NOTICE

1. The Health Care Committee will meet on **Tuesday, September 17, 2019 at 11:30 a.m.** in the offices of the Board.

2. The **OPERS Board** will meet on **Wednesday, September 18, 2019 at 9:00 a.m.** in the offices of the Board.

3. The **Personnel and Salary Review Committee** will meet on **Wednesday, September 18, 2019 immediately following the Board meeting** in the offices of the Board.
I. Discussion Items:

A. Individual Marketplace Overview – John Barkett, Senior Director of Policy Affairs, Willis Towers Watson

B. Fahlgren Mortine survey results – Fahlgren Mortine Presenters
John Barkett is the Senior Director of Policy Affairs for Willis Towers Watson. John is responsible for strategy and development as it pertains to both federal and state health policy, as well as the product development and marketing of Willis Towers Watson’s various marketplace solutions. He previously worked for Extend Health, the nation’s largest private Medicare exchange, before it was acquired by Towers Watson in 2012. (Towers Watson merged with Willis in 2016.)

Before joining Extend Health, John spent two and a half years in Washington, D.C., where he contributed to the writing, passage, and implementation of the Patient Protection and Affordable Care Act. John served on the health subcommittee staff of the Ways and Means Committee in the House of Representatives in 2009 where he drafted and negotiated the final details of legislation aimed at reducing fraud in the Medicare program. After the bill’s passage, John joined the staff of the Office of Health Reform in the Department of Health and Human Services, where he helped guide the implementation of all sections of the Affordable Care Act related to delivery system reform.


Contact

John Barkett
Senior Director of Policy Affairs, Benefits Delivery and Administration
Willis Towers Watson
Phone: 415-264-2516
Email: john.barkett@willistowerswatson.com
Individual Marketplace Overview

OPERS Board Meeting

John Barkett, Senior Director of Policy Affairs

September 17, 2019
Agenda

I. Individual Marketplace Overview

II. Ohio Individual Marketplace

III. OPERS Pre-Medicare Plans vs. Individual Market Plans

IV. Policy Environment

V. Connector Services for Pre-Medicare Retirees

VI. Wrap-up — Big Picture
Definitions

**ACA**: Affordable Care Act
- Also known as “Obamacare”

**CMS**: Center for Medicare and Medicaid Services
- The federal agency that administers Medicare, Medicaid and the public exchanges

**FPL**: Federal Poverty Level
- $12,490 in 2019
I. Individual Marketplace Overview
Section I. Individual Marketplace Overview

What we’ll discuss:

▪ How the ACA changed individual market plans
▪ How Ohio has implemented the ACA
▪ Seven key aspects of the individual market
Prior to the ACA, individual health plans lacked consumer protections commonly found in group health plans

<table>
<thead>
<tr>
<th>Before the ACA:</th>
<th>After the ACA:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No coverage of pre-existing conditions</td>
<td>Coverage of all pre-existing conditions</td>
</tr>
<tr>
<td>Deny coverage to sick people</td>
<td>Offer coverage to everyone</td>
</tr>
<tr>
<td>Sicker people charged more</td>
<td>Sicker people charged the same as healthy</td>
</tr>
<tr>
<td>No coverage of certain benefit categories (e.g. hospitalization; Rx)</td>
<td>Coverage of all Essential Health Benefits</td>
</tr>
<tr>
<td>Sales through insurers, agents or brokers</td>
<td>Option to purchase through public exchange</td>
</tr>
<tr>
<td>No discounts for lower income buyers</td>
<td>Tax credits for lower income buyers who purchase through public exchange</td>
</tr>
</tbody>
</table>
States implementing the ACA can shape their marketplaces by expanding Medicaid and operating their own exchange

Ohio chose not to operate a state exchange
- By choosing not to run its own exchange, Ohio decided to have CMS run the public exchange in its place
- Ohio’s Department of Insurance remains responsible for certifying which insurance carriers offer individual market plans in the state

Ohio chose to expand the state’s Medicaid program
- By expanding Medicaid, Ohio made all Ohioans who earn less than 133% of the FPL eligible for Medicaid coverage
- Research shows individual market premiums in Medicaid expansion states are lower than they would be had the state not expanded its Medicaid program

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Medicaid Eligibility Ceiling</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Single)</td>
<td>$16,612</td>
</tr>
<tr>
<td>2 (Couple)</td>
<td>$22,491</td>
</tr>
<tr>
<td>4 (Family of four)</td>
<td>$34,248</td>
</tr>
</tbody>
</table>
Individual market carriers compete in a regulated marketplace

Here are the rules you need to know:

1. Essential Health Benefits
2. Metal Tiers
3. Individual and Family Plans
4. Tax Credits for Low Income Households
5. On-exchange and Off-exchange Plans
6. Rating Rules
7. Medical Loss Ratio (MLR) Rule
Individual market plans cover the same benefits as traditional group health plans

**Essential Health Benefits:** All individual market plans must cover the Essential Health Benefits (EHB):

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Pregnancy, maternity, and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care
Metal tiers make it easier to compare “like” plans

Metal tiers:

- All plans fall into one of five metal tiers according to the plan’s actuarial value (AV).
- The AV is a measure of the plan’s generosity; the higher the AV, the larger percentage of costs the plan is expected to cover.

<table>
<thead>
<tr>
<th>Metal Tier</th>
<th>Actuarial Value</th>
<th>% of Ohioans in This Type of Plan*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catastrophic</td>
<td>50%</td>
<td>2%</td>
</tr>
<tr>
<td>Bronze</td>
<td>60%</td>
<td>45%</td>
</tr>
<tr>
<td>Silver</td>
<td>70%</td>
<td>48%</td>
</tr>
<tr>
<td>Gold</td>
<td>80%</td>
<td>5%</td>
</tr>
<tr>
<td>Platinum**</td>
<td>90%</td>
<td>0%</td>
</tr>
</tbody>
</table>

* Source: CMS Public Use File 2019. Numbers do not include plans sold outside the public exchange.
** No carrier offers platinum plan coverage in the Ohio individual market.
People can enroll in plans as individuals or as a family

**Individual and Family Plans:** Unlike in Medicare, individual market consumers can purchase coverage as individuals or as a family.

- Premiums for family plans increase with each new family member, but families may only be charged for up to three dependents 20 years old or younger.

- A household may choose to enroll a family member with significant medical needs into a different plan than the rest of the household.
  - For example, if one member of a family requires significant care, that member can enroll in a gold plan while the other family members can enroll in a bronze plan.

- While family members may enroll in unique plans, by enrolling in one family plan they can lower their total out-of-pocket exposure for the year.

