OPERS Ohio Public Employees Retirement System

2022 Health Care Report

Presented to the Ohio Retirement Study Council June 2023

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Ohio Public Employees Retirement System
2022 ORSC Health Care Report
(For period January 1, 2022-December 31, 2022)

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Year in Review-2022

As of year-end 2022, Ohio Public Employees Retirement System (OPERS) serves approximately 1,250,000 members, including more than 220,000 retirees and beneficiaries. In addition, OPERS partners with approximately 3,700 public employers. With a net asset base of $106.8 billion, OPERS is the largest public pension system in Ohio and the 14th largest public pension system in the nation. For more than half of our history, OPERS has provided access to health care coverage for retirees which, although not mandated, we believe is an important part of a secure retirement. This dedication to maintaining health care has become increasingly challenging as health care overall becomes more expensive.

We anticipate that health care costs will continue to increase based on the combination of the growing number of retirees, increasing life expectancies and overall increases in the cost of health care due to medical advances especially in the prescription drug component. We also do not anticipate funding health care until the pension funding status improves.

As a result of these challenges, OPERS adopted changes to the health care program over the past several years, with the most recent changes effective in January 2022. The 2022 changes included the elimination of the group health care plan for Pre-Medicare retirees. Similar to the changes made in 2015 for the Medicare retirees, OPERS no longer offers a group plan but provides eligible Pre-Medicare retirees with funding in a health reimbursement arrangement (HRA) account. OPERS provides Pre-Medicare retirees with an OPERS vendor to help members select their own plan on the open market or through the federal subsidy program. The amount of HRA varies based on the member's age and years of service.

Health care expenses decreased in 2022 by 30.7% as a result of the elimination of the Pre-Medicare group health plan and changes to the Medicare-eligible HRA allowance. The Pre-Medicare group health plan was replaced with an HRA allowance (for eligible retirees) for the reimbursement of health care coverage premiums and other qualified medical expenses that was effective January 1, 2022.

Via Benefits, offered by Willis Towers Watson, administers the OPERS Connector for eligible Pre-Medicare retirees effective in 2022. Via Benefits can assist participating Pre-Medicare retirees in choosing a medical plan from the open market. Via Benefits also administers the process by which participants can be reimbursed for qualifying medical expenses, using an HRA that OPERS provides. Via Benefits has administered the OPERS Medicare Connector, a similar service available to OPERS Medicare-eligible retirees since its inception in 2015. Unlike the Pre-Medicare plan, the OPERS Medicare Connector is a closed HRA, which necessitates retirees enrolling through Via Benefits to select a plan.

HRA Allowances

Effective January 1, 2022, eligible Pre-Medicare retirees began receiving a monthly HRA allowance for reimbursement of health care coverage premiums and other qualifying medical expenses. The OPERS Connector assists them with enrolling in a medical plan on the open market if they so choose. The Pre-Medicare monthly base allowance is $1,200. Both Pre-Medicare and Medicare-eligible retirees receive a percentage (ranging between 51%-90%) of the base allowance determined by their age and qualified years of service at retirement.

Also, effective January 1, 2022, the base allowance used to determine the monthly HRA allowance for Medicare-eligible retirees decreased from $450 per month to $350 per month. Additionally, Medicare-eligible retirees who retired prior to January 1, 2015, and were granted an allowance of 75% now have their allowance determined based on their age when they first enrolled and their years of service at retirement. Those Medicare-eligible retirees affected by this change now receive an allowance percentage between 51% and 74% of the base allowance as calculated on the OPERS allowance table.

Transition Deposit

A one-time HRA deposit of $1,200 was provided to retirees who were enrolled in the OPERS Pre-Medicare group plan effective December 1, 2021. This deposit was intended to assist in the transition to the individual marketplace.

Dependent Children

Effective January 1, 2022, retirees no longer receive an additional allowance for eligible dependent children, regardless of age, ability or mental capacity. The retiree can use their HRA to reimburse any qualifying medical expenses incurred by their eligible dependents.

Re-employed Retirees

Effective January 1, 2022, eligible re-employed retirees will no longer have their HRA suspended during the re-employment period. Instead, re-employed retirees will receive the HRA allowance throughout the re-employment period provided enrollment requirements are met. The monthly HRA deposits will accrue in a Re-employed Accumulated HRA. However, re-employed retirees will not be able to use the accumulated HRA balance to be reimbursed for qualified medical expenses during the re-employment period. Upon completion of the re-employment period, all funds will be available for reimbursement of eligible expenses incurred outside of the re-employment period.

