Ohio Public Employees Retirement System

opers 2013 Health Care Report

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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 that it plays in sustaining its mission: to provide retirement security for its members.

Therefore, OPERS offers health care coverage to eligible members and their eligible dependents. Members currently must have at least 10 years of qualifying service credit and retire under the Traditional Pension Plan or the Combined Plan to access the health care plan. Those eligibility requirements increase to 20 years of qualifying service and age 60 (or any age with 30 years of qualifying service) for retirements beginning Jan. 1, 2015.

In 2013, we focused on implementing essential changes to the program that the OPERS Board of Trustees approved in 2012. These updates, coupled with the passage of a new pension law by the Ohio General Assembly, provide the foundation for a health care plan that recognizes the needs of retirees while remaining financially stable.

One of the key health care changes is a Medicare Connector, a company we'll partner with to help eligible retirees and spouses select an individual Medicare Supplement or Medicare Advantage Plan. A detailed procurement process to secure a Medicare Connector vendor is under way, with an anticipated Connector introduction in 2016.

In concert with the Connector, OPERS is educating members about the many details of Medicare. We're explaining each facet of the recent health care plan changes with targeted communication to address member concerns.

Here are a few highlights. Greater detail on each item is provided within the report.

A Plan to Preserve Health Care for the Future—OPERS is confident that its health care solution presents positive, long-term solvency solutions given the challenges that all retirement system health care plans face. 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 well into the future.

OPERS Health Care Changes Simplified—The changes OPERS has made to the health care program 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.

For retirees under 65, OPERS will continue to provide a group plan. For those over age 65, OPERS will contract with a Medicare Connector to help retirees select an individual Medicare plan that fits their specific needs. OPERS chose to implement a Medicare Connector after learning that despite our large purchasing power, we could not compete with the prices of the entire Medicare market. We want to offer retirees more choice at a lower cost. However, retirees will not need to pick a Medicare plan all on their own. The Connector will help them make a selection, much like a broker can help select an insurance policy. Additionally, OPERS will stand behind the Medicare Connector providing the strong support we have always offered our retirees.

Depending on a retiree's choice of Medicare plan, they may have allowance dollars remaining to use toward other qualified health care expenses (such as coverage for their spouse, Medicare Part B premiums, out-of-pocket expenses or future health care needs). We've protected current retirees by ensuring their allowance does not fall below a minimum acceptable level. Because retirees are faced with more choices then ever before, OPERS will provide communications and education to help them become good consumers.

Funding Retiree Health Care—In 2013, the OPERS Board of Trustees reviewed the funding framework to support health care, with a goal of maintaining a long-term, annual contribution rate to the health care fund. With the adoption of the new program and the passage of pension legislation, the OPERS health care trust fund will support sustained access to quality programs for eligible participants. OPERS is one of the few systems in the country that with the inception of the program in 1974 began pre-funding health care and consequently has one of the largest health care funds ($13 billion at the end of 2013).

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. Recently introduced plan design elements include Patient-Centered Medical Homes (PCMH) and Value-Based Insurance Design (VBID).

OPERS worked with Medical Mutual of Ohio (MMO) its self-insured plan administrator, to yield better health care value for OPERS and its retirees. We partnered with community-based lifestyle programs to help participants prevent common and costly chronic diseases, such as diabetes.

We also made a number of changes to prescription drug coverage to better align the Medicare and Non-Medicare plan designs and to promote cost-conscious purchasing of prescription medications and supplies.

Eye on Quality—OPERS continues to focus on maximizing quality. In 2013, OPERS conducted its second annual Participant Experience Survey to assess respondents' self-reported health status, their participation in OPERS health and wellness programs, and the impact of those programs. OPERS' Clinical Quality Improvement Committee (CQIC) continued its mission to favorably impact OPERS' health care trend. The committee finalized the CQIC Report Card, a tool designed to monitor quality and usage outcomes against industry benchmarks.

Key findings:

- Offering retirees access to quality health care coverage has become increasingly difficult in recent years. But OPERS has adopted a guiding principle of preserving access to coverage for eligible retirees and their eligible dependents.
- The OPERS Board of Trustees has adopted a funding plan for health care that will assure its future solvency by astutely managing employer contributions and investment returns.
- The OPERS Health Care Fund had a market value of $13 billion at the end of 2013. It returned 11.4% for the year and has returned 8% net of fees over the past three years.
- OPERS is one of a relatively few retirement systems to set aside assets to fund retiree health care coverage. At year end 2012, OPERS estimated health care funding liability was $19.2 billion. Assets within the health care fund were $12.2 billion which accounts for 63.6% of its current liabilities leaving a $7 billion unfunded liability.
- OPERS' new health care plan adjusts three components to achieve optimal savings and plan longevity: eligibility, participant cost (allowance), and plan sponsorship in the form of a Medicare Connector.
- The Medicare Connector, scheduled to begin in January 2016, addresses the fact that sponsoring group supplemental health care coverage for Medicare participants has become increasingly expensive in comparison to individual Medicare plans currently offered. Individual Medicare plans offer greater choice and, in most cases, greater affordability. This will allow our retirees to meet their individual health and budgetary needs.
- Three-fourths of OPERS' health care costs go toward treating chronic conditions, and the fastest-growing contributor to our annual drug costs are high-cost, specialty medications.
- OPERS is working with Medical Mutual of Ohio (MMO), our self-insured, non-Medicare plan administrator, to yield better health care value for our system and our retirees.
- Plan participants report that the health and wellness programs that we offer are having a positive impact on their overall health and quality of life.

A Plan to Preserve Health Care for the Future

Key changes to the OPERS health care program, 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 remaining fiscally responsible for financial stability within the health care fund. The pension fund continues to meet statutory requirements, and the health care trust fund is one of the strongest in the nation at 63.6% funded. Although the adopted changes will have a direct impact on current and future retirees, our funded status will allow us to honor our commitment to 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 program would have become unsustainable and exhausted the health care trust fund in a matter of years.

- **Health Care Coverage is Discretionary—** OPERS is required by law to fund and provide pension benefits, but 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 that its retiree population will increase by 40% (from 162,000 to 225,000) by 2022.

- **Life Expectancy—**Retirees are living longer. The average OPERS member retires at age 59.6; using a 78.7 year average life expectancy, a retiree would have access to OPERS health care coverage for more than 19 years. This is far more than anticipated when we established the health care program in 1974.

- **Health Care Fund—**The OPERS Health Care Fund had a market value of $13 billion at the end of 2013. However, health care costs would have depleted the fund within ten years if we had not adopted significant changes to the health care program.

- **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 2013, the rate of health care inflation was 4.0% while the CPI was 1.5%.

