016—3.9% 2017—4.3%

* Per Member Per Month Plan Drug Trend Source: 2014 annual report furnished by Express Scripts

**Per Member Per Year Plan Drug Trend Source: 2014 Express Scripts Drug Trend Report

Competition from biosimilars would improve access to specialty drugs and save billions each year in treatment costs. A recent study conducted by Express Scripts, OPERS' pharmacy benefit manager, projects savings of $250 billion in 10 years if only the 11 likeliest biosimilars enter the market. Express Scripts projects that OPERS itself would save more than $129 million. OPERS continues to closely monitor and manage our specialty drug expenditures and work to influence the availability of biosimilars.

New Generics to the Marketplace

OPERS' traditional drug trend and overall drug trend were positively influenced by the continued growth in the use of generic drugs by participants. In 2014, 86.7% of prescriptions filled for OPERS participants were filled using generic drugs. We saved $32 million in 2014 due to increased generic drug utilization. The increase can be attributed to new generic drugs becoming available in the market, OPERS communications efforts and OPERS Value Based Insurance Design programs. OPERS will continue to see growth in generic utilization in 2015 because of these same factors as well as the implementation of a more restrictive High Performance Formulary that encourages the use of generics.

Strategies for Addressing Trends

OPERS is Evolving with the Health Care Marketplace

OPERS continues to work to meet the health and wellness needs of OPERS retirees while operating within available funding. In 2014, OPERS devoted considerable effort to evaluating health care resources available to retirees as individuals and as a covered population. Constantly rising health care costs, an expanding population of aging baby boomers, a high prevalence of chronic conditions, and increasing life expectancies are the driving forces behind the push to explore innovative solutions to best serve our program participants. OPERS is challenged with identifying opportunities that will educate and empower individuals to take responsibility for their own health as both health care costs and the prevalence of chronic diseases continue to rise at rates that are unsustainable.

OPERS Health Care Plan Evaluation

On an ongoing basis, OPERS and its plan administrators worked jointly to develop meaningful strategies that are expected to have a favorable impact on OPERS' trends and yield better health care value for OPERS and its retirees into the future.

In 2014, OPERS identified specific opportunities for improvement and took actionable steps to drive value. Some of the areas of focus in 2014 included:

- Empowering participants to take an active role in their relationships with providers
- Maximizing the value of OPERS health care expenditures associated with specialty medications
- Evaluating OPERS' return on investment associated with its wellness program with specific attention on the value-based insurance design plan features related to the disease management program
- Piloting high-touch care coordination and community resources to eliminate barriers to care, promote appropriate use of emergency room and hospital-based services, and/or support higher quality end-of-life among participants with multiple chronic conditions

OPERS Biosimilar and Generic Drug Efforts

OPERS, along with partners such as the Public Sector Healthcare Roundtable and Generic Pharmaceutical Association, engaged the U.S. Food and Drug Administration (FDA) as well as legislators on the importance of biosimilar and generic drug competition. OPERS will continue these efforts in 2015.

In 2014, OPERS submitted five comments on a variety of issues, including four letters to the FDA addressing product safety labels for generics, international nonproprietary names for biosimilar medications, recommendations regarding the agency's guidance on the implementation of the Biologics Price Competition and Innovation Act's (BPCIA) biosimilar development pathway and requests that the agency encourage and enhance biologic drug competition by restricting practices used by brand-name drug manufacturers to stifle development of generic or biosimilar alternatives. OPERS also sent a letter to the a U.S. Senate Committee supporting Sandoz, a drug manufacturer, as it filed an abbreviated new drug application for the first biosimilar (filgrastim) in the United States, as well as the first application of the BPCIA's biosimilar pathway. Copies of these letters are available on the OPERS website, www.opers.org.

Patient-Centered Medical Homes (PCMH)

OPERS continues to support the availability of medical homes for retirees through plan design and participant education. The model promotes improvements in how care is delivered and paid for, recognizing the importance of coordinated care and performance-based reimbursements. The model addresses the health and wellness needs of retirees and takes advantage of the value of primary care. The model is showing promise of yielding improved clinical quality, a better overall patient experience, and lower health care costs.

OPERS' commitment to PCMHs is aligned with the $75 million four-year State Innovation Models testing grant recently awarded to the state of Ohio to expand the availability of enhanced primary care throughout the state.

OPERS continues to educate retirees on the value of medical homes and encourage their utilization of recognized PCMHs via newsletters and other communication vehicles. These efforts are coupled with a plan design that offers a reduce office visit copay to non-Medicare enrollees when care is provided by a PCMH.

In 2014,

- The number of PCMHs in Ohio recognized by the National Committee on Quality Assurance increased 22% from 1,180 in January 2014 to 1,440 in October 2014.

- The number of OPERS participants who took advantage of the innovative primary care model continues to grow. In 2014, more than 9,900 or 12.6% of OPERS' non-Medicare participants residing in Ohio sought care from a PCMH. This is an increase from 10% in 2013.

Value-Based Insurance Design (VBID)

In 2014, OPERS continued to offer important VBID features to maximize the value of our health care fund and support participants' efforts to improve their health and quality of life. Non-Medicare participants who sought care from Patient-Centered Medical Homes recognized by the National Committee for Quality Assurance paid a reduced office visit copay of just $10 per visit.

Continuing in 2014, non-Medicare participants with common chronic conditions like high blood pressure, depression, or diabetes, were encouraged to seek care by taking advantage of reduced office visit copayments to primary care as well as specialist physicians. In addition, OPERS removed financial barriers to medication adherence for approximately 52,000 non-Medicare participants who paid nothing out-of-pocket for generic medications used to treat their common chronic conditions.

Chronic Diseases and Community-Based Resources

In 2014, OPERS took advantage of proven community-based resources to address retirees' personal health-management needs and gaps in care. Non-Medicare participants and their caregivers had the opportunity to enroll in the Ohio Department of Aging's Chronic Disease Self-Management Program, a six week-long workshop offered through Ohio's Local Area Agencies on Aging.

The workshops promote self-management and provide support to those with chronic conditions.

Medical Specialty Drug Management

In 2014, Medical Mutual of Ohio implemented a cancer clinical pathways program, a more comprehensive approach to addressing the growing spend and trends in cancer care. Steeped in evidence-based guidelines, cancer clinical pathways are the next evolution in the management of cancer.

OPERS and MMO continue working together to identify and implement solutions to variations in specialty drug pricing (inflation) based on site of service. Currently, the cost for the exact same specialty drug can be vastly different depending on where a specialty drug is administered to a participant, the doctors' office, an outpatient infusion clinic or inpatient hospital.

Finally, our self-insured plan administrator implemented 27 new prior authorization drug categories. Prior authorizations are required for drugs that may cause potentially serious side effects and/or have a high potential for inappropriate use.

Medication Therapy Management

The Medication Therapy Management Program (MTM) is a program available to OPERS health care plan participants by Express Scripts and SinfoniaRx via telephone. MTM offers an extra level of pharmacist support for enrollees with multiple chronic conditions such as high blood pressure, diabetes or high cholesterol. MTM counseling topics range from addressing drug safety issues, discussing potential gaps in drug care, and identifying cost savings opportunities. In 2014, 37,400 of all OPERS health care participants met the criteria for MTM and were extended an invitation for a one-on-one medication counseling session with a pharmacist. Of those targeted in 2014, 3,600 participants engaged in these personalized counseling sessions.

Catalyst for Payment Reform (CPR)

OPERS continues to support national efforts underway to improve the current health care payment system and strives to influence the trend to pay for high quality and cost-effective services. During 2014, OPERS worked jointly with our self-insured medical plan administrator on payment reform strategies to develop a reference-based pricing model for commodity-based health care services. As a result, OPERS will be implementing reference-based pricing for 40 lab services beginning in the 2016 plan year.

