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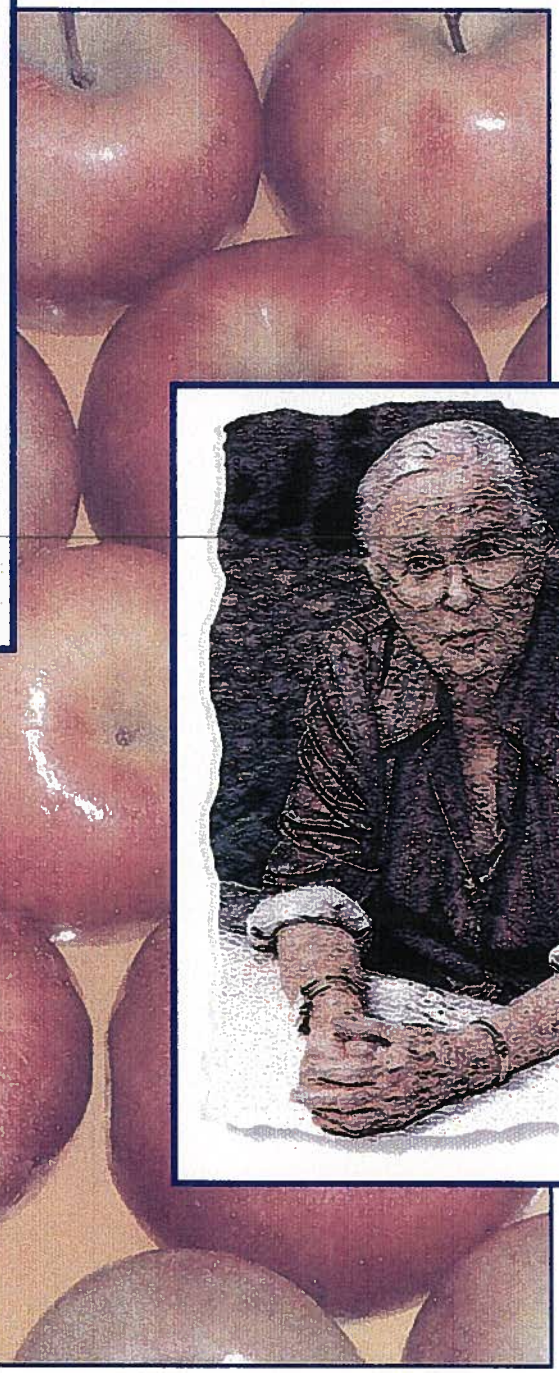
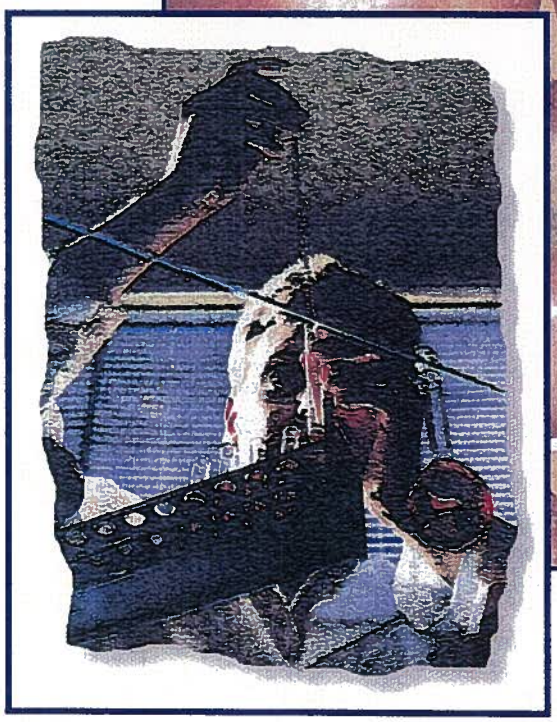
Annual Health Care Report





December, 1999

School Employees Retirement System
Annual Health Care Report

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Sec. 3309.49 Employer's contribution rate.

Each employer shall pay annually to the employers' trust fund an amount certified by the secretary that shall be a certain per cent of the earnable compensation of all employees, and shall be known as the "employer contribution." The rate per cent of such contribution shall be fixed by the actuary on the basis of his evaluation of the liabilities of the school employees retirement system, but shall not exceed fourteen per cent, and shall be approved by the school employees retirement board. The school employees retirement board may raise the rate per cent of the contribution to fourteen per cent of the earnable compensation of all employees. In making such evaluation, the actuary shall use, as the actuarial assumptions, regular interest and such mortality and other tables as are adopted by the school employees retirement board. He shall compute the percentage of such earnable compensation, to be known as the "employer rate," required annually to fund the liability for all allowances, annuities, pensions and other benefits, and any deficiencies in the various funds, provided for in this chapter, after deducting therefrom the annuity and other benefits provided by the contributor's accumulated contributions and deposits or other applicable moneys.

Eff. 6/30/91; H.B. 382

Sec. 3309.491 Minimum compensation amount, employer minimum compensation contribution.

(A) An actuary employed by the school employees retirement board shall annually determine the minimum annual compensation amount for each member that will be needed to fund the cost of providing future health care benefits under section 3309.69 of the Revised Code. The amount determined by the actuary under this division shall be approved by the board and shall be known as the "minimum compensation amount."

(B) For each member whose compensation for the prior year was less than the minimum compensation amount, the secretary of the school employees retirement board shall annually determine and certify to the member's employer the "employer minimum compensation contribution," which shall be the amount determined as follows:

(1) Subtract the member's compensation for the prior year from the minimum compensation amount;

(2) Multiply the remainder obtained under division (B)(1) of this section by one, or if the member earned less than a year's service credit for the prior year, by the same fraction as the fraction of a year's service credit credited to the member under section 3309.30 of the Revised Code.;

(3) Multiply the product obtained under division (B)(2) of this section by the employer contribution rate in effect for the year the service credit was earned.

(C) In addition to the employer contribution required by section 3309.49 of the Revised Code, each employer shall pay annually to the employer's trust fund the total of the amounts certified to the employer under division (B) of this section.

Annually by the first day of August, the secretary shall submit to the superintendent of public instruction a list of the payments made by each employer under this division during the preceding fiscal year.

Eff. 9/9/88

Sec. 3309.375 Hospital insurance coverage for retirants.

(A) Except as otherwise provided in division (B) of this section, the board of the school 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. Not less than twenty-five per cent of the cost for such coverage shall be paid from the appropriate funds of the school employees retirement system and the remainder 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 sections 3309.49 and 3309.51 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 3309.69 of the Revised Code.

Notwithstanding sections 3309.49 and 3309.51 of the Revised Code, the employer's contribution rate shall not be increased until July 1, 1969, or later to reflect the increased costs created by this section.

(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 3309.69 of the Revised Code from paying or reimbursing the cost of such insurance.

Eff. 7/29/92; S.B. 346 6/30/91; H.B. 382

Section 3309.69 Group hospitalization coverage; ineligible individuals; service credit; alternative use of health insuring corporation

(A) As used in this section, "ineligible individual" means all of the following:

(1)A former member receiving benefits pursuant to section 3309.34, 3309.35, 3309.36 3309.38, or 3309.381 of the Revised Code for whom eligibility is established more than five years after June 13, 1981, and who, at the time of establishing eligibility, has accrued less than ten years of service credit, exclusive of credit obtained after January 29, 1981, pursuant to sections 3309.021, 3309.301, 3309.31, and 3309.33 of the Revised Code;

(2) The spouse of the former member;

(3) The beneficiary of the former member receiving benefits pursuant to section 3309.46 of the Revised Code.

(B) The school employees retirement board may enter into an agreement 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 those individuals receiving service retirement or a disability or survivor benefit subscribing to the plan and their eligible dependents.

If all or any portion of the policy or contract premium is to be paid by any individual receiving service retirement or a disability or survivor benefit, the person shall, by written authorization, instruct the board to deduct the premiums agreed to be paid by the individual to the companies, corporations, or agencies.

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 school employees retirement system. The cost paid from the funds of the system shall be included in the employer's contribution rate provided by sections 3309.49 and 3309.491 of the Revised Code. The board shall not pay or reimburse the cost for health care under this section or section 3309.375 of the Revised Code for any ineligible 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 the rules of the board.

(C) If the board provides health, medical, hospital, or surgical benefits through any means other than a health insuring corporation, it shall offer to each individual eligible for the benefits the alternative of receiving benefits through enrollment in a health insuring corporation, if all of the following apply:

(1) The health insuring corporation provides health care services in the geographical area in which the individual lives;

(2) The eligible individual was receiving health care benefits through a health maintenance organization or a health insuring corporation before retirement;

(3) The rate and coverage provided by the health insuring corporation to eligible individuals is comparable to that currently provided by the board under division (B) of this section. If the rate or coverage provided by the health insuring corporation is not comparable to that currently provided by the board under division (B) of this section, the board may deduct the additional cost from the eligible individual's monthly benefit.

The health insuring corporation shall accept as an enrollee any eligible individual who requests enrollment.

The board shall permit each eligible individual to change from one plan to another at least once a year at a time determined by the board.

(D) The board shall, beginning the month following receipt of satisfactory evidence of the payment for coverage, make a monthly payment to each recipient of service retirement, or a disability or survivor benefit under the school employees retirement system who is eligible for insurance coverage under part B of "The Social Security Amendments of 1965," 79 Stat. 301, 42 U.S.C.A. 1395j, as amended, except that the board shall make no such payment to any ineligible individual. effective on the first day of the month after the effective date of this amendment, the amount of the payment shall be the lesser of an amount equal to the basic premium for such coverage, or an amount equal to the basic premium in effect on January 1, 1992.