- **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 program and the health care system at large.

Guiding Principles

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

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.

- **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, in most cases. 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.

- **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 members

or benefit recipients with less than 20 years of service credit will be phased-out to 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 reduced from $96.40 to $0 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 employed in an OPERS-covered position.

- **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 health care plan.

- **Plan Sponsorship—**Beginning in 2016, health care coverage for retirees and spouses age 65 and over and 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 (and over age 65 but not eligible for Medicare Part A) will be provided through an OPERS-sponsored plan.

- **Consumer Choice—**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 items such as coverage for their spouse, Medicare Part B premiums, out-of-pocket costs or savings for future health care expenses.

Medicare Connector

In 2016, OPERS plans to introduce a Medicare Connector. OPERS will form a partnership with 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. Health care coverage for retirees and dependents under age 65 (age 65 and over but not eligible for Medicare Part A) will continue to be provided through an OPERS-sponsored plan.

OPERS will form a partnership with 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.

Advantages to providing Medicare-eligible retirees with 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 budget
- Supporting active consumerism by Medicare-eligible retirees

The Medicare 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 health care allowance amount from OPERS to purchase this plan. Depending on their selection, the Medicare Connector should increase participants' purchasing power to offset some of the changes OPERS has made to preserve the health care fund.

Connector Procurement

In June 2013, OPERS distributed a Request for Proposal (RFP) to procure a connector company. Major phases of the procurement process included a rigorous RFP development process, setting minimum requirements, defining key contract terms, vendor candidate presentations and site visits. OPERS staff conducted an extensive evaluation of the vendor's proposal that met the minimum requirements, which included the written proposal, one presentation and a site visit. Contract negotiations are underway with this vendor, following the extensive evaluation and board approval to begin contract negotiations.

Plan Implementation and Communications

The new OPERS health care program 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 medical expense reimbursement processes and guaranteed issue will be a major portion of our ongoing strategic communication plan.

OPERS will address each facet of the key changes with specific communication methods and techniques to ensure the appropriate audience is reached and concerns and issues are addressed.

Funding Retiree Health Care

OPERS' main goal in creating the new health care plan was to design a program that could be sustained using the available funding.

OPERS has two main sources of funding for the retiree health care program:

Employer Contributions—Depending on pension funding, OPERS has the discretion to direct a portion of employer contributions to fund health care. A portion of the employer contributions is currently allocated to fund retiree health care. The plan design assumes that a portion of employer contributions will continue to be allocated to the retiree health care plan each year. With the pension fund meeting the statutory requirement of a 30-year amortization period, employer contributions allocated to the health care trust fund can begin to reach the funding goal of 4%. The employer contribution will increase by 1% per year from its current rate of 1% in 2013 to reach 4% employer contributions by 2016.

Investment returns on the health care portfolio—OPERS has established a separate health care trust fund with a balance of $13.1 billion as of December 31, 2013. The health care portfolio experienced a gain of 11.4% in 2013. An additional $387.5 million was earned compared to 2012.

The primary indicator for monitoring the health care trust fund is the self-funding rate.

Self-Funding Rate (SFR)—SFR is the percentage of the employer contribution rate required to fund health care indefinitely (OPERS actuaries define indefinitely as 100 years). In 2012, the board approved a health care plan design that can be funded by 4%, thus matching expenses to revenues. Prior to the adoption of plan changes in 2012, the OPERS health care program required 7.6% of employer contributions.

Short-term Funding Support—The Early Retiree Reinsurance Program (ERRP), authorized in the Patient Protection and Affordable Care Act (PPACA), provided short-term funding support for the OPERS health care plan. As a participant, OPERS applied for and received more than $180 million. ERRP funds could be used to offset participant health care costs and were required to be exhausted by December 31, 2013. OPERS held the health care self-supporting rate (often referred to as a "premium") flat for 2012 and 2013 (0% increase over 2011 and 2012 rates), an action that provided a direct benefit to OPERS plan participants.

OPERS Health Care Funding—National Comparison—Comparatively, the OPERS health care funding level exceeds the vast majority of funds across the nation. OPERS has pre-funded its health care liability since 1974. This is something most public and private sector employers and retirement systems do not do, opting instead to follow a pay-as-you-go model.

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.

Category	2013 Costs	Cost Per Day
Cardiovascular & Circulatory	$287,623,000	$800,000
Orthopedic (Musculoskeletal)	$200,709,000	$549,900
Neoplasms (Cancer)	$175,267,000	$480,200
Diabetes & Complications	$143,250,000	$392,500
Respiratory/Pulmonary	$ 86,564,000	$237,200

The majority of the above 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 will positively impact efforts to fight chronic disease and keep overall health costs down.

A Careful Eye on Prescription Drug Costs and Trends

In an effort to provide the most cost effective health care program 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%

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 $3,000 per month in 2013. 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 2013* 21.6% Medicare 19.8% Non-Medicare	**Actual 2013*** - 6.3% Medicare 6.0% Non-Medicare
Projected** 2014—16.8% 2015—18% 2016—18.2%	**Projected**** 2014—2.0% 2015—1.9% 2016—1.9%

* Per Member Per Month Plan Drug Trend: 2013 annual report furnished by Express Scripts
**Per Member Per Year Plan Drug Trend Source: 2013 Express Scripts Drug Trend Report

Competition from biosimilars would improve access to specialty drugs and save billions each year in treatment costs. 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 use of generic drugs by participants. OPERS saved $40 million in 2013 due to increased generic drug utilization. The increase can be attributed to new generic drugs becoming available on the market, OPERS communications efforts and OPERS Value Based Insurance Design (VBID) programs. OPERS will continue to see growth in generic utilization in 2014 because of these same factors as well as the implementation of a more restrictive National Preferred 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 2013, 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," 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 chronic disease continue to rise at rates that are unsustainable.

OPERS Program Evaluation

In 2013, OPERS and its plan administrator worked jointly to develop meaningful strategies expected to have a favorable impact on OPERS' trends and yield better health care value for OPERS and its retirees into the future.

The following strategies were identified as the result of a comprehensive assessment of cost, utilization, and quality trends across the covered population:

- Find ways to improve continuously
- Define and implement "actionable" steps to drive value
- Justify actions through positive results
- Measure and evaluate success regularly

OPERS will be working with their plan administrators and key stakeholders to work on solutions that align with the strategies above, with a commitment to continual improvement.

Patient-Centered Medical Homes (PCMH)

OPERS continues to support the availability of PCMHs for retirees through plan design and participant education. The medical home model is a strategic initiative expected to affect the OPERS health care program favorably. 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 health and wellness needs of retirees, takes advantage of the value of primary care, and will ultimately yield improved clinical quality and a better overall patient experience.