OPERS Connector Education and Support

In recent years, we have adapted to the needs of our members and retirees by continuing to offer a hybrid approach in our counseling and educational efforts—both virtual and in-person. Customer service is critical, especially when changes have recently been implemented. Throughout 2022, OPERS sustained efforts to ensure all eligible participants receiving a monthly HRA deposit from OPERS were successfully using their HRA account to receive reimbursements if they so desired. These efforts included interactive webinars, print and online newsletters and personal outreach to retirees with little or no HRA activity. OPERS works constantly with Via Benefits, the OPERS Connector administrator, to refine and improve the HRA reimbursement experience for all eligible participants.

2022 Financial Highlights

OPERS has been fortunate to benefit from the positive investment markets for the last several years. However, the 2022 investment markets performed poorly and OPERS was impacted. The Health Care portfolio reported an investment loss of 15.51% in 2022, compared to a gain of 14.34% in 2021. The overall 115 Health Care Trust (115 Trust) net position balance decreased to $11.5 billion in 2022 from $14.2 billion in 2021.

Funded Status

Health care coverage is not statutorily guaranteed and can only be funded if pension funding is adequate. That said, retirees continue to inform us of the importance of meaningful access to health care. OPERS continues its goal of ensuring financial stability of both the pension and health care funds and will continue to evaluate plan and product designs to encourage sustainability.

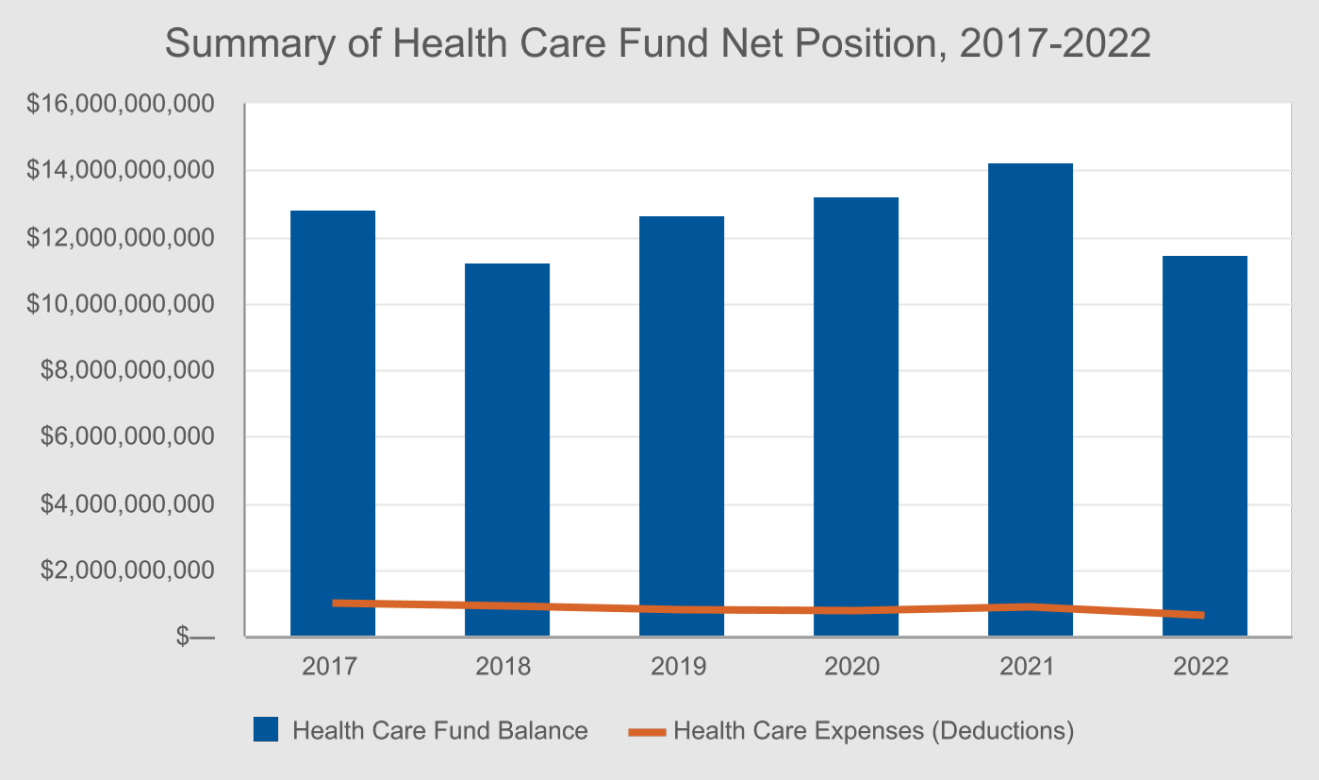
Effective July 1, 2022, OPERS increased the portion of the 14% employer contribution rate allocated to health care funding from 0.0% to 2.0% for the Combined Plan. The employer contribution as a percent of covered payroll deposited for Member-Directed Plan health care accounts for 2022 was 4.0%. No portion of the employer contribution rate was allocated to health care for the Traditional Pension Plan.