(E) The board shall establish by rule requirements for the coordination of any coverage, payment, or benefit provided under this section or section 3309.375 of the Revised Code with any similar coverage, payment, or benefit made available to the same individual by the public employees retirement system, police and firemen's disability and pension fund, state teachers retirement system, or state highway patrol retirement system.

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

Eff. 12/8/98; Sub. H.B. 673 6/4/97; S.B. 67 3/6/97; Am. Sub. S.B. 82
7/29/92; S.B. 346 6/30/91; H.B. 382 5/4/92; H.B. 383

Sec. 3309.691 Long term health care programs.

The school employees retirement board shall establish a program under which members of the retirement system, employers on behalf of members, and persons receiving service, disability or survivor benefits are permitted to participate in contracts for long-term health care insurance. Participation may include dependents and family members. If a participant in a contract for long-term care insurance leaves employment, the participant and the participant's dependents and family members may, at their election, continue to participate in a program established under this section in the same manner as if the participant had not left employment, except that no part of the cost of the insurance shall be paid by the participant's former employer.

Such program may be established independently or jointly with one or more of the other retirement systems. For purposes of this section, "retirement systems" has the same meaning as in division (A) of section 145.581 of the Revised Code.

The board may enter into an agreement with insurance companies, health insuring corporations, or government agencies authorized to do business in the state for issuance of a long-term care insurance policy or contract. However, prior to entering into such agreement with an insurance company or health insuring corporation, the board shall request the superintendent of insurance to certify the financial condition of the company or corporation. The board shall not enter into the agreement if, according to that certification, the company or corporation is insolvent, is determined by the superintendent to be potentially unable to fulfill its contractual obligations, or is placed under an order of rehabilitation or conservation by a court of competent jurisdiction or under an order of supervision by the superintendent.

The board shall adopt rules in accordance with section 111.15 of the Revised Code governing the program. The rules shall establish methods of payment for participation under this section, which may include establishment of a payroll deduction plan under section 3309.27 of the Revised Code, deduction of the full premium charged from a person's service, disability or survivor benefit, or any other method of payment considered appropriate by the board. If the program is established jointly with one or more of the other retirement systems, the rules also shall establish the terms and conditions of such joint participation.

Eff. 6/4/97; S.B. 67 7/1/93; H.B. 152 10/29/91; H.B. 180

Sec. 3309.70 Overpayment of benefit; recovery.

If a member, former member, contributor, former contributor, retirant, or beneficiary is paid any benefit by the school employees retirement system to which he is not entitled, the benefit shall be repaid to the retirement system by him. If he fails to make the repayment, the retirement system shall withhold the amount due from any benefit due him or his beneficiary under this chapter, or may collect the amount in any other manner provided by law.

Eff. 7/29/92; S.B. 346

Section 3305.01 Alternative Retirement Plans-Definitions.

As used in this chapter:

(A) "Public institution of higher education" means a state university as defined in section 3345.011 of the Revised Code, the medical college of Ohio at Toledo, the northeastern Ohio universities college of medicine, or a university branch, technical college, state community college, community college, or municipal university established or operating under Chapter 3345., 3349., 3355., 3357., or 3358. of the Revised Code.

(B) "State retirement system" means the public employees retirement system created under Chapter 145. of the Revised Code, the state teachers retirement system created under Chapter 3307. of the Revised Code, or the school employees retirement system created under Chapter 3309. of the Revised Code.

(C) "Academic or administrative employee" means any full-time employee who is a member of the faculty or administrative staff of a public institution of higher education serving in a position in the unclassified civil service pursuant to section 124.11 of the Revised Code and is not receiving any benefit, allowance, or other payment from a state retirement system. In all cases of doubt, the board of trustees of the public institution of higher education shall determine whether any person is an academic or administrative employee for purposes of this chapter, and the board's decision shall be final.

(D) "Electing employee" means any academic or administrative employee who elects, pursuant to section 3305.05 of the Revised Code, to participate in an alternative retirement plan provided pursuant to this chapter.

(E) An electing employee is "continuously employed" if no more than one year intervenes between each period of employment by a public institution of higher education in a position for which three or more alternative retirement plans are available under this chapter.

(F) "Compensation," for purposes of an electing employee, has the same meaning as the applicable one of the following:

(1) If the electing employee would be subject to Chapter 145. of the Revised Code had the employee not made an election pursuant to section 3305.05 of the Revised Code, "earnable salary" as defined in division (R) of section 145.01 of the Revised Code;

(2) If the electing employee would be subject to Chapter 3307. of the Revised Code had the employee not made an election pursuant to section 3305.05 of the Revised Code, "compensation" as defined in division (U) of section 3307.01 of the Revised Code;

(3) If the electing employee would be subject to Chapter 3309. of the Revised Code had the employee not made an election pursuant to section 3305.05 of the Revised Code, "compensation" as defined in division (V) of section 3309.01 of the Revised Code.

3309-1-35 Health care and medicare "B".

(A) As used in this rule:

(1) "Ineligible person" has the same meaning as in section 3309.69 of the Revised Code.

(2) "Member" has the same meaning as in section 3309.01 of the Revised Code.

(3) "Age and service retirant" means a former member who is receiving a retirement allowance pursuant to section 3309.34, 3309.35, 3309.36 or 3309.381 of the Revised Code.

(4) "Disability benefit recipient" means a member who is receiving a benefit or allowance pursuant to section 3309.35, 3309.40 or 3309.41 of the Revised Code.

(5)"Child" means an unmarried, biological, adopted or step-child of the retirant, member, deceased retirant or deceased member or other child who lives or lived with the retirant, member, deceased retirant or deceased member in a parent-child relationship in which the retirant, member, deceased retirant or deceased member has or had custody of the child.

(6) "Dependent child" means a child who:

(a) (i) Is under age eighteen or under age twenty-two if attending an institution of learning or training pursuant to a program designed to complete in each school year the equivalent of at least two-thirds of the full-time curriculum requirements of such institution, or

(a) (ii) Regardless of age is physically or mentally incompetent, provided that the incompetency existed prior to the retirant's or member's death and prior to the dependent child reaching age eighteen or age twenty-two if attending an institution of learning or training pursuant to a program designed to complete in each school year the equivalent of at least two-thirds of the full-time curriculum requirement of such institution, and

(b) During the twelve-month period preceding the application for health care coverage or the member or retirant's death, lived with the member or retirant in a parent-child relationship or received at least one-half of his/her support from the member, retirant, deceased member or deceased retirant.

(7) "Health care coverage" means the plan offered by the system including, but not limited to, the medical plan, the prescription drug program, and the medicare part "B" premium reimbursement.

(B) Any person who is not an "ineligible person" as defined in section 3309.69 of the Revised Code, is eligible for health care coverage under the system's health care plan so long as the person qualifies as one of the following:

(1)An age and service retirant or his/her spouse or dependent child,

(2)A disability benefit recipient or his/her spouse or dependent child,

(3)The spouse or dependent child of a deceased age and service retirant or disability benefit recipient, if the spouse or dependent child is receiving a benefit pursuant to section 3309.45 or 3309.46 of the Revised Code,

(4)The dependent child of a deceased member or deceased retirant who is living with the primary recipient of a benefit under section 3309.45 or 3309.46 of the Revised Code in a parent-child relationship in which the primary recipient has custody of the dependent child.

(C) The effective date of health care coverage for persons eligible for health care coverage as set forth in paragraph (B) of this rule shall be as follows:

(1) Disability benefit recipient, spouse or dependent child of a disability benefit recipient - health care coverage shall begin on the first of the month following approval of the benefit or the benefit effective date, whichever is later.

(2) Age and service retirant, spouse or dependent child of an age and service retirant - health care coverage shall begin on the first of the month following the date that the retirement application is filed with the school employees retirement system or the benefit effective date, whichever is later.

(3) Eligible spouse or dependent child of a deceased member or deceased retirant – health care coverage shall begin on the effective date of the benefit if the appropriate application is received within three months of the date of the member's or retirant's death, or the first of the month following the date that the appropriate application is received if not received within three months of the date of the member's or retirant's death.

(4) Eligibility for health care shall terminate when the person ceases to qualify as one of the persons listed in paragraph (B) of this rule.

(5) After waiver of coverage - health care coverage approved after waiver as provided in paragraph (D) of this rule or rule 3309-1-55 of the Administrative Code shall begin on the first of the month following the date that the application for health care is approved.

(D) An age and service retirant or disability benefit recipient may waive health care coverage and such waiver is effective during the age and service retirant's or disability benefit recipient's lifetime as to both the retirant or benefit recipient and his/her dependents. The waiver is irrevocable except as follows:

(1) Within thirty-one days of reaching age sixty-five, an age and service retirant or disability benefit recipient may apply for health care coverage; or

(2) Within thirty-one days of termination of coverage under another group plan, and with proof of such termination, an age and service retirant or disability benefit recipient may apply for health care coverage.

Upon the death of an age and service retirant or disability benefit recipient, the recipient of a benefit has the same option as to waiving the health care coverage.

(E) The effective date of the medicare "B" premium to be paid by the board shall be:

(1) January 1, 1977; or

(2) The first of the month following the date that the retirant or benefit recipient first began payment of the premium as documented by proof satisfactory to the school employees retirement system; or

(3) The effective date of SERS health care coverage, whichever is later.

(F) (1) The board shall not pay more than one monthly medicare "B" premium when a retirant or benefit recipient is receiving more than one monthly benefit from this system.

(2) The board shall not pay a medicare "B" premium to a retirant or benefit recipient who

is receiving reimbursement for this premium from the highway patrol retirement system, the police and firemen's disability and pension fund, the public employees retirement system and/or the state teachers retirement system.

