2020 Health Care Report

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OPERS

Ohio Public Employees Retirement System
2020 ORSC Health Care Report
(For period January 1, 2020-December 31, 2020)

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Year in Review-2020

As of year-end 2020, with a net asset base of $114.3 billion, OPERS is the largest pension system in Ohio and the 12th largest public pension system in the nation. For more than half of our history, OPERS has provided access to health care coverage for retirees which, although not mandated, we believe is an important part of a secure retirement.

Changes to the OPERS Health Care Program

On January 15, 2020, the OPERS Board of Trustees voted to adopt changes to health care coverage for Medicare and Pre-Medicare retirees. These changes will preserve access to health care coverage for current and future retirees. The overall goal was to design a flexible health care program that can provide access to coverage based on available funding. Implementing the approved package of changes will make great progress towards this goal. As designed, the new program extends our ability to provide access to health care coverage for eligible retirees. Changes to the OPERS health care program are effective January 1, 2022.

The new health care program will eliminate the current group medical plan for Pre-Medicare retirees and replace it with a Health Reimbursement Arrangement (HRA). The amount of the HRA allowance will vary based on the retiree's age at which they first enrolled in the OPERS health care program and years of service. The HRA model was put in place for the Medicare retirees in 2015 and has been successful. Other changes include a reduced monthly base allowance amount for Medicare retirees (from $450 to $350), and modifications to eligibility, beginning in 2022.

Following an extensive search and negotiation process during 2020, OPERS selected Via Benefits, offered by Willis Towers Watson, to administer the OPERS Pre-Medicare Connector for eligible retirees beginning in 2022. Via Benefits can help transition

participating Pre-Medicare retirees to a new medical plan if they decide to choose one from the open market. Via Benefits also will administer the process by which participants can be reimbursed for qualifying medical expenses, using an HRA that OPERS provides. Via Benefits has administered the OPERS Medicare Connector, a similar service available to OPERS Medicare-eligible retirees since its inception in 2015.

During 2020, OPERS began a robust communication and education plan to prepare Pre-Medicare retirees to make the transition from an OPERS-sponsored group medical plan to an HRA. Although OPERS will no longer administer a group medical plan, we are committed to assisting retirees through each phase of this transition and continuing our support even after the changes have been implemented. OPERS will provide extensive communications and educational opportunities to ensure Pre-Medicare retirees understand their options and are prepared to enroll in a plan outside of the OPERS Pre-Medicare group plan and begin using their HRA account to receive reimbursement for qualifying medical expenses.

OPERS Medicare Connector

Throughout 2020, OPERS continued efforts to ensure all eligible participants enrolled in individual Medicare plans via the OPERS Medicare Connector were successfully using their HRA account if they so desired. These efforts included interactive webinars and personal outreach to retirees with little or no HRA activity. OPERS works continually with Via Benefits, the OPERS Medicare Connector administrator, to refine and improve the HRA reimbursement experience for participants in the OPERS Medicare Connector.

OPERS Pre-Medicare Health Plan

OPERS continues to implement annual adjustments to plan design and premiums for the OPERS Pre-Medicare plan to keep pace with rising costs. For the 2020 plan year, the full premium amount was raised to keep pace with increased costs associated with health care cost inflation, the prevalence of chronic conditions, significant use of the emergency room, high specialty drug prices, and the need to better align with the health insurance marketplace.

Increased plan use contributed to the need to increase deductibles, copays and co-insurance amounts. In previous years, a $49 premium reduction was automatically applied to qualifying accounts in preparation for the Affordable Care Act's excise

("Cadillac") Tax. Since the tax was repealed, OPERS decided not to provide the premium reduction for 2020 and will not provide it in future years.

2020 Financial Highlights

OPERS finished 2020 with strong investment returns of 12.02% for our Defined Benefit portfolio. The Health Care portfolio reported an investment return of 10.96% in 2020, compared to a return of 19.59% in 2019. The overall 115 Health Care Trust (115 Trust) net asset balance increased to $13.2 billion in 2020 from $12.6 billion in 2019.

Funded Status

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

On January 15, 2020, the Board approved several changes to the health care plan offered to Medicare and Pre-Medicare retirees in efforts to decrease costs and increase the solvency of the health care program. These changes are effective January 1, 2022 and include changes to base allowances and eligibility for Medicare retirees, as well as replacing OPERS-sponsored medical plans for Pre-Medicare retirees with monthly allowances, similar to the program for Medicare retirees. These changes are not reflected in the current year financial statements but have been incorporated into the actuarial results as of December 31, 2019, the most recent valuation.

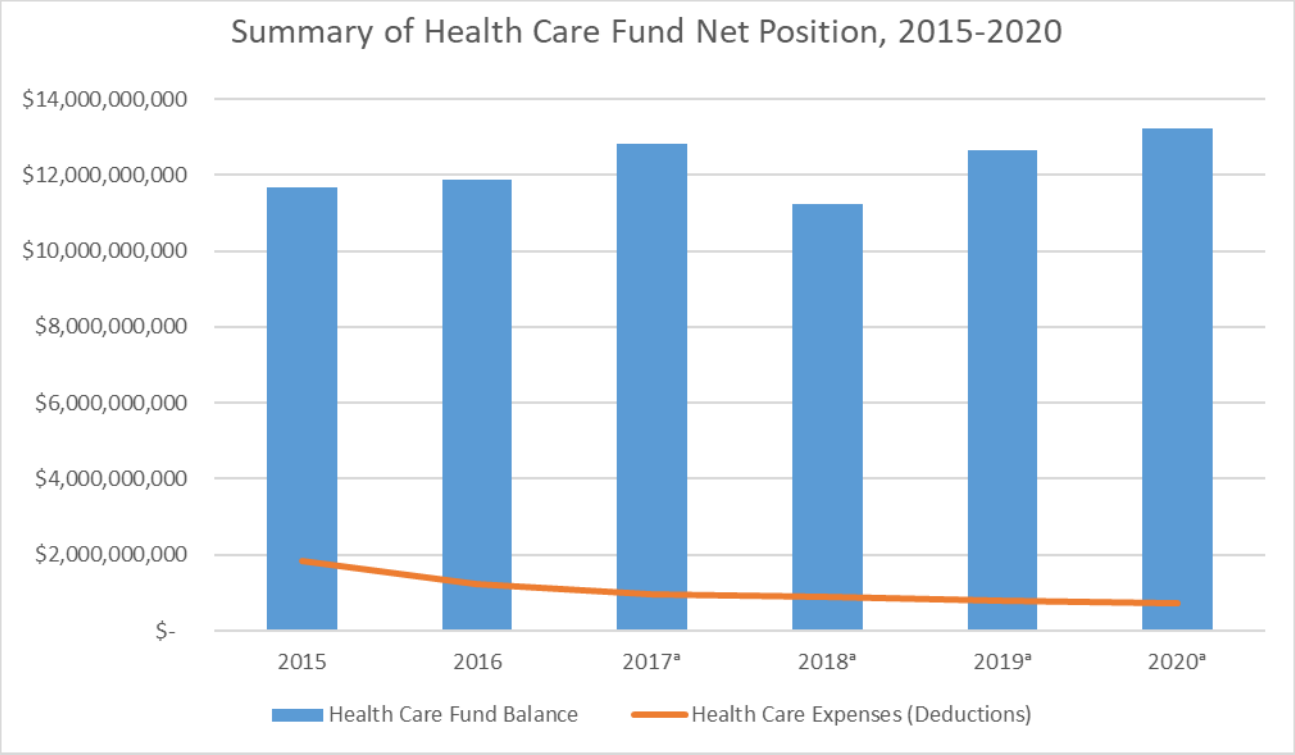
In addition to plan changes, the assumptions used in developing the appropriate funding are monitored and evaluated annually to ensure that the assumptions remain reasonable. Every five years, the actuaries conduct a detailed review of the actuarial assumptions known as an experience study. This experience study incorporates both a historical review and forward-looking projection to determine the appropriate assumptions to maintain the plan on path toward full funding. The last experience study was completed in 2016 for the period 2010-2015 and no changes were made to the long-term investment return assumption which was at 6.5% for the health care portfolio. However, during 2018 in response to changes in the market conditions, the long-term investment return assumption rate was changed from 6.5% to 6.0%. The next