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

In 2013,

- The number of PCMHs in Ohio recognized by the National Committee on Quality Assurance (NCQA) increased 25% from 943 in January to 1,180 in December 2013,
- The number of OPERS participants who took advantage of the innovative primary care model is also growing. In 2013, almost 8,500 non-Medicare participants, approximately 10% of the eligible population, sought care from a PCMH.

Value-Based Insurance Design (VBID)

In 2013, 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.

Also in 2013, to encourage participants with common chronic conditions like high blood pressure, depression, or diabetes, to seek care and prevent complications commonly associated with chronic conditions, OPERS offered these participants reduced office visit copayments to primary care as well as specialist physicians. In addition, OPERS removed any financial barriers to medication adherence for approximately 55,000 participants who paid nothing out-of-pocket for generic medications used to treat their common chronic conditions. To help the 41,000 participants with diabetes manage their health, OPERS eliminated cost-share for diabetes medications and testing supplies.

Chronic Diseases and Community-Based Resources

Community-based lifestyle programs can prevent or delay the onset of common and costly chronic diseases, like diabetes. In 2013, OPERS took advantage of proven community-based resources as additional tools to address retirees' personal health-management needs and gaps in care. We offered retirees opportunities to enroll in the Ohio Department of Aging's Chronic Disease Self-Management Program, six week-long workshops offered through Ohio's local Area Agencies on Aging. The workshops promote self-management and provide support to those with chronic conditions. OPERS is researching additional partnerships with organizations such as Ohio-based YMCAs to provide diabetes prevention programs for retirees with pre-diabetes, a condition thought to affect up to one in three adults in the U.S. and that puts one at significant risk for diabetes in the absence of any intervention.

Medical Specialty Drug Management

In 2013, OPERS and our self-insured plan administrator identified drug categories that may need prior authorizations in 2014. Prior authorizations are required for drugs that may cause potentially serious side effects and/or have a high potential for inappropriate use. The drug categories identified were cancer, pulmonary arterial hypertension and respiratory conditions. Additionally, OPERS and Medical Mutual of Ohio collaborated on the development of 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 to the management of cancer.

Finally, OPERS and MMO began 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 upon where a specialty drug is administered to a participant, the doctors' office, outpatient infusion clinic or inpatient hospital.

Medication Therapy Management

The Medication Therapy Management Program (MTM) is a program available to OPERS health care plan participants via telephone through Express Scripts and Sinfonia. 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 2013, 34,400 (>25%) 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 2013, 3,700 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 2013, OPERS worked jointly with our self-insured plan administrator on payment reform strategies aimed at shifting from the traditional fee for service model that pays for volume to payment strategies that recognize and reward value (quality + cost).

Health Care Consumerism

In 2013, OPERS developed a strategic plan for facilitating the transition of health care participants from being passive patients to informed consumers of health care. In its communications to retirees, OPERS conveyed the importance of taking care of oneself to enjoy retirement and maximize the value of OPERS health care dollars.

Going forward, OPERS' communications both in terms of appearance/branding as well as content will contain tools, resources, and messages designed to stimulate a call to action on the part of the retiree when it comes to their overall well-being and health care utilization.

Changes to Prescription Drug Coverage

OPERS made a number of changes to the prescription drug coverage in 2013 to better align the Medicare and Non-Medicare plan designs and promote cost-conscious purchasing of prescription medications and supplies. Changes included increasing coinsurance percentages, minimum and maximum amounts paid for medications, shifting from flat copays to coinsurance for some classes of medications, and increasing the annual out-of-pocket maximum to align with the Center for Medicaid and Medicare Services (CMS).

Public Sector Health Care Roundtable

OPERS continued its participation in the Public Sector Healthcare Roundtable (PSHR), 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.

Medicare Individual Market Offers Future Opportunities

Within the individual Medicare marketplace, Medicare health care connectors have been emerging as an evolving business model. 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, eligible OPERS retirees will receive an allowance to purchase a plan through the Medicare Connector.

Connectors serve as an intermediary between an organization's retiree population and the individual Medicare marketplace. Their role is to provide education as well as plan selection and enrollment support to Medicare-eligible retirees and their Medicare-eligible dependents. Retirees are able to select among multiple individual Medicare plan options (Medicare Supplement Plans, Medicare Advantage Plans, Medicare Advantage with Prescription Drug Plans, Special Needs Plans, and Part D Drug Plans). Given the large Medicare population (47 million), there are more affordable options on the individual Medicare market than our group plan can offer.



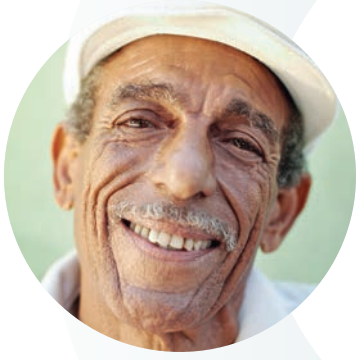

Eye on Quality

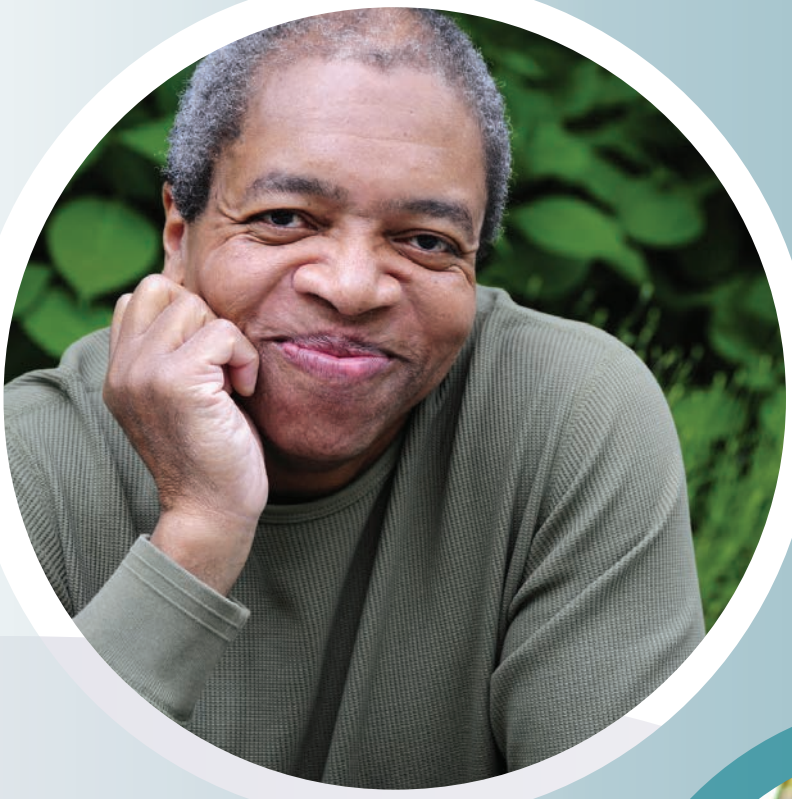
OPERS Maintains Focus on Maximizing Quality

In 2013, OPERS conducted its second annual Participant Experience Survey. Approximately 6,100 OPERS health care program participants responded to the telephone survey for a greater than 50% response rate. The purpose of the survey was to assess respondents' self-reported health status, participation in OPERS health and wellness programs, and the impact of the latter on respondents' health status and quality of life. Of the 54%, who reported having participated in an OPERS health and wellness program, 38% said their overall health improved and 57% said their quality of life improved because of their participation in the health and wellness resources provided by OPERS.