Effective Date: 11/9/98

Promulgated under: R.C. 111.15

Authorized by: R.C. 3309.04

Rule amplifies: R.C. 3309.69

Prior effective date: 8/10/98;1/2/93; 7/20/89; 3/20/80; 1/1/77

Rule review date: 2/1/2003

3309-1-51 Long-Term Care Coverage.

(A) The School Employees Retirement System may contract directly with an insurer to establish a program that provides contracts for long-term care insurance for members and benefit recipients of the system and members of their families. If the program is established jointly with another retirement system, the contract shall separately establish the terms and conditions for participation through the School Employees Retirement System.

(B) Members of the School Employees Retirement System who have contributed to the system during the previous eighteen months may make application to participate in contracts effective on and after July 1, 1994 for long-term care coverage offered pursuant to section 3309.691 of the Revised Code, provided:

(1) Application for coverage shall be made directly to the insurer during enrollment periods specified by the School Employees Retirement System; and

(2) Determination of eligibility for participation under the terms of any such contract shall be made by the insurer with approval of the School Employees Retirement System.

(C) The recipient of any monthly benefit may participate in contracts for longterm care coverage, subject to the same conditions as those applicable to members under the terms of paragraph (B) of this rule.

(D) Payment for coverage shall be made by the member or benefit recipient to the insurer in such amounts and by such methods approved by the School Employees Retirement System.

(E) A spouse, parent or parent-in-law of any individual who has made application pursuant to paragraph (B) or (C) of this rule may apply for coverage subject to the sanne terms and conditions as those applicable to members under the terms of paragraph (B) of this rule, provided that in the case of a spouse, the individual participating pursuant to paragraph (B) or (C) of this rule agrees to remit the cost of such coverage along with his or her own payment.

Effective: June 10, 1994

Promulgated Under: R.C. 1 11. 15

Authorized By: R.C. 3309.04

Rule Amplifies: R.C. 3309.691

HEALTH CARE HISTORY

1962, August - Blue Cross/Blue Shield

1968, October - Medicare B (medical) Deduction

Voluntary premium deduction from a benefit recipient's retirement benefit for their and/or their spouse's Medicare B coverage and forwarded monthly to the Medicare Payment Center.

1974, January - Benefit Recipient Cost-Free Blue Cross/Blue Shield

Voluntary enrollment for Blue Cross/Blue Shield coverage paid for by SERS for the benefit recipient. Premium required to cover eligible dependents.

1974, July - Blue Cross/Blue Shield program replaced.

Aetna replaced the Blue Cross/Blue Shield Program in July; all benefit recipients enrolled with no cost coverage. Eligible dependents were covered. $20,000 maximum lifetime benefit per covered person for hospital and medical benefits established. Coordination of benefits insures that total claim payment does not exceed total cost when individual is covered by more than one health care plan.

1975, July - Maximum lifetime benefit increased to $250,000.

Kaiser HMO offered to benefit recipients and dependents in Cleveland area.

1977, January - Medicare Part B (medical) Reimbursement

SERS begins reimbursing benefit recipients for the cost of Medicare Part B premiums.

1978, January - Filing Date Limitation - Provider Edits

Two-year limitation on liability for health care claims established; Problem Provider edits implemented - edits identify providers who consistently charge in excess of reasonable/ customary amounts.

1980, February - Hospital Audits

On-site hospital billing audit program implemented by Aetna; all hospital bills over $15,000 and bills with ancillary charges greater than 70% of total bill are audited by Aetna staff.

1981, February - Increased Aetna Maximum

Annual lifetime maximum increased to $500,000;

1981, March - Mail Order Drug Plan Introduced

Mail order prescription drug program introduced through National Rx Services, Inc. 90-day supply of prescription drugs for $1 retiree copay;

1981, June - 10 years of Service Credit required for Health Care Eligibility

H.B. 126 establishes 10 years of service credit as minimum required for health care benefits, to become effective June, 1986;

1981, July - Aetna Individual Case Management

Aetna implements individual case management to provide cost-effective alternative treatments;

1981, July - Aetna Split Funded Agreement

Replaced traditional indemnity-type insurance program with Split-Funded program. Split-funded arrangement permits detailed analysis of health care expenses and better control of claim processing costs. Reserves previously held by insurance company transferred to SERS; Health Care Reserve account established to receive funds. Separate accounting insures no commingling of funds accumulated to provide health care benefits with funds accumulated to provide basic retirement benefits.

1982, May - Fraud Investigation

Aetna investigators who review and document potential cases of fraud identified through claim processors, complaints, government agencies, audits, employers and other sources.

1982, December - Disclosure of Health Care Liabilities

SERS becomes first Ohio retirement system to publicly disclose long-term actuarial accrued liabilities of retiree health care. Employer contribution rate required for health care funding is determined by actuary; annual transfer of assets (based on this actuarially-determined rate) to Health Care Reserve account initiated.

1982, December - Health Care Questionnaire

Health care questionnaire mailed to all retirees soliciting ideas for reducing health care costs and opinion regarding six cost containment proposals currently being considered by retirement board.

1983, July - Premiums Established

Premium charges for spouse and dependent insurance coverage implemented; annual program deductible established.

1984, July - Reasonable/Customary Fees Enforced by Aetna

The reasonable and customary fee is the prevailing fee for the same service or supply in the same geographic area, by those of similar professional standing.

1984, September - Special Health Care Task Force

Special Task Force meeting organized by SERS. Representatives from member and employer organizations, Retirement Study Commission, health care providers, actuaries and accountants meet to study SERS' increasing health care costs. Panel members given actuarial estimate of potential tripling of health care costs by 1992 if effective cost containment measures were not implemented.

1985, January - Increase in Deductibles and Copays

50% increase in annual deductible and 100% increase in per-prescription retiree cost of mail order drug program implemented.

1985, July - Hospice Care Benefits provided.

Covers charges for services rendered to a terminally ill patient as part of a Hospice Care Program. A terminally ill patient is a person who has received from a physician a medical prognosis of six months or less to live.

1986, March - Warning from Actuary regarding Health Care Financing

Actuary informs retirement board that health care program costs can no longer be funded on a level cost basis with current employer contribution rate; continued level cost funding of basic retirement benefits in peril.

1986, March - Health Care Seminar

Two-day Health Care Seminar, sponsored by Ohio Retirement Systems. The seminar was attended by members of all five retirement boards, the Chairman and members of Ohio Retirement Study Commission, executive directors and key staff members of all retirement systems and actuaries and auditors of some systems. Featured speakers included former chief actuary of the Social Security Administration and CEOs of health insurance and benefits consulting firms.

1986, June - Implementation of Service Credit Requirement

Effective June 13, 1986, Ohio law now requires minimum of 10 years of service to qualify for health care benefits.

1986, July - Hospital Admission Charge introduced.

Separate $50 retiree charge for hospital admission instituted;

1986, October - H.B. 1060 introduced

Among other provisions, legislation would freeze Medicare Part "B" reimbursement, change the definition of a "year" of service credit and establish an employer surcharge on low salaries.

1987, September - New HMOs Introduced

Kaiser Plus and United Health Plan HMOs introduced;

1987, December - GASB Statement Number 5 Implemented

Early adoption of Governmental Accounting Standards Board Statement No. 5 - although not required to do so, SERS chooses to disclose health care liabilities as part of Pension Benefit Obligation to draw attention to long-term nature of health care financing problem.

1987, December - Independent Actuarial Review of Health Care

Retirement board authorizes engagement of independent actuarial firm to project health care program costs and propose alternative courses of action to contain future costs.

1987, December - Precertification and Second Surgical Opinions

Hospital pre-certification and second surgical opinions required for retirees and dependents not eligible for Medicare;

1987, December - H.B. 290 introduced.

Additional board action promised on passage. Health care provisions of legislation and board action:

a) establish "career" vesting of health care benefits - 25 years of service required for full benefit subsidy. Benefit subsidy established at 25% (10-14 years), 50% (15-19 years) and 75% (20-24 years);

b) 40% reduction of System's subsidy of dependent health care premiums, to be phased-in over five years;

c) freeze Medicare Part "B" reimbursement at current level;

d) establish 80%/20% relationship between System costs and retiree costs of mail order drug program;

e) establish an employer surcharge (additional employer contribution) on members who earn less than an actuarially-determined minimum salary; the surcharge revenues to be used exclusively for funding health care benefits;

1988, June - H.B. 290 becomes law;

1988, June - Medicare Direct Program Offered

Medicare-direct program offered to SERS retirees, over 23,000 retirees and dependents enroll in program;

1988, October - Deductibles and Copays Increased

Aetna deductible increased 67%, retiree cost of mail order drug program increased 200%;

1988, November - Prototype Prescription Card Program Tested

Testing of card-based program for dispensing of prescription drugs at retail level begins in Cuyahoga and Richland counties;

1988, December - Actuarial Report confirms effectiveness.

Actuary informs SERS that, as a result of H.B. 290 and other cost containment efforts, level-cost funding of health care benefits has been restored;

1989, October - Mail Order Drug Copay Increased

Retiree co-payment for mail order drugs increased 33%, in accordance with 80/20 funding of mail order drug program instituted in 1987;

1989, December - Major Modifications to Mail Order Drug Program Approved

Retirement board approves significant changes to retiree costs under mail order prescription drug program, to be implemented in early 1990;

1990, April - Implementation of Mail Order Drug Program Modifications

Mail order drug program modified to encourage use of lower-cost generic drugs; retiree cost of brand name drugs increased 25%, retiree cost of generic drugs eliminated - projected 1-year savings of modification = $1 million or 6%-7% of total mail order program costs;

1990, March - Health Care Seminar Sponsored

Ohio Retirement Systems sponsors intensive two-day health care seminar. Members of retirement boards, executive directors, senior management and insurance personnel from all five retirement systems and Ohio Retirement Study Commission members and staff in attendance. Featured speakers include actuaries, physicians, insurance company executives, director of pension system outside Ohio and Ohio member of U.S. House of Representatives.