The funding objective is to meet long-term pension benefit obligations and, to the extent possible, fund post-employment health care. As of December 31, 2021, the date of the latest health care actuarial valuation, the actuarial liability for health care was $11.0 billion and the System had accumulated assets of $12.7 billion for that obligation, an excess of $1.7 billion. This compares to the 2020 excess assets of $1.2 billion. The funded ratio increased from 110.4% at the end of 2020 to 115.2% in 2021 due primarily to investment gains from 2021. Since the health care valuation is one year in arrears, this is not reflective of the poor market returns of 2022.

Additional financial information pertaining to 2022 can be found on page 5 and within Appendix C and Appendix D.

Financial Information

Additions[1]	Deductions	Fund Balance	Solvency Period[2]	Employer Allocation[3]
($2,156,736,452)	$603,263,614	$11,465,339,238	29	0%



Health Care Fund Balance (as graphed above)		
	Health Care Fund Balance	Health Care Expenses (Deductions)
2017	$12,818,833,665	$971,410,051
2018	$11,252,985,702	$889,891,322
2019	$12,647,057,751	$785,846,596
2020	$13,227,419,100	$741,460,732
2021	$14,225,339,304	$868,573,891
2022	$11,465,339,238	$603,263,614

[1]Total additions for 2022 were negative due to a significant net loss from investing activities.

[2]Solvency period based on each system's individual valuation and underlying assumptions.

[3]No employer contributions were allocated to health care in 2018 through 2022 for the Traditional Pension Plan. No employer contributions were allocated to health care in 2018 through 2021 for the Combined Plan. Effective July 1, 2022, the contribution rate for the Combined Plan was set to 2.0%. The contributions for the Member-Directed RMAs for 2022 remained at 4%.

Average Annual Cost Per Participant Paid by OPERS

Pre-Medicare Recipients	Re-employed Recipients	Medicare Recipients
$9,886	$7,501	$3,141

Note: Above chart includes monthly HRA allowance and any applicable Medicare Part A reimbursements.

Pre-Medicare Recipients include OPERS benefit recipients who met OPERS health care eligibility requirements, had not yet reached age 65, did not qualify for any type of early Medicare eligibility and had opted into receiving a monthly HRA deposit.

Re-employed Recipients include OPERS benefit recipients who met OPERS health care program eligibility requirements and had returned to work in an OPERS-covered position.

Medicare Recipients include OPERS benefit recipients who met OPERS health care program eligibility requirements, were Medicare-eligible, were enrolled in Medicare Parts A and B and were enrolled in an individual medical plan through the OPERS Medicare Connector.

Population of Recipients

Age-and-Service	Disability	All Others (Survivors, Beneficiaries, etc.)	Total Recipients	Percent Medicare
121,870	12,826	196	134,892	79.8%

OPERS Health Care Plans

Pre-Medicare and Re-Employed Retirees

Effective January 1, 2022, OPERS discontinued the group medical and prescription drug plans offered to Pre-Medicare retirees and re-employed retirees. Instead, eligible Pre-Medicare and re-employed retirees selected an individual medical plan. OPERS provides funding in a health reimbursement arrangement (HRA) account to those retirees who meet health care eligibility requirements. Retirees can receive reimbursement for plan premiums and other qualifying medical expenses. Pre-Medicare retirees also have the option to select the federally provided premium subsidy in lieu of the OPERS allowance based on their financial economics.

Medicare-eligible Retirees

During 2022, Medicare-eligible retirees selected an individual medical or prescription drug plan (or both) through the OPERS Medicare Connector. They were also eligible for a monthly HRA allowance to be used for reimbursement of qualifying medical expenses.

Reimbursable Medical Expenses

The HRA allowance can be used to reimburse the cost of any of the following:

- Post-tax medical plan premiums,
- Medicare Part B premium,
- Vision and dental premiums,
- Deductibles, co-insurance and other out-of-pocket medical expenses,
- Qualifying medical expenses for a spouse or child,
- Future qualifying medical expenses, including premium increases as the member ages.

A look ahead

OPERS faces two major challenges to providing access to health care. First, we anticipate that health care expenses will continue to increase based on the combination of the growing number of retirees, their increasing life expectancies and overall increases in the cost of health care due to medical advances, especially in the prescription drug component. Second, the funding status of the pension requires that all contributions be allocated to strengthen the pension funding. Thus, until the pension funding improves, no employer contributions will be allocated to health care for the foreseeable future.

OPERS cannot control many aspects of the business of pensions, including market volatility and the global economies. However, we are diligent in making responsible decisions for the actions we can control and anticipating challenges beyond our control. We have taken significant action in recent years to preserve the health care fund through incremental changes designed to lengthen the solvency of that fund.