Clinical Quality Improvement Committee (CQIC)

CQIC, 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 2013, the committee finalized the CQIC Report Card. The report card is being used to measure and monitor quality and utilization outcomes against industry benchmarks on an ongoing basis. Going forward, CQIC members will turn their attention toward using the report card to identify opportunities for improving clinical outcomes and evaluating the impact of agreed-upon interventions.





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 of nearly 400,000 in the next twenty years.

Promoting a Culture of Wellness and Disease Prevention—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 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 how care delivery and payment methods creates a unique opportunity to assist our participants to take 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. In addition, because OPERS has sponsored a group Medicare plan for nearly 40 years, the switch to a Medicare Connector in 2016 requires a great deal of dedication and resource allocation to ensure that the implementation is smooth for our participants.

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— Complying with new accounting compliance standards– In June 2012, the Governmental Accounting Standards Board (GASB) issued two new standards (Statement Numbers 67 and 68) related to the 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 are under discussion by GASB for reporting of Other Post-Employment Benefits (OPEB), which includes health care. GASB is expected to release exposure drafts for these standards in the summer of 2014.

Understanding the impact of Federal Health Care Reform—The implementation of the Patient Protection and Affordable Care Act (PPACA) is ongoing. OPERS is staying informed and complying with updates to this important law. In July 2013, OPERS learned that the provision requiring employers with more than 50 employees to provide health care for their full-time employees or pay a monthly fee would be delayed for at least a year. Also delayed until 2015 in order to give health care plan sponsors additional time to comply is a provision limiting patients' total annual out-of-pocket costs for essential health benefits. These are significant issues for OPERS and our employers. They will require persistent attention and evaluation to ascertain the short and long-term effect on the OPERS health care plan, health care delivery system, and the population we serve.

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 for both medical and prescription coverage and the demographic and health status of covered participants play a large part in determining health care costs on a yearly basis. In addition, new technologies, including expensive specialty medications, and compliance with federal and state legislation all impact health care inflation.

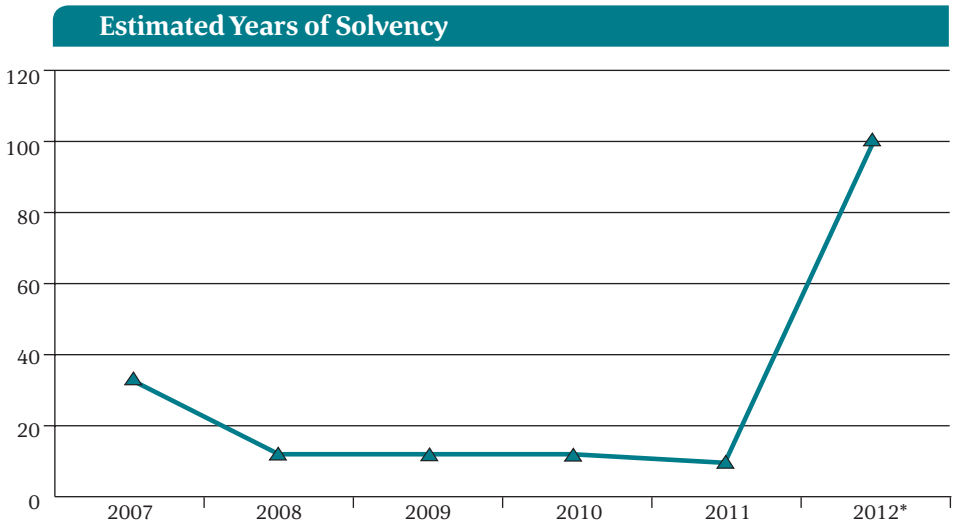
Funding update

Beginning in fiscal 2006, GASB required retirement systems to estimate their liability for health care coverage similar to the manner in which pension liabilities are estimated. However, unlike pensions, the health care coverage that OPERS provides (with the exception of Medicare Part B reimbursements) is not statutorily guaranteed. As of December 31, 2012, the date of the latest actuarial valuation, OPERS has an estimated liability for future health care of $19.2 billion, a significant decrease from the prior year's liability of $31.0 billion. OPERS is one of a relatively few retirement systems that has systematically set aside assets to fund retiree health care coverage. As of December 31, 2012, OPERS had $12.2 billion in health care fund assets as stated on a funding basis (actuarially smoothed over a four year period), leaving an unfunded liability of $7.0 billion, again a significant decrease from the prior year's unfunded liability of $18.9 billion. The changes to the design of the health care plan described earlier resulted in this significant reduction in liabilities and compounds improvement in funding. Simply put, OPERS has accumulated 63.6% of the assets necessary to pay these liabilities.

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 smoothing of actuarial gains and losses mitigates the impact of 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.

In order to ensure that the funding value of assets and the market value of assets remain within a logical proximity of each other, OPERS uses a 12% market corridor in conjunction with its four-year smoothing. This policy, instituted by the OPERS Board of Trustees in 2001, is known as the Market Corridor, and ensures that the funding value of assets is neither lower than 88% nor higher than 112% of the market value of the assets. At the end of 2012, the most recent actuarial valuation, OPERS' fair value of assets was greater than the funding value due to the deferral of approximately three-fourths of the investment gains recognized in 2012. Simply put, the unfunded liability on a market value of assets would be $6.4 billion rather than the $7.0 billion unfunded liability on a funding value. The $0.6 billion difference will be recognized over the next three years and will reduce the liability.

OPERS is one of a relatively few retirement systems that has systematically set aside assets to fund retiree health care coverage.



Source: *2013 Comprehensive Annual Financial Report*
*Estimated solvency is indefinite as of 2012.