regularly scheduled experience study will occur in 2021 for the period 2016-2020. The results of this experience study are expected to be available in October 2021.

The funding objective is to meet long-term pension benefit obligations and, to the extent possible, fund post-employment health care. As of December 31, 2019, the date of the latest health care actuarial valuation, the actuarial liability for health care was $11.5 billion and the System had accumulated assets of $11.9 billion for that obligation, an excess of approximately $0.5 billion. This compares to the 2018 unfunded actuarial accrued liability of $6.2 billion. The funded ratio increased from 65.3% at the end of 2018 to 104.2% in 2019. The improvement from the prior year results from the combination of recent changes to the health care plan reducing the cost of the program and strong investment returns. These changes decreased the actuarial accrued liabilities by approximately $6.4 billion from 2018 to 2019.

Financial Information

Additions	Deductions	Fund Balance	Solvency Period[1]	Employer Allocation[2]
$ 1,321,822,081	$ 741,460,732	$ 13,227,419,100	23	0%



Health Care Fund Balance (as graphed above)		
	Health Care Fund Balance	Health Care Expenses (Deductions)
2015	$ 11,678,627,027	$ 1,851,680,887
2016	$ 11,880,487,863	$ 1,220,424,124
2017ª	$ 12,818,833,665	$ 971,410,051
2018ª	$ 11,252,985,702	$ 889,891,322
2019ª	$ 12,647,057,751	$ 785,846,596
2020ª	$ 13,227,419,100	$ 741,460,732

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

[2]No employer contributions were allocated to health care in 2017 through 2020 for the Traditional Pension and Combined plans. The contributions for the Member-Directed RMAs for 2020 remained at 4%.

[a]GASB Statement No. 74 requires health care expenses be reported net of certain health care receipts. The presentation of Retiree-Paid Health Care Premiums, Federal Subsidy and formulary rebates included in Contract and Other Receipts has been revised and is now included in Health Care Expenses, starting in 2017 upon implementation of this standard.

Average Annual Cost Per Participant Paid by OPERS

Pre-Medicare Recipients	Re-employed Pre-Medicare Recipients	Medicare Recipients
$14,052	$10,204	$4,060

Pre-Medicare Recipients include OPERS benefit recipients who meet OPERS health care eligibility requirements, have not yet reached age 65 and do not qualify for any type of early Medicare eligibility.

Re-employed Pre-Medicare Recipients include OPERS benefit recipients who are not yet eligible for Medicare, meet OPERS health care program eligibility requirements and have returned to work in an OPERS-covered position. OPERS requires these recipients to enroll in their employer's health plan, provided the employer offers coverage to other employees in similar positions, allowing the OPERS Pre-Medicare plan to be a secondary payer.

Medicare Recipients include OPERS benefit recipients who meet OPERS health care program eligibility requirements, are Medicare-eligible, are enrolled in Medicare Parts A and B and are enrolled in an individual Medicare plan through the OPERS Medicare Connector. This group also includes re-employed Medicare-eligible recipients who are enrolled in the Medical Mutual Medicare Secondary Plan and receive an allowance toward their premium based on their years of qualified health care service credit and age. There are also some retirees under age 65 who qualify for Medicare due to specific conditions.

Population of Recipients

Age-and-Service	Disability	All Others (Survivors, Beneficiaries, etc.)	Total Recipients	Percent Medicare
138,288	17,743	87	156,118	83.3%

2020 Medical Mutual PPO Plan for OPERS Pre-Medicare and Pre-Medicare Re-Employed Participants

	In-Network	Out-of-Network
Deductible	$2,500	$5,000
Out-of-Pocket limit	$5,750	No limit
Lifetime Maximum	Unlimited	Unlimited
Outpatient	75%	60%
Mental health	75%	60%
Surgery	75%	60%
Emergency Room	$250* copay (emergency) $550 copay (non-emergency) 75% facility 75% all other charges	$250* copay (emergency) $550 copay (non-emergency) 75% facility 75% all other charges
Urgent Care	$60 copay	60%
Annual physical	100%**	60%***
Flu vaccines	100%**	60%***
PAP, Mammography, Colonoscopy, Sigmoidoscopy, Bone Density Testing†	100%**	60%***

All services are subject to medical necessity. After a participant meets the annual deductible and the out-of-pocket limit in a calendar year, all medically necessary services are covered at 100% with the exception of lab services subject to coverage maximums. Plan Features are general descriptions of coverage.