1990, May - Retail Drug Program Introduced

Retail drug program implemented; program permits significant discounts for drugs dispensed at retail level and electronic filing of retirees' prescription drug claims;

1991, March - Health Care Seminar

ORS sponsors another in a series of health care seminars intended to inform O.R.S.C., retirement boards, and key legislators responsible for health care legislation of current and proposed direction of retiree health care programs offered by ORS.

1991, February - Expansion of Medicare Direct Program

Medicare Direct expanded into the state of Florida.

1991, April - Mail-order drug copays to be maintained.

Generic drug utilization increased by 33%, as the result of the SERS Board's actions of April, 1990. No retiree increase in overall cost of SERS mail-order drug program is necessary (first time since 1987.)

1991, August - Expansion of Medicare Direct Program

Medicare Direct expanded into all other participating states.

1991, November - Hospital Discount Program

Aetna (in conjunction with SERS) begins program to negotiate lower rates for hospital confinements of SERS/Aetna health plan participants.

1992, February - Increased utilization of generic drugs permits copay freeze.

For the second year in a row, because of increased generic drug utilization, no increase in the retiree's cost of mail-order drugs is necessary.

1992, March - Managed Care Seminar

Other Ohio retirement systems join SERS in sponsoring a managed care workshop.

1992, May - Hospital Discount Program expanded

The Aetna/SERS hospital discount program adds nine more Ohio hospitals granting discounts to SERS retirees and their dependents.

1992, June - Medicare Direct Program Expanded

Medicare Direct expanded to all recipients of Medicare through Railroad Retirement.

1992, October - Health Care Report reviewed by Board

Board is presented report of the future of SERS health care program. Reasons for rising costs are analyzed and short-term solutions to problems are proposed. Board begins work on its' health care cost management strategy.

1993, February - SERS reports Board decision on managed care.

Article 'SERS Studies Managed Care' published in February, 1993 issue of Focus on Retirees. Proposed July, 1993 managed care implementation date announced. Numerous comments received from interested retirees.

1993, February - Increased utilization of generic drugs permits copay freeze.

For the third year in a row, because of increased generic drug utilization and new contract with National Rx Services, no increase in the retiree's cost of mail-order drugs is necessary.

1993, June - Board makes decision on managed care and new plan design

At its May meeting, the SERS Board adopts plan design changes. Some changes are necessary to properly administer the managed care program, and some are necessary to adjust retiree cost participation (last changed in 1987). Effective January 1, 1994, per-person deductibles are increased from $250 to $275; family deductibles are increased from $500 to $550; out-of-pocket maximums are increased from $500 to $750 (individual) and from $750 to $1500 (family). Inpatient hospital deductible increased from $74 to $100. General differential between PPO and non-PPO deductibles established at 2 times the PPO deductible. Increased first-dollar benefits ($20 physician office charge and $100 annual cancer-screening test) established for PPO participants. Managed care to become effective October 1, 1993 for Aetna participants residing in greater Cincinnati, Cleveland and Columbus areas. Lifetime maximum increased to $1,250,000.

1993, September - Aetna toll-free line established

In order to most effectively administer SERS' health care plan, Aetna agrees to install toll-free phone service for SERS retirees.

1993, October - Managed Care begins - SERS adopts ASC agreement with Aetna

Managed care begins with participants who reside in greater Cincinnati, Cleveland and Columbus areas. Only non-Medicare participants enrolled under managed care; over 3,700 participants enrolled. SERS adopts Administrative Services Only contract with Aetna. Under the ASC arrangement, SERS will be totally self-insured and Aetna will only administer claims; fees paid to Aetna for this service will be limited by contractual agreement. New claim form and explanation of Aetna benefits introduced - claims submission effort by retirees greatly reduced.

1994, February - Change to retail drug program announced.

SERS Board adopts new retail drug program. Major feature of new program will result in lower retail prescription drug costs for both SERS and its retirees. First-dollar coverage established with 80/20 copayments [minimum copayments of $2.50 (generic) and $5.00 (brand name)]. Copays of $10.00 (brand) and $0.00 (generic) maintained under mail-order program.

1994, March - Managed Care program expands

SERS/Aetna managed care PPO expands to cover all participants residing in Cincinnati, Cleveland and Columbus areas; over 2,000 additional participants covered by managed care.

1994, January - Managed Care program expands

SERS/Aetna managed care PPO expands to cover all participants residing in Akron, Ohio service area. Over 1,000 additional participants covered by managed care.

1994, March - Managed Care program expands.

Expansion of managed care PPO into eastern Ohio.

1994, April - Managed Care program expands.

Expansion of managed care PPO into Dayton area.

1994, June - Managed Care program expands.

Expansion of managed care PPO into Toledo area.

1994, July - Change in prescription drug benefit announced.

SERS Board adopts coordinated prescription drug program. Prescription drug program, both retail and mail-order to be administered by a single vendor, MEDCO. In addition to higher discounts, MAC pricing and additional patient/physician/provider communications, program permits full utilization review to occur on concurrent and prospective basis, rather than only a retroactive basis. Prescription drugs dispensed through rest-home pharmacies continue to be covered by Aetna.

1994, October - Managed Care program expands.

Further eastern Ohio PPO expansion; over 8,500 SERS health care participants now under the PPO.

1996, January - Managed Care Program Expands.

76 Ohio counties offer PPO and 12 Ohio counties offer PPO access. Managed care now available for the entire state.

1996, Summer - Board adopts criteria for HMO selection.

SERS Board adopts criteria for selecting HMOs to offer as another health care choice. The criteria includes no (Gag orders), no incentive for withholding care, NCQA accreditation, must offer coverage in same geographical area for under and over age 65.

1996, October - Open enrollment meetings.

SERS sponsors HMO meetings in 9 cities with over 2300 retirees and dependents attending.

1997, January - Introduction of HMO

27 Counties offer HMO Choice.

1997, October - Open enrollment meetings.

SERS sponsors HMO meetings in 12 cities with over 700 retirees and dependents attending.

1998, March - Health Care Benefits Policy

The Board adopts statement of Health Care policy.

1998, July - Mental Health and Substance abuse

The calendar year maximum was removed.

1998, December - H.B. 673 passes.

Raises the monthly Medicare Part B premium reimbursement from $24.80 to $31.80. This increase is effective January 1, 1992.

1999, January - SERS offers Aetna National Advantage Program

This program offers discounts from participating hospital and facilities outside of Ohio for our PPO and non-Medicare Indemnity plans.

NOTE: No increase in Aetna premiums since 1993.

1999, January - Board revised reserve level increase from 125% to 150% of projected health care expense.

1999, January - HMO Expands

31 Ohio counties, 1 Michigan county and 3 Kentucky counties offer HMO Choice.

1999, March - Health Care Provision Rescinded

SERS Board rescinded the health care provision that applied to members who joined the system after July 1, 1993. The provision required any member who joined SERS after July 1, 1993 to pay the full premium for health care until eligible for Medicare.

1999, April - Change to prescription drug program.

SERS Board adopts new drug program. Mail-order generic drug co-payment $3, brand drug co-payment $15 with a 90 day supply limit. Eliminating coverage for over-the-counter drugs, except for diabetic supplies. Exclusion of drugs such as Viagra. Implementing a generic incentive program, and limiting maintenance drugs to only one refill at retail.

1999, August - Change to prescription drug program

SERS worked with Merck Medco to develop a program that coordinates with Medicare to reimbursement SERS for prescription drugs covered by Medicare.

1999, October - Open enrollment meetings

31 Ohio counties, 1 Michigan county and 3 Kentucky counties offer HMO Choice. SERS sponsors HMO meetings in 8 cities with over 900 retirees and depenendts attending.

2000, January - HMO

SERS offers an additional choice with Anthem HMO.

2000, January - HMO expands

38 Ohio counties, 1 Michigan and 3 Kentucky counties offer HMO choice.

2000, January - PPO/Indemnity

SERS offers Medical Mutual of Ohio as a choice for retirees and depenents who do not desire to enroll in an HMO or Aetna PPO/Indemnity plan.

ELIGIBILITY REQUIREMENTS

Eligibility for SERS' health insurance benefits is based on service credit. In 1981, H.B. 126 was passed to require ten years of service credit, exclusive of most types of purchased credit, to be able to participate in the health plan. The effective date was June 13, 1986.

Thus, members who retire after June, 1986 need ten years of service credit to qualify to participate in SERS' health plan. The following types of credit purchased after January 29, 1981 do not count toward insurance eligibility: military, federal, out of state, municipal, private school, exempted, and early retirement incentive credit.

LEVEL OF COVERAGE

SERS members have a choice of coverage by HMO's in 38 Ohio counties or the basic SERS health plan. Retirees under the plan who do not have Medicare and who live in Ohio are enrolled in a managed care network.

The following describes the benefits under the basic plan after the yearly deductible and hospital admission charge have been paid by the retiree:

Hospital Charges

The plan pays 100% (or 65% for those in managed care who do not use participating hospitals) for the following charges:

- Room and Board (semi-private charge) and other services and supplies the hospital furnishes while an in-patient.
- Outpatient emergency treatment of an injury or illness severe enough for hospital treatment.
- Outpatient services required because of surgery performed on the date of the service.

Medical Charges

The plan pays 80% (or 65% for those in managed care who do not use participating providers) for the following charges:

- Charges made by a physician and/or surgeon (including office visits, in-hospital visits, and surgery). Routine office visits are subject to a $20 co-pay for managed care enrollees.
- Charges made by a registered nurse that are deemed medically necessary. Not covered are charges by a R.N. who resides in the retiree's home or is a member of the retiree's family.
- Hospital outpatient charges.
- Professional ambulance services or the trip to the first hospital of treatment.
- Artificial limbs and eyes but not eye exams.