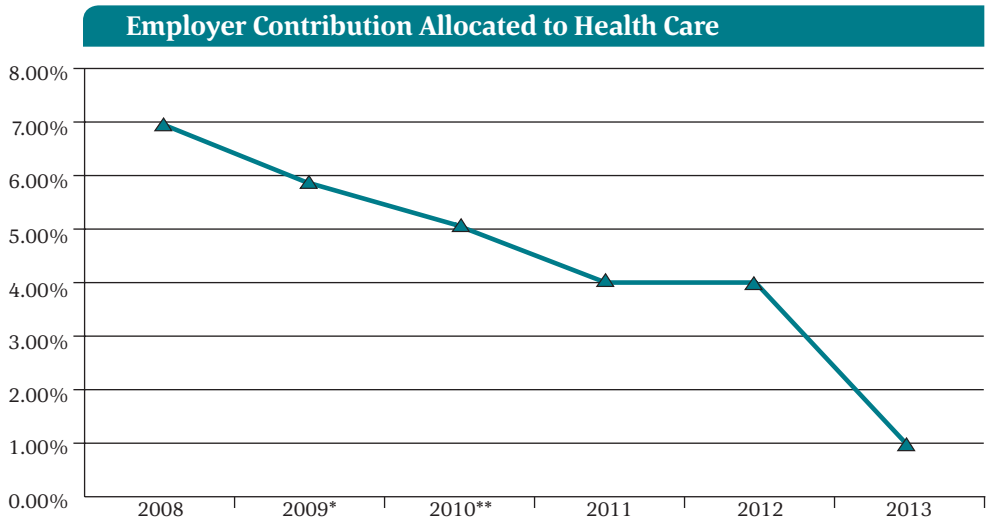
By comparison, the health care liability as of December 31, 2011, was $31.0 billion compared to the actuarial value of assets of $12.1 billion, leaving an unfunded liability of $18.9 billion and a funded ratio of 39.1%. As previously noted, OPERS has made changes to the health care plan design. Through Health Care Preservation Plan efforts, OPERS proactively pursued plan design changes to extend the solvency period of the fund to indefinite while maintaining the funding priority of pension benefits and focusing available health care funding on the needs of career members.

Additions to the health care fund

Additions to the health care fund are comprised primarily of employer contributions and investment returns. Revenues from member contributions (health care premium pension deductions or direct billed premiums), federal subsidies, and contract and other receipts comprise the balance. A comparative chart is shown on page 28 while a detailed explanation of each category follows.

1 **Investment Income–**The Health Care portfolio experienced a gain of 11.4% in 2013 compared to gains of 13.7% in 2012 and a loss of 0.52% in 2011.

2 **Employer Contributions–**The portion of the employer rate allocated to the health care fund declined from 4% in 2012 to 1% in 2013, causing a $374.0 million reduction in employer contributions to the health care fund. Prior to the enactment of pension plan changes, the employer rate allocated to health care was going to be reduced to zero by 2013. Passage of the pension reform legislation enabled OPERS to continue funding the health care plan. The portion of employer contributions to health care will increase by 1% each year until a maximum of 4% is attained in 2016. The employer contributions into the health care fund had also decreased due to a decrease in the active member population.



Source: *2013 Comprehensive Annual Financial Report*

* The portion of the employer contribution rate allocated to fund health care was 7% for the period January 1, 2009 through March 31, 2009 and decreased to 5.5% for the period April 1, 2009 through December 31, 2009. The overall effective rate for the year was 5.88%.

** The portion of the employer contribution rate allocated to fund health care was 5.5% for the period January 1, 2010 through February 28, 2010 and decreased to 5.0% for the period March 1, 2010 through December 31, 2010. The overall effective rate for the year was 5.08%

3 Member Contributions–Member contributions to the health care plan 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 2013, these contributions totaled $178.1 million, compared to $159.6 million in 2012. This increase reflects the rising cost of health care, an increase in the retiree population, and the impact of program design changes. The number of retirees eligible for health care in 2013 increased by 1.2% compared to 2012. However, the number of dependents and beneficiaries receiving health care coverage decreased by 2.3% compared to 2012.

Because 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 program. To determine the member's cost share OPERS determines, with the help of its actuary, the 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) to cover cost increases that otherwise would have been passed on to the retirees. Under the federal guidelines, these ERRP funds must be used by 2014. As of December 31, 2013, all ERRP funds were exhausted.

Plan design changes adopted in 2004 and 2009 shifted a greater portion of health care expense to the retiree. In 2004, the Board adopted the Health Care Preservation Plan to extend the solvency of the health care fund. The plan featured coverage levels and monthly allowances for health care coverage for retirees

and their eligible dependents based on the retiree's years of service. Members who were eligible to retire on January 1, 2007 with at least 10 years of service (Group 1) receive an allowance equal to 100% of the cost of health care coverage. Members hired prior to January 1, 2003 but eligible to retire after January 1, 2007 (Group 2), receive allowances ranging from 50% to 100%, while members hired after January 1, 2003 (Group 3) receive allowances ranging from 25% to 100%. The allowances for Groups 2 and 3 increase with each year of service, up to the maximum of 100% with 30 years of service.

The majority of retirees participating in the health care plan represent Group 1 members who were provided allowances covering the majority of their health care premium at the time the changes were introduced. Group 1 retirees have begun feeling the impact of inflation change on their monthly allowance, although the amount they pay is still significantly lower than Group 2 or Group 3 retirees. By the end of 2013, 20.0% of the retirees in the health care plan were Group 2 and 3 members receiving lower allowances and required to pay a portion of their health care premiums, compared to 16.9% in 2012. In addition, effective in 2011, OPERS ceased subsidizing health care coverage for retiree spouses under the age of 55. These spouses may continue to participate in the health care program, but must pay 100% of the premium cost. The plan design changes increased member contribution revenues for health care by $18.5 million in 2013 over the 2012 revenues.

The 2012 plan design changes include provisions that become effective at various times beginning January 1, 2014. The impact of this set of changes is not reflected in the health care expenses yet, but the impact is reflected in the reduction of the Accrued Actuarial Liability as previously noted.

4 **Contract & Other Receipts–**Contracts and other receipts represent funds received for vendor rebates and other miscellaneous income. These receipts totaled $126.9 million in 2013, reflecting a 34.0% increase over the $94.7 million earned in 2012.

The majority of this increase represents gain sharing revenues received in conjunction with the Medicare Advantage program. OPERS is self-insured for retirees under the age of 65, but contracts with a vendor to provide a premium-based Medicare Advantage program for retirees over the age of 65. The premium is estimated at the beginning of the year, and adjusted at year-end based on OPERS actual claims experience. In essence, these revenues represent a premium adjustment based on actual experience. In 2013, gain sharing revenues totaled $77.9 million compared to $52.2 million in 2012.