Out-of-pocket limit includes deductibles, copays and co-insurance amounts.
**Waived if admitted*
***Not subject to co-insurance or deductible*
****Subject to annual deductible*
† Subject to age and frequency limitations

2020 Prescription Drug Plan for Pre-Medicare and Pre-Medicare Re-Employed Participants

	Retail Preferred/Home Delivery	Retail/Non-Preferred Network
Annual deductible	$200 (generics) $400 (brands)	$200 (generics) $400 (brands)
Generic	25% co-insurance $4 min/$12 max retail $10 min/$30 max mail	30% co-insurance $7 min/$20 max
Formulary brand	35% co-insurance $30 min/$80 max retail $75 min/$200 max mail	40% co-insurance $35 min/$100 max
Non-formulary Brand	Not Covered	Not Covered
Specialty Drugs – Brand, Biosimilar/Generic	$300 max	$300 max
Annual out-of-pocket maximum	$2,400	$2,400

Supplemental Drug List (by request)

No Requests for 2020

OPERS Health Care Coverage for Medicare-eligible Retirees

OPERS Medicare Connector Health Reimbursement Arrangement (HRA)

During 2020, Medicare-eligible retirees selected an individual medical or prescription drug plan (or both) through the OPERS Medicare Connector. They were also eligible for a monthly allowance to be used for reimbursement of qualifying medical expenses. Any remaining allowance can be used to reimburse the cost of any of the following:

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

Medical Mutual Medicare Secondary Plan

The Medical Mutual Medicare Secondary Plan is the plan OPERS provides for Medicare-eligible retirees who are not eligible to participate in the OPERS Medicare Connector and receive an HRA allowance during re-employment. These retirees include Medicare-eligible, re-employed retirees and their eligible Medicare dependents as well as Medicare–eligible retirees under age 65 with specific conditions.

Medical Mutual Plan for OPERS Medicare-eligible Participants

Deductible	$1,000
Out-of-Pocket limit	$3,500*
Medical Services (% covered by plan)	
Outpatient Hospice	80% (covered by Medicare at a certified hospice agency)
Mental health	80%
Surgery	80%
Emergency Services	
Emergency Room	$150 copay (waived if admitted)
Urgent Care	$50 copay
Preventive Services**	
Annual physical	100%
Flu vaccines	100%
PAP, Mammography, Colonoscopy, Sigmoidoscopy, Bone Density Testing	100%

**Out-of-pocket limit includes deductibles, copays and co-insurance amounts.*

***This is just a representative list of the preventive services covered.*

All charges subject to medical necessity. After a participant meets the annual deductible and the out-of-pocket limit in a calendar year, all medically necessary services are covered at 100%.

A look ahead

Although health care is neither mandated nor guaranteed, the Board, management and staff, recognize the importance to our members of providing access to health care as it is a significant component of a secure retirement. This dedication to maintaining access to meaningful health care has become increasingly expensive as OPERS retirees, aligning with national trends, have increased in number, have longer life expectancies, and higher health care costs as health care expenditures continue to increase significantly faster than inflation.

OPERS faces two major issues to providing health care. First, we anticipate that health care expenses will continue to increase based on the combination of the growing number of retirees, their increasing life expectancies and overall increases in the cost of health care due to medical advances especially in the prescription drug component. Second, the funding status of the pension necessitates that all contributions be allocated to improve the pension funding. Thus, until the pension funding improves, no funding will be made available for health care. Refer to the following section for the comprehensive plan to reduce the unfunded pension liabilities.

As a result, OPERS adopted additional changes to the health care program referred to as Health Care Preservation Plan 3.1 (or HCPP 3.1). A high-level summary of changes to the health care program are described below.

On January 15, 2020, the Board voted to adopt additional changes to health care coverage for Medicare and non-Medicare retirees. These changes are designed to improve the sustainability of the health care program.
Effective January 1, 2022, OPERS will discontinue the group plans currently offered to non-Medicare retirees and re-employed retirees. Instead, eligible non-Medicare retirees will select an individual medical plan. OPERS will provide a subsidy or allowance via an HRA allowance to those retirees who meet health care eligibility requirements. Retirees will be able to seek reimbursement for plan premiums and other qualified medical expenses. A summary of the changes effective January 1, 2022 is:

Eligibility

Current retirees eligible (or who become eligible prior to January 1, 2022) to participate in the OPERS health care program will continue to be eligible after January 1, 2022. Eligibility requirements will change for those retiring after January 1, 2022.

Effective January 1, 2022, retirees in the Traditional Pension Plan or Combined Plan must meet the following health care eligibility requirements to receive an HRA allowance:

1) Medicare Retirees—Medicare-eligible with a minimum of 20 years of qualifying service credit.
2) Non-Medicare Retirees—Non-Medicare retirees qualify based on the following age-and-service criteria:
    a) Group A—30 years of qualifying service credit at any age;
    b) Group B—32 years of qualifying service credit at any age or 31 years of qualifying service credit and minimum age 52;
    c) Group C—32 years of qualifying service credit and minimum age 55; or,
    d) A retiree from groups A, B or C that qualifies for an unreduced pension, but a portion of their service credit is not health care qualifying service can still qualify for health care at age 60 if they have at least 20 years of qualifying health care service credit.

Retirees who don't meet the requirement for coverage as a non-Medicare participant can become eligible for coverage at age 65 if they have at least 20 years of qualifying service.

HRA Allowances

Effective December 31, 2021, OPERS will no longer sponsor a medical and prescription drug group plan for non-Medicare retirees. Instead, effective January 1, 2022, eligible non-Medicare retirees may receive a monthly HRA allowance for reimbursement of health care coverage premiums and other qualified medical expenses. Non-Medicare retirees will have access to the OPERS non-Medicare Connector to help them determine if the OPERS HRA allowance or the Premium Tax Credit provided through the Affordable Care Act (if they are eligible) would be most beneficial for their situation. The non-Medicare Connector will also assist them with enrolling in a medical plan on

the open market. The non-Medicare monthly base allowance will be $1,200. Retirees will receive a percentage (ranging between 51%-90%) of the base allowance determined by their age and qualified years of service at retirement.

Also effective January 1, 2022, the base allowance used to determine the monthly HRA allowance for Medicare retirees will decrease from $450 per month to $350 per month. Additionally, Medicare retirees who retired prior to January 1, 2015 and were granted an allowance of 75% will have their allowance determined based on their age and years of service at retirement. Their allowance percentage will be between 51% and 74% of the base allowance as calculated on the OPERS allowance table.

Transition Deposit

A one-time HRA deposit of $1,200 will be provided to retirees who are enrolled in the OPERS group plan effective December 1, 2021. This deposit is to assist in the transition to the individual marketplace.