Health Care Consumerism

As part of OPERS' commitment to help transition health care participants from passive patients to informed consumers, OPERS launched Consumer Health Choices' Choosing Wisely® in 2014. Choosing Wisely ® is an initiative of the American Board of Internal Medicine Foundation aimed at reducing waste in the health care system by engaging in conversations about potentially overused medical tests and procedures and helping support patients in making smart and effective care choices.

Public Sector Health Care Roundtable (PSHR)

OPERS continued its participation in the Public Sector Healthcare Roundtable, a non-partisan, member-directed coalition that exists to give public employers, and their health plan administrators, a voice in critical national discussions. The PSHR will be exploring how to help generic specialty medications enter the marketplace more quickly.

Eye on Quality

OPERS Maintains Focus on Maximizing Quality

In 2014, OPERS conducted its third annual Participant Experience Survey. Approximately 6,100 OPERS health care plan participants responded to the telephone survey for a 55% response rate. The purpose of the survey was to assess respondents' self-reported health status, participation in OPERS health and wellness programs, the impact of the latter on respondents' health status and quality of life, and the extent to which they had an advance directive in place. Of the 50% of respondents who participated in an OPERS health and wellness program, 94% said their overall health improved or stayed the same and 94% indicated their quality of life improved or stayed the same because of their participation in the health and wellness resources provided by OPERS. Approximately two-thirds of individuals who participated in the OPERS health and wellness programs reported they had an advance directive (living will or healthcare power of attorney) in place.

Clinical Quality Improvement Committee (CQIC)

The Clinical Quality Improvement Committee, a body comprised of clinical thought leaders from OPERS' Health Care division and health care vendor partners and consultants, continues its mission to favorably influence OPERS' health care trend via improvements in clinical quality. In 2014, the committee used the CQIC Report Card to identify opportunities for improving clinical outcomes and evaluating the impact of existing interventions. Also in 2014, the CQIC turned its attention toward identifying areas of potential savings in OPERS health care spending including, for example, costs associated with duplicative medical testing and care provided that is not consistent with evidence-based guidelines.

Future Challenges and Opportunities

Addressing Changing Demographics— Retirees are living longer than ever before and our retiree population is growing at the fastest rate in our retirement system's history. These two factors have led OPERS to develop a strategic plan to help us prepare for an estimated retiree population increase of 40% in the next 10 years.

Promoting Chronic Disease Prevention and Management—The prevalence of preventable chronic conditions among OPERS health care plan participants supports the continued need for wellness efforts aimed at preventing the onset of and complications associated with chronic conditions such as diabetes and heart disease.

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.

Helping Retirees to Take Charge of Their Own Health—The anticipated transformations in care delivery and payment methods create a unique opportunity to assist our participants in taking an active role in their personal health and health care decision making.

Adapting to a Changing Health Care Marketplace

Medicare

After careful analysis of the individual Medicare market over the last several years, it became evident that many different plan options are available that will give more affordable choices to our participants in comparison to the one primary plan option currently offered through OPERS. Because OPERS has sponsored a group Medicare plan for nearly 40 years, the switch to the OPERS Medicare Connector in 2016 requires a great deal of dedication and resource allocation to ensure that the implementation is smooth for our participants. Understanding this, we have embarked on an unprecedented communication and education effort. We have distributed an increased amount of print communications, added pages to our website, posted monthly videos to opers.org, increased the number of blog posts addressing health care change and increased the number of in-person education seminars we conduct annually.

Non-Medicare

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 that plan participants have easy access to provider care. OPERS is looking into methods to integrate our coverage so we can better deliver easily accessible and quality health care for our participants.

Financial Reporting

Upcoming new accounting standards– In June 2012, the Governmental Accounting Standards Board (GASB) issued two new standards (Statements 67 and 68) related to accounting and financial reporting requirements for pensions. The intent of the standards is to enhance the decision-usefulness of pension-related information in financial reports, improve transparency and accountability, and to standardize valuation practices to enhance comparability for similar types of pension plans. Under these new standards, employers are now required to recognize their proportionate share of the net pension liability in their financial statements.

Similar standards were recently approved by GASB for reporting of Other Postemployment Benefits (OPEB), which includes health care. GASB is expected to release these newly approved standards in the summer of 2015.

Impact of Health Care Reform and Federal Regulations/Legislation—The implementation of the Patient Protection and Affordable Care Act (PPACA) is now in its fourth year, and OPERS continues to monitor the impact of this legislation on the OPERS retiree health plan. OPERS has followed several key provisions of this law, including IRS and member reporting standards, the Cadillac tax, and maximum out-of-pocket. These provisions will impact our health care plan in the future.

As stated previously in this report, OPERS voiced its opinion for the need of biosimilar competition and streamlined administrative policies and procedures in order to reduce unnecessary spending on specialty drugs. OPERS provided federal regulatory responses to the Food and Drug Administration with the goal of developing a pathway of development for biosimilar drugs.

Managing Ongoing Health Care Inflation— Many factors contribute to the ongoing cost of health care for any plan sponsor in the country. Anticipating, analyzing and developing a plan to offset some of these inflationary factors is key to reduce the impact to the OPERS health care plan. The utilization of services and the unit cost increases for both medical and prescription coverage play a large part in determining health care costs on a yearly basis. In 2014, high-cost specialty medications have had a large impact on health care inflation for our retiree health plan.

Funding Update

Beginning in fiscal 2006, the Governmental Accounting Standards Board (GASB) required retirement systems to estimate their liability for health care benefits similar to the manner in which pension liabilities are estimated. However, unlike pensions, the health care coverage OPERS provides (with the exception of Medicare Part B reimbursements) is not statutorily guaranteed. As of December 31, 2013, the date of the latest health care actuarial valuation, the actuarial liability for OPERS health care was $19.8 billion and the System had accumulated assets of $12.0 billion for that obligation. OPERS had an unfunded actuarial accrued liability of $7.8 billion, representing an increase of approximately $0.8 billion from the 2012 valuation. The funding ratio also decreased from 63.6% in 2012 to 60.8% in 2013. These changes in the unfunded liability and funding ratio were primarily due to employer contributions of 1.0% of payroll allocated to health care during 2013 compared to 4.0% allocated for 2012. This decrease in funding occurred as a result of the extended time period associated with securing legislative changes to the pension plan. OPERS is one of a relatively few retirement systems that has systematically set aside assets to fund health care.

As mentioned previously, health care coverage is not statutorily guaranteed and may be changed to ensure the long-term solvency of the fund and the ability to provide future coverage. The funding progress of the Health Care Fund is measured in terms of solvency years and in terms of the self funding rate. The solvency years are the number of years that funds are projected to be available to pay health care expenses under the current plan structure before the plan would be reduced to a pay-as-you-go basis. The market losses of 2008 reduced the solvency years of the Health Care Fund from 31 years as of December 31, 2007, to 11 years for the years ended December 31, 2008 through 2010. The investment losses of 2011 resulted in a decline in the solvency years to 10 for the year ended December 31, 2011. The investment gains of 2012 and 2013, the implementation of plan design changes approved by the OPERS Board of Trustees in 2012, and changes in assumptions resulted in transitioning the solvency years from 10 to a solvency period that indicates that health care assets are projected to be sufficient to fund expected liabilities as of the December 31, 2012 and 2013 valuations.

The self funding rate reflects the portion of the employer contribution rate required to fund the health care plan. Through plan changes, the self funding rate has decreased from approximately 10% in 2004 to 4% in 2014.

The actuarial value of assets used to calculate funded status is not based on year-end fair value (market value) as of the valuation date. Market gains and losses for actuarial funding purposes are smoothed over a rolling four-year period subject to a 12% market corridor. This policy, instituted by the Board in 2001, ensures that the funding value of assets is neither lower than 88% nor higher than 112% of the fair value of the assets. Smoothing of actuarial gains and loss mitigates the need to constantly increase or lower contribution rates because volatile market conditions can be recognized (smoothed in) over several years. The reality of actuarial smoothing techniques is that the fair value (market value) of assets may be different from the funding value (actuarial value) of assets at a given point in time. This means that in periods of extended market decline the fair value of assets will usually be less than the funding, or actuarial value of assets. Conversely, during periods of extended market gains, the fair value of assets will usually be greater than the funding, or actuarial value of assets.