Prescription drug rebates also increased from $37.6 million in 2012 to $43.7 million in 2013, as purchase volumes subject to the rebate program continued to increase.

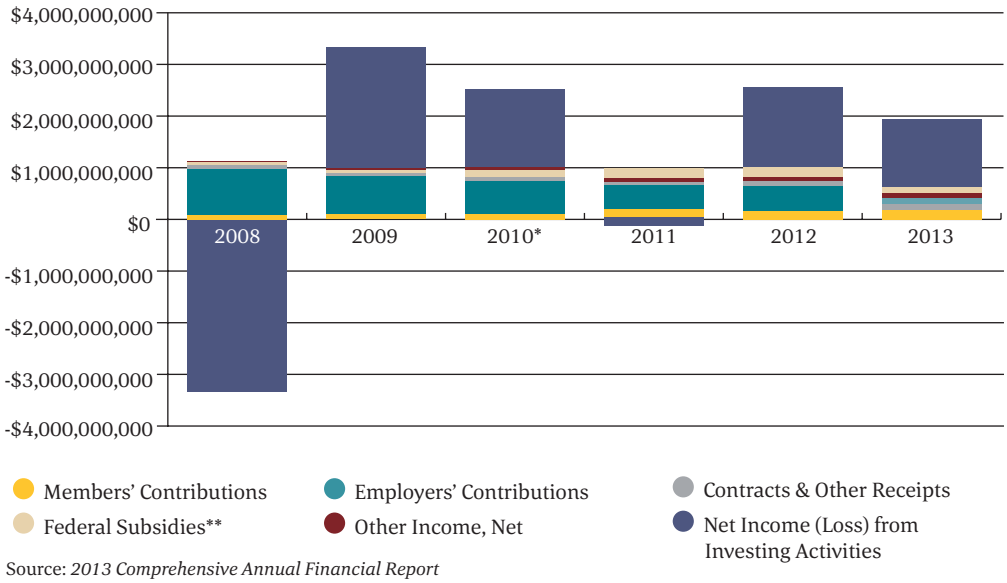
5 **Federal Subsidies–**Federal subsidies are comprised of reimbursements and direct subsidies OPERS received from the federal government for participation in Medicare prescription drug programs (PDP).

In 2013, total federal subsidies decreased by $76.6 million, from $182.6 million in 2012 to $106.0 million in 2013, primarily due to mandatory payment reductions in Medicare Part D programs (referred to as Sequestration), part of a series of across-the-board reductions in Federal spending in accordance with the Balanced Budget and Emergency Deficit Act of 1985, as amended. This change was effective April 1, 2013 and has reduced OPERS' monthly direct subsidy income.

Employers that offer a high-quality prescription drug program for retirees and their dependents are eligible for a federal subsidy under either the Medicare Part D program or a qualified prescription drug plan (PDP). OPERS initially participated in the Medicare Part D program and beginning in 2011 implemented a Medicare prescription drug plan (PDP). The Medicare PDP is structured as a direct subsidy rather than a reimbursement program. OPERS receives a fixed amount per member based on the member's risk score, regardless of the member's actual claims experience. Members participate in either the Medicare Part D reimbursement program or the PDP subsidy program, but not both. With the vast majority participating in the PDP plan, in 2013, the PDP subsidies totaled $105.7 million compared to $181.7 million in 2012. The Medicare D reimbursement in 2013 totaled $0.2 million and $0.9 million in 2012.

6 Other Income, Net–Other income includes miscellaneous income and significant adjustments to prior years' expense accruals. Historically, 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 program is mandatory when a retiree and their spouse reach age 65, and 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. The liability account is gradually being reduced over a four-year period commensurate with the claims lag history. The amounts included in other income for 2013 and 2012, for the reversal of prior years' accruals, are $13.5 million and $10.7 million, respectively.

Six-Year History of Additions to the Health Care Fund



Source: *2013 Comprehensive Annual Financial Report*

* 2010 restated for reclassification of Early Retirement Reinsurance Program to Federal Subsidies and the reclassification of the 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 Medical Benefits Payable.

**Includes: Medicare Part D Reimbursements effective in 2006. Early Retiree Reinsurance Program effective in 2010. Medicare qualified prescription drug plan (PDP) effective in 2011.

Note: Members' Contributions reflect retiree cost share of premium.

Deductions to the health care fund

The expenses displayed in the graph on page 30 reflect the cost of health care expenses for retirees, their spouses and their dependents. The following provides detailed information about the components.

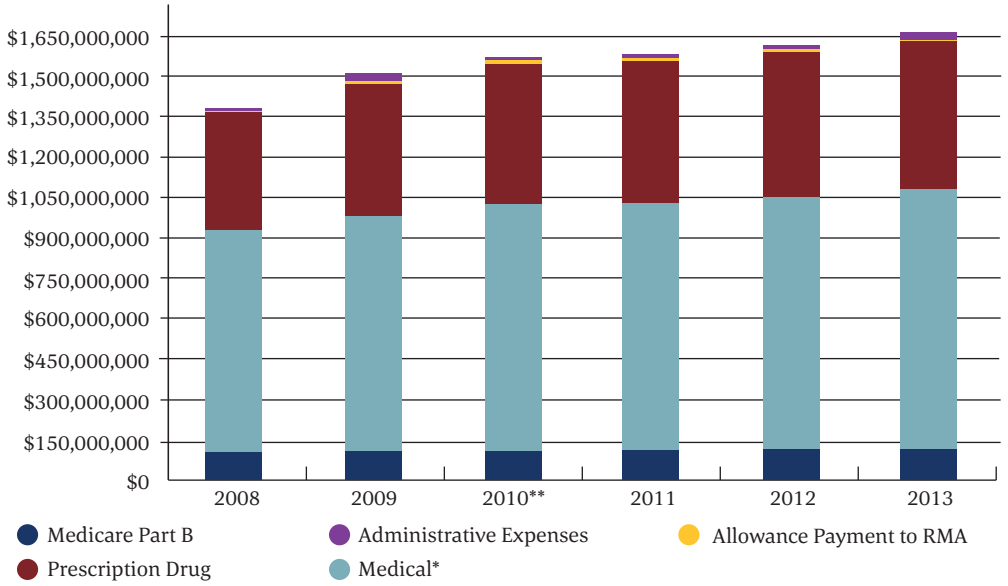
The increase in post-employment health care expenses reflects the expanding retiree population and the nationwide trend in health care inflation that continues to be in excess of general inflation. National health care cost trends in 2013 reported a 4.0% increase in health care costs compared to a general inflation rate of 1.5%. Despite the increase in total health care recipients, OPERS health care costs increased a modest 2.2%. OPERS has controlled the rate of increase of these expenses through a combination of plan design and cost-sharing changes, and extensive cost containment efforts.