Health Care Preservation Plan
In 2020, the OPERS Board voted to adopt further changes to health care coverage for Medicare and Pre-Medicare retirees. These changes, as provided within the previous sections of this report and referred to as the Health Care Preservation Plan (HCPP 3.1), were designed to improve the sustainability of the health care program.

Eligibility
Eligibility requirements have changed for those retiring after January 1, 2022.

Effective with January 1, 2022 benefit effective dates and after, members retiring from the Traditional Pension or Combined Plan are required to meet one of the below criteria:

- Age 65 or older
    - Minimum of 20 years of qualified health care service credit

- Age 60 - 64
    - Retirement Group A – Have 30 years of pension service credit with at least 20 years of qualified health care service credit or
    - Retirement Group B – Have 31 years of pension service credit with at least 20 years of qualified health care service credit or
    - Retirement Group C – Have 32 years of pension service credit with at least 20 years of qualified health care service credit.
- Age 59 or younger
    - Retirement Group A – Have 30 years of qualified health care service credit or
    - Retirement Group B – Have 32 years of qualified health care service credit at any age or 31 years of qualified health care service credit and be age 52 or
    - Retirement Group C – Have 32 years of qualified health care service credit and be age 55.
- Members receiving a benefit payment prior to reaching age 65 will be eligible as of their benefit effective date or become eligible when they turn age 60 or age 65 depending on their service credit as of their benefit effective date (see criteria above).

Funding

As of December 31, 2021, the date of the most recent health care valuation, the health care assets accumulated to fund the liabilities exceeded the liabilities by $1.7 billion, resulting in a funded ratio of 115.2%, an improvement over the prior year's funded ratio of 110.4%. Based on the combination of the level of health care expenditures, the investment gains from 2021, and that OPERS is currently unable to fund the health care trust for all members, the current trust fund is expected to last approximately 29 years, an improvement over the prior year's solvency period of 25 years. The improvement over these measurements is a direct result of the strong investment market in 2021.

Since the health care valuation is one year in arrears, this is not reflective of the poor market returns of 2022.

The OPERS Board, management and staff acknowledge that access to meaningful health care is a significant component of a secure retirement to members. Our tradition of working to preserve the health care fund through incremental changes designed to lengthen the solvency of that fund will continue.

Supplementary Statutory Requirements

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

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

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

Appendices A and B are copies of ORC Section 145.58 (group hospitalization coverage; ineligible individuals; service credit; alternate use of Health Maintenance Organization) and ORC Section 145.584 (Medicare-equivalent benefits for members ineligible for Medicare), as they existed during 2022. Both sections were amended by Substitute Senate Bill 343, effective January 7, 2013 and Senate Bill 42, effective March 23, 2015

(2) **A summary of coverage for 2022:**

The following is an outline of OPERS health care coverage in 2022:

OPERS Pre-Medicare Connector Health Reimbursement Arrangement (HRA)

Effective December 31, 2021, OPERS terminated its Pre-Medicare group plan, and migrated to a model in which benefit recipients can receive a monthly Health Reimbursement Arrangement (HRA) allowance. During 2022, Pre-Medicare benefit recipients who met health care eligibility requirements had the option to opt-in to the HRA. Upon opting into the HRA, benefit recipients received a monthly allowance that could be used for reimbursement of qualifying medical expenses such as medical, vision, and dental premiums; deductibles; co-insurance; and any qualifying medical expenses incurred by a spouse or child.

The amount of the HRA monthly allowance depends on age and years of qualifying service. HRA balances roll over from month-to-month, year-to-year, and when the Pre-Medicare retiree becomes Medicare-eligible.

The Internal Revenue Service defines qualifying medical expenses. Reimbursements of qualifying medical expenses are not taxable income and are not reported on any tax form.

The Pre-Medicare Connector is administered by a vendor selected by OPERS. Pre-Medicare benefit recipients have the option to work with the vendor to enroll into an individual or family medical plan; however, working with the vendor is not a requirement to receive the monthly HRA allowance.

To aid in the transition to the Pre-Medicare marketplace, OPERS provided a one-time HRA deposit of $1,200 into any benefit recipients who was previously enrolled in the OPERS group plan.

OPERS Medicare Connector Health Reimbursement Arrangement (HRA)

During 2022, Medicare-eligible benefit recipients selected an individual medical or prescription drug plan (or both) through the OPERS Medicare Connector. The Connector is administered by a vendor selected by OPERS. Upon enrolling into a medical plan with the vendor, benefit recipients received a monthly Health Reimbursement Arrangement (HRA) allowance that could be used for reimbursement of qualifying medical expenses such as medical, vision, and dental premiums; deductibles; co-insurance; and any qualifying medical expenses incurred by a spouse or child.

The amount of the HRA monthly allowance depends on age and years of qualifying service. HRA balances roll over from month-to-month and year-to-year.