Post-employment Health Care

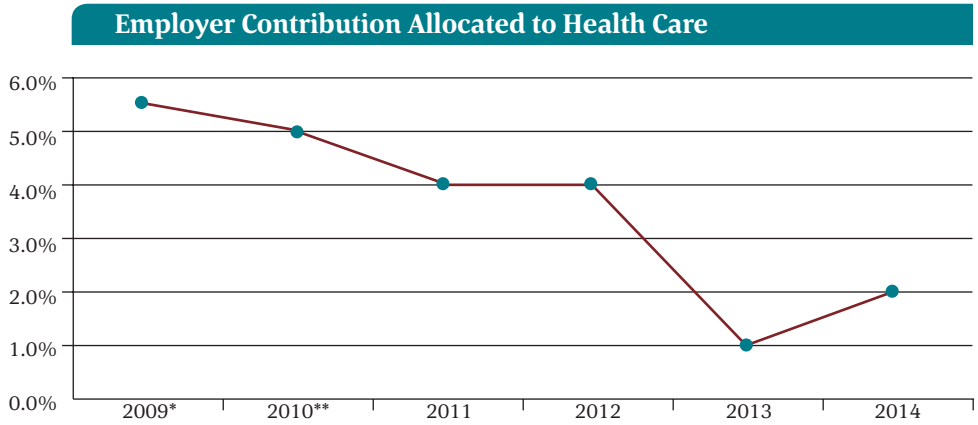
During the 2014 plan year, the Post-employment Health Care Fund, established under Section 401(h) of the Internal Revenue Code, provided coverage to eligible OPERS retirees. This trust is pre-funded and holds the portion of employer contributions of the Traditional Pension and Combined plans that are set aside for funding retiree health care. The health care portion of the employer contribution rate for the Traditional Pension and Combined Plans is comparable, as the same coverage and eligibility are provided to participants in both plans. While the 401(h) fund will continue to be used to fund health care expenses, employer contributions to this fund ceased in September 2014 upon the establishment of the 115 Health Care Trust.

115 Health Care Trust

In 2014, OPERS established the 115 Health Care Trust (115 Trust) under Section 115 of the Internal Revenue Code. This trust will provide health care in much the same manner as the 401(h) health care trust and similarly, will be for the benefit of members of the Traditional Pension and Combined Plans. On January 1, 2016, OPERS will launch the OPERS Medicare Connector (Connector), a program whereby eligible enrolled retirees over the age of 65 may have an allowance deposited to a Health Reimbursement Arrangement (HRA) to apply toward the health care program of their choice selected with the assistance of an OPERS vendor. As OPERS prepares to change the manner of funding health care for Medicare eligible retirees, OPERS added a vehicle that could accommodate such reimbursement mechanisms as the HRA. Employer contributions to this plan began in September 2014, with the initial health care disbursements from this trust to commence with January 2016 premiums. OPERS will use both the 401(h) and the 115 Trusts to fund health care expenses.

Additions to the health care fund

Additions to the Health Care Fund are comprised primarily of employer contributions and investment returns. Retiree health care premiums (member contributions), federal subsidy, and contract and other receipts comprise the balance.



Source: *2014 Comprehensive Annual Financial Report*
* The health care contribution rate decreased from 7.0% to 5.5% effective April 1, 2009.
** The health care contribution rate decreased from 5.5% to 5.0% effective March 1, 2010.

1 **Investment Income–**The 401(h) Health Care portfolio experienced a gain of 5.3% in 2014 compared to gains of 11.4% in 2013 and 13.7% in 2012. The 115 Health Care Trust portfolio, established in September 2014, experienced losses of less than 0.1%.

2 **Employer Contributions–**The portion of the employer rate allocated to the health care fund increased from 1% in 2013 to 2% in 2014, providing a combined $127.0 million increase in employer contributions to the 401(h) health care fund and 115 Health Care Trust. Beginning in September 2014, employer contributions ceased to the 401(h) fund and were allocated to the 115 Health Care Trust.

Prior to the enactment of pension plan changes, the employer rate allocated to health care was planned to be reduced to zero by 2013. Passage of the pension reform legislation enabled OPERS to continue funding health care. The portion of employer contributions to health care will increase each year until a maximum of 4% is attained. The employer contributions into the health care fund had additional pressure from OPERS decreasing active member population.

3 **Retiree Health Care Premiums–**Retiree premiums (member contributions) include amounts paid by retirees towards the cost of OPERS-provided health care. Retirees share in the cost of health care coverage for themselves, their spouses and dependents. In 2014, these amounts totaled $238.4 million, compared to $178.1 million in 2013. This increase is primarily related to an increase in the retiree population, the rising cost of health care, plan design changes and the exhaustion of federal dollars historically available to contain increases in cost to the retiree. The number of retirees eligible for health care in 2014 increased by 0.8% compared to 2013. However, the number of dependents and beneficiaries receiving health care coverage decreased by 3.8% compared to 2013.

Since OPERS is self-insured for health care provided to retirees under the age of 65, the member's cost share is not based on market premiums. Retirees over the age of 65 are covered by the Medicare Advantage Plan. To determine the retiree's cost share, OPERS determines self-supporting rates for each population based on claims and premium experience. In 2012 and 2013, the self-supporting rates were frozen using funds received from the federal Early Retirement Reinsurance Program (ERRP) by covering cost increases that otherwise would have been passed on to the retirees. Under the federal guidelines, these ERRP funds had to be used by 2014. As of December 31, 2013, all ERRP funds were used. By keeping the retiree's cost share low with the ERRP funds, the retiree realized an increase in cost share in 2014 equal to the difference between the 2014 self-supporting rate and the 2011 self-supporting rate.

4 **Contract and Other Receipts–**Contracts and other receipts represent funds received for vendor rebates and other miscellaneous income. These receipts (combined 401(h) and 115 Health Care Trusts) totaled $154.8 million in 2014, reflecting a 21.9% increase over the $126.9 million earned in 2013.

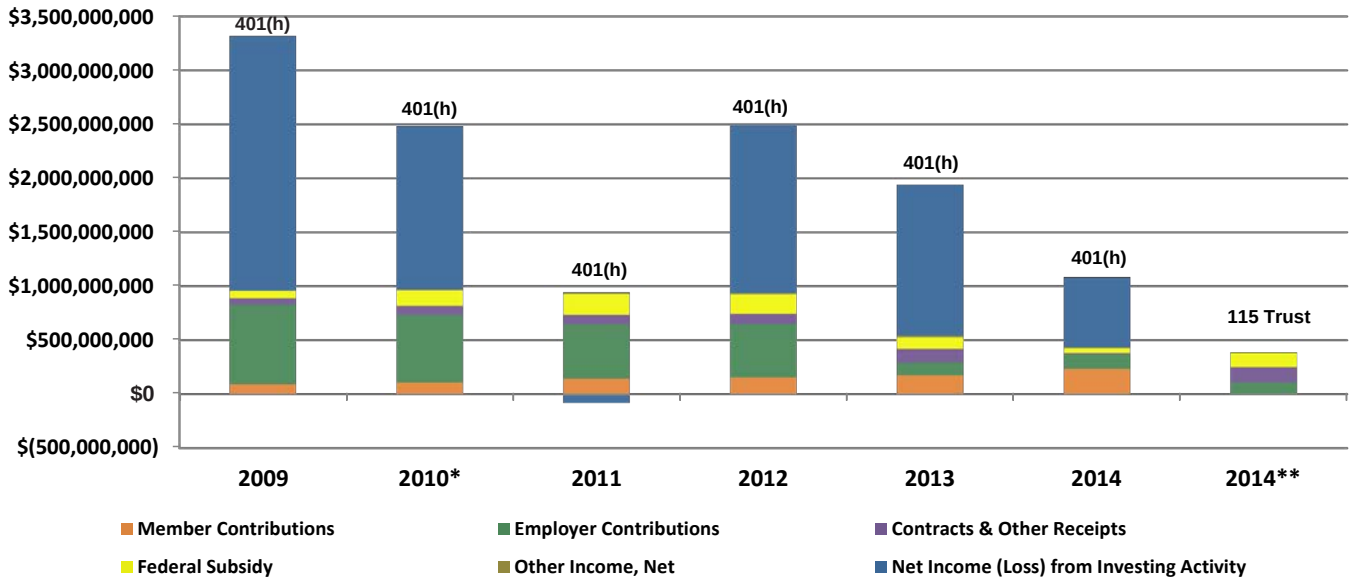
The majority of this increase results from gain sharing revenues received in conjunction with the Medicare Advantage Plan, provided to retirees over the age of 65. The Medicare Advantage premiums are estimated at the beginning of the year, and adjusted at year end based on actual claims experience. These gain-sharing revenues represent a premium adjustment based on actual experience that results in receiving a vendor rebate. In 2014, gain-sharing revenues totaled $109.2 million compared to $77.9 million in 2013.