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>2019 Out-of-Pocket Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$7,900</td>
</tr>
<tr>
<td>Family</td>
<td>$15,800</td>
</tr>
</tbody>
</table>
Tax credits that lower premium and cost-sharing are available to lower premiums for those who qualify

**Tax credits for lower income households:**

- Households that earn less than 400% of FPL are eligible for tax credits that lower their premiums.
- Households that earn less than 250% of FPL can purchase silver plans “enhanced” with gold and platinum-level benefits.
- Household that earn less than 133% of FPL qualify to enroll in Medicaid.

<table>
<thead>
<tr>
<th>Income as a Percentage of FPL</th>
<th>Income in $</th>
<th>Medicaid Eligibility</th>
<th>Tax Credit Eligibility</th>
<th>Enhanced Silver Plan Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 133%</td>
<td>Less than $16,612</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>133% to 250%</td>
<td>$16,612 – $24,980</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>250% to 400%</td>
<td>$24,980 – $49,960</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Above 400%</td>
<td>More than $49,960</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
People eligible for subsidized coverage must enroll through the public exchange

**On-exchange vs. off-exchange:** All individual market plans sold through the public exchange (“on-exchange”) or purchased directly from an insurer or broker (“off-exchange”) must comply with the ACA’s rating rules, consumer protections and minimum benefit requirements.

- **On-exchange enrollment**
  - Access to federal tax credits upon enrollment
  - Access to federal tax credits if you have a change of income midyear

- **Off-exchange enrollment**
  - Access to additional carrier and plan options in some states
    - In Ohio, all carriers offer plans on- and off-exchange
  - Access to lower cost silver plans in most states
    - Three of nine Ohio carriers offered a subset of their silver plans at a discount off-exchange in 2019
      - (MedMutual, Oscar and Paramount)
    - Six of nine Ohio carriers priced their silver plans the same way on- and off-exchange

Remember: Benefit advisors will help Pre-Medicare retirees choose the right type of plan
Premiums are set according to pre-defined rating rules, not health status

**Rating rules**: The ACA requires insurers to set premiums according to a rules that all carriers must follow

Consumers must be charged the same premiums, with allowable modifications for:

- Age (3:1)
- Family size (per capita)
- Geography (rating area)
- Tobacco usage (1.5:1)

**Key Takeaway**: Premiums for 60-64 year olds increase faster than any other age.
Insurers must pay back customers when their profits are too high

**Medical Loss Ratio (MLR) Rule:** an MLR is a ratio of claims paid to premiums collected that insurers use when measuring profitability. In a competitive insurance market, at least 80-85% of collected premiums should go toward paying for medical claims or quality improvement activities.

- The ACA requires insurers with MLRs under 80% to pay refunds to their customers.
- Most insurers did not pay refunds from 2014-2016, though that is starting to change as carriers have become profitable.
Individual Marketplace Overview Wrap-up

Key Take-aways:

▪ The ACA added consumer protections to the individual market consistent with protections commonly found in the group market

▪ Ohio expanded Medicaid but chose not to run their own state-based public exchange

▪ Lower income individuals can qualify for tax credits that lower their premiums and cost-sharing

▪ Higher income individuals can lower their premiums if they are part of a retiree program that provides an allowance

▪ Navigating a marketplace with unique rating rules, metal tiers, and a choice between on-exchange and off-exchange plans can be made easier for retirees with the help of a connector service
II. Ohio Individual Marketplace
Section II. Ohio Individual Marketplace

What we’ll discuss:

- Carrier options available across the country and in Ohio
- How carrier options differ in urban and rural areas
- How carrier options in Ohio have changed over time
Insurer participation has fluctuated since 2014

Source: Kaiser Family Foundation

Key Takeaway: With 9 carriers available in 2020, carrier participation has stabilized in Ohio.
A majority of counties in the United States have one or two insurer options in 2019
But over 58% of marketplace consumers have three or more insurer options

**Insurer Participation by County, 2019**

Source: CMS

**Key Takeaway:** Carriers enter markets with the most customers, though states can play a role in attracting carriers to participate
Insurers enter markets with the most customers

Public Exchange Enrollment and Ohio Insurer Participation by County, 2019

Source: CMS and Ohio Department of Insurance
44 counties in Ohio will gain one or two carriers in 2020

Ohio Insurer Participation by County, 2019 and 2020

Source: Ohio Department of Insurance
Nine carriers will offer coverage in Ohio in 2020

Ohio Insurer Participation by Carrier, 2014 – 2020

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambetter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AultCare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CareSource</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Med Mutual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Molina</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paramount</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SummaCare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anthem</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oscar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For carriers previously participating in the Ohio Individual Market, see Appendix.
The Ohio Individual Marketplace Wrap-up

Key Take-aways:

▪ When it comes to carrier participation, the Ohio Individual marketplace has entered a period of stability

▪ Competition is increasing in Ohio, as carriers expand their footprints in 2020

▪ We are seeing similar trends in other parts of the country

▪ Increased competition will lead to a better environment for consumers in the individual marketplace
III. OPERS Pre-Medicare Plans vs. Individual Market Plans
Section III. OPERS Pre-Medicare Plans vs. Individual Market Plans

What we’ll discuss:

▪ How tax credits and plan sponsor contributions work with Individual Market plans

▪ How the 2019 OPERS Pre-Medicare Plan features compare to Individual Market plan features, including:
  ▪ Premiums
  ▪ Plan Designs
  ▪ Provider Networks

▪ How the 2019 OPERS Pre-Medicare Dental and Vision Plans compare to Individual Market plans
A major difference between the OPERS Pre-Medicare Plan and the Individual Market is the availability of tax credits to lower premiums.

**Tax credits for lower income households:**

- Households that earn less than 400% of FPL are eligible for tax credits that lower their premiums.
- The tax credits are designed to limit premiums a person would pay for the “benchmark plan” in a the person’s zip code to a percentage of that person’s income.*

**Example:** 60-year-old retiree living in Franklin County, OH earns $38,000 a year.

* The benchmark plan is the second lowest cost silver plan available.
A major difference between the OPERS Pre-Medicare Plan and the Individual Market is the availability of tax credits to lower premiums

Tax credits for lower income households:

- Households that earn less than 400% of FPL are eligible for tax credits that lower their premiums.
- The tax credits are designed to limit premiums a person would pay for the “benchmark plan” in a the person’s zip code to a percentage of that person’s income.*

Example: 60-year-old retiree living in Franklin County, OH earns $38,000 a year.