Dependent Children

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

Re-employed Retirees

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

Incorporating the results from HCPP 3.1, as of December 31, 2019, the date of the most recent health care valuation, the health care assets accumulated to fund the liabilities

exceeded the liabilities by $0.5 billion resulting in a funded ratio of 104.2%, a significant improvement over the prior years funded ratio of 65.3%. Based on the expected level of health care expenditures and that OPERS has discontinued funding the health care fund, the current trust fund is expected to last approximately 23 years, a significant improvement over the prior-year solvency period of 11 years. These improvements reflect the approximate net savings of $6 billion from the HCPP 3.1 changes.

In October 2021, OPERS actuaries will also complete an experience study for the health care fund in 2021 and, as such, the above results may change. The actuarial investment return assumption for health care is 6.0%. The health care portfolio long-term investment earnings assumption is lower than the pension portfolio as the health care portfolio has a shorter duration and thus has more liquid assets and excludes the illiquid assets that provided relatively higher returns for the pension portfolio.

A Comprehensive Plan to Reduce the Unfunded Liability

During 2020, the OPERS Board approved a four-part plan with a goal of reducing the unfunded pension liabilities. While the need to reduce the unfunded pension liabilities is independent, this plan impacts health care because the System is only able to fund health care once the pension obligations are stable. The plan components and status are as follows:

Proposed Retiree Cost-of-Living Adjustment Freeze

The first component of the plan is a two-year freeze on retiree's cost-of-living adjustments. A significant portion of the unfunded liability relates to retiree's benefits and the two-year freeze on the cost-of-living adjustments provides intergenerational equity. This proposal would also modify cost-of-living adjustments for new retirees to begin 24 months after retirement rather than the current 12 months. This component of the plan has been approved by the Board; however, OPERS needs legislative approval for the change.

Combined and Member-Directed Plan Changes

The second component of the plan involves changes to the OPERS' Member-Directed (defined contribution) Plan and the Combined Plan. The Combined Plan option will no

longer be available for new hires beginning in 2022. This component is being implemented and will be effective January 1, 2022.

The Member-Directed Plan will be modified with changes to the vesting schedule, annuitization, mitigating rate, COLA, and retiree medical account funding. These changes, which have been approved by the Board and do not require legislative approval, would only impact future new members. These changes are in the process of being implemented and the final implementation date will be determined in conjunction with Group D discussed below.

New Group D Tier

OPERS proposes to create a new benefit tier for future new members. The specifics of this new tier are in discussion with stakeholder groups. This component of the plan would require legislative approval for the changes. The date of implementation will be determined by the legislative timeline.

Health Care 3.1

Changes to the health care program represent the final component of the plan. These changes, effective in 2022, will eliminate the current group plan for pre-Medicare retirees and replace it with a health reimbursement arrangement (HRA) and provide assistance from an OPERS vendor to help retirees select an individual plan on the open market. The amount of HRA allowance would vary based on the retiree's years of service and age at retirement. The HRA model was put in place for the Medicare retirees in 2015 and has been successful. In addition, HCPP 3.1 includes changes to the base allowance and reductions in the grandfathering protection. These changes are being implemented and will be effective January 1, 2022.

The combination of these four components comprise the plan to reduce the cost of both the pension plan and the health care program and improve funding. The cost reductions are necessary to adequately fund the pension program and to extend the health care program.

Note: The information contained in this section is intended to be a summary only. Complete pension and health care details can be obtained through OPERS. This document reflects approved information as of the date listed. All plans are subject to change. Health care is not a statutorily guaranteed benefit. As such, the Board has the discretion to review, rescind or modify the health care plans at any time. There is no promise, guarantee, contract, or vested right to health care coverage or an allowance.

Supplementary Statutory Requirements

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

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

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

Appendices A and B are copies of ORC Section 145.58 (group hospitalization coverage; ineligible individuals; service credit; alternate use of Health Maintenance Organization) and ORC Section 145.584 (Medicare-equivalent benefits for members ineligible for Medicare), as they existed during 2020. Both sections were amended by Substitute Senate Bill 343, effective January 7, 2013.

(2) A summary of coverage for 2020:

The following is an outline of OPERS health care coverage in 2020:

The 2020 OPERS Retiree Health Plan for Pre-Medicare Recipients

The 2020 OPERS health care plan administrator, Medical Mutual, utilized a Preferred Provider Organization (PPO) for our Pre-Medicare participants. Doctors and medical facilities that belong to the PPO network agree to perform services at agreed-upon contract rates. While participants were able to choose any provider and still receive coverage, they had lower out-of-pocket costs if they chose a network provider. Pre-Medicare re-employed retirees were in a separate plan with identical coverage. **A more detailed explanation of coverage can be found on page 6.**

Prescription Drug Coverage

Retirees enrolled in the OPERS retiree health care plan (Medical Mutual) or the Medical Mutual Pre-Medicare Re-Employed Plan received prescription drug coverage through Express Scripts.

OPERS Pre-Medicare Prescription Drug Coverage

In 2020, plan participants could receive up to a 30-day supply of medication, plus refills, as prescribed by their physician at a retail pharmacy. Plan participants could receive up to a 90-day supply of medication, plus refills, as prescribed by their physician, through the Express Scripts home delivery program. Cost share for prescriptions differs based on the delivery method, whether a drug is a generic or a name brand and its formulary status. **A more detailed explanation of coverage can be found on page 7.**

Wellness Retiree Medical Account (RMA)

Prior to 2017, Pre-Medicare plan participants also had the opportunity to earn modest wellness incentives that were deposited in a Wellness RMA. The Wellness RMA also contained excess retiree health care premium allowances. In plan year 2018, Wellness RMA participants were notified of account balances and a transition campaign was implemented with the goal of encouraging participants to seek reimbursement from their remaining balances with the intent to close these accounts. No additional deposits were made to the Wellness RMA accounts in 2019 or 2020. Account funds can be used to reimburse the retiree's qualified medical expenses.

Member-Directed Retiree Medical Account (RMA)

Upon termination from OPERS-covered employment and a distribution from the Member-Directed Plan, a participant may use the vested funds in their Member-Directed RMA to reimburse qualifying medical expenses. Vesting requirements for the Member-Directed RMA have changed over the life of the plan. The Member-Directed RMA originally required 10 years of participation to fully vest in the contributions and interest earned on the account. Effective January 1, 2009, participants were required to participate for a five-year period to become fully vested. Effective July 1, 2015, new participants to the Member-Directed RMA are required to participate for 15 years to become fully vested.