5 **Federal Subsidy–**Federal subsidy revenue is comprised of reimbursements and direct subsidies OPERS received from the federal government for participation in the Medicare Prescription Drug Program (PDP).

In 2014, the PDP subsidy totaled $176.2 million (combined 401(h) and 115 Health Care Trusts) compared to $105.7 million in 2013. In 2013, total federal subsidies decreased primarily due to across-the-board reductions in federal spending in accordance with the Balanced Budget and Emergency Deficit Act of 1985 as amended, which resulted in mandatory payment reductions to Medicare PDP subsidies (referred to as sequestration). Despite the continuation of the sequestration throughout 2014, receipts for the PDP increased by $21.1 million in 2014 compared to 2013. The higher subsidy reflects an increase in plan participants and individual risk scores assigned by the Center for Medicare & Medicaid Services (CMS) for each participant.

Additionally, the PDP is eligible for a Catastrophic Reinsurance subsidy for retirees that reach the level of catastrophic drug costs as defined by CMS. Once a member reaches the catastrophic threshold, CMS covers 80% of the drug costs over the threshold. Plan sponsors, such as OPERS, receive a subsidy to recover claims paid for retirees exceeding the threshold. The number of retirees exceeding the threshold cannot be determined until after the plan year is complete and the amount of this subsidy can vary from year to year. Catastrophic claims reimbursements for 2014 are estimated to increase by more than $50.0 million when compared to 2013, mainly due to rising costs in prescription medications in 2014 resulting in an increase in the number of retirees exceeding the threshold.

Six-Year History of Additions to the Health Care Fund



Source: *2014 Comprehensive Annual Financial Report*
* Year 2010 401(h) health care expenses restated for reclassification of Pending Medical Claims adjustment from Health Care Medical Expense to Other Income. Pending Medical Claims consists of the annual adjustment made to the incurred but not reported liability included in Benefits Payable. This liability fluctuates from year to year based on changes in the claims experience.
**The 115 Health Care Trust was established in 2014.
Note: Member Contributions reflect retiree cost share of premium.

6 Other Income, Net–Other income includes miscellaneous income and significant adjustments to prior years' expense accruals. The majority of other income in 2012 and 2013 included adjustments to prior years' expense accruals for health care claims. The amounts related to the reversal of prior years' accruals or reduction to the liability included for 2013 and 2012 was $13.5 million and $10.7 million, respectively. At the end of each year, OPERS estimates the value of health care claims incurred but not yet reported (IBNR), and records an expense necessary to adjust the medical accounts payable liability for the value of these pending claims. Payment of these delayed claims may lag several years beyond the incurred date. Accordingly, the accrual is estimated based on an average of the historical claims experience for the preceding four years. Participation in the Medicare Advantage Plan is mandatory when a retiree and spouse reach age 65. As a premium-based program, OPERS does not bear the risk of unreported claims. As the retiree population ages and moves to the Medicare Advantage Program, the IBNR reserve also decreases, with a corresponding charge to other income for the write-off of prior years' expense accruals or reduction of the liability. The liability account was gradually reduced for this impact over a four-year period through 2013, commensurate with the claims lag history. The accrual estimate for the end of 2014 did not result in a significant reduction or increase to the liability and remained relatively flat compared to 2013.

Deductions to the health care fund

The expenses displayed in the graphs on the next page reflect the cost of health care expenses for retirees, their spouses and their dependents.

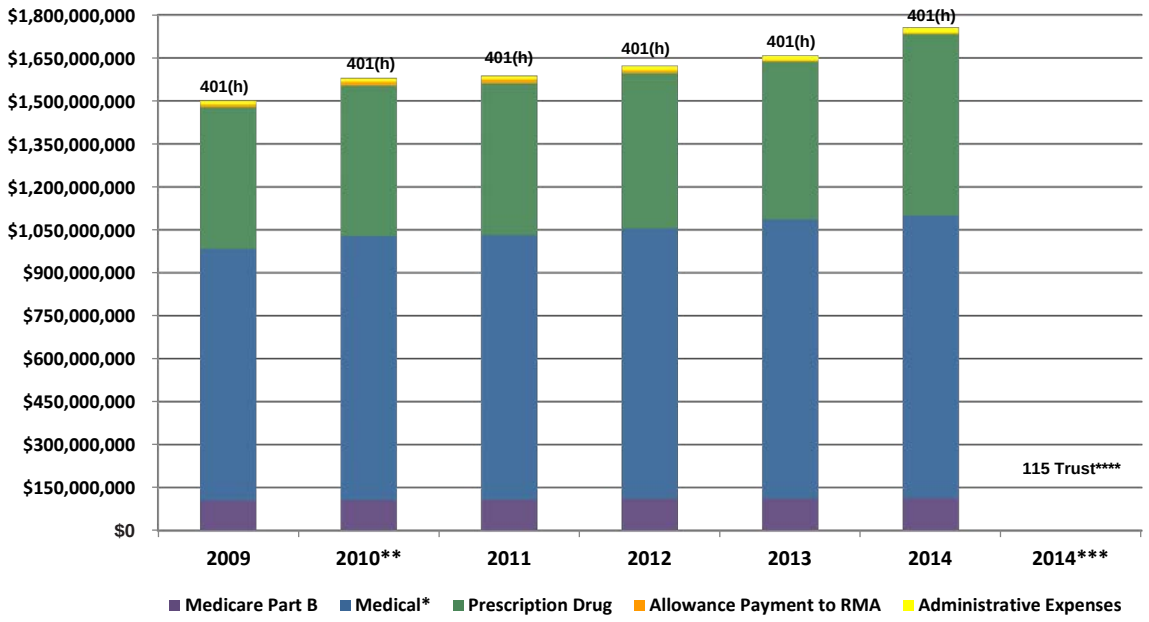
Total health care expenses increased to $1.7 billion in 2014, or a 5.9% increase, compared to 2013. The majority of health care expenses are comprised of medical, dental, vision, and prescription drug costs, as well as reimbursements to retirees for Medicare Part B premiums. Medical, dental, vision and disease management costs represent approximately 56% of the total health care expenses for 2014, a decrease from 2013 and 2012 which approximated 59% of total health care expenses each year. Prescription drug costs comprised 36% of total health care expenses in 2014, an increase over the 34% reported for both 2013 and 2012. Medicare Part B premium reimbursements were approximately 7% of the total and remained constant over the past three years.