Convalescent Facility Charges

The plan will pay 100% coverage for room and board for skilled treatment only. If private accommodations are used, the plan will cover the facility's average daily semi-private room charge.

Also covered are physical therapy, use of special treatment rooms, drugs, casts and dressing.

Expenses listed above will be payable for up to 365 days of confinement in any convalescent period.

Screening Tests

For those under managed care who use participating providers, the plan pays up to $100 each year for preventive tests for cancer: mammogram, PAP smear and PSA test for prostate cancer. Charges above $100 are reimbursed at 90% after the deductible. Managed care enrollees who do not use participating providers are reimbursed 65% after the deductible.

Retirees with Medicare and those not in managed care receive 80% reimbursement for these tests after the deductible.

Outpatient Mental Health and Substance Abuse Treatment

The plan will pay 90% coverage, for those in managed care who do not use participating providers, the plan will pay 50% for covered medical services.

Retirees with Medicare and those not in managed care receive 80% coverage.

Home Health Care

The plan pays 100% for up to 100 visits per year, and 80% after 100 visits.

Hospice Care

The plan pays 100% for 30 days lifetime of inpatient expenses; 80% up to $5,000 lifetime for outpatient expenses.

Coordination of Benefits

The SERS plan contains a "Coordination of Benefits" provision. Payment on covered expenses will be reduced to the extent of duplicate coverage by any other group carrier determined to be primary insurer under the model COB provisions recommended by the National Association of Insurance Commissioners and adopted by the Trustees of the Ohio Retirement Systems Health Care Plan.

Prevailing Fee

The insurers have established prevailing fees for medically necessary charges and reimburses at the prevailing fee level.

Out-of-pocket Maximum

The maximum out-of-pocket limit under the SERS basic plan is $1,025 per person per calendar year, including the deductible, or $1,125 including the deductible and one hospital admission charge.

The office visit co-pay of $20 for those in the managed care network is not applied against the out-of-pocket limit.

The maximum expense limit for a retiree in the managed care network who does not use participating providers is $2,550 per person, including the deductible.

Lifetime Maximum

The plan will pay up to $1,250,000 of covered expenses per person's lifetime.

PRESCRIPTION DRUG COVERAGE

SERS offers a retail and a mail-order prescription drug plan for retirees not enrolled in an HMO.

Retail Plan

Retirees receive a card to use at participating pharmacies. Retirees pay 20% of the cost of the drug, or a minimum of $2.50 for a generic and $5.00 for a brand name. There is no deductible to meet and co-payments are not applied against the yearly Aetna deductible.

Retirees may receive up to a 34-day supply, or 100 units, whichever is less.

If a participating pharmacy is not used, there is no reimbursement, except for nursing home confinements.

Mail-Order Plan

Basic plan enrollees and dependents living in the continental U.S. may receive prescriptions by mail. Most prescriptions can be filled for up to a 90 day supply.

Retirees pay $15 co-payment for a brand name prescription drug and $3 co-payment for a generic prescription drug.

COST SHARING - DEDUCTIBLE, PREMIUMS. CO-PAYMENTS

Deductible

SERS instituted a yearly deductible in 1983. The rate was $100 and has risen to $275 per person in 1994. For those in managed care who do not use participating providers, the calendar year deductible is $550 per person. The deductible is indexed to the increase in health care expenses.

Hospital Admission Charge

The retiree is charged $100 for each hospital admission unless readmitted within 60 days. The charge for those in managed care who do not use a participating hospital is $250.

Premiums

SERS was the first Ohio system to charge monthly premiums for retiring members. Those who retired after July, 1989 who have less than 25 years of service, excluding most types of purchased credit, pay a monthly premium based on the following schedule:

Years of Service	*Percent of Premium*
10 - 14.999	75%
15 - 19.999	50%
20 - 24.999	25%

The percents equate to the following monthly premiums:

Years of Service	*Percent of Premium*
10-14.999 years	$268.50
with Medicare	45.25
15-19.999 years	$179.00
with Medicare	30.17
20-24.999 years	$ 89.50
with Medicare	15.08

The premium rates listed above are for the basic plan - rates under the HMO's are in some cases higher and some cases lower.

Dependent premiums are $138 per month for a spouse under 65, $41 for a spouse with Medicare, and $39 a month for children. Dependent premiums are subsidized by SERS at 30%.

All premium rates are indexed to the increase in health care expenses and are subject to change yearly.

CO-PAYMENTS

Under the basic medical plan, the retiree pays 20% of doctor and other medical charges, up to the maximum yearly limit.

Retirees in the managed care network pay $20 per routine doctor office visit.

Those in the managed care network who do not use participating providers pay 35%.

Under the retail prescription drug plan, the retiree pays 20% of the cost of the drug, or a minimum of $2.50 for a generic and $5.00 for a brand name. Under the mail-order prescription plan, retirees pay $15 co-payment for a brand name drug and $3 co-payment for a generic drug.

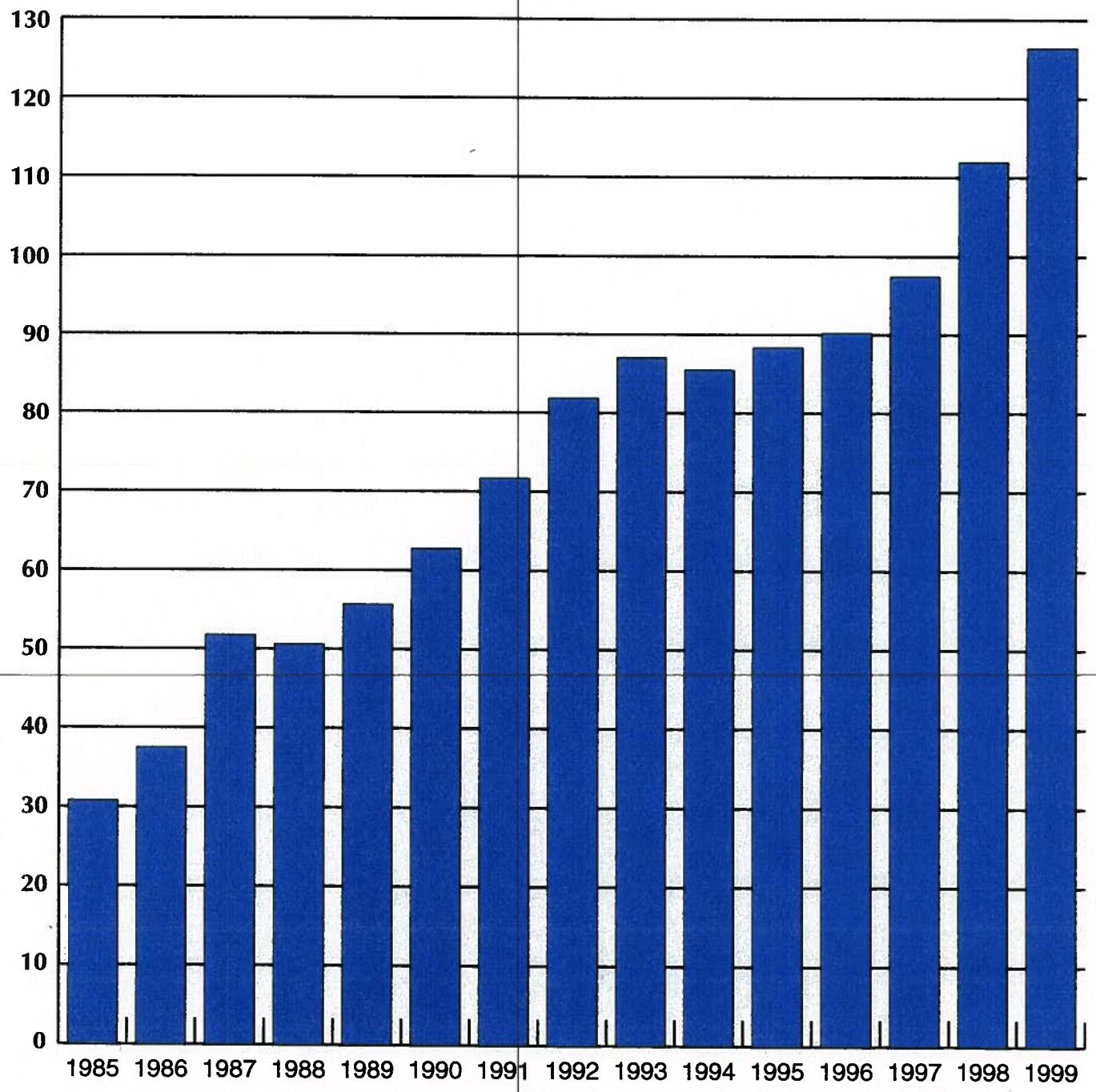
MEDICARE B REIMBURSEMENT

The Medicare Part B reimbursement rate is $31.80 per month. Retirees must pay the difference between the $31.80 and the current Medicare Part B premium, which is $45.50.