OPERS Medicare Connector Health Reimbursement Arrangement (HRA)

During 2020, Medicare-eligible retirees selected an individual medical or prescription drug plan (or both) through the OPERS Medicare Connector. The Connector is administered by a vendor selected by OPERS. The vendor assists retirees, spouses and dependents with selecting a medical and pharmacy plan. They were also eligible for a monthly allowance to be used for reimbursement of qualifying medical expenses. The allowance can be used toward the reimbursement of the premium of an individual Medicare plan. Any remaining allowance can be used to reimburse the cost of any of the following:

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

The Internal Revenue Service defines qualifying medical expenses. Claims filed through the HRA are reimbursed for qualifying medical expenses retirees and their dependents incur. Reimbursements of qualifying medical expenses are not taxable income and are not reported on any tax form. The amount of the HRA monthly allowance depends on years of qualifying service and age when first enrolled in the OPERS health care plan. HRA balances roll over from month-to-month and year-to-year.

Medical Mutual Medicare Secondary Plan

The Medical Mutual Medicare Secondary Plan is the plan OPERS provides for Medicare-eligible retirees who are not eligible to participate in the OPERS Medicare Connector and receive an HRA allowance during re-employment. These retirees include Medicare-eligible, re-employed retirees and their eligible Medicare dependents as well as Medicare–eligible retirees under age 65 with end-stage renal disease. Retirees and dependents enrolled in the Medical Mutual Medicare Secondary Plan are also enrolled in the Express Scripts Prescription Drug plan. **A more detailed explanation of prescription drug and medical coverage can be found on pages 7 and 9, respectively.**

Medicare Part A Reimbursement

Ohio law allows OPERS to provide premium reimbursement to those who are not eligible for premium-free Medicare Part A. Medicare-eligible OPERS retirees are required to enroll in, and pay, the monthly premium for Medicare Part A coverage through the Centers for Medicare and Medicaid Services. OPERS provides a monthly reimbursement for the Medicare Part A premium cost and provides a 50% Medicare Part A premium reimbursement to eligible spouses. With enrollment in both Medicare Parts A and B, retirees and eligible spouses can make a plan selection through the Connector and retirees may receive an HRA allowance.

The Dental Plan

During 2020, voluntary dental coverage was available to all OPERS retirees, and their eligible dependents, regardless of their participation in OPERS health care. The dental plan,

administered by MetLife, is intended to help defray the costs of dental care, including oral examinations, diagnostic services and extractions, as well as crowns, bridges and dentures. If a retiree chooses coverage under the dental plan, a premium payment is deducted from each monthly benefit payment. OPERS does not subsidize this plan.

The Vision Plan

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

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

Eligibility requirements for 2020 OPERS health care plans are as follows:

Age-and-Service Retirement

All OPERS members are in one of three retirement groups: Group A, Group B or Group C. The retirement group determines pension eligibility and benefit calculation. The group also affects when members will be eligible for health care coverage through OPERS. In 2020, a benefit recipient must be age 60 and have 20 years of qualifying health care service credit or have 30 years of qualifying health care service credit at any age under Group A; 31 years of qualifying health care service credit at any age under Group B; and 32 years of qualifying health care service credit at any age under Group C to be eligible for OPERS retiree health care.

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

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

Once a retiree voluntarily withdraws from OPERS health care on or after January 1, 2014, they cannot reenroll absent proof of creditable coverage or a recent involuntary termination under another plan.

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

Disability Benefit Recipients

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

Recipients with an initial disability effective date on or after January 1, 2014, will have coverage during the first five years of disability benefits. After five years, the recipient must meet minimum age-and-service health care eligibility requirements or be enrolled in Medicare due to disability status to remain enrolled in OPERS health care. If enrolled, the allowance will be determined in the same way as an age-and-service retiree.

Coverage for Surviving Spouses

If a member retired, chose a joint life or multiple life annuity plan of payment and dies, their surviving spouse will have access to the OPERS health care plans. Surviving spouses do not receive an allowance and are responsible for the full cost of coverage for the Pre-Medicare health plan. However, OPERS does provide limited HRA funding to Medicare-enrolled surviving spouses meeting a low-income requirement.

Eligible Dependents

In accordance with Ohio Administrative Code 145-4-09 and Section 152 of the Internal Revenue Code (IRC), retirees receiving a monthly age-and-service or disability benefit may enroll their legal spouse and any eligible children under the age of 26.

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

- For a child to be eligible for coverage, the child must be under the age of 26 (regardless of enrollment as a full-time student or marital status). Coverage may be extended if the child is permanently and totally disabled prior to age 22. This means that the child is not able to work in any substantial gainful activity because of a physical or mental impairment which has lasted or is expected to last for at least 12 months. Evidence of the incapacity is required and is subject to approval by OPERS.

Participants in OPERS health care receiving a monthly benefit as the surviving spouse or beneficiary of a deceased retiree or deceased member may only enroll those dependents that would have been eligible dependents of the deceased retiree or member as defined on this page.

Coverage Options

In 2020, OPERS continued to provide monthly allowances for health care coverage for Traditional Pension Plan and Combined Plan retirees and their eligible dependents in various OPERS-sponsored plans. For those retiring on or after January 1, 2015, the allowance (subsidy) provided by OPERS is based on age and years of qualifying service credit when a recipient first enrolls in OPERS health care.

In 2020, OPERS offered medical and pharmacy plans for recipients yet to enroll in Medicare. Monthly allowances were used to offset the monthly premium for the coverage provided. Traditional Pension Plan and Combined Plan retirees enrolled in Medicare Parts A and B received an allowance credited to an HRA to be used to reimburse qualifying medical expenses associated with the coverage in which the retiree is enrolled through the Connector. If the retiree is living, the retiree may use their HRA to reimburse the cost of a spouse's coverage. Spouses eligible for Medicare began to have access to the Connector in 2016; spouses not yet eligible for Medicare have access to OPERS coverage at full cost. If the retiree has at least 20 years of qualifying service and is enrolled in OPERS health care, children (up to age 26) receive half of the retiree's allowance percentage. If the recipient has less than 20 years of qualifying service, children (up to age 26) have access to OPERS coverage at the full cost.