- The benchmark plan in Franklin County is the Oscar Classic Silver plan.
- The 2019 premium for this plan for a 60-year-old is $9,801 per year ($818 per month)**
- The retiree’s premium for the benchmark plan is capped at 9.86% of their income, or $3,747 per year ($312 per month)
- The retiree is eligible for a tax credit of $6,054 per year ($505 per month)
- The tax credit can be applied to lower the premium of any plan purchased through the public exchange, not just the benchmark plan

* The benchmark plan is the second lowest cost silver plan available.
** Numbers may not appear exact due to rounding.
People with lower income are eligible for higher tax credits

Tax credits for lower income households:

- Households that earn less than 400% of FPL are eligible for tax credits that lower their premiums.
- The tax credits are designed to limit premiums a person would pay for the “benchmark plan” in a the person’s zip code to a percentage of that person’s income.*

Example: 60-year-old retiree living in Franklin County, OH earns $20,000 a year.

- The benchmark plan in Franklin County is the Oscar Classic Silver plan.
- The 2019 premium for this plan for a 60-year-old is $9,801 per year ($818 per month)
- The retiree’s premium for the benchmark plan is capped at 4.85% of their income, or $970 per year ($81 per month)
- The retiree is eligible for a tax credit of $8,831 per year ($736 per month)
- The tax credit can be applied to lower the premium of any plan purchased through the public exchange, not just the benchmark plan

* The benchmark plan is the second lowest cost silver plan available.
Premiums jump significantly for those ineligible for tax credits

The table below shows the tax credits available to the 60 year-old in Franklin County from the previous example at income levels between $15,000 and $50,000.

<table>
<thead>
<tr>
<th>2019 Income</th>
<th>Premium Cap for Benchmark Plan* (% of annual income)</th>
<th>Premium for Benchmark Plan* (Monthly)</th>
<th>Tax Credit Applicable to Any Public Exchange Plan (Monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,000</td>
<td>Medicaid eligible</td>
<td>Medicaid eligible</td>
<td>$0</td>
</tr>
<tr>
<td>$20,000</td>
<td>4.85%</td>
<td>$81</td>
<td>$737</td>
</tr>
<tr>
<td>$25,000</td>
<td>6.76%</td>
<td>$141</td>
<td>$677</td>
</tr>
<tr>
<td>$30,000</td>
<td>8.26%</td>
<td>$207</td>
<td>$611</td>
</tr>
<tr>
<td>$35,000</td>
<td>9.51%</td>
<td>$277</td>
<td>$541</td>
</tr>
<tr>
<td>$40,000</td>
<td>9.86%</td>
<td>$329</td>
<td>$489</td>
</tr>
<tr>
<td>$45,000</td>
<td>9.86%</td>
<td>$370</td>
<td>$448</td>
</tr>
<tr>
<td>$50,000</td>
<td>Not eligible</td>
<td>$818</td>
<td>$0</td>
</tr>
</tbody>
</table>
Certain households are eligible to buy “enhanced” silver plans that offer more generous benefits

- In our example, a retiree earning $20,000 can enroll in a silver plan whose cost-sharing has been reduced so that it has the benefits of a gold or platinum plan.
- They may also take their $737 monthly tax credit and apply it to a any bronze or gold plan.

<table>
<thead>
<tr>
<th>2019 Income</th>
<th>Premium Cap for Benchmark Plan* (% of annual income)</th>
<th>Premium for Benchmark Plan* (Monthly)</th>
<th>Tax Credit Applicable to Any Public Exchange Plan (Monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,000</td>
<td>Medicaid eligible</td>
<td>Medicaid eligible</td>
<td>$0</td>
</tr>
<tr>
<td>$20,000</td>
<td>4.85%</td>
<td>$81</td>
<td>$737</td>
</tr>
<tr>
<td>$25,000</td>
<td>6.76%</td>
<td>$141</td>
<td>$677</td>
</tr>
<tr>
<td>$30,000</td>
<td>8.98%</td>
<td>$207</td>
<td>$611</td>
</tr>
<tr>
<td>$35,000</td>
<td></td>
<td>$277</td>
<td>$541</td>
</tr>
<tr>
<td>$40,000</td>
<td></td>
<td>$329</td>
<td></td>
</tr>
<tr>
<td>$45,000</td>
<td></td>
<td>$370</td>
<td></td>
</tr>
<tr>
<td>$50,000</td>
<td>Not eligible</td>
<td>$818</td>
<td>$0</td>
</tr>
</tbody>
</table>

Available Plans include:
- Silver plans with $750 Deductible and $2,600 OOPM for $75/month.
- Bronze plans with $0 Premium.
Certain households may learn they are eligible for Medicaid

- A retiree earning $16,612 who files taxes as an individual will qualify for Medicaid.
- They cannot gain eligibility for tax credits.
- They can opt out of Medicaid, enroll in an individual plan, and opt in to an OPERS HRA/Allowance if eligible.

<table>
<thead>
<tr>
<th>2019 Income</th>
<th>Premium Cap for Benchmark Plan* (% of annual income)</th>
<th>Premium for Benchmark Plan* (Monthly)</th>
<th>Tax Credit Applicable to Any Public Exchange Plan (Monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,000</td>
<td>Medicaid eligible</td>
<td>Medicaid eligible</td>
<td>$0</td>
</tr>
<tr>
<td>$20,000</td>
<td>4.85%</td>
<td>$81</td>
<td>$737</td>
</tr>
<tr>
<td>$25,000</td>
<td>6.76%</td>
<td>$141</td>
<td>$677</td>
</tr>
<tr>
<td>$30,000</td>
<td>8.30%</td>
<td>$207</td>
<td>$614</td>
</tr>
<tr>
<td>$35,000</td>
<td>9.26%</td>
<td>$277</td>
<td>$541</td>
</tr>
<tr>
<td>$40,000</td>
<td>9.76%</td>
<td>$329</td>
<td>$489</td>
</tr>
<tr>
<td>$45,000</td>
<td>9.86%</td>
<td>$370</td>
<td>$448</td>
</tr>
<tr>
<td>$50,000</td>
<td>Not eligible</td>
<td>$818</td>
<td>$0</td>
</tr>
</tbody>
</table>

Connector Service will support this retiree as they are filling out their public exchange eligibility application. A determination of Medicaid eligibility triggers an outreach call from their state’s Medicaid program.
Certain households will be ineligible for federal support

A retiree earning $50,000 or more will not be eligible for premium tax credits.