Medicare Part A Reimbursement

Ohio law allows OPERS to provide premium reimbursement to those who are not eligible for premium-free Medicare Part A. Medicare-eligible OPERS retirees are required to enroll in, and pay, the monthly premium for Medicare Part A coverage through the Centers for Medicare and Medicaid Services. OPERS provides a monthly reimbursement for the Medicare Part A premium cost and provides a 50% Medicare Part A premium reimbursement to eligible spouses.

The Dental Plan

During 2022, voluntary dental coverage was available to all OPERS benefit recipients, and their eligible dependents, regardless of their participation in OPERS health care. The dental plan, administered by MetLife, is intended to help defray the costs of dental care, including oral examinations, diagnostic services and extractions, as well as crowns, bridges and dentures. If a retiree chooses coverage under the dental plan, a premium payment is deducted from each monthly benefit payment. OPERS does not subsidize this plan.

The Vision Plan

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

Member-Directed Retiree Medical Account (RMA)

Upon termination from OPERS-covered employment and a distribution from the Member-Directed Plan (refunded or pensioned), a participant may use the vested funds in their Member-Directed RMA to receive reimbursements for any qualifying medical expenses they or their qualifying dependents may incur.

Vesting requirements for the Member-Directed RMA have changed over the life of the plan. The Member-Directed RMA originally required 10 years of participation to fully vest in the contributions and interest earned on the account. Effective January 1, 2009, participants were required to participate for a five-year period to become fully vested. Effective July 1, 2015, new participants to the Member-Directed RMA are required to participate for 15 years to become fully vested

Wellness Retiree Medical Account (RMA)

Prior to 2017, Pre-Medicare plan participants had the opportunity to earn modest wellness incentives that were deposited into a Wellness RMA. The Wellness RMA also contained excess retiree health care premium allowances.

In plan year 2018, Wellness RMA participants were notified of account balances and a transition campaign was implemented with the goal of encouraging participants to seek reimbursement from their remaining balances with the intent to close these accounts. No additional deposits were made to the Wellness RMA accounts in 2019 or after. In plan year 2022, participants were notified again of OPERS intent to terminate the Wellness RMA plan. Communications were sent to participants encouraging them to seek reimbursements from their balance for any qualifying medical expenses they or their qualifying dependents may have incurred. Following the termination of this program, effective December 31, 2022, remaining balances in member accounts were either transferred to the retiree's HRA account or forfeited in 2023.

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

Eligibility requirements for 2022 OPERS health care plans are as follows:

Age-and-Service Retirement

All OPERS members are in one of three retirement groups: Group A, Group B or Group C. The retirement group determines pension eligibility and benefit calculation. The member's group also affects when members will be eligible for health care coverage through OPERS.

Effective with January 1, 2022 benefit effective dates and after, members retiring from the Traditional Pension or Combined Plan are required to meet one of the below criteria:

- Age 65 or older
    - Minimum of 20 years of Qualified Health care Service Credit
- Age 60 - 64
    - Retirement Group A – Have 30 years of Pension Service Credit with at least 20 years of Qualified Health Care Service Credit or
    - Retirement Group B – Have 31 years of Pension Service Credit with at least 20 years of Qualified Health Care Service Credit or
    - Retirement Group C – Have 32 years of Pension Service Credit with at least 20 years of Qualified Health Care Service Credit.
- Age 59 or younger
    - Retirement Group A – Have 30 years of Qualified Health Care Service Credit or
    - Retirement Group B – Have 32 years of Qualified Health Care Service Credit at any age or 31 years of Qualified Health Care Service Credit and be age 52 or
    - Retirement Group C – Have 32 years of Qualified Health Care Service Credit and be age 55.
- Members receiving a Benefit Payment prior to reaching age 65 will be eligible as of their Benefit Effective Date or become eligible when they turn age 60 or age 65 depending on their Service Credit as of their Benefit Effective Date (see criteria above).

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

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

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

Disability Benefit Recipients

Recipients of disability benefits prior to January 1, 2014, have continued access to health care coverage while the disability benefit continues and will not be subject to the five-year rule described below. The allowance will be determined in the same way as an age-and-service benefit recipient. If the recipient does not meet minimum age-and-service requirements, the minimum allowance will be used.

Recipients with an initial disability effective date on or after January 1, 2014, will receive a monthly HRA deposit during the first five years of disability benefits. After five years, the recipient must meet health care age and qualifying service requirements that were in effect on their disability effective date or be enrolled in Medicare through Social Security due to disability. If enrolled, the allowance will be determined in the same way as an age-and-service benefit recipient.

Eligible Dependents

In accordance with Ohio Administrative Code 145-4-25 and Section 152 of the Internal Revenue Code (IRC), benefit recipients receiving a monthly age-and-service or disability benefit may enroll their legal spouse and any eligible children under the age of 26 into the Dental and/or Vision plans.