Plan Benefits

	MMO or Aetna PPO/Indemnity Plan & Medco Drugs	Paramount HMO Plan (Medicare only)	Anthem HMO Plan	Aetna HMO Plan	Kaiser HMO Plan
Deductible	$275	None	None	None	None
Out-of-Pocket	$750	None	None	None	None
Lifetime Maximum	$1,250,000	None	None	None	None
Emergency Room Treatment	Subject to deductible	$25 co-pay	$50 co-pay	$25 co-pay	$25 co-pay
Hospital Admittance Deductible	$100	None	None	None	None
Inpatient/Semi-private room	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Physician office calls	80%, PPO $20	Medicare: $5 co-pay	$5 co-pay Medical $10 co-pay Non-Med.	$5 co-pay Medicare $10 co-pay Non-Med.	$5 co-pay Medicare $10 co-pay Non-Med.
Skilled Facility	100% 365 days	100% 100 days	100% Medicare 100 days Non-Med. Unlimited	100% 100 days	100% 100 days
Home health care	100% first 100 visits, 80% after	Medically necessary covered in full	Medically Necessary covered in full	Medically Necessary covered in full	Medically Necessary covered in full
Dental	None	100% preventive $50 deductible 80% basic 50% restorative $1,500 annual max. Network Dentists	100% preventive $50 deductible 80% basic $1500 annual max. Any Dentist	100% preventive $50 deductible 80% basic Other services at a discount $1,000 annual max. Network Dentists	100% Preventive 60% bridges, dentures and crowns 70% Oral surgery/ minor restorative Network Dentists
Prescription Drug Plan	80% Covered 34 day supply Mail service: $15 brand $3 generic 90 day supply	80% covered 34 day supply Mail service: $3 generic $15 brand 90 day supply	$5 generic $15 brand formulary $25 non-formulary 30 day supply $10 generic $30 brand formulary $50 non-formulary 90 day supply	80% Covered; 30 day supply Mail service: $10 generic $15 brand formulary $30 non-formulary 90 day supply	$5 copay 31 day supply Mail service: $5 copay for 90 day supply
Vision	None	$200 benefit every 2 years	$200 benefit every 2 years	$200 Benefit every 2 years	Standard clear lenses covered in full every year. Discounts on frames
Hearing Aid	None	$700 benefit every 3 years	$700 benefit every 3 years	$700 Benefit every 3 years	One aid covered in full every 3 years

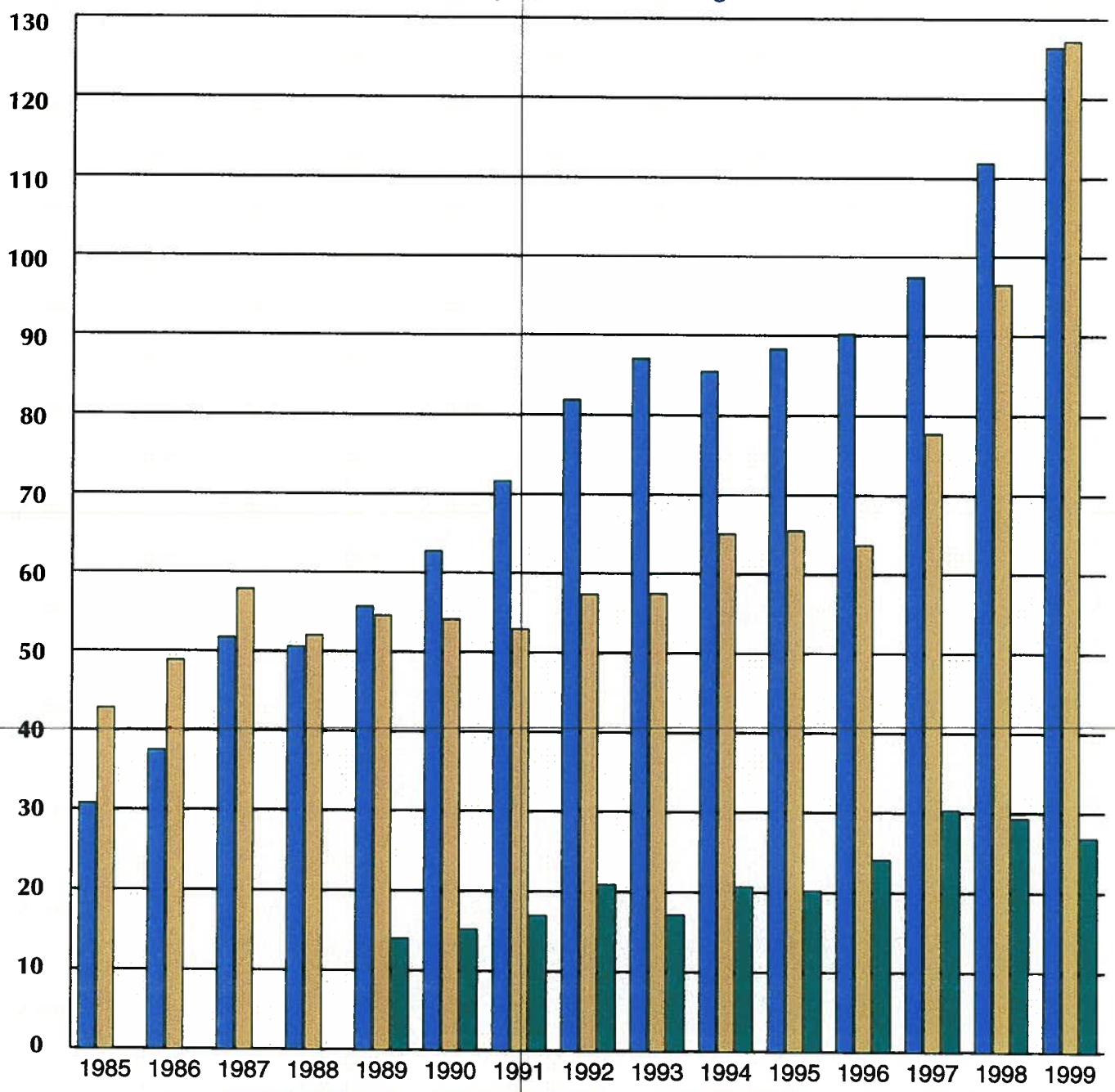
Health Care Expense - 1985 through 1998



Year	Health Care Expense
1985	$30,778,698
1986	37,499,209
1987	51,728,280
1988	50,568,576
1989	55,688,417
1990	62,746,014
1991	71,633,065

Year	Health Care Expense
1992	$81,851,492
1993	87,079,286
1994	85,496,108
1995	88,340,780
1996	90,212,211
1997	97,429,197
1998	111,900,575
1999	126,380,984

Health Care Expense - 1985 through 1998



Year	Health Care Expense	Health Care Contributions	Health Care Surcharge	Health Care Reserve Acct.
1985	$30,778,698	$42,819,706	$0	$119,942,659
1986	37,499,209	48,849,661	0	131,000,000
1987	51,728,280	57,869,789	0	137,434,620
1988	50,568,576	52,027,865	0	138,893,909
1989	55,688,417	54,524,273	14,010,283	151,740,048
1990	62,746,014	54,119,027	15,217,909	158,330,970
1991	71,633,065	52,924,239	16,990,015	156,612,159
1992	81,851,492	57,330,290	20,900,346	152,991,303
1993	87,079,286	57,460,971	17,184,995	140,557,983
1994	85,496,108	65,058,408	20,744,932	140,865,215
1995	88,340,780	65,441,338	20,244,221	138,209,994
1996	90,212,211	63,675,017	24,131,511	135,804,311
1997	97,429,197	77,720,194	30,288,515	146,383,823
1998	111,900,575	96,488,389	29,336,734	160,308,371
1999	126,380,984	127,195,042	26,847,444	184,969,874

Funding Alternatives and Asset Levels

Funding alternatives for SERS post retirement health care benefits program range from pay-as-you-go to level contribution funding.

Level contribution funding (pre-funding) provides for greater equity between the generations and for relatively stable rate of contributions from year to year. However, unlike pensions, health care is not a predictable expense. This method would require SERS to increase contributions to unrealistic levels. Even assuming medical inflation equal to general inflation, the assets required would be in excess of $1.8 billion. This compares to current assets of $140 million.

Pay-as-you-go funding requires the minimum amount of revenue necessary to cover disbursements. Only a minimum level of assets would be needed to cover the difference in timing between the contributions and disbursements. The drawback to pay-as-you-go funding, in addition to placing a financial burden on future generations, is that it is highly volatile. Contribution increases or decreases would have to be made frequently and the annual rate of change may vary 0% to 25%, which would create a budgeting problem for the school districts.

The SERS Retirement Board has adopted an alternative method of funding to pay-as-you-go with the establishment of a fund balance that would serve to protect the plan from insolvency in periods when contributions cannot be increased and to smooth the annual rate of change in the contribution level. The amount of assets that should be held in this fund is the level necessary to provide the desired degree of stability and security. This amount is called the target asset level. The target asset level for SERS is 150 percent of annual claims and expenses.

Health Care Benefits

The School Employees Retirement System of Ohio is a cost-sharing multiple-employer public employee retirement system established by the Ohio General Assembly in 1937 to provide retirement benefits to employees of the Ohio public schools who are not required to possess a certificate in order to perform their duties. Benefits provided to participants in SERS include age and service retirement, disability benefits, survivor benefits, death benefits, and post-retirement health care benefits.

SERS currently has over 106,000 contributing members and 55,500 retirees. Currently 7.70 percent of the employer rate is necessary to fund basic pension benefits and to amortize the unfunded actuarial accrued liabilities over a 21 year period (in 1986 the funding period was 48 years).

The SERS post-retirement health care program provides comprehensive medical and prescription drug coverage to more than 62,000 participants (eligible benefit recipients and their dependents). Access to this coverage is provided through several program including an indemnity program, three HMO's, a PPO, and a retail/mail order prescription drug program.

Over the past ten years, SERS experienced a doubling of health care costs, from $49.4 million in fiscal year 1988 to more than $126 million in 1999. This rapid growth can be attributed to demographic and economic factors that are outside of SERS' direct control, including:

- Medical price inflation: inflation which has ranged between 1.5 to 4 times the general rate of inflation over the same time period.

- Market cost shifting: shifting of health care costs by providers to Medicare, Medicaid, and traditional indemnity programs.