<table>
<thead>
<tr>
<th>2019 Income</th>
<th>Premium Cap for Benchmark Plan* (% of annual income)</th>
<th>Premium for Benchmark Plan* (Monthly)</th>
<th>Tax Credit Applicable to Any Public Exchange Plan (Monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,000</td>
<td>Medicaid eligible</td>
<td>Medicaid eligible</td>
<td>$0</td>
</tr>
<tr>
<td>$20,000</td>
<td>4.85%</td>
<td>$81</td>
<td>$737</td>
</tr>
<tr>
<td>$25,000</td>
<td>6.76%</td>
<td>$141</td>
<td>$677</td>
</tr>
<tr>
<td>$30,000</td>
<td>8.26%</td>
<td>$207</td>
<td>$611</td>
</tr>
<tr>
<td>$35,000</td>
<td>9.51%</td>
<td>$277</td>
<td>$541</td>
</tr>
<tr>
<td>$40,000</td>
<td>9.86%</td>
<td>$329</td>
<td>$489</td>
</tr>
<tr>
<td>$45,000</td>
<td>9.86%</td>
<td>$370</td>
<td>$448</td>
</tr>
<tr>
<td>$50,000</td>
<td>Not eligible</td>
<td>$818</td>
<td>$0</td>
</tr>
</tbody>
</table>

If ineligible for federal support, Pre-Medicare retirees may need to rely on an HRA/Allowance program to make premiums affordable.
Key facts to keep in mind about federal tax credits

- The amount of federal tax credits one is eligible for is determined by several factors:
  - Tax Household size
  - Zip Code
  - Income

- If you live in a large tax household, you could be eligible for significantly higher federal tax credits

- If the benchmark plan in your zip code is expensive, your tax credit will be higher than if you lived in a neighboring zip code with a lower premium benchmark plan*

- The income you report when applying for coverage is an estimate of your income for the next calendar year.
  - Your tax credits will be reconciled when you complete your taxes 18 months later.

* The benchmark plan is the second lowest cost silver plan available.
OPERS Pre-Medicare retirees can find lower premium plans throughout Ohio

- The OPERS Pre-Medicare Plan monthly premium is $1,306 in 2019
- A 60-year old can find the Benchmark Silver Plan at lower premiums than the OPERS Plan in all but two counties
- In the state’s most populous counties, monthly Benchmark plan premiums are significantly lower:

<table>
<thead>
<tr>
<th>County</th>
<th>Premium</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin</td>
<td>$818</td>
<td>$488</td>
</tr>
<tr>
<td>Cuyahoga</td>
<td>$694</td>
<td>$612</td>
</tr>
<tr>
<td>Hamilton</td>
<td>$732</td>
<td>$574</td>
</tr>
</tbody>
</table>

- In 2020, Ohio Individual plan premiums are projected to decrease by 7%; OPERS premiums will increase by 6%
The OPERS Pre-Medicare Plan’s benefit design is comparable to gold plans, more generous than bronze and silver plans

<table>
<thead>
<tr>
<th>Carrier/Plan Name</th>
<th>Deductible</th>
<th>PCP</th>
<th>Specialist</th>
<th>Inpatient Hospital</th>
<th>Generic</th>
<th>Preferred Brand</th>
<th>Non-Preferred Brand</th>
<th>Specialty</th>
<th>OOP Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPERS 2019 PPO Plan</td>
<td>$1,600</td>
<td>$25</td>
<td>$40</td>
<td>$150</td>
<td>20%/$8 Max</td>
<td>30%/$60 Max</td>
<td>Not Covered</td>
<td>40%/$300 Max</td>
<td>$7,900</td>
</tr>
<tr>
<td>Ambetter Gold Secure Care 1</td>
<td>$1,500</td>
<td>$0</td>
<td>20%</td>
<td>20%</td>
<td>$10</td>
<td>$25</td>
<td>$75</td>
<td>30%</td>
<td>$6,350</td>
</tr>
<tr>
<td>Anthem Gold Gold Pathway X</td>
<td>$2,000</td>
<td>$25</td>
<td>$45</td>
<td>20%</td>
<td>$10</td>
<td>$35</td>
<td>40%</td>
<td>40%</td>
<td>$6,750</td>
</tr>
<tr>
<td>MedMutual Gold Market HMO 2000</td>
<td>$2,000</td>
<td>$25</td>
<td>$75</td>
<td>20%</td>
<td>$20</td>
<td>$40</td>
<td>50%</td>
<td>50%</td>
<td>$7,900</td>
</tr>
<tr>
<td>Ambetter Silver Balanced Care 5</td>
<td>$7,350</td>
<td>$40</td>
<td>$80</td>
<td>NCAD</td>
<td>$20</td>
<td>$60</td>
<td>NCAD</td>
<td>NCAD</td>
<td>$7,350</td>
</tr>
<tr>
<td>Oscar Silver Silver Classic</td>
<td>$4,400</td>
<td>$50</td>
<td>$75</td>
<td>50%</td>
<td>$15</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>$7,900</td>
</tr>
<tr>
<td>CareSource Silver Low Premium</td>
<td>$6,400</td>
<td>$25</td>
<td>$50</td>
<td>$500</td>
<td>$20</td>
<td>$50</td>
<td>15%</td>
<td>15%</td>
<td>$7,900</td>
</tr>
<tr>
<td>MedMutual Bronze Market HMO 5250</td>
<td>$5,250</td>
<td>NCAD</td>
<td>NCAD</td>
<td>NCAD</td>
<td>$40</td>
<td>$80</td>
<td>50%</td>
<td>50%</td>
<td>$6,750</td>
</tr>
<tr>
<td>AultCare Bronze Bronze 7350</td>
<td>$7,350</td>
<td>NCAD</td>
<td>NCAD</td>
<td>NCAD</td>
<td>NCAD</td>
<td>NCAD</td>
<td>NCAD</td>
<td>NCAD</td>
<td>$7,350</td>
</tr>
<tr>
<td>Anthem Bronze Bronze Pathway X</td>
<td>$5,000</td>
<td>$50</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>$7,900</td>
</tr>
</tbody>
</table>

* NCAD = No Charge After Deductible
Many silver and bronze plans require you to pay up to your out-of-pocket maximum before coverage kicks in.