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

Surviving spouses of a deceased benefit recipient disability recipient may only enroll those dependents that would have been eligible dependents of the deceased benefit recipient or disability recipient as defined on this page.

Coverage Options

In 2022, OPERS provided HRA monthly allowances to offset qualifying medical expenses incurred by Traditional Pension Plan and Combined Plan benefit recipients and their eligible dependents. For those retiring on or after January 1, 2015, the allowance provided by OPERS is based on age and years of qualifying service.

Member-Directed Retiree Medical Account (RMA)

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

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

As of December 31, 2022, there were 161,695 OPERS Pre-Medicare and Medicare benefit recipients eligible to receive a monthly HRA allowance.

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

OPERS financial statements are prepared using the economic resources measurement focus and accrual basis of accounting under which deductions are recorded when the expense is incurred and revenues are recognized when earned. Health care payments are considered an expense and recognized as a liability when a present obligation exists and a condition that requires the event creating the liability has taken place. Therefore, health care expenses are recognized when the benefits are currently due and payable in accordance with the benefit terms. Health care expenses contain estimates on claims which have been incurred at year-end, but which have not yet been reported to the System as of fiscal year end, based on information received from health care vendors and other sources.

Investment purchases and sales are recorded as of their trade date. Investments are generally reported at fair value. Fair value is the amount that a plan can reasonably expect to receive for an investment in a current sale between a willing buyer and a willing seller, that is, other than in a forced or liquidation sale. All investments, with the exception of real estate, private equity, risk parity 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 some real estate investments, private equity, risk parity and hedge funds is based on a net asset value, which is established by the fund or by the fund's third-party administrator.

Employer contributions and investment earnings can be used to fund health care expenses. No portion of the employer contribution rate was allocated to health care for the Traditional Pension Plan. Effective July 1, 2022, OPERS increased the portion of the 14% employer contribution rate allocated to health care funding from 0.0% to 2.0% for the Combined Plan. The health care contribution rate allocation for the Member-Directed Plan retiree medical accounts (RMAs) for 2022 remained at 4.0%.

The funded status of health care as of December 31, 2021, the most recent actuarial valuation, was 115.2%. The funding progress of health care is measured in terms of solvency years, or the number of years funds are projected to be available to pay health care expenses under the current plan design before health care would be reduced to a pay-as-you-go basis. As of the December 31, 2021 valuation the fund's solvency stood at approximately 29 years.

The Board approved changes to the OPERS health care plans in 2012. The ultimate goal of the health care changes was to fund the health care expenditures from the health care income. Additionally, the Board established a health care stabilization fund to hold excess income if income exceeds expenditures. The balance of the stabilization fund will supplement income to the health care core (operating) fund when employer contributions, investment income or disbursements do not meet targets. The stabilization fund is an accounting function only and

not listed separately in the financial statements. This stabilization fund is included in the health care results provided throughout this report. Health care valuations are prepared using total health care fund assets.

On January 15, 2020, the Board approved several changes to the health care plan offered to Medicare and Pre-Medicare retirees in efforts to decrease costs and increase the solvency of the health care plan. These changes were effective January 1, 2022, and include changes to base allowances and eligibility for Medicare retirees, as well as replacing the OPERS-sponsored self-insured medical plans for Pre-Medicare retirees with monthly allowances, similar to the program for Medicare retirees.

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

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

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

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

(8) For the last six consecutive fiscal years, a schedule of the net assets available for the benefits, the annual cost of benefits, administrative expenses incurred, and annual employer contributions allocated for the provision of benefits:

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

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

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

Health care expenses decreased in 2022 by 30.7% as a result of the elimination of the pre-Medicare group health plan and the implementation of the HRA allowance (for eligible retirees) for the reimbursement of health care coverage premiums and other qualified medical expenses that was effective January 1, 2022.

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

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

Appendix A – Ohio Revised Code Sec. 145.58

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

(B) The board may enter into agreements with insurance companies, health insuring corporations, or government agencies authorized to do business in the state for issuance of a policy or contract of health, medical, hospital, or surgical coverage, or any combination thereof, for eligible individuals receiving age and service retirement or a disability or survivor benefit subscribing to the plan, or for PERS retirants employed under section 145.38 of the Revised Code, for coverage in accordance with division (D)(2) of section 145.38 of the Revised Code. Notwithstanding any other provision of this chapter, the policy or contract may also include coverage for any eligible individual's spouse and dependent children and for any of the eligible individual's sponsored dependents as the board determines appropriate. If all or any portion of the policy or contract premium is to be paid by any individual receiving age and service retirement or a disability or survivor benefit, the individual shall, by written authorization, instruct the board to deduct the premium agreed to be paid by the individual to the company, corporation, or agency.