OPERS is self-insured for the health care expenses of recipients under the age of 65. For retirees over and under the age of 65, OPERS is also self-insured for prescription drug costs. Medical coverage for recipients over the age of 65 is provided through a premium based Medicare Advantage Plan. Costs in self-insured plans will fluctuate based on the timing of claims incurrence and the magnitude of catastrophic claims, in addition to overall increases in costs occurring in the market. Medical, dental, vision and disease management expenses for 2014 rose 1.2% to $985.5 million compared to $973.8 million in 2013. Prescription drug costs rose 15.1% to $634.5 million in 2014 compared to $551.4 million in 2013. The Truveris National Drug Index cited double-digit price increases for prescription medications in 2014 with branded drugs rising 14.8%, specialty drugs by 9.7% and generic drugs by 4.9%, for a combined increase of 10.9%.

Statutorily required Medicare Part B reimbursements have increased steadily by 1% over the past three years. As part of the 2012 legislation and the plan changes approved by the Board in 2012, the Medicare Part B reimbursement will be phased-out over the next two years, resulting in no reimbursements beginning January 1, 2017.

OPERS has consistently managed its administrative expense budget with no material variances experienced between planned and actual expenditures in either 2013 or 2012. Administrative expenses, not including investment administrative expenses, for the Retiree Health Care Plan, totaled $18.4 million in 2014 compared to $16.4 million in 2013. The increase in 2014 administrative expenses was primarily related to an increase in custodial-related costs associated with an international custodian change mandated by the Ohio Treasurer of State and not within OPERS control.

Six-Year History of Health Care Expenses By Type



Source: *2014 Comprehensive Annual Financial Report*

*Includes Medical, Disease Management, Wellness, Dental and Vision (OPERS receives member contributions for Dental and Vision).

**Year 2010 401(h) health care expenses restated for reclassification of Pending Medical Claims adjustment from Health Care Benefits to Other Income. Pending Medical Claims consists of the annual adjustment made to the incurred but not reported liability included in Benefits Payable. This liability fluctuates from year to year based on changes in the claims experience.

***The 115 Health Care Trust was established in 2014.

****Expenses for the 115 Trust for 2014 consist of only three months worth of Administrative Expenses totaling $82,201. Due to the scale of the chart, this amount is not visible.

Statutory Requirements

The 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 145.325 and 145.58 of the Ohio Revised Code. The report shall be made as of December 31, 1997 and the thirty-first day of December of each year thereafter. The report shall include the following:

The following information fulfills the requirements of the Ohio Public Employees Retirement System as outlined in Ohio Revised Code Section 145.22(E). The requirements and the System's responses follow:

1 A description of the statutory authority for the benefits provided

Appendixes B and C are copies of ORC Sec. 145.58 (Group Hospitalization coverage; ineligible individuals; service credit; alternate use of HMO) and ORC Sec. 145.584 (Medicare benefits for members of Ohio Public Employees Retirement System), as they existed during the majority of 2014. Both sections were amended by Sub. S.B. 343, effective January 7, 2013.

2 A summary of coverage for 2014

The following is an outline of OPERS health care coverage in 2014:

The 2014 OPERS Retiree Health Plan for non-Medicare participants

The 2014 OPERS health care plan administrator, Medical Mutual, utilized a Preferred Provider Organization (PPO) for our non-Medicare benefit recipients. PPO networks are based on a partnership between doctors, hospitals, health plan administrators and participants. Doctors and medical facilities that belong to the PPO network agree to perform services at discounted rates. Therefore, through plan design and education, OPERS encouraged the use of these providers. While participants were able to choose any provider and still receive coverage, they received a higher level of reimbursement if they chose network providers of service. All states in the U.S. were within the PPO network. Participants living outside of the U.S. were able to choose any provider of services (regardless of Medicare status) without a decrease in coverage.

The Humana Medicare Advantage Plan

The Humana Medicare Advantage Plan continued to be offered to Medicare-eligible participants in 2014. A Medicare Advantage Plan is a plan offered by an insurer that contracts with Medicare to provide plan participants with all Medicare Part A and Part B benefits. To be eligible, participants must have Medicare Part B and must continue to pay Part B premiums.

Humana offers plan participants care management programs not always available with other administrators, including: access to the Silver Sneakers program, personal health programs and wellness coaching, disease management programs, case management (help with home health care and equipment), and transition of care services.

Alternate health care coverage

HealthSpan (formerly Kaiser Permanente) was available in 2014 to OPERS health care plan participants who resided in certain counties in Ohio. HealthSpan offered hospital and medical services through participating physicians and facilities.

Plan participants were responsible for the cost difference in coverage if that cost was more than the cost of coverage under Medical Mutual of Ohio or the Humana Medicare Advantage Plan.

Prescription drug coverage—Retirees enrolled in the OPERS health care plan (Medical Mutual), the Humana Medicare Advantage Plan, or an alternate plan receive prescription drug coverage through Express Scripts.

OPERS Non-Medicare prescription plan—In 2014, 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 differ based on the delivery method, whether a drug is a generic or a name brand and its formulary status. In 2014, Medication Therapy Management continues to be available for eligible participants.

OPERS Medicare Part D prescription plan—In 2014, OPERS continues to offer a Medicare Part D Prescription Drug Plan to Medicare-eligible enrollees. The Medicare Part D Plan provided retirees with a number of enhancements including Medication Therapy Management for eligible participants and coverage for medications adjudicated in the "donut hole."

Medicare

The following requirements regarding Medicare were in effect for 2014:

- If an OPERS health care plan participant was eligible for Medicare Part A (hospital) at no cost, OPERS required enrollment in Medicare coverage (if covered by the OPERS health care plan). If Medicare Part A was not available to the participant without cost, OPERS provided comparable substitute coverage.
- Plan participants who turned age 65, or who qualify for Medicare prior to age 65 (and who are enrolled in OPERS health care), were also required to enroll in Medicare Part B (medical).
- When a plan participant or covered spouse reached the age of 65, OPERS requested a copy of the Medicare card. If the covered individual was not eligible for free Medicare Part A, OPERS requested a copy of his or her card showing Part B coverage or a letter from Social Security stating there would be a charge assessed for Medicare Part A.

Medicare Part B reimbursement

If an OPERS retiree was enrolled in the OPERS health care plan, and was not being reimbursed from another source for his or her Medicare Part B premium, he or she was eligible for reimbursement from OPERS. In order to receive this reimbursement, the retiree was required to send a copy of his or her Medicare card, showing enrollment in Part B. As long as the plan participant remained enrolled in Part B coverage, the allowable reimbursement was added to the recipient's monthly retirement check. Enrolled spouses are not eligible for this reimbursement.

The Dental Plan

During 2014, voluntary dental coverage was made available to all OPERS retirees, and their eligible dependents, regardless of their participation in the OPERS health care plan. The dental plan, administered by MetLife, was intended to help defray the costs of dental care, including oral examinations, diagnostic services, and extractions, as well as crowns, bridges, and dentures. If a retiree chose to be covered under the dental plan, a premium payment was deducted from each monthly benefit check. OPERS does not subsidize this plan.

The Vision Plan

Voluntary vision coverage was offered to all OPERS retirees, and their eligible dependents, regardless of their participation in the OPERS health care plan. The vision plan, administered by Aetna, covers services provided by ophthalmologists, optometrists, or opticians for examinations, frames, and lenses. A premium payment was deducted from each monthly benefit check 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 2014:

Listed here are the eligibility requirements for the OPERS health care plan. As noted previously, these requirements will change in the upcoming years.

These requirements were *in effect during 2014*:

Age-and-Service Retirement

When applying for age-and-service retirement, a benefit recipient must have 10 years of Ohio service credit to qualify for the OPERS health care plan. These 10 years may not include out-of-state or certain military service purchased after Jan. 29, 1981; service credit granted under a retirement incentive plan; or exempt service purchased after May 4, 1992.