Member-Directed Retiree Medical Account (RMA)

Member-Directed Plan participants are provided with a Member-Directed RMA. The plan holds the portion of employer contributions of the Member-Directed Plan participants that are set aside for funding retiree health care. Upon separation or retirement, the participant may use the vested funds in their Member-Directed RMA to reimburse qualified health care expenses. Members with an account prior to July 1, 2015 become vested in the account at a rate of 20% for each year of participation until the member is fully vested at the end of five years. For members establishing accounts on or after July 1, 2015, the member is fully vested after 15 years at a rate

of 10% for each year starting in the sixth year of participation. The account earns a fixed annual interest rate established by the Board. Interest on the RMA accrues only if the investment portfolio containing the RMA assets earns a return greater than zero in the prior year.

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

As of December 31, 2020, there were 175,606 OPERS retirees and primary beneficiaries eligible to participate in OPERS health care. In addition to a retiree, a primary benefit recipient could be a survivor of a deceased retiree continuing to receive coverage on the retiree's account, which is representative of the OPERS contributing membership.

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

OPERS financial statements are prepared using the accrual basis of accounting under which deductions are recorded when the expense is incurred, and revenues are recognized when earned. Health care payments are considered an expense and recognized as a liability when a present obligation exists and a condition that requires the event creating the liability has taken place. Therefore, OPERS estimates health care claims which have been incurred at year-end, but which have not yet been reported to the System as of fiscal year end. Health care reimbursements are recognized when they become measurable and due to OPERS based on contractual requirements. Therefore, health care reimbursements contain estimates based on information received from health care vendors and other sources.

Investment purchases and sales are recorded as of their trade date. Investments are generally reported at fair value. Fair value is the amount that a plan can reasonably expect to receive for an investment in a current sale between a willing buyer and a willing seller, that is, other than in a forced or liquidation sale. All investments, with the exception of real estate, private equity, and hedge funds, are valued based on closing market prices or broker quotes. Securities not having a quoted market price have been valued based on yields currently available on comparable securities of issuers with similar credit ratings. The fair value of some real estate investments, private equity and hedge funds is based on a net asset value, which is established by the fund or by the fund's third-party administrator.

Employer contributions and investment earnings are used to fund health care expenses. No portion of the employer contributions for the Traditional Pension and Combined plan members were credited to the 115 Health Care Trust (115 Trust) for the year ended December 31, 2020. The health care contribution rate allocation for the Member-Directed Plan retiree medical accounts (RMAs) for 2020 remained at 4%. In 2017, OPERS implemented Governmental Accounting Standards Board Statement No. 74 (GASB 74), Financial Reporting for

Postemployment Benefit Plans Other Than Pension Plans. GASB 74 requires that certain health care receipts, or payments, from retirees and health care vendors to OPERS, offset the related health care expenses reported in the Health Care Expenses category in the Statement of Changes in Fiduciary Net Position. The presentation of Retiree-Paid Health Care Premiums, Federal Subsidy, and rebates previously included in Contract and Other Receipts, has been revised and these health care receipts are now included in health care expenses.

The 115 Trust was established in 2014. The 401(h) Health Care Trust and Voluntary Employees' Beneficiary Association Trust were closed as of June 30, 2016 and the net positions transferred to the 115 Trust on July 1, 2016. Beginning 2016, the 115 Trust pre-funds and holds the portion of employer contributions of the Traditional Pension, Combined and Member-Directed plans set aside for funding retiree health care.

The funded status of health care as of December 31, 2019, the most recent actuarial valuation, was 104.2%. The funding progress of health care is measured in terms of solvency years, or the number of years funds are projected to be available to pay health care expenses under the current plan design before health care would be reduced to a pay-as-you-go basis. The fund is expected to become insolvent after 23 years as of the December 31, 2019 valuation.

The Board approved changes to the OPERS health care plans in 2012. The ultimate goal of the health care changes was to match the funding of the health care trust and disbursements from the health care trust. Additionally, the Board established a health care stabilization fund to hold investment earning income in excess of the funding assumption. The balance of the stabilization fund will supplement income to the health care core (operating) fund when employer contributions or investment income of 4% was not available during the year or disbursements from the trust exceed 4% during the year. The stabilization fund is an accounting function only and not listed separately in the financial statements. This stabilization fund is included in the health care results provided throughout this report. Health care valuations are prepared using total health care fund assets.

On January 15, 2020, the Board approved several changes to the health care plan offered to Medicare and Pre-Medicare retirees in efforts to decrease costs and increase the solvency of the health care plan. These changes are effective January 1, 2022 and include changes to base allowances and eligibility for Medicare retirees, as well as replacing OPERS-sponsored medical plans for Pre-Medicare retirees with monthly allowances, similar to the program for Medicare retirees. These changes are not reflected in the current year financial statements; however, they are reflected in the total actuarial accrued liability in the most recent actuarial valuation as of December 31, 2019.

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

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

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

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

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

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

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

No significant changes affecting the comparability of the report.