<table>
<thead>
<tr>
<th>Carrier/Plan Name</th>
<th>Deductible</th>
<th>PCP</th>
<th>Specialist</th>
<th>Inpatient Hospital</th>
<th>Generic</th>
<th>Preferred Brand</th>
<th>Non-Preferred Brand</th>
<th>Specialty</th>
<th>OOP Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPERS 2019 PPO Plan</td>
<td>$1,600</td>
<td>$25</td>
<td>$40</td>
<td>$150</td>
<td>20%/$8 Max</td>
<td>30%/$60 Max</td>
<td>Not Covered</td>
<td>40%/$300 Max</td>
<td>$7,900</td>
</tr>
<tr>
<td>Ambetter Gold Secure Care 1</td>
<td>$1,500</td>
<td>$0</td>
<td>20%</td>
<td>20%</td>
<td>$10</td>
<td>$25</td>
<td>$75</td>
<td>30%</td>
<td>$6,350</td>
</tr>
<tr>
<td>Anthem Gold Gold Pathway X</td>
<td>$2,000</td>
<td>$25</td>
<td>$45</td>
<td>20%</td>
<td>$10</td>
<td>$35</td>
<td>40%</td>
<td>40%</td>
<td>$6,750</td>
</tr>
<tr>
<td>MedMutual Gold Market HMO 2000</td>
<td>$2,000</td>
<td>$25</td>
<td>$75</td>
<td>20%</td>
<td>$20</td>
<td>$40</td>
<td>50%</td>
<td>50%</td>
<td>$7,900</td>
</tr>
<tr>
<td>Ambetter Silver Balanced Care 5</td>
<td>$7,350</td>
<td>$40</td>
<td>$80</td>
<td>NCAD</td>
<td>$20</td>
<td>$60</td>
<td>NCAD</td>
<td>NCAD</td>
<td>$7,350</td>
</tr>
<tr>
<td>Oscar Silver Silver Classic</td>
<td>$4,400</td>
<td>$50</td>
<td>$75</td>
<td>50%</td>
<td>$15</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>$7,900</td>
</tr>
<tr>
<td>CareSource Silver Low Premium</td>
<td>$6,400</td>
<td>$25</td>
<td>$50</td>
<td>$50</td>
<td>$20</td>
<td>$50</td>
<td>15%</td>
<td>15%</td>
<td>$7,900</td>
</tr>
<tr>
<td>MedMutual Bronze Market HMO 5250</td>
<td>$5,250</td>
<td>NCAD</td>
<td>NCAD</td>
<td>NCAD</td>
<td>$40</td>
<td>$80</td>
<td>50%</td>
<td>50%</td>
<td>$6,750</td>
</tr>
<tr>
<td>AultCare Bronze Bronze 7350</td>
<td>$7,350</td>
<td>NCAD</td>
<td>NCAD</td>
<td>NCAD</td>
<td>NCAD</td>
<td>NCAD</td>
<td>NCAD</td>
<td>NCAD</td>
<td>$7,350</td>
</tr>
<tr>
<td>Anthem Bronze Bronze Pathway X</td>
<td>$5,000</td>
<td>$50</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>$7,900</td>
</tr>
</tbody>
</table>

* NCAD = No Charge After Deductible
Most OPERS retirees can find gold plans with lower premiums than the OPERS Pre-Medicare Plan

- The OPERS Pre-Medicare Plan monthly premium is $1,306 in 2019
- A 60-year-old retiree can find a **Gold Plan** with lower premiums than the OPERS plan
- In the state’s most populous counties, gold plan premiums are still significantly lower:

<table>
<thead>
<tr>
<th>County</th>
<th>Premium</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin</td>
<td>$1,061</td>
<td>$245</td>
</tr>
<tr>
<td>Cuyahoga</td>
<td>$849</td>
<td>$457</td>
</tr>
<tr>
<td>Hamilton</td>
<td>$896</td>
<td>$410</td>
</tr>
</tbody>
</table>

- No gold plans are available in three counties: Crawford, Richland, and Holmes
For some OPERS retirees, bronze plans may present the best value

- The OPERS Pre-Medicare Plan monthly premium is $1,306 in 2019

- A 60-year-old retiree can find a Bronze Plan with lower premiums than the OPERS plan in every county

- In the state’s most populous counties, bronze plan premiums are significantly lower:

<table>
<thead>
<tr>
<th>County</th>
<th>Premium</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin</td>
<td>$597</td>
<td>$709</td>
</tr>
<tr>
<td>Cuyahoga</td>
<td>$537</td>
<td>$769</td>
</tr>
<tr>
<td>Hamilton</td>
<td>$628</td>
<td>$678</td>
</tr>
</tbody>
</table>

- No bronze plans are available in five counties: Van Wert, Shelby, Logan, Holmes and Harrison
Individual Market plans have lower premiums due in part to their smaller provider networks

Provider Networks: Though all marketplace plans must provide their enrollees with access to covered services “without unreasonable delay,” many do so with smaller provider networks than typically offered through group coverage

Some facts to keep in mind:

- Nationwide, two-thirds of marketplace plans have less than 60% of providers in an area in network

- In Ohio, Medical Mutual’s marketplace provider networks are, on average, about 40% of the size of its SuperMed PPO network

- Rates of participation of providers in any Individual Market plan are near those in traditional group coverage

2. Willis Towers Watson Review of Medical Mutual’s provider directory

Key Takeaway: Benefit advisors can help participants choose a plan with their doctor and key facilities in network.
Dental and vision coverage is available on the Individual Market

**Dental and Vision Coverage:** Pre-Medicare retirees can enroll in Individual Market dental and vision plans.

Example from Via Benefits Connector Service*:

- All OPERS retirees in the US would have access to a dental plan through Via Benefits
- Dental and Vision products cover services from both in-network and out-of-network providers
- Market Overview:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Number of Plans Offered</th>
<th>2019 Monthly Premium</th>
<th>Insurer Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>4</td>
<td>$19 - $39</td>
<td>IHC, Surebridge</td>
</tr>
<tr>
<td>Vision</td>
<td>1</td>
<td>$9</td>
<td>Surebridge</td>
</tr>
</tbody>
</table>

*Dental plans are also available in many markets through healthcare.gov, or even as part of the benefits in an Individual Market plan. No vision plans are available through healthcare.gov, however."
A side by side comparison shows Individual Market dental plans are similar to the OPERS Pre-Medicare offerings.

Dental:

<table>
<thead>
<tr>
<th></th>
<th>2019 OPERS Dental Options</th>
<th>Sample 2019 Individual Market Dental Options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low Option</td>
<td>High Option</td>
</tr>
<tr>
<td>Monthly Premium</td>
<td>$20</td>
<td>$34</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$50/$100</td>
<td>$0</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Care</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Major Care</td>
<td>25%</td>
<td>50%</td>
</tr>
</tbody>
</table>
A side by side comparison shows Individual Market vision plans are similar to the OPERS Pre-Medicare offerings

Vision:

<table>
<thead>
<tr>
<th></th>
<th>2019 OPERS Vision Options</th>
<th>2019 Individual Market Vision Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aetna Low Option</td>
<td>Aetna High Option</td>
</tr>
<tr>
<td></td>
<td>(In-Network)</td>
<td>(In-Network)</td>
</tr>
<tr>
<td>Monthly Premium</td>
<td>$2.41</td>
<td>6.02</td>
</tr>
<tr>
<td>Comprehensive eye exam</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Contact lens fit &amp; follow-up: Standard</td>
<td>$32 copay</td>
<td>$17 copay</td>
</tr>
<tr>
<td>Frames</td>
<td>$0 copay up to $50 retail value; 80% of balance over $50</td>
<td>$0 copay up to $140 retail value; 80% of balance over $140</td>
</tr>
<tr>
<td>Lenses: Single, Bifocal, Trifocals</td>
<td>$5 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Contact lenses</td>
<td>$10 copay up to $200 retail value</td>
<td>$0 copay up to $240 retail value</td>
</tr>
<tr>
<td>Coverage period for exams</td>
<td>Once per calendar year</td>
<td>Once per calendar year</td>
</tr>
</tbody>
</table>
There are some differences between the Individual Market and the OPERS Pre-Medicare Plan