- Breakthroughs in medical technology: the cost of rapid advances, including breakthrough drugs, magnetic resonance imaging scanners, and other diagnostic technology; advances in the treatment of cancer, heart disease and other disease.

- Increased life expectancies.

These increases in cost of health have not been a total surprise to SERS. In 1982 SERS was one of the first retirement systems in the country to publicly disclose actuarial accrued liabilities for retiree health care. SERS organized and participated in several task forces to address health care concerns. Representatives on these task forces have come from the membership, retirees, employer organizations, the retirement study commission, health care providers, actuaries, and accountants.

As a result of this early concern SERS has taken aggressive action to constrain cost yet continue providing a valuable benefit. An early step was the passage of H.B. 126 in 1981 which, effective in 1986, required members to have 10 years of contributing service to be eligible to participate in the health care program. In 1988, H.B. 290 became law which in conjunction with action by the SERS Retirement Board established:

- Career vesting of health care benefits: 25 years of contributing service required for full benefit subsidy. Benefit subsidy established at 25 percent (10-14 years), 50 percent (15-19 years) and 75% (20-24 years).

- 40 percent reduction of system's subsidy of dependent health care premiums (70% to 30%).

- Freezing the Medicare Part "B" reimbursement at $24.80 (current Medicare "B" premium is $46.10). December, 1998 raised the Medicare Part B reimbursement to $31.80, effective to January 1, 1992.

- Establishes an employer surcharge (additional employer contributions) for members who earn less than an actuarially determined minimum salary, the surcharge revenues to be used exclusively for funding health care benefits.

In 1992, the Retirement Board acted to eliminate the pre-Medicare health care premium for anyone who became a member of SERS after July 1, 1993. In 1990 SERS prototyped and then fully implemented a retail prescription drug program which received the 1992 national "Award for Excellence" in retirement administration from the Government Finance Officers Association. This retail program has since evolved into an integrated retail/mail order program with the following elements: significant discounts, formularies, disease management, compliance, drug interactions, manufacturer rebates, and administration performance guarantees. The Board rescinded this action March, 1999.

In 1993 SERS established a preferred provider network, for those retirees eligible for Medicare. Preferred provider organizations reduce health care costs by incensing or "steering" participants toward health care providers who are members of the PPO network. The degree of "steerage" or leverage is dependent on two primary factors:

- the plan design: lower co-pays, deductibles, and out of pocket maximum provide a substantial incentive for the participant to use in-network providers, and

- selection of a PPO vendor: selected through a competitive bid process, the PPO vendor is required to provide quality doctors and hospitals, guarantees of efficient administration, responsiveness to participants requests for assistance, and limits on the growth of SERS costs.

SERS invests a lot of time and resources in monitoring its health care programs and will continue to be proactive in this area, including legislation at the state and national level. We are particular concerned about proposed legislation such as freedom of choice, any willing provider, proposed reductions in Medicare spending which may shift cost to the retirement system, and efforts to reduce supplemental funding for health care through the elimination of the surcharge.

Regarding the funding of the health care benefit, SERS long ago "built the wall" between pensions and health care. The funding of pensions is our first priority. Health care is funded from the portion of the employer contribution rate not needed for pension funding (6.30 percent) and from the employer surcharge which is currently equal to 1.47 percent of payroll. The challenge for SERS has always been to fund health care from a relatively low salary base (an average of $16,021 in 1999). The same percent of salary for a member of other systems would generate significantly more revenue per capita to fund health care for SERS.

In summary, SERS has been very aggressive in identifying health care funding issues and in developing initiatives to reduce cost through cost sharing, provider contracting, competitive vendor bidding, and educational programs. There is no easy solution to the on-going challenge.

Summary of Benefits

Year	Total Benefits	Health Care	Percent Of Total Benefits	Average Benefit Per Retiree/Per Year
1985	$146,221,717	$30,778,698	21%	$785
1986	165,966,256	37,499,209	23	913
1987	190,559,149	49,847,188	27	1,166
1988	202,368,747	49,420,459	25	1,124
1989	227,333,363	55,688,417	25	1,219
1990	254,575,919	62,746,014	25	1,326
1991	276,194,261	71,633,065	26	1,478
1992	302,422,078	81,581,492	27	1,650
1993	323,608,827	87,079,286	27	1,728
1994	338,368,402	85,496,108	25	1,661
1995	306,159,496	88,340,780	25	1,685
1996	399,739,194	90,213,211	23	1,687
1997	429,956,496	97,429,197	23	1,785
1998	466,173,461	111,900,575	24	2,014
1999	507,255,292	126,380,984	25	2,024

SPEECH TO NCPERS ANNUAL CONFERENCE
BALTIMORE, MARYLAND - APRIL 7, 1992

A Principle-Based Approach to Changes in Post-Retirement Health Care Programs

I appreciate the opportunity to participate in this general discussion entitled "The Health Crisis of America and its impact on pension funds". Walter Knorr, Comptroller of Chicago, just spoke on the problems which health care benefits have created for the City of Chicago. Carolyn Abelanet, an Actuary with William M. Mercer, will follow with a presentation on the broader implications of ever-increasing health care costs in the public sector.

This morning I would like to talk about an approach which we have followed to implementing changes in our post-retirement health care program at the Ohio School Employees Retirement System. We all know that change is inevitable as we go through the revolution in the funding, financing and administration of health care benefits in the United States. Many of you are public pension fund trustees who also have the responsibility for administering health care benefits for retired employees. If you do not currently have that responsibility, you may likely have it in the future. What I will advocate this morning is an principle-based approach to implementing changes in our health care benefit programs. "Principle-based" simply means that everyone involved in the change process agrees to certain basic principles before any decisions are made regarding specific changes in programs. If carefully followed, this approach will substantially reduce the risk of litigation and will minimize political risk. It will also help trustees feel that their decisions have sound moral basis.

Before I begin my discussion, I would like to thank the NCPRS for the opportunity to speak this morning. I should also issue a disclaimer that none of the opinions, conclusions, or statements made this morning necessarily represent the opinion of any of the actuaries, consultants, or other retirement systems which have worked with us in the process of implementing the changes.

By way of background, Ohio is one of the few remaining non-social security states. All public employees in Ohio are covered by one of the five state-wide pension funds with the exception of the employees of the City of Cincinnati, which are covered by its own municipal pension fund. The five state-wide pension funds have been providing post-retirement health care coverage since 1974. The major part of the health care program is provided through a trust agreement, calls ORS, which provides a common level of benefits for all retirees, yet allows each of the five systems to fund and finance these benefits on a separate basis.

Skipping ahead to 1984, SERS paid $33 million in retiree health care costs in that year. All retirees were eligible to participate in the program and there were no premiums for retirees. Spouses were allowed to participate and the system subsidized 50% of the premium. Retirees were (and still are) required to enroll in Medicare B at age 65, but SERS reimbursing the retiree the full amount of the premium each month.

In 1984, SERS was using 4 1/2% of management pay (out of a total of 22% collected) to cover the health care outlay and to provide a very modest reserve. By the way, our Actuary in 1974 (who is no longer our Actuary), estimated that the postretirement health care program could be supported with 3/4 of 1% of pay.

In 1984, we funded a study which projected our health care costs (at 10% inflation) by 1992 to be $70.74 million. The study also projected that if the retirement system were to freeze its share of the cost of the program at 4 1 /2% a pay, by 1992 42% of the cost of the program would have to be picked up by someone else. That "someone else" obviously would be either employers or retirees. There was no escaping the fact that we could not support the current program and that changes were inevitable. Woody Allen had this to say about the kind of dilemma we faced: "More than anytime in history mankind faces a crossroads — one path leads to despair and utter hopelessness, the other to total extinction. Let us pray we have the wisdom to choose correctly.

In 1984, the Retirement Board determined that it would find a path which led to neither hopelessness nor to total extinction. The Board felt very strongly that it could make changes, that those changes would be accepted by the retirees, and that the changes would allow us to reasonably assure our retirees the program would continue well into the future.

As the Board faced the challenge of change, it had three major goals: First, we wanted to avoid any actions which would risk a lawsuit challenging our authority to make the changes; secondly, we had to assure that all interested parties were part of the process of change so that the risk of political interference would be minimized; and thirdly, the Board felt a very strong moral duty to minimize the impact of the change on our current retirees.

We knew we were at a crossroads in the mid 1980's but there were no roadmaps, not even a good compass, to help us find the right road!

The problem was complicated by statements we had made in earlier years about "free health care coverage", and further complicated by a rash of court decisions which severely limited the availability of many companies to change their post-retirement health care benefits. After seeking input and advice from all interested parties, including retirees, unions, employers, legislators, retirement study commission, various consultants, the Board adopted a series of principles to guide it as it implemented changes to the post retirement health care program. The first set of principles were intended to set priorities for legislative changes. These principles amounted to the Executive Director's "marching orders" in the legislature. On October 2, 1987, the Board adopted the following principles:

1) SERS is bound by law to make payment of pensions its first priority.

The health care benefit will be funded from revenues remaining after pension obligations have been provided for;

2) As changes to the health care program become necessary in order to keep health care revenues in line with expenses, SERS will endeavor to minimize the impact of those changes on current retirees;

3) The level of health care benefits or level of participation by retirees should be determined in the same manner as basic benefits;

4) Maintain the health care program into the future for those members

not yet retired;

5) Fund the program over time at a level cost basis.