The board may contract for coverage on the basis of part or all of the cost of the coverage to be paid from appropriate funds of the public employees retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by sections 145.48 and 145.51 of the Revised Code. The board may by rule provide coverage to individuals who are not eligible under the rules adopted under division (A) of this section if the coverage is provided at no cost to the retirement system. The board shall not pay or reimburse the cost for coverage under this section or section 145.584 of the Revised Code for any such individual.

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

(C) The board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, pay monthly to each recipient of service retirement, or a disability or

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

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

(D) The board shall establish by rule requirements for the coordination of any coverage or payment provided under this section or section 145.584 of the Revised Code with any similar coverage or payment made available to the same individual by the Ohio police and fire pension fund, state teachers retirement system, school employees retirement system, or state highway patrol retirement system.

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

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

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

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

Appendix B – Ohio Revised Code Sec. 145.584

(A) Except as otherwise provided in division (B) of this section, the board of the public employees retirement system shall make available to each retirant or disability benefit recipient receiving a monthly allowance or benefit on or after January 1, 1968, who has attained the age of sixty-five years, and who is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program without payment of premiums, one of the following:

(1) Hospital insurance coverage substantially equivalent to the federal hospital insurance benefits, Social Security Amendments of 1965, 79 Stat. 291, 42 U.S.C.A. 1395c, as amended;

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

This coverage or amount shall also be made available to the spouse, widow, or widower of such retirant or disability benefit recipient provided such spouse, widow, or widower has attained age sixty-five and is not eligible to receive hospital insurance benefits under the federal old age, survivors, and disability insurance program without payment of premiums. The widow or widower of a retirant or disability benefit recipient shall be eligible for such coverage or amount only if he or she is the recipient of a monthly allowance or benefit from this system. A portion of the cost of the premium or amount for the spouse may be paid from the appropriate funds of the system. The remainder of the cost shall be paid by the recipient of the allowance or benefit.

The cost of such coverage or amount, paid from the funds of the system, shall be included in the employer's rate provided by section 145.48 of the Revised Code. The retirement board is authorized to make all necessary rules pursuant to the purpose and intent of this section, and may contract for such coverage as provided in section 145.58 of the Revised Code.

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

(B) The board need not make the hospital insurance coverage or amount described in division (A) of this section available to any person for whom it is prohibited by section 145.58 of the Revised Code from paying or reimbursing the premium cost of such insurance.

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

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

Appendix C – Statements of Fiduciary Net Position – Health Care

	2022	2021	2020	2019	2018	2017
115 Health Care Trust						
Assets						
Cash and Cash Equivalents	**$599,117,458**	**$601,259,856**	**$1,027,292,218**	**$818,204,587**	**$595,183,342**	**$823,866,242**
Receivables						
Members and Employers	3,648,553	3,073,969	1,911,304	1,892,495	2,016,190	17,310,993
Vendor and Other	760,750	13,324,552	17,761,491	12,585,164	12,173,150	10,325,432
Investment Sales Proceeds	5,777,133	27,052,473	31,752,833	52,212,702	38,943,225	58,028,023
Accrued Interest and Dividends	51,436,232	39,152,066	45,461,914	46,169,385	44,840,466	44,801,284
Total Receivables	**61,622,668**	**82,603,060**	**96,887,542**	**112,859,746**	**97,973,031**	**130,465,732**
Investments						
Fixed Income	4,489,603,482	4,990,704,874	4,895,416,249	4,855,122,000	4,117,147,799	4,348,639,837
Domestic Equities	3,505,476,720	4,955,808,406	3,518,558,498	3,183,847,864	2,911,258,188	3,403,242,732
International Equities	2,755,333,550	3,430,623,707	3,079,326,933	2,674,811,901	2,240,589,009	2,645,509,612
Risk Parity	208,064,227	302,208,248				
Other Investments	4,307,527	27,222,822	726,811,028	1,237,576,242	1,495,996,430	1,654,750,270
Total Investments	**10,962,785,506**	**13,706,568,057**	**12,220,112,708**	**11,951,358,007**	**10,764,991,426**	**12,052,142,451**
Collateral on Loaned Securities	**1,883,181,055**	**1,473,586,654**	**53,244,143**			
Capital Assets						
Land	942,728	942,728	942,728	942,728	942,728	942,728
Building and Building Improvements	27,835,927	27,877,452	27,894,673	27,971,184	27,986,068	27,998,673
Furniture and Equipment	43,454,909	39,229,340	32,258,995	34,246,182	32,854,966	33,676,485
Intangible Right-to-use Assets	3,277,868	2,641,732	2,521,393			
Total Capital Assets	75,511,432	70,691,252	63,617,789	63,160,094	61,783,762	62,617,886
Accumulated Depreciation and Amortization	(43,547,513)	(43,023,677)	(40,619,545)	(41,103,250)	(38,171,032)	(36,873,343)
Net Capital Assets	**31,963,919**	**27,667,575**	**22,998,244**	**22,056,844**	**23,612,730**	**25,744,543**
TOTAL ASSETS	**13,538,670,606**	**15,891,685,202**	**13,420,534,855**	**12,904,479,184**	**11,481,760,529**	**13,032,218,968**
Liabilities						
Benefits Payable	146,568,144	178,969,160	107,300,342	115,181,776	119,532,084	114,643,770
Investment Commitments Payable	43,428,618	12,158,010	32,561,762	142,043,307	109,027,945	98,511,166
Accounts Payable and Other Liabilities[1]	13,947	1,316,692	22,848	196,350	214,798	230,367
Obligations Under Securities Lending	1,883,320,659	1,473,902,036	53,230,803			
TOTAL LIABILITIES	**2,073,331,368**	**1,666,345,898**	**193,115,755**	**257,421,433**	**228,774,827**	**213,385,303**
Net Position Restricted for OPEB	**$11,465,339,238**	**$14,225,339,304**	**$13,227,419,100**	**$12,647,057,751**	**$11,252,985,702**	**$12,818,833,665**