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 and vision costs represent approximately 59% of the total health care expenses for the years 2013 and 2012, followed by prescription drug costs at approximately 34% and Medicare Part B premium reimbursements at approximately 7% of the total. Total health care expenses (excluding VEBA) increased by $34.6 million in 2013 compared to an increase of $32.4 million in 2012.

Medical, dental and vision expenses increased from $943.0 million in 2012 to $973.8 million in 2013. Prescription drug costs rose from $541.6 million in 2012 to $551.4 million in 2013. Because OPERS is self-insured for the health care expenses of recipients under the age of 65, these costs will fluctuate based on the timing of claims incurrence and the magnitude of catastrophic claims.

Medicare Part B reimbursements increased by $0.3 million in 2013, compared to an increase of $3.5 million in 2012. Legislative changes that became effective in 2009 permit the Board to determine the value of Medicare Part B reimbursements above a base threshold. This change effectively permits the Board to establish a cap on these reimbursements. Legislation passed in 2012, modified the Boards statutory authority removing the concept of a base and allowing the Board to set the Medicare Part B reimbursement amount at a level they deemed fiduciary responsible. As of the December 31, 2012 (the most recent actuarial valuation), the average age of OPERS' retirees was 69. In 2012, the Board of Trustees also passed changes to the health care plan design known as the Health Care Preservation Plan 3.0, increasing the age and service required for eligibility in the health care plan and phasing out the Medicare Part B reimbursement. The health care plan design includes a transition plan that will ultimately result in the elimination of these Medicare B expenses.

Six-Year History of Health Care Expenses By Type



Source: *2013 Comprehensive Annual Financial Report*
*Includes Medical, Disease Management, Wellness, Dental and Vision (OPERS receives member contributions for Dental and Vision).

**2010 Post-employment 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 Medical Benefits Payable. This liability fluctuates from year to year based on changes in the claims experience.

OPERS has consistently managed its Administrative Expense budget with no material variances between planned and actual expenditures in either 2013 or 2012. Total Administrative Expenses include both Investment Administrative Expenses and Non-Investment Administrative Expenses.

Administrative expenses for the Post-employment health care plan, excluding investment expenses, totaled $16.4 million in 2013 compared to $15.2 million in 2012. The increase in 2013 administrative expenses was primarily related to an increase in staff time and IT resources required for the implementation of health care plan changes.

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 Sections145.325 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 2013. Both sections were amended by Sub. S.B. 343, effective January 7, 2013.

2 A summary of coverage for 2013

The following is an outline of OPERS health care coverage in 2013:

The 2013 OPERS Retiree Health Plan for non-Medicare participants

The 2013 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 2013. 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 both Medicare Part A and 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 2013 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 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 2013, 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 2013, Medication Therapy Management was made available for eligible participants.

OPERS Medicare Part D prescription plan— In 2013, 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 2013:

- 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 2013, 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.

The Long-Term Care Plan

The voluntary long-term care plan, administered by Prudential, is a program in which currently enrolled OPERS participants are covered by the protection from the expense of long-term care. OPERS does not subsidize this plan.

This plan is designed to cover those long-term care expenses not covered by the basic hospital or medical coverage (such as custodial care), including Medicare. The intent is to provide daily cash benefits when the insured is no longer able to independently perform the activities of daily living. This plan no longer accepts any new enrollments as of July 2013, however, any plan participant enrolled prior to this date will remain covered.

3 A summary of the eligibility requirements for health care coverage in 2013:
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 2013:

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 January 29, 1981; service credit granted under a retirement incentive plan; or exempt service purchased after May 4, 1992.

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 in 2013.

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, 2013, 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 real estate, private equity and hedge funds are valued based on closing market prices or broker quotes. Securities not having a quoted market price have been valued based on yields currently available on comparable securities of issuers with similar credit ratings. The fair value of real estate investments is based on estimated current values and independent appraisals. The fair value of private equity is based on management's valuation of estimates and assumptions from information and representations provided by the respective general partners, in the absence of readily ascertainable market values. The fair value of hedge funds is based on a net asset value which is struck by the fund or by the fund's third party administrator.

Member (pension deductions and direct-billed premiums), employer contributions and investment earnings are used to fund health care expenses. Employer contributions equal to 1% of covered payroll were credited to the health care fund for the period of January 1, 2013 through December 31, 2013. 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. 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, in addition to implementation of the Health Care Preservation Plan 3.0 and changes in assumptions, resulted in an increase in the solvency years from 10 to an indefinite period as of the December 31, 2012 valuation.

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.** No significant accounting changes affect this report. However, see description of plan changes in previous sections.

10 **A statement of the amount paid under division (C) of section 145.58 of the Revised Code.** OPERS paid approximately $112.8 million in Medicare Part B premiums to its benefit recipients in 2013.

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 ten 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.

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 program 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.

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 benefits, or any combination thereof, for eligible individuals receiving age and service retirement or a disability or survivor benefit subscribing to the plan, or for OPERS retirants employed under section 145.38 of the Revised Code, for coverage of benefits in accordance with division (C)(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 benefits 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, payment, or benefit provided under this section or section 145.584 of the Revised Code with any similar coverage, payment, or benefit 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)

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, 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. This coverage 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. The widow or widower of a retirant or disability benefit recipient shall be eligible for such coverage 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 for the spouse may be paid from the appropriate funds of the public employees retirement system. The remainder of the cost shall be paid by the recipient of the allowance or benefit.