These principles were later expanded into a broader set of principles, which last year were adopted by all five of the state-wide pension funds in Ohio. These broader principles are intended to guide the retirement systems individually and jointly as changes are made to our plans in the future. The principles are preceded by a Preamble, which is intended to document why the retirement systems should continue in the business of post retirement health care. This is the Preamble and the General Principles as adopted by the five retirement systems:

Preamble

WHEREAS, most public employees have access to health care through their employer while they are working; and,

WHEREAS, retired public employees have for the past 16 years looked to ORS for continuation of health care coverage; and,

WHEREAS, ORS' ability to continue providing post retirement health care is seriously impaired by factors largely beyond ORS' control; and,

WHEREAS, ORS believes that the interests of retirees and employers will be best served by ORS continuing to provide and fund post retirement health care;

WHEREAS, ORS desires to be guided by concepts of fairness and equity as changes are made to the health care program in the future; and,

THEREFORE, the members of ORS subscribe to the following general principles concerning post retirement health care for Ohio's public employees.

General Principles

1. ORS will use its best efforts within available resources to provide retirees access to quality health care at reasonable cost to retirees.

2. ORS will require its retirees, in turn, to act as reasonable and informed consumers in this process.

3. ORS believes that career public employees should receive greater value due to their longer service, but also recognizes that all eligible retirees should have access to the same health care.

4. The resources to fund the health care program should continue to come primarily from employers.

5. The funding of the program will be premised on concepts of intergenerational equity.

6. Health care benefits are secondary to basic benefits and cannot be paid from assets reserved for basic benefits.

7. Just as the systems are required to disclose the costs of the basic benefits program, so too should the short-term and long-term costs of the health care program be disclosed in a timely and appropriate manner.

I have a few comments on each principle. The first principle clarifies that the promise regarding health care is considerably different from the promise regarding pensions. Few retirees expect an unchanging health care benefit but they do deserve to feel that the program will be there when they need it. This principle is worthy of a speech in its own right and I will not comment further.

The second principle puts retirees on notice that the health care promise has two parties. Health care is not like the pension benefit, which is a unilateral promise by the pension fund to pay a monthly amount to the retiree as long as the retiree is alive. The quality and durability of a post retirement health care program is directly proportional to the extent to which the retiree is required to participate in purchase decisions.

The third principle recognizes the fact that post retirement health care should be funded over the working career of the employee. The shorter the funding period, the more the retiree will be asked to pay in retirement. At the same time, no one argues that access or quality of care should hinge on the amount of service credit.

The fourth principle recognizes the fact that in most cases the employer has the deeper pocket when it comes to funding health care.

The fifth principle is intended to remind us that we cannot ask our children and grandchildren to clean up our financial toxic waste debts.

The sixth principle tells pension trustees that they cannot use assets reserved for pensions to pay health care benefits.

The seventh principle is intended to create requirements for full disclosure so that trustees can be truly accountable for the health care programs they administer.

These principles certainly are not intended to address all of the questions and problems created by the necessity to change post retirement health care programs, but they are appropriate in Ohio. These principles are not substitutes for analysis, planning, monitoring, and communicating, but without a solid set of principles, the process of change will likely be chaotic and extremely risky from a legal and political standpoint. "Will a daily dose of principles make the pain of change go away?" No, not hardly, but is pain all bad? I remember a famous quote from a young Okinawan, Sekeine, in Teahouse of the August Moon, "Pain makes man think. Thought makes man wise. And wisdom makes life endurable." If we can endure the process of change in our health care delivery system for the next several years, what more can we ask?

History of the Employer Surcharge

The current employer contribution of 14% is insufficient to fund the health care benefits on a pay-as-you-go basis.

The fundamental problem is the disproportionate number of short-hour, part-time employees in non-certificated ranks. Most SERS members work less than a calendar year and less than 8 hours per day. The average pay of SERS members is $15,000, roughly half that of PERS members and a little over one-third that of STRS members.

Therefore, the employer contribution received to support the health care benefits is substantially less for SERS and places an obvious burden on SERS' ability to maintain health care benefits. For those who would promote a merger with PERS or equal health care benefits must also promote equal salaries of SERS members from which contributions (revenues) are obtained.

Legislators recognized this problem of low salaries and continued to support more employer surcharge money because of the Retirement Board commitment to control health care costs through the premium charges to retirees with less than 25 years of service credit and the freezing of the Medicare "B" reimbursements.

The SERS Retirement Board continues the challenge of balancing the employer surcharge and the level of affordable benefits.

Statement of Health Care Benefits Policy

I. Purpose

The purpose of this Statement of Health Care Benefits Policy is to describe the philosophy and objectives of the Retirement Board of the School Employees Retirement System of Ohio. This Statement sets forth policy and describes the organization and division of responsibilities to prudently implement the Board's philosophy and objectives in accordance with Section 3309.69 of the Ohio Revised Code. It also establishes the framework and specific objectives to monitor the systems financing policy and to promote effective communication between the Board, staff, members, retirees, employers and vendors.

II. Background

Beginning in 1974, the Retirement Board provided retirees access to high levels of doctor, hospital, and prescription drug benefits. Over the years, as the cost of these benefits has increased, numerous changes to the program have occurred:

- Mail order prescription drugs
- Deductibles and co-payments increased
- Eligibility increased from 5 to 10 years
- Premiums required
- System subsidy for dependents reduced
- Preferred Providers introduced
- Plan design changes and out-of-pocket maximums increased
- *• New members as of July 1, 1993 will pay full premium cost prior to attaining the minimum age necessary for Medicare benefits.
- Health Maintenance Organization/Medicare Risk introduced.

III. Philosophy

The Board realizes the importance of providing retirees access to quality health care programs. The Board further realizes that by Statute, Section 3309.69 of the Ohio Revised Code, the amount paid by the Board for the health care programs is not guaranteed. The Board:

Will use its best efforts within available resources to provide retirees access to quality health care while achieving the lowest possible cost to retirees and employers.

Will require its retirees, in turn, to act as responsible and informed consumers in this process.

Believes that career public employees should receive greater value due to their longer service, but also recognizes that all eligible retirees should have access to the same health care.

Believes Resources to fund the health care program should continue to come primarily from employers.

Recognizes that health care benefits are secondary to basic pension benefits and cannot be paid from assets reserved for basic benefits.

Believes the short-term and long-term experience of the health care program should be disclosed in a timely and appropriate manner.

*Rescinded by the Board March, 1999

IV. Environment

In defining objectives the Board seeks to maintain the level of benefits available to retirees while achieving the lowest possible cost to retirees and employers.

There are many changes occurring within the health care delivery systems as we know them. Several factors will be driving these changes:

- Federal and State government changes in Medicare and Health Care programs
  - Cost Shifting
  - Mandated Benefits
  - Eligibility
- Market forces on insurance companies
  - Competition
  - Mergers
  - Profitability
- Doctors and hospitals forming delivery groups
  - Compete with Insurance Companies
  - Small Coverage Areas
- Expansion of Medicare HMOs
  - Competition
  - Medicare Limiting Risk
- Legislation mandating levels of benefits
  - Consumer Protection
- Increase in the cost of prescription drugs
  - New Drugs
  - Less Competition

All of these factors will have a direct impact on the administration of the SERS program.

V. Objectives

In order to provide stability in the program while these issues are addressed, the following objectives have been established:

- Continue to advocate the current method of financing health care benefits and oppose any attempts to cap or limit the surcharge.
- Continue to advocate that 150 percent of projected health care expense constitute a minimum reserve.
- Avoid, wherever possible, major restructuring of the health care delivery processes.
- Seek alternative programs that will result in high quality and less cost to the retiree and system while providing a higher level of benefits.

- Maintain the current level of health care options available to retirees.
- Avoid programs that increase cost, provide less service, or do not benefit the majority of health care recipients.
- Maintain relationships with vendors who are reputable, financially sound and capable of serving SERS retirees.

VI. Responsibilities

In order to implement the Board's statement of Health Care Benefits Policy the following responsibilities have been assigned:

A. To the Retirement Board:

After consultation with the Board's consultant, the Executive Director and SERS staff, the Retirement Board will determine the system's level of participation in financing the cost of the health care program.

Where possible and when appropriate, the Board will provide Statements of Policy to direct and focus the activities of SERS staff and consultants.

B. To the SERS staff:

In accordance with the Retirement Board's Statement of Policy, the SERS staff will strive to satisfy the Mission of SERS to enhance the well-being and financial security of our members, retirees and beneficiaries through benefit programs and services which are soundly financed, prudently administered and delivered with a focus on understanding and responsiveness.

The SERS staff will periodically report to the Retirement Board on its actions and activities in carrying out the Board's policies and directives. The staff is responsible for monitoring the activity of all health care vendors and reporting to the Board issues of concern or non-compliance with contract terms.

C. To the System Consultant:

In addition to preparing reports required by law, the Consultant will assist the Board and SERS staff by providing education and insight regarding effective health care programs and assist in the strategic planning process by identifying emerging trends in the health care delivery system. The Consultant will provide cost projections based upon SERS experience and demographics.

D. To the Vendors:

It will be the responsibility of the Vendors to provide SERS retirees access to quality health care services.

- Hospital and Doctor Credentialling and Re-credentialling
- Monitor Performance of Providers
- Decisions About Care are Being made by Doctors

Vendors offering benefits through a Health Maintenance Organization must meet the following criteria:

- Accreditation by the National Committee on Quality Assurance (NCQA)
- Networks of physicians and hospitals that are accessible
- Peer review and quality assurance committee, procedures and plans
- Member grievance process
- No "gag" orders or restriction on physician/patient communications
- Resources to meet customer service needs to retirees
- Compliance with performance guarantees.

VII. Review and Evaluation

In order to establish appropriate and effective policy and to maintain an efficient and affordable healthcare program, the Board will employ the services of a qualified Consultant who will prepare at a minimum, the following reports:

A. Annually

- Report to Legislative Committees on the financial status of the SERS Health Care reserve account
- Cost projections and plan design efficiencies
- Trends and issues in the industry which may have an impact on the health care for retirees.