Retirees may not recognize all carriers participating in the marketplace:

Medical Mutual of Ohio offers coverage in 55 of 88 counties in 2019.
There are some key differences between the Individual Market and the OPERS Pre-Medicare Plan

- All plans in the Ohio Individual Market are HMOs
  - These plans typically require a referral to see a specialist
- Most Individual Market provider networks center on the market in which the plan is purchased
  - Snowbirds will not find in-network providers while out of state, though they can switch plans during the year
- Individuals living abroad cannot enroll in Individual Market plans
  - They will have to seek out other insurance options
- It is illegal to sell an individual market plan to an individual enrolled in Medicare, including those eligible due to end stage renal disease (ESRD)
  - As of today, Ohio does not require Medicare Supplement insurers to offer plans to ESRD Medicare beneficiaries who have not turned 65
  - Starting in 2021, retirees with ESRD will be able to enroll in Medicare Advantage plans
OPERS Pre-Medicare Plans vs. Individual Market Plans Wrap-up

Key Take-aways:

- Some OPERS Pre-Medicare retirees may be eligible for Medicaid or tax credits that significantly lower their premiums
  - Pre-Medicare retirees in large households or rural areas may benefit most from these opportunities

- The Individual Market offers Pre-Medicare retirees significant flexibility when it comes to carrier and plan design options
  - More choice is available in metropolitan areas than rural areas

- Individual Market premiums offer significant discounts to the OPERS Pre-Medicare Plan
  - Keep in mind any one plan is likely to have a smaller provider network, though across all plans a majority of providers will be in-network with at least one plan

- Dental and Vision options are available in the Individual Market, with premiums and benefits in line with those offered by OPERS today

- There are some differences like plan type (HMO-only) and limited out-of-area provider coverage.
IV. Policy Environment
Section IV. Policy Environment

What we’ll discuss:

- Individual Market carriers are finally profitable
- How Individual Market carriers are expanding their footprints
- How premiums have grown at a slower rate (or decreased) in recent years
- Policy events on the horizon that could shape the individual market in the coming years

* The benchmark plan is the second lowest cost silver plan available.
Despite losing money from 2014-2016, Individual Market carriers have been profitable since 2017

**Average First Quarter Individual Market Medical Loss Ratios, 2011-2019**

<table>
<thead>
<tr>
<th>Year</th>
<th>Medical Loss Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2011</td>
<td>79%</td>
</tr>
<tr>
<td>Q1 2012</td>
<td>81%</td>
</tr>
<tr>
<td>Q1 2013</td>
<td>81%</td>
</tr>
<tr>
<td>Q1 2014</td>
<td>83%</td>
</tr>
<tr>
<td>Q1 2015</td>
<td>88%</td>
</tr>
<tr>
<td>Q1 2016</td>
<td>85%</td>
</tr>
<tr>
<td>Q1 2017</td>
<td>75%</td>
</tr>
<tr>
<td>Q1 2018</td>
<td>68%</td>
</tr>
<tr>
<td>Q1 2019</td>
<td>73%</td>
</tr>
</tbody>
</table>

Source: Ohio Department of Insurance
44 counties in Ohio will gain one or two carriers in 2020

Ohio Insurer Participation by County, 2019 and 2020

2019

2020

# of Carriers

1  6+
Early signs point to continued Individual Market stability in 2020
Preliminary rate increases average 0.6% nationally

2020 Projected Rate Increases by State (based on initial filings)

According to the Ohio Department of Insurance, Individual Market premiums will decrease by 7.7% in Ohio in 2020
Despite efforts to repeal the ACA, markets have stabilized and are poised to get more competitive

- Congressional Republicans’ efforts to repeal the ACA failed in 2017
  - Trump Administration’s attempt to repeal the ACA through the Courts are not predicted to succeed

- CMS has been approved reinsurance programs in 12 states that have lowered rates by 5-20% in those states
  - Ohio has not engaged CMS in such a program

- New Trump Administration HRA rule is estimated to add 7 million new customers into individual plans over the next five years
  - The rule relies on the ACA’s consumer protections, creating a new reason for Republicans to avoid repeal efforts

- Bipartisan legislation to further improve the Individual Market has been drafted in the last two Congresses, and could get signed into law under a Democratic president.
Policy Environment Wrap-up

Key Take-aways:

▪ It’s taken five years, but carriers now understand how to price Individual Market plans

▪ Carriers are expanding their footprints within states, and, in some cases, entering new states

▪ Premium growth is likely to continue at moderate levels in the coming years

▪ Policymakers appear poised to move on from ACA repeal
V. Connector Services for Pre-Medicare Retirees
Section V. Connector Services for Pre-Medicare Retirees

What we’ll discuss:

- Overview of services provided by Individual Market Connector for Pre-Medicare Retirees
- What a Pre-Medicare retiree’s enrollment experience is like
- Pre-Medicare HRA Administration model – similarities and differences to Medicare HRA Administration
Pre-Medicare Retiree Connector Overview

1. Plan sponsor provides subsidy via HRA/allowance

2. Participant education

3. Shop Individual Market Plans (on-and off-exchange)

4. Technology and live support to help retirees select and enroll in a plan

5. HRA/allowance reimbursement

6. Ongoing advocacy services

***Key Service***
Vendor provides support when retiree must choose between allowance and premium tax credits
Connector Services: Participant Education

- Initial Communication
  - Vendor can provide support to OPERS on timing and content of initial communication to pre-Medicare retiree

- Pre-season Consultation
  - Benefit advisors can answer questions about the upcoming enrollment season and OPERS HRA/Allowance program

- Marketplace and Enrollment Guides
  - Marketplace Guide provides information on Individual Market plan options
  - Enrollment Guide provides information on eligibility and enrollment process
Connector Services: Shopping the Individual Market

- Retirees can shop online or over the phone
  - Nearly all retirees consult with a benefit advisor
  - Enrollment typically takes 2.5 phone calls averaging 35 minutes per call

- Retirees can enroll in any Individual Market plan, including vision and dental
  - Vendor can facilitate on-exchange enrollments (best for retirees eligible for premium tax credits) or off-exchange enrollments
  - Via Benefits will facilitate enrollment into any on-exchange plan regardless of whether the carrier appoints Via Benefits as a broker
Connector Services: Choosing the Right Subsidy