[1]**Undistributed deposits were reclassified into this line item for all years presented.**

Source: 2017-2022 Annual Comprehensive Financial Reports

Appendix D

Statements of Changes in Fiduciary Net Position – Health Care

	2022	2021	2020	2019	2018	2017
115 Health Care Trust						
Additions						
Employer Contributions	$29,899,481	$25,631,727	$24,489,938	$24,318,141	$23,441,668	$157,417,888
Contract and Other Receipts	1,655,731	235,362	513,509	540,809	279,178	857,541
Other Income, net		35,954	430,729	1,724	732,193	117,882
Total Non-investment Additions	31,555,212	25,903,043	25,434,176	24,860,674	24,453,039	158,393,311
Income/(Loss) From Investing Activities						
Net Increase/(Decrease) in the Fair Value of Investments	(2,486,728,932)	1,558,420,836	1,098,039,399	1,600,900,770	(862,731,054)	1,303,745,052
Bond Interest	137,805,771	146,678,770	136,102,586	162,002,938	108,077,693	162,929,606
Dividends	159,983,217	145,288,202	92,781,749	428,602,794	88,148,545	325,553,345
Other Investment Income/(Loss)[1]	13,897,764	1,858,827	(877,624)	2,399,977	692,432	644,668
External Asset Management Fees	(11,791,604)	(11,143,188)	(24,247,532)	(33,296,008)	(28,772,749)	(36,062,800)
Net Investment Income/(Loss)	(2,186,833,784)	1,841,103,447	1,301,798,578	2,160,610,471	(694,585,133)	1,756,809,871
From Securities Lending Activity						
Securities Lending Income	28,913,059	6,516,945	452,507			
Securities Lending Expenses	(24,856,640)	(766,175)	(229,778)			
Net Securities Lending Income	4,056,419	5,750,770	222,729			
Unrealized Gains/(Loss)	175,778	(328,074)	12,692			
Net Income from Securities Lending	4,232,197	5,422,696	235,421			
Investment Administrative Expenses	(5,690,077)	(5,935,091)	(5,646,094)	(5,552,500)	(5,824,547)	(5,447,329)
Net Income/(Loss) from Investing Activity	(2,188,291,664)	1,840,591,052	1,296,387,905	2,155,057,971	(700,409,680)	1,751,362,542
TOTAL ADDITIONS	(2,156,736,452)	1,866,494,095	1,321,822,081	2,179,918,645	(675,956,641)	1,909,755,853
Deductions						
Health Care Expenses	591,090,699	853,113,419	725,265,912	767,888,929	870,284,919	952,001,573
Administrative Expenses	12,172,915	15,460,472	16,194,820	17,957,667	19,606,403	19,408,478
TOTAL DEDUCTIONS	603,263,614	868,573,891	741,460,732	785,846,596	889,891,322	971,410,051
Net Increase/(Decrease)	(2,760,000,066)	997,920,204	580,361,349	1,394,072,049	(1,565,847,963)	938,345,802
Net Position Restricted for OPEB						
Balance, Beginning of Year	14,225,339,304	13,227,419,100	12,647,057,751	11,252,985,702	12,818,833,665	11,880,487,863
Balance, End of Year	$11,465,339,238	$14,225,339,304	$13,227,419,100	$12,647,057,751	$11,252,985,702	$12,818,833,665

Source: 2017-2022 Annual Comprehensive Financial Reports

[1]International Income/(Loss) was reclassified into Other Investment Income/(Loss) for all years presented.