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

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

Appendix A – Ohio Revised Code Sec. 145.58

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

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

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

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

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

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

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

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

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

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

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

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

Appendix B – Ohio Revised Code Sec. 145.584

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

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

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

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

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

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

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

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

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

Appendix C – Statements of Fiduciary Net Position – Health Care

	2020	2019	2018	2017	2016	2015
115 Health Care Trust[1]						
Assets						
Cash and Cash Equivalents	**$1,027,292,218**	**$818,204,587**	**$595,183,342**	**$823,866,242**	**$874,632,840**	**$228,930,728**
Receivables						
Members and Employers	1,911,304	1,892,495	2,016,190	17,310,993	28,954,270	31,146,407
Vendor and Other	17,761,491	12,585,164	12,173,150	10,325,432	67,090,996	140,747,042
Investment Sales Proceeds	31,752,833	52,212,702	38,943,225	58,028,023	70,760,106	744,048
Accrued Interest and Dividends	45,461,914	46,169,385	44,840,466	44,801,284	41,092,533	1,246,089
Total Receivables	**96,887,542**	**112,859,746**	**97,973,031**	**130,465,732**	**207,897,905**	**173,883,586**
Investments						
Fixed Income	4,895,416,249	4,855,122,000	4,117,147,799	4,348,639,837	4,087,785,698	296,365,386
Domestic Equities	3,518,558,498	3,183,847,864	2,911,258,188	3,403,242,732	3,071,759,733	82,245,096
International Equities	3,079,326,933	2,674,811,901	2,240,589,009	2,645,509,612	2,265,107,975	58,142,626
Other Investments	726,811,028	1,237,576,242	1,495,996,430	1,654,750,270	1,534,240,696	48,222,156
Total Investments	**12,220,112,708**	**11,951,358,007**	**10,764,991,426**	**12,052,142,451**	**10,958,894,102**	**484,975,264**
Collateral on Loaned Securities	**53,244,143**					
Capital Assets						
Land	942,728	942,728	942,728	942,728	942,728	
Building and Building Improvements	27,894,673	27,971,184	27,986,068	27,998,673	28,004,098	
Furniture and Equipment	32,258,995	34,246,182	32,854,966	33,676,485	32,759,796	1,441,984
Right-to-use Assets	2,521,393					
Total Capital Assets	63,617,789	63,160,094	61,783,762	62,617,886	61,706,622	1,441,984
Accumulated Depreciation	(40,619,545)	(41,103,250)	(38,171,032)	(36,873,343)	(33,678,510)	
Net Capital Assets	**22,998,244**	**22,056,844**	**23,612,730**	**25,744,543**	**28,028,112**	**1,441,984**
TOTAL ASSETS	**13,420,534,855**	**12,904,479,184**	**11,481,760,529**	**13,032,218,968**	**12,069,452,959**	**889,231,562**
Liabilities						
Undistributed Deposits	22,848	196,350	214,798	230,367	287,413	10,021
Benefits Payable	107,300,342	115,181,776	119,532,084	114,643,770	109,142,271	1,634,811
Investment Commitments Payable	32,561,762	142,043,307	109,027,945	98,511,166	79,535,412	1,789,658
Accounts Payable and Other Liabilities						44,685,032
Obligations Under Securities Lending	53,230,803					
TOTAL LIABILITIES	**193,115,755**	**257,421,433**	**228,774,827**	**213,385,303**	**188,965,096**	**48,119,522**
Net Position Restricted for OPEB	**$13,227,419,100**	**$12,647,057,751**	**$11,252,985,702**	**$12,818,833,665**	**$11,880,487,863**	**$841,112,040**

Source: 2015-2020 Comprehensive Annual Financial Reports

[1]The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association (VEBA) Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016.

Appendix C – Statements of Fiduciary Net Position – Health Care

	2015
401(h) Health Care Trust[1]	
Assets	
Cash and Cash Equivalents	**$437,888,805**
Receivables	
Members and Employers	
Early Retirement Incentive Plan	
Vendor and Other	677,725
Investment Sales Proceeds	43,193,263
Accrued Interest and Dividends	39,359,404
Total Receivables	**83,230,392**
Investments	
Fixed Income	3,733,008,136
Domestic Equities	2,969,522,823
International Equities	2,221,451,642
Other Investments	1,390,445,167
Total Investments	**10,314,427,768**
Capital Assets	
Land	916,220
Building and Building Improvements	27,256,121
Furniture and Equipment	29,358,536
Total Capital Assets	57,530,877
Accumulated Depreciation	(30,510,198)
Net Capital Assets	**27,020,679**
TOTAL ASSETS	**10,862,567,644**
Liabilities	
Undistributed Deposits	243,005
Benefits Payable	91,451,759
Investment Commitments Payable	76,923,764
Accounts Payable and Other Liabilities	22,880,935
TOTAL LIABILITIES	**191,499,463**
Net Position Restricted for OPEB	**$10,671,068,181**

Source: 2015 Comprehensive Annual Financial Report

[1] The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association (VEBA) Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. No activity exists as of December 31, 2016 through 2020.

Appendix C – Statements of Fiduciary Net Position – Health Care

	2015
Voluntary Employees' Beneficiary Association Trust[1]	
Assets	
Cash and Cash Equivalents	**$4,675,584**
Receivables	
Members and Employers	13,932,389
Investment Sales Proceeds	532,305
Accrued Interest and Dividends	437,722
Total Receivables	**14,902,416**
Investments	
Fixed Income	37,189,326
Domestic Equities	27,429,090
Real Estate	17,627,759
Private Equity	19,309,205
International Equities	28,135,488
Other Investments	23,392,047
Total Investments	**153,082,915**
Collateral on Loaned Securities	**18,887,694**
Capital Assets	
Land	26,508
Building and Building Improvements	788,568
Furniture and Equipment	2,196,905
Total Capital Assets	3,011,981
Accumulated Depreciation	(2,180,336)
Net Capital Assets	**831,645**
TOTAL ASSETS	**192,380,254**
Liabilities	
Benefits Payable	208,449
Investment Commitments Payable	843,360
Due to Other Plans	5,992,744
Obligations Under Securities Lending	18,888,895
TOTAL LIABILITIES	**25,933,448**
Net Position Restricted for OPEB	**$166,446,806**

Source: 2015 Comprehensive Annual Financial Reports

[1] The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association (VEBA) Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. No activity exists as of December 31, 2016 through 2020.