- Retirees may qualify for an allowance from OPERS and a premium tax credit, but must choose between the two forms of subsidy
  - By regulation, enrollment in a retiree HRA program makes a retiree ineligible for a premium tax credit

- Benefit advisors help retirees decide which subsidy option best suits the retiree
  - Choice of subsidy is a key difference between the Pre-Medicare and Medicare connector service models

Choosing the right subsidy requires a consultative process with experienced advisors
Connector Services: HRA Administration

- Pre-Medicare HRA administration operates like Medicare HRA administration:
  - Retiree pays their insurer
  - A receipt is submitted to the vendor
  - A claim is processed and the retiree is reimbursed

- There are three important differences:
  - Retiree must submit receipt, can use recurring claims forms
    - Auto-reimbursement is not available for Pre-Medicare retirees
  - Retiree must contact vendor to opt-in to HRA
  - Retiree can enroll in coverage outside of the vendor (“Open HRA ecosystem”)
Connector Services for Pre-Medicare Retirees Wrap-Up

Key Takeaways:

- Given the number of carrier and subsidy options available, Pre-Medicare retirees will benefit from support navigating the Individual Market

- A Connector Service can help retirees:
  - Get educated on their enrollment and coverage options
  - Determine their eligibility for federal tax credits
  - Choose the right plan
  - Opt into the right subsidy program
  - Enroll in a plan and subsidy program
  - Follow up with their carrier or public program through advocacy after enrollment

- Pre-Medicare HRA Administration differs from Medicare due to market realities and regulations
VI. Wrap-Up — Big Picture
The Individual Market offers a viable alternative to group health coverage for early retirees.

In Ohio the market has stabilized and will strengthen next year, as premiums drop and carriers expand their offerings in the state.

OPERS Pre-Medicare retirees will find plans with benefits similar to their current plan in the Individual Market. Those plans will also have:
- Lower prices points in most locations
- Smaller networks in most plans
- Significant choice of carriers and plan designs.

Most states have moved on from fighting political battles and begun working together and with the federal government to strengthen their marketplaces.

A Pre-Medicare Connector Service will simplify the transition to the Individual Market, ensuring retirees can take advantage of that market’s carrier, plan, and subsidy options.
Thank you
10 carriers are no longer offering coverage in Ohio

**Ohio Insurer Participation by Carrier, 2014 – 2020**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assurant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coventry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HealthSpan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humana</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>InHealth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premier</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Health Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>US Health Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: [Ohio Department of Insurance](https://www.insurance.ohio.gov/).  Back to slide.
Premiums vary significantly by age and metal tier

Lowest Cost Premium by County, Age and Metal Tier, 2019

- Bronze
- Silver
- Gold

OPERS PPO
OPERS HEALTHCARE MEMBER RESEARCH FINDINGS

September 2019
BACKGROUND
OPERS faces many challenges as it evaluates continuation of health care coverage for its members. As the Board of Trustees considers paths forward, OPERS sought the input of its membership to inform crucial decisions. OPERS engaged Fahlgren Mortine to conduct this research, which was executed in partnership with Scott Holley Consulting LLC.

RESEARCH OVERVIEW
The primary research findings are based on a random sample member survey. The sample was randomly drawn from current members for each of the target segments:
- Retired, age 65 or older
- Retired or disabled, not on Medicare (under 65 years old)
- “Ready to Retire:” Actively working, within five years of retirement
- Actively working, five or more years from retirement
RESEARCH OVERVIEW (continued)
The research was conducted primarily through an email-distributed online survey. The Retired 65+ group was invited to participate through both an email version and a paper-based survey because we were not sure how this group would respond to an online survey. We received a strong response to both versions, so we have opted to present the results from the paper survey as a separate point of comparison.

To offer opportunities for all members to participate, the survey was also made available on the OPERS website. To add context, we have also reviewed comments through OPERS education meetings and some members who shared open-ended comments through the online or paper survey.
ISSUES EXPLORED

• Importance of health care coverage to OPERS members

• Willingness to consider changes to extend the life of the health care fund

• Views on specific proposed changes, including:
  • Eligibility
  • Base allowance
  • Grandfathering
  • Low-Income Discount Program
  • Rate increase vs. working longer to extend fund (Active Workers)
RESEARCH APPROACH
ONLINE SURVEY METHODOLOGY

- Scott Holley Consulting LLC conducted this research online on behalf of Fahlgren Mortine for OPERS. Questionnaire was created by Fahlgren Mortine in collaboration with the OPERS staff.

- Four key groups to compare:
  - Retired, age 65 or older
  - Retired or disabled, not on Medicare (under 65 years old)
  - “Ready to Retire:” Actively working, within five years of retirement
  - Actively working, five or more years from retirement

- OPERS distributed a link to the online survey via email invitation.

- Survey included a video explaining the challenges ahead for OPERS in preserving health care coverage.
ONLINE SURVEY METHODOLOGY

• A total of 20,100 emails invitations were distributed:
  • Initial sample was distributed August 12 to 8,000 members (2,000 members in each segment)
  • Goal: 400 completes per segment
  • Reminder emails distributed to all groups

• Additional sample was distributed on August 20, 2019 to an additional 12,100 members:
  • 1,800 to Retired, age 65 or older
  • 2,500 to Retired or disabled not on Medicare (under 65 years old)
  • 2,800 to Actively Working, within five years of retirement
  • 5,000 to Actively Working, five years or more from retirement

• The survey closed August 30 at 11:55 p.m. EDT.

• Totals may be greater than 100% due to rounding.
PARTICIPANT STATISTICS

n=2,439 qualified completes

<table>
<thead>
<tr>
<th>SEGMENTS</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retired, age 65 or older</td>
<td>25%</td>
</tr>
<tr>
<td>Retired or disabled, not on Medicare (under 65 years old)</td>
<td>23%</td>
</tr>
<tr>
<td>Actively working, within five years of retirement</td>
<td>29%</td>
</tr>
<tr>
<td>Actively working, five or more years from retirement</td>
<td>21%</td>
</tr>
<tr>
<td>None of the above/Not an OPERS member</td>
<td>2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOUSEHOLD INCOME</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $25,000</td>
<td>3%</td>
</tr>
<tr>
<td>$25,000 to $34,999</td>
<td>8%</td>
</tr>
<tr>
<td>$35,000 to $49,999</td>
<td>14%</td>
</tr>
<tr>
<td>$50,000 to $74,999</td>
<td>24%</td>
</tr>
<tr>
<td>$75,000 to $99,999</td>
<td>16%</td>
</tr>
<tr>
<td>$100,000 to $124,999</td>
<td>11%</td>
</tr>
<tr>
<td>$125,000 to $149,999</td>
<td>4%</td>
</tr>
<tr>
<td>$150,000 or more</td>
<td>6%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>13%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ZIP CODE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• 797 unique zip codes represented</td>
<td></td>
</tr>
<tr>
<td>• Only one zip code, 43123 (Grove City) at 1.27%, achieved greater than 1% of total representation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOUSEHOLD STRUCTURE</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Person HH</td>
<td>21%</td>
</tr>
<tr>
<td>Two Person HH</td>
<td>61%</td>
</tr>
<tr>
<td>Three or More Person HH</td>
<td>18%</td>
</tr>
</tbody>
</table>