In September, 2014, OPERS limited the types of service credit counting toward health care eligibility to the following for those with a benefit effective date of Jan. 1, 2014 and beyond:

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

In order for service credit other than these types to count toward health care eligibility, the retirement effective date must be on or before December 1, 2013. Once a retiree voluntarily withdraws from the OPERS health care plan on or after January 1, 2014, he or she cannot re-enroll.

Disability Retirement

If a person is receiving a disability benefit from OPERS, health care coverage is provided even if he or she has less than 10 years of service credit.

Coverage for surviving spouses

If a member retired, chose a joint and survivor annuity plan of payment (Plan A, C, D or F) and died, the surviving spouse was entitled to health care coverage if the deceased retiree was eligible.

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

Eligible dependents

In accordance with Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code, retirees receiving a monthly age-and-service or disability benefit may only enroll:

Their legal spouse—This must be a person of the opposite gender and they must have a valid marriage certificate recognized by Ohio law.

OPERS does not subsidize the monthly health care premium costs for spouses under the age of 55.

- This rule does not apply to children, spouses of disability recipients, spouses with early Medicare or any spouse who is receiving a benefit as the surviving spouse of an age-and-service retiree (joint and survivor annuity) or as the surviving spouse of a deceased working member (receiving a survivor benefit).

- A spouse under age 55 may participate in the plan; however, the retiree is responsible for the full health care premium.

- The month the enrolled spouse reaches age 55, OPERS will again subsidize a portion of his or her health care premium.

Their child(ren)—This must be a biological or legally adopted child or minor grandchild if the grandchild is born to an unmarried, unemancipated minor child and they are 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 the OPERS health care plan 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.

It is the retiree's responsibility to notify OPERS, in writing, within 30 days of the date his or her dependent fails to meet eligibility requirements. Failure to notify OPERS could result in overpaid health care claims for which the retiree will be responsible.

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

As of December 31, 2014, there were 175,610 OPERS retirees eligible to participate in the OPERS health care plan.

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

OPERS financial statements are prepared using an 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 Retirement System as of fiscal year end. Health care reimbursements are recognized when they become measurable and due 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.

Plan 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 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 private equity are 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 struck by the fund or by the fund's third party administrator.

Member contributions (pension deductions and direct billed premiums), employer contributions and investment earnings are used to fund health care expenses. Employer contributions equal to 2% of covered payroll were credited to the health care fund for the period of January 1, 2014 through December 31, 2014. Revenues from member contributions (amounts paid by retirees towards 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 prefunded health care through a trust established under Section 401(h) of the Internal Revenue Code. In September 2012, the OPERS Board-approved changes referred to as the Post-employment Health Care Preservation Plan 3.0, which became effective beginning January 1, 2014. These changes reduced the actuarial accrued liability for health care by approximately $12.1 billion.

In September 2014, OPERS established the 115 Health Care Trust under Section 115 of the Internal Revenue Code. This trust is discussed in detail in item number 9 on page 38.

The 115 Health Care Trust did not have any active, inactive or retired membership as of December 31, 2014. Therefore, no actuarial accrued liability exists for the 115 Health Care Trust as of December 31, 2014. The funded status of the 401(h) health care trust as of December 31, 2013, the most recent actuarial valuation, was 60.8%. The solvency measure of the Health Care Fund indicates that the Fund's assets will be sufficient to provide health care coverage to retirees into the foreseeable future.

6 **A statement of the net assets available for the provision of the coverage as of the last day of the fiscal year.** Please see Appendix D, "Statements of Fiduciary Net Position—Health Care".

7 **A statement of any changes in the net position 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 E, "Statements of Changes in Fiduciary Net Position - Health Care".

8 **For the last six consecutive fiscal years, a schedule of the net position 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 E, "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 2014, OPERS established the 115 Health Care Trust (115 Trust) under Section 115 of the Internal Revenue Code. This trust will provide health care in much the same manner as the 401(h) health care trust and similarly, will be for the benefit of members of the Traditional Pension and Combined Plans. On January 1, 2016, OPERS will launch the OPERS Medicare Connector (the Connector), a program whereby enrolled retirees over the age of 65 will have an allowance deposited to a Health Reimbursement Arrangement (HRA) to apply towards the health care program of their choice selected with the assistance of OPERS vendor. As OPERS prepares to change the manner of funding health care for Medicare eligible retirees, OPERS added a vehicle that could accommodate such reimbursement mechanisms as the HRA. Thus, OPERS will use both the 401(h) and the 115 Trusts to fund health care expenses. Employer contributions to the 115 Health Care Trust began in September 2014 with the initial health care disbursements from this plan to commence with January 2016 premiums.

10 A statement of the amount paid under division (C) of section 145.58 of the Revised Code. OPERS paid approximately $114.0 million in Medicare Part B premiums to its benefit recipients in 2014.

Medicare Individual Market Offers Future Opportunities

Within the individual Medicare marketplace, Medicare health care connectors have been emerging as an evolving business model for the past decade. Connectors provide retirees an opportunity to select a health care plan that best suits their individual situation and medical needs as well as work with a defined health care budget.

Beginning in 2016

The role of OneExchange is to provide education as well as plan selection and enrollment support to retirees and dependents enrolled in Medicare Parts A and B. In addition, OneExchange will administer all aspects of the HRA. Retirees are able to select among multiple individual Medicare plan options (Medicare Supplement Plans, Medicare Advantage Plans, Medicare Advantage with Prescription Drug Plans, and Part D Drug Plans). Given the large Medicare population (nearly 50 million), there are many affordable options on the individual Medicare market for OPERS participants to select that will best fit their individual needs.

Appendix A—OPERS' Health Care History

Prior to 1990

OPERS first offered health care coverage to its retirees in 1962. The plan was not subsidized by the System. The retiree paid the entire premium. In 1974, OPERS established a health care fund, began pre-funding health care and began paying premiums for retirees.

OPERS signed an agreement with Kaiser Permanente in 1975, thereby offering its first HMO. Through the following years, OPERS offered as many as six alternative plans (HMOs) in a given year, further expanding retirees' options.

Mail order prescription services were first offered in 1981. Using National Rx as a business partner, a 90-day supply could be obtained initially for a $1 co-pay.

In 1986, the five-year service eligibility requirement to qualify for health care coverage under OPERS increased to the current standard of 10 years.

1990—1999

In 1993, OPERS added a second plan administrator, Medical Mutual of Ohio. The plan was switched from a pure indemnity plan to a Preferred Provider Organization (PPO) model.

In 1999, OPERS made significant strides in its attention to preventive services and wellness. Coverage was provided for influenza and pneumonia vaccines, and several enhancements were made to coverage of preventive services and screenings.

2000—2005

In 2003, the Choices Plan was introduced, effective for newly hired employees only. Choices introduced a service-based approach to the cost of access to health care coverage upon retirement, replacing the one-size-fits-all 10 year eligibility method. The first comprehensive disease management program was also introduced.

In 2004, OPERS began using formulary/non-formulary co-pays in its drug plan to help retirees better manage their prescription medication costs and save OPERS money as well.

Dependent eligibility definitions became more restrictive in 2005. Over-the-counter medicines, non-sedating antihistamines and other medications were eliminated from coverage.

2006—2012

In 2006, the emergency room co-pay was increased to $75. The hospital admission deductible was introduced and our subsidy of dental and vision coverage was reduced by half and subsequently eliminated. OPERS' partnership with the Ohio QuitLine smoking cessation program was established.

In 2007, the Health Care Preservation Plan was implemented, establishing three groups of retirees, each with eligibility standards based on length of service and start date. The plan added two additional plan tiers or options for health care coverage. Retirees received a monthly health care allowance to be applied toward their selection of one of the three medical/prescription plan offerings and optional dental and vision coverage.

In April 2007, the OPERS Board approved increasing our target solvency period to be consistent with the principles of the health care preservation plan.