Appendix D

Statements of Changes in Fiduciary Net Position – Health Care

	2020	2019	2018	2017	2016	2015
115 Health Care Trust[1]						
Additions						
Employer Contributions	$24,489,938	$24,318,141	$23,441,668	$157,417,888	$274,419,455	$253,673,333
Contract and Other Receipts[2]	513,509	540,809	279,178	857,541	93,306,585	95,860,582
Retiree-Paid Health Care Premiums[2]					184,368,783	
Federal Subsidy[2]					4,065,058	175,930,875
Other Income, net	430,729	1,724	732,193	117,882	15,715	10
Interplan Activity					6,036,782	
Total Non-investment Income	**25,434,176**	**24,860,674**	**24,453,039**	**158,393,311**	**562,212,378**	**525,464,800**
Income/(Loss) From Investing Activities						
Net Increase/(Decrease) in the Fair Value of Investments	1,098,039,399	1,600,900,770	(862,731,054)	1,303,745,052	160,473,865	(17,539,101)
Bond Interest	136,102,586	162,002,938	108,077,693	162,929,606	92,284,043	6,517,201
Dividends	92,781,749	428,602,794	88,148,545	325,553,345	130,678,719	(9,556,397)
International Income/(Loss)	(45,357)	227,029	398,457	248,369	(1,998)	(1,178)
Other Investment Income/(Loss)	(832,267)	2,172,948	293,975	396,299	(282,340)	(43,576)
External Asset Management Fees	(24,247,532)	(33,296,008)	(28,772,749)	(36,062,800)	(27,669,191)	(2,147,433)
Net Investment Income/(Loss)	**1,301,798,578**	**2,160,610,471**	**(694,585,133)**	**1,756,809,871**	**355,483,098**	**(22,770,484)**
From Securities Lending Activity						
Securities Lending Income	452,507					
Securities Lending Expenses	(229,778)					
Net Securities Lending Income	222,729	-	-	-	-	-
Unrealized Gains	12,692					
Net Income from Securities Lending	**235,421**	**-**	**-**	**-**	**-**	**-**
Investment Administrative Expenses	(5,646,094)	(5,552,500)	(5,824,547)	(5,447,329)	(2,853,560)	(302,871)
Net Income/(Loss) from Investing Activity	**1,296,387,905**	**2,155,057,971**	**(700,409,680)**	**1,751,362,542**	**352,629,538**	**(23,073,355)**
TOTAL ADDITIONS	**1,321,822,081**	**2,179,918,645**	**(675,956,641)**	**1,909,755,853**	**914,841,916**	**502,391,445**
Deductions						
Health Care Expenses[2]	725,265,912	767,888,929	870,284,919	952,001,573	1,195,956,899	45,184,620
Administrative Expenses	16,194,820	17,957,667	19,606,403	19,408,478	21,693,387	2,174,957
TOTAL DEDUCTIONS	**741,460,732**	**785,846,596**	**889,891,322**	**971,410,051**	**1,217,650,286**	**47,359,577**
Special Item[1]						
Interplan Activity—Trust Closures					**11,342,184,193**	
Net Increase/(Decrease)	580,361,349	1,394,072,049	(1,565,847,963)	938,345,802	11,039,375,823	455,031,868
Net Position Restricted for OPEB						
Balance, Beginning of Year	12,647,057,751	11,252,985,702	12,818,833,665	11,880,487,863	841,112,040	386,080,172
Balance, End of Year	**$13,227,419,100**	**$12,647,057,751**	**$11,252,985,702**	**$12,818,833,665**	**$11,880,487,863**	**$841,112,040**

Source: 2015-2020 Comprehensive Annual Financial Reports

[1]The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association (VEBA) Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. The Special Item represents this interplan activity and nets to zero in consolidation.

[2] GASB Statement No. 74 requires health care expenses be reported net of certain health care receipts. The presentation of Retiree-Paid Health Care Premiums, Federal Subsidy and formulary rebates included in Contract and Other Receipts, has been revised and is now included in Health Care Expenses, beginning in 2017 upon implementation of this standard.

Appendix D

Statements of Changes in Fiduciary Net Position – Health Care

	2016	2015
401(h) Health Care Trust[1]		
Additions		
Contract and Other Receipts		$9,435
Retiree-Paid Health Care Premiums		248,601,375
Total Non-investment Income		**248,610,810**
Income/(Loss) From Investing Activities		
Net Increase/(Decrease) in the Fair Value of Investments	$428,632,525	(453,577,747)
Bond Interest	(60,085,563)	157,207,141
Dividends	131,736,664	105,609,193
International Income/(Loss)	3,751	(11,506)
Other Investment Income	14,158	652,343
External Asset Management Fees	(7,012,448)	(27,988,205)
Net Investment Income/(Loss)	**493,289,087**	**(218,108,781)**
Investment Administrative Expenses	(3,080,517)	(5,355,603)
Net Income/(Loss) from Investing Activity	**490,208,570**	**(223,464,384)**
TOTAL ADDITIONS	**490,208,570**	**25,146,426**
Deductions		
Health Care Expenses		1,774,989,836
Administrative Expenses		19,611,199
TOTAL DEDUCTIONS		**1,794,601,035**
Special Item[1]		
Interplan Activity—Trust Closures	**(11,161,276,751)**	
Net Decrease	(10,671,068,181)	(1,769,454,609)
Net Position Restricted for OPEB		
Balance, Beginning of Year	10,671,068,181	12,440,522,790
Balance, End of Year	**$0**	**$10,671,068,181**

Source: 2015-2016 Comprehensive Annual Financial Reports

[1] The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association (VEBA) Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. The Special Item represents this interplan activity and nets to zero in consolidation. No activity exists for years ended December 31, 2017 through 2020.

Appendix D

Statements of Changes in Fiduciary Net Position – Health Care

	2016	2015
Voluntary Employees' Beneficiary Association Trust[1]		
Additions		
Employer Contributions[2]	$10,483,804	
Contract and Other Receipts	22,722	
Total Non-investment Income	**10,506,526**	
Income/(Loss) From Investing Activities		
Net Increase/(Decrease) in the Fair Value of Investments	2,277,759	($5,883,465)
Bond Interest	1,222,858	1,902,518
Dividends	1,738,911	826,237
Real Estate Operating Income	1,026,057	2,959,962
International Income	79	371
Other Investment Income	517,933	1,724,353
External Asset Management Fees	(92,819)	(907,438)
Net Investment Income	**6,690,778**	**622,538**
From Securities Lending		
Securities Lending Income	92,902	106,312
Securities Lending Expense	(41,106)	(23,811)
Net Securities Lending Income	51,796	82,501
Unrealized Gains/(Losses)	4,152	(1,202)
Net Income from Securities Lending	**55,948**	**81,299**
Investment Administrative Expenses	(40,192)	(75,920)
Net Income from Investing Activity	**6,706,534**	**627,917**
TOTAL ADDITIONS	**17,213,060**	**627,917**
Deductions		
Health Care Expenses	1,417,445	2,396,972
Administrative Expenses	629,201	1,330,559
Interplan Activity	727,192	5,992,744
TOTAL DEDUCTIONS	**2,773,838**	**9,720,275**
Special Item[1]		
Interplan Activity—Trust Closures	**(180,886,028)**	
Net Increase/(Decrease)	(166,446,806)	(9,092,358)
Net Position Restricted for OPEB		
Balance, Beginning of Year	166,446,806	175,539,164
Balance, End of Year	**$0**	**$166,446,806**

Source: 2015-2016 Comprehensive Annual Financial Reports

[1] The 115 Health Care Trust was established in 2014. The 401(h) Health Care Trust and the Voluntary Employees' Beneficiary Association (VEBA) Trust were terminated as of June 30, 2016 and the net positions of these trusts were consolidated into the 115 Health Care Trust on July 1, 2016. The Special Item represents this interplan activity and nets to zero in consolidation. No activity exists for years ended December 31, 2017 through 2020.

[2] Beginning in October 2014, the Board approved the funding of the VEBA Trust participant accounts using the reserves in the VEBA Trust rather than the allocation of employer contributions. Instead, employer contributions were allocated to the Member-Directed Plan to repay the original plan start-up and administrative costs.