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

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

Appendix D—Statements of Fiduciary Net Position—Health Care

	2013	2012	2011*	2010*	2009	2008
Assets						
Cash and Short-Term Investments	**$491,371,340**	**$446,851,345**	**$516,841,401**	**$673,728,399**	**$82,384,335**	**$214,267,049**
Receivables:						
Members' and Employers'	19,417,032	43,429,976	51,989,914	62,635,516	70,351,872	99,321,334
Early Retirement Incentive Plan	64,600	177,884	773,991	2,183,860	3,185,825	344,045
Vendor and Other	147,929,032	147,616,824	67,535,218	133,916,383	49,921,976	57,775,901
Investment Sales Proceeds	75,148,940	261,962,739	185,275,974	135,342,122	884,914,266	57,319,401
Accrued Interest and Dividends	47,924,681	47,650,966	49,585,342	49,049,361	37,732,716	46,426,349
Total Receivables	**290,484,285**	**500,838,389**	**355,160,439**	**383,127,242**	**1,046,106,655**	**261,187,030**
Investments, at fair value:						
Fixed Income	4,313,177,166	4,731,050,357	4,349,713,914	4,355,743,585	3,746,406,051	4,363,406,922
Domestic Equities	3,594,242,223	3,293,138,146	3,642,820,108	3,950,499,244	3,806,887,666	2,731,493,461
Private Equity	110,263,964	73,443,686	54,927,514	27,877,976	39,341,186	5,150,008
International Equities	3,333,565,455	3,506,799,272	3,310,599,792	3,649,437,854	2,974,380,740	2,201,764,403
Other Investments	1,159,221,629	563,094,682	134,339,269	27,740,509		
Total Investments	**12,510,470,437**	**12,167,526,143**	**11,492,400,597**	**12,011,299,168**	**10,567,015,643**	**9,301,814,794**
Collateral on Loaned Securities				**1,517,578,594**	**299,502,780**	**2,297,927,070**
Capital Assets:						
Land	729,981	729,981	665,394	665,394	665,394	665,394
Building and Building Improvements	21,476,205	21,737,564	19,627,154	19,641,200	19,660,159	19,663,497
Furniture and Equipment	26,907,290	24,688,709	24,809,991	22,850,746	20,582,082	17,141,828
Total Capital Assets	49,113,476	47,156,254	45,102,539	43,157,340	40,907,635	37,470,719
Accumulated Depreciation	(24,246,817)	(20,530,484)	(18,156,668)	(16,294,444)	(13,530,325)	(11,267,149)
Net Capital Assets	**24,866,659**	**26,625,770**	**26,945,871**	**26,862,896**	**27,377,310**	**26,203,570**
TOTAL ASSETS	**13,317,192,721**	**13,141,841,647**	**12,391,348,308**	**14,612,596,299**	**12,022,386,723**	**12,101,399,513**
Liabilities:						
Undistributed Deposits	146,606	69,659	62,273	80,073	52,974	52,974
Medical Benefits Payable	90,019,865	100,495,333	118,529,285	142,952,643	134,007,772	131,776,992
Investment Commitments Payable	99,797,215	194,165,994	294,572,622	253,257,695	163,153,464	69,811,443
Accounts Payable RMA Claims	15,544,228	18,485,339	19,183,817	16,114,872	10,474,459	5,748,957
Obligations Under Securities Lending				1,517,578,594	299,502,780	2,297,927,070
TOTAL LIABILITIES	**205,507,914**	**313,216,325**	**432,347,997**	**1,929,983,877**	**607,191,449**	**2,505,317,436**
Net Position Held in Trust for Post-Employment Health Care as Restated	**$13,111,684,807**	**$12,828,625,322**	**$11,959,000,311**	**$12,682,612,422**	**$11,415,195,274**	**$9,596,082,077**

Source: 2013 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.

Appendix E—Statements of Changes in Fiduciary Net Position—Health Care

	2013	2012	2011*	2010**	2009	2008
Additions:						
Members' Contributions	$178,140,822	$159,614,898	$148,370,246	$111,638,313	$94,370,543	$82,695,255
Employers' Contributions	120,056,440	494,048,415	503,458,216	628,685,237	740,817,891	891,561,073
Contract and Other Receipts	126,941,889	94,730,390	89,087,996	83,572,868	58,649,547	66,343,542
Federal Subsidy	105,965,762	182,579,917	192,118,407	142,658,293	69,132,772	63,310,194
Other Income, Net	13,483,861	11,774,199	10,915,043	7,163,609	654,031	614,989
Total Non-Investment Income	**544,588,774**	**$942,747,819**	**943,949,908**	**$973,718,320**	**963,624,784**	**1,104,525,053**
Income/ (Loss) from Investing Activities:						
Net Appreciation / (Depreciation) in Fair Value	1,106,685,064	1,183,656,950	(401,560,941)	1,240,024,373	2,081,098,064	(3,734,049,668)
Bond Interest	116,748,678	201,317,018	202,859,266	137,927,458	152,358,418	182,944,355
Dividends	206,180,289	183,422,898	134,235,895	134,809,505	134,487,014	139,099,121
International Income / (Loss)	(4,659)	10,894	(92,053)	48,675	52,944	552,901
Other Investment Income / (Loss)	13,183,549	10,861,876	3,671,640	3,778,346	661,628	147,998
External Asset Management Fees	(40,036,389)	(24,118,062)	(13,648,040)	(10,904,604)	(7,709,148)	(8,674,498)
Net Investment Income / (Loss)	1,402,756,532	1,555,151,574	(74,534,233)	1,505,683,753	2,360,948,920	(3,419,979,791)
From Securities Lending Activity:						
Security Lending Income				14,236,338	2,336,740	103,004,243
Security Lending Expenses				(4,259,969)	(562,862)	(79,967,808)
Net Security Lending Income				9,976,369	1,773.878	23,036,435
Unrealized Loss					(2,396,132)	
Net Income/(Loss) from Securities Lending				**9,976,369**	**(622,254)**	**23,036,435**
Less: Investment Administrative Expenses	(5,407,709)	(5,180,680)	(4,389,394)	(4,495,158)	(3,771,803)	(3,703,986)
Net Income / (Loss) from Investing Activity	**1,397,348,823**	**1,549,970,894**	**(78,923,627)**	**1,511,164,964**	**2,356,554,863**	**(3,400,647,342)**
TOTAL ADDITIONS	**1,941,937,597**	**2,492,718,713**	**865,026,281**	**2,484,883,284**	**3,320,179,647**	**(2,296,122,289)**
Deductions:						
Health Care Benefits	1,642,525,598	1,607,921,528	1,575,561,578	1,567,551,611	1,488,032,855	1,377,146,173
Administrative Expenses	16,352,514	15,172,174	13,076,814	12,782,968	13,033,595	13,596,943
TOTAL DEDUCTIONS	**1,658,878,112**	**1,623,093,702**	**1,588,638,392**	**1,580,334,579**	**1,501,066,450**	**1,390,743,116**
Net Increase/ (Decrease)	283,059,485	869,625,011	(723,612,111)	904,548,705	1,819,113,197	(3,686,865,405)
Net Position Held in Trust for Post-employment Health Care Balance, Beginning of Year, as Restated	12,828,625,322	11,959,000,311	12,682,612,422	11,415,195,274	9,596,082,077	13,282,947,482
BALANCE, END OF YEAR	**$13,111,684,807**	**$12,828,625,322**	**$11,959,000,311**	**$12,319,743,979**	**$11,415,195,274**	**$9,596,082,077**

Source: 2013 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.

**2010 restated for reclassification of Early Retirement Reinsurance Program from Contracts and Other Receipts to Federal Subsidies and the reclassification of the 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 Medical Benefits Payable. This liability fluctuates from year to year based on changes in the claims experience.

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