Appendix A—OPERS' Health Care History

In January 2008, OPERS began offering the Aetna Medicare Open Plan to Medicare-eligible retirees and their covered, Medicare-eligible spouses.

In April 2008, Express Scripts, Inc. began serving as the pharmacy benefit manager (PBM) for the OPERS health care plan.

In 2009, OPERS implemented Senate Bill 267, which took effect on March 24, 2009. SB 267 established the monthly reimbursement by OPERS for Medicare Part B premiums at an amount, determined by the OPERS Board of Trustees that is not less than $96.40.

In 2010, Humana began administering the medical portion of the OPERS health care plan for Medicare-eligible retirees. Medical Mutual became the sole administrator for health care plan participants not yet eligible for Medicare.

The Patient Protection and Affordable Care Act (PPACA), also referred to as health care reform, was signed into law by President Obama in 2010. PPACA contained numerous provisions that impacted the OPERS health care plan. Notably, OPERS added the required preventive care coverage, increased dependent eligibility to age 26 and removed the lifetime maximum.

In 2010, OPERS modified its medical plan design to incrementally increase retiree cost-share. The increase was seen in changes such as increased out-of-pocket maximums, deductibles and co-pays, as opposed to charging retirees more to participate in the plan.

The OPERS Clinical Quality Improvement Committee (CQIC) began working toward improvements in clinical quality in 2010. The CQIC is comprised of leaders and clinicians from the health care division, OPERS' vendor partners, and consultants.

OPERS implemented legislation that capped the Medicare B reimbursement rate at $96.40 for 2010 and retained this rate for 2011.

In 2011, OPERS began offering a Medicare Part D Prescription Drug Plan to Medicare-eligible enrollees. The Medicare Part D Plan provided retirees with a number of enhancements including Medication Therapy Management and an annual out-of-pocket maximum.

OPERS participated in the Early Retirement Reinsurance Program (ERRP), a provision of PPACA. OPERS received approximately $180 million in ERRP reimbursement.

OPERS also adopted additional VBID design features in 2011, encouraging participants to use high valued services.

On September 19, 2012, OPERS adopted a set of key changes to the current retiree health care plan designed to keep the program sustainable within available funding. The new plan design adjusted three main levers to achieve optimal savings while minimizing the risk to retirees. Eligibility, participant cost and plan sponsorship are the key components.

Also in 2012, OPERS introduced the concept of Patient-Centered Medical Homes (PCMH). The support of the PCMH model is a strategic initiative that is expected to favorably impact the OPERS health care plan by promoting improvements in how care is delivered and paid for, recognizing the importance of coordinated care and performance-based reimbursements.

2013

OPERS implemented the health care plan changes approved by the OPERS Board of Trustees in September 2012. In March of 2013, OPERS approved delaying certain aspects of these changes, including the eligibility requirements, allowance transition, and the Medicare Connector by one year so OPERS could better communicate and set up internal infrastructure to support these changes.

OPERS communicated more in-depth Medicare information in OPERS newsletters and the OPERS website with the goal of preparing plan participants as we transition to the OPERS Medicare Connector in 2016.

OPERS began partnering with the Ohio Department Aging to promote their Chronic Disease Self-Management Programs (Healthy U) to Medical Mutual plan participants. These programs are designed to teach participants to better manage their chronic conditions by changing certain lifestyle habits.

OPERS saved approximately $40 million in 2013 due to increased generic drug utilization. Generic drugs and biosimilar drugs are integral to our strategy to help keep prescription drugs more affordable for our retirees and to help keep our overall costs as low as possible.

2014

OPERS selected OneExchange to assist retirees in finding, evaluating and enrolling in an individual Medicare plan that best fits their needs and lifestyle. The contract was fully executed in September 2014; Connector implementation began immediately in October 2014.

OPERS continued our focus on implementing essential changes to the health care plan as approved by the Board in 2012. Several of the key elements of the new health care plan came to fruition in 2014. We embarked on an unprecedented communication campaign addressing each facet of the key health care changes with specific communication methods and techniques to ensure the appropriate audience is reached and concerns and issues are addressed.

In 2014, 1% of employer contributions were allocated to fund retiree health care. After review of the pension funding status, OPERS will evaluate opportunities to increase health care funding with the goal of moving toward a full 4% allocation.

Also in 2014, OPERS established the 115 Health Care Trust (115 Trust) under Section 115 of the Internal Revenue Code. This trust will fund a Health Reimbursement Arrangement (HRA) in future plan years to Medicare-eligible retirees of the Traditional Pension and Combined Plans.

Appendix B—Ohio Revised Code Sec. 145.58

(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.

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

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.

(ENACTED: SB 256, Eff. 10/14/59; HB 957, Eff. 10/27/61; HB 225, Eff. 11/13/65; HB 430, Eff. 11/20/73; HB 268, Eff. 8/20/76; HB 1, Eff. 8/26/77; HB 126, Eff. 6/13/81; HB 236, Eff. 2/2/82; HB 631, Eff. 3/28/85; HB 706, Eff. 12/16/86; SB 124, Eff. 10/1/87; HB 382, Eff. 6/30/91; HB 383, Eff. 5/4/92; SB 346, Eff. 7/29/92; HB 151, Eff. 2/9/94; SB 82, Eff. 3/6/97; SB 67, Eff. 6/4/97; HB 222, Eff. 11/2/99; HB 535, Eff. 4/1/01; SB 247, Eff. 10/1/02; SB267, Eff. 3/24/09; SB 343, Eff. 1/7/13; SB 42, Eff. 3/23/15)

Appendix C—Ohio Revised Code Sec. 145.584

(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.

(ENACTED: HB 402, Eff. 12/14/67; HB 1, Eff. 6/13/75; HB 1, Eff. 8/26/77; HB 126, Eff. 6/13/81; SB 346, Eff. 7/29/92; HB 628, 9/21/00; SB 343, Eff. 1/7/13 (former Sec. 145.325 renumbered to 145.584); SB 42, Eff. 3/23/15)

Appendix D—Statements of Fiduciary Net Position—Health Care

401(h) Post-employment Health Care Trust	2014	2013	2012	2011*	2010*	2009
Assets						
Cash and Short-Term Investments	**$503,893,407**	**$491,371,340**	**$446,851,345**	**$516,841,401**	**$673,728,399**	**$82,384,335**
Receivables						
Members and Employers	12,096,566	19,417,032	43,429,976	51,989,914	62,635,516	70,351,872
Early Retirement Incentive Plan	6,062	64,600	177,884	773,991	2,183,860	3,185,825
Vendor and Other	1,309,906	147,929,032	147,616,824	67,535,218	133,916,383	49,921,976
Investment Sales Proceeds	64,470,004	75,148,940	261,962,739	185,275,974	135,342,122	884,914,266
Accrued Interest and Dividends	47,590,193	47,924,681	47,650,966	49,585,342	49,049,361	37,732,716
Total Receivables	**125,472,731**	**290,484,285**	**500,838,389**	**355,160,439**	**383,127,242**	**1,046,106,655**
Investments, at fair value						
Fixed Income	4,434,483,598	4,313,177,166	4,731,050,357	4,349,713,914	4,355,743,585	3,746,406,051
Domestic Equities	3,296,381,497	3,594,242,223	3,293,138,146	3,642,820,108	3,950,499,244	3,806,887,666
Private Equity		110,263,964	73,443,686	54,927,514	27,877,976	39,341,186
International Equities	2,661,469,316	3,333,565,455	3,506,799,272	3,310,599,792	3,649,437,854	2,974,380,740
Other Investments	1,615,807,236	1,159,221,629	563,094,682	134,339,269	27,740,509	
Total Investments	**12,008,141,647**	**12,510,470,437**	**12,167,526,143**	**11,492,400,597**	**12,011,299,168**	**10,567,015,643**
Collateral on Loaned Securities					**1,517,578,594**	**299,502,780**
Capital Assets						
Land	916,220	729,981	729,981	665,394	665,394	665,394
Building and Building Improvements	27,261,277	21,476,205	21,737,564	19,627,154	19,641,200	19,660,159
Furniture and Equipment	28,536,399	26,907,290	24,688,709	24,809,991	22,850,746	20,582,082
Total Capital Assets	56,713,896	49,113,476	47,156,254	45,102,539	43,157,340	40,907,635
Accumulated Depreciation	(28,082,475)	(24,246,817)	(20,530,484)	(18,156,668)	(16,294,444)	(13,530,325)
Net Capital Assets	**28,631,421**	**24,866,659**	**26,625,770**	**26,945,871**	**26,862,896**	**27,377,310**
TOTAL ASSETS	**12,666,139,206**	**13,317,192,721**	**13,141,841,647**	**12,391,348,308**	**14,612,596,299**	**12,022,386,723**
Liabilities						
Undistributed Deposits	183,002	146,606	69,659	62,273	80,073	52,974
Benefits Payable	99,279,185	90,019,865	100,495,333	118,529,285	142,952,643	134,007,772
Investment Commitments Payable	113,120,724	99,797,215	194,165,994	294,572,622	253,257,695	163,153,464
Accounts Payable RMA Claims	13,033,505	15,544,228	18,485,339	19,183,817	16,114,872	10,474,459
Obligations Under Securities Lending					1,517,578,594	299,502,780
TOTAL LIABILITIES	**225,616,416**	**205,507,914**	**313,216,325**	**432,347,997**	**1,929,983,877**	**607,191,449**
Net Position Held in Trust for Health Care, as Restated	**$12,440,522,790**	**$13,111,684,807**	**$12,828,625,322**	**$11,959,000,311**	**$12,682,612,422**	**$11,415,195,274**

Source: *2014 Comprehensive Annual Financial Report*

* 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.

115 Health Care Trust*	2014
Assets	
Cash and Short-Term Investments	**$7,797,254**
Receivables	
Employers	20,597,780
Vendor and Other	175,326,214
Investment Sales Proceeds	988,589
Accrued Interest and Dividends	728,607
Total Receivables	**197,641,190**
Investments, at fair value	
Fixed Income	66,380,103
Domestic Equities	50,172,724
International Equities	41,687,272
Other Investments	24,508,856
Total Investments	**182,748,955**
TOTAL ASSETS	**388,187,399**
Liabilities	
Investment Commitments Payable	1,803,774
Accounts Payable and Other Liabilities	303,453
TOTAL LIABILITIES	**2,107,227**
Net Position Held in Trust for **Health Care, as Restated**	**$386,080,172**

Source: *2014 Comprehensive Annual Financial Report*

*The 115 Health Care Trust was established in 2014.

401(h) Post-employment Health Care Trust	2014	2013	2012	2011*	2010**	2009
Additions						
Member Contributions	$238,406,380	$178,140,822	$159,614,898	$148,370,246	$111,638,313	$94,370,543
Employer Contributions	135,522,351	120,056,440	494,048,415	503,458,216	628,685,237	740,817,891
Contract and Other Receipts	10,950,386	126,941,889	94,730,390	89,087,996	83,572,868	58,649,547
Federal Subsidy	44,715,641	105,965,762	182,579,917	192,118,407	142,658,293	69,132,772
Other Income, Net	7,601,841	13,483,861	11,774,199	10,915,043	7,163,609	654,031
Total Non-investment Income	**437,196,599**	**544,588,774**	**942,747,819**	**943,949,908**	**973,718,320**	**963,624,784**
Income From Investing Activities						
Net Appreciation/(Depreciation) in Fair Value	209,726,745	1,106,685,064	1,183,656,950	(401,560,941)	1,240,024,373	2,081,098,064
Bond Interest	284,087,239	116,748,678	201,317,018	202,859,266	137,927,458	152,358,418
Dividends	186,495,341	206,180,289	183,422,898	134,235,895	134,809,505	134,487,014
International Income/(Loss)	18,941	(4,659)	10,894	(92,053)	48,675	52,944
Other Investment Income	4,302,396	13,183,549	10,861,876	3,671,640	3,778,346	661,628
External Asset Management Fees	(30,811,500)	(40,036,389)	(24,118,062)	(13,648,040)	(10,904,604)	(7,709,148)
Net Investment Income/(Loss)	**653,819,162**	**1,402,756,532**	**1,555,151,574**	**(74,534,233)**	**1,505,683,753**	**2,360,948,920**
From Securities Lending Activity						
Security Lending Income					14,236,338	2,336,740
Security Lending Expenses					(4,259,969)	(562,862)
Net Security Lending Income					9,976,369	1,773,878
Unrealized Gains/(Losses)						(2,396,132)
Net Income/(Loss) from Securities Lending					**9,976,369**	**(622,254)**
Investment Administrative Expenses	(5,252,268)	(5,407,709)	(5,180,680)	(4,389,394)	(4,495,158)	(3,771,803)
Net Income / (Loss) from Investing Activity	**648,566,894**	**1,397,348,823**	**1,549,970,894**	**(78,923,627)**	**1,511,164,964**	**2,356,554,863**
TOTAL ADDITIONS	**1,085,763,493**	**1,941,937,597**	**2,492,718,713**	**865,026,281**	**2,484,883,284**	**3,320,179,647**
Deductions						
Health Care Expenses	1,738,596,173	1,642,525,598	1,607,921,528	1,575,561,578	1,567,551,611	1,488,032,855
Administrative Expenses	18,329,337	16,352,514	15,172,174	13,076,814	12,782,968	13,033,595
TOTAL DEDUCTIONS	**1,756,925,510**	**1,658,878,112**	**1,623,093,702**	**1,588,638,392**	**1,580,334,579**	**1,501,066,450**
Net Increase/(Decrease)	(671,162,017)	283,059,485	869,625,011	(723,612,111)	904,548,705	1,819,113,197
Net Position Held in Trust for Health Care Balance, Beginning of Year	13,111,684,807	12,828,625,322	11,959,000,311	12,682,612,422	11,415,195,274	9,596,082,077
Balance, End of Year	**$12,440,522,790**	**$13,111,684,807**	**$12,828,625,322**	**$11,959,000,311**	**$12,319,743,979**	**$11,415,195,274**

Source: *2014 Comprehensive Annual Financial Report*

*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.

**The year 2010 was restated for reclassification of Early Retirement Reinsurance Program from Contracts and Other Receipts to Federal Subsidy, and the reclassification of the Pending Medical Claims adjustment from Health Care Expenses to Other Income. Pending Medical Claims consists of the annual adjustment made to the incurred but not reported liability included in Benefits Payable. This liability fluctuates from year to year based on changes in the claims experience.

115 Health Care Trust*	2014
Additions	
Employer Contributions	$111,561,319
Contract and Other Receipts	143,813,190
Federal Subsidy	131,904,250
Other Income, Net	76,970
Total Non-investment Income	**387,355,729**
Income From Investing Activities	
Net Appreciation/(Depreciation) in Fair Value	(2,660,677)
Bond Interest	535,544
Dividends	1,019,374
International Income/(Loss)	223
External Asset Management Fees	(61,239)
Net Investment Income/(Loss)	**(1,166,775)**
Investment Administrative Expenses	(26,581)
Net Income/(Loss) from Investing Activity	**(1,193,356)**
TOTAL ADDITIONS	**386,162,373**
Deductions	
Administrative Expenses	82,201
TOTAL DEDUCTIONS	**82,201**
Net Increase/(Decrease)	386,080,172
Net Position Held in Trust for Health Care Balance, Beginning of Year	
Balance, End of Year	**$386,080,172**

Source: *2014 Comprehensive Annual Financial Report*

***The 115 Health Care Trust was established in 2014.**

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