32% of respondents have attended a health care seminar where OPERS was a presenter
## PARTICIPANT STATISTICS

### YEARS RECEIVING BENEFITS

<table>
<thead>
<tr>
<th>Years</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1</td>
<td>7%</td>
</tr>
<tr>
<td>1 to 5</td>
<td>29%</td>
</tr>
<tr>
<td>6 to 10</td>
<td>32%</td>
</tr>
<tr>
<td>11 to 20</td>
<td>26%</td>
</tr>
<tr>
<td>20+</td>
<td>6%</td>
</tr>
</tbody>
</table>

### YEARS TO RETIREMENT

<table>
<thead>
<tr>
<th>Years</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5</td>
<td>57%</td>
</tr>
<tr>
<td>6 to 10</td>
<td>24%</td>
</tr>
<tr>
<td>10+</td>
<td>19%</td>
</tr>
</tbody>
</table>

### HEALTH CARE COVERAGE

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer health plan</td>
<td>93%</td>
</tr>
<tr>
<td>Spouse’s health plan</td>
<td>5%</td>
</tr>
<tr>
<td>Individual plan through a health care exchange</td>
<td>1%</td>
</tr>
<tr>
<td>I don’t have coverage</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
</tbody>
</table>

### TYPE OF OPERS BENEFIT

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service retirement</td>
<td>91%</td>
</tr>
<tr>
<td>Disability retirement</td>
<td>9%</td>
</tr>
</tbody>
</table>

### SERVICE CREDIT BEFORE RECEIVING BENEFITS

<table>
<thead>
<tr>
<th>Years of Service Credit</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>1 to 5</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>6 to 10</td>
<td>3%</td>
</tr>
<tr>
<td>11 to 20</td>
<td>16%</td>
</tr>
<tr>
<td>21 to 30</td>
<td>37%</td>
</tr>
<tr>
<td>More than 30</td>
<td>44%</td>
</tr>
</tbody>
</table>

### ANTICIPATED YEARS SERVICE CREDIT BEFORE RECEIVING BENEFITS

<table>
<thead>
<tr>
<th>Years of Service Credit</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 5</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>6 to 10</td>
<td>1%</td>
</tr>
<tr>
<td>11 to 20</td>
<td>8%</td>
</tr>
<tr>
<td>21 to 30</td>
<td>30%</td>
</tr>
<tr>
<td>More than 30</td>
<td>60%</td>
</tr>
</tbody>
</table>
TOPLINE INSIGHTS
Members overwhelmingly indicated OPERS should continue to offer health care.

- 95% of all respondents said yes, OPERS should continue to offer health care.
- Results are consistent across the four groups, ranging from 97.1% (Retired 65+) to 92% (Actively Working, 5 or more years from retirement).
- On the paper survey, 96.8% of Retired 65+ said OPERS should continue health care.
Members overwhelmingly recommend (84%) “Make changes” to extend the healthcare fund compared to “Leaving coverage unchanged” knowing it will cause the healthcare fund to decrease to $0 in approximately 7-11 years.

- 91% of those furthest from retirement would recommend making changes. This is significantly more when compared to other segments.

- Interestingly, 23% of those Retired/Disabled Not on Medicare (under 65) recommend that OPERS leave coverage unchanged. This is significantly higher than the other segments.

Q3: ... all OPERS members (retirees and active members) ...
Interestingly, this sentiment is lower when considering immediate family vs OPERS retirees and active members.

When considering immediate family:
- 78% would recommend “make changes ...”
- 22% would recommend “leaving coverage unchanged ...”

When considering all OPERS retirees and active members:
- 84% would recommend “make changes ...”
- 16% would recommend “leaving coverage unchanged ...”

Q4: ... your immediate family ...
Importance Of Available Retirement Healthcare Coverage Through OPERS

It is important to nearly 9 of 10 respondents to have retirement health care coverage available through OPERS.

- 89% of all respondents indicated that it is Extremely Important or Very Important to have a retirement health care program available through OPERS.
Though more Retired/Disabled members indicated that it was Extremely Important, more Actively Workings indicated it was Very Important – top two box totals were nearly the same.
Eligibility

74% of all respondents recommend revising eligibility requirements for new retirees.

- 53% of all respondents recommend revising eligibility so that “new retirees are eligible for health care under age 65, but only with 30 or more years of qualified service.”

- Significantly more respondents in the Retired/Disabled Not on Medicare and Ready to Retire groups recommend new retirees be eligible for health care under the age of 65, but only with 30 or more years of service.

- 35% of those Retired 65+ recommend new retirees not be eligible for health care until age 65. This is significantly higher than all other groups. This compares to 40% on the paper survey.
Allowance

58% of all respondents recommend reducing the base allowance to extend the life of the fund.

- 52% of Retired/Disabled and 62% of Actively Working respondents recommend reducing the base allowance in order to extend the life of the health care fund.
- 22% of ALL respondents said they are not sure what they would recommend when thinking about revision to the base allowance on behalf of all OPERS members.

* 64% on paper survey
Grandfathering

More members recommend maintaining grandfathering but reducing the allowance to extend fund life.

- 60% of ALL respondents recommend OPERS maintain grandfathering but reduce the allowance grandfathered retirees receive in order to extend the life of the health care fund.
Members split over responsibility for Low-Income Discount Program.

- 55% of all respondents do not feel it is the responsibility of OPERS.
- 62% of respondents Retired Age 65+ do not feel it is the responsibility of OPERS, significantly more than other segments.
Active Workers prefer rate increase over working longer.

Actively Working respondents prefer to absorb a member contribution rate increase to improve the pension fund compared to working longer to extend OPERS’ health care for as long as possible.

- 60% of respondents Actively Working indicate they would be willing to absorb a member contribution rate increase to improve pension funding.

- Only 38% of Actively Working respondents indicated that they would be willing to work longer to extend OPERS’ health care for as long as possible.

Q12: In order to extend OPERS’ health care offering for as long as possible, would you be willing to work longer?

- Yes: 62.1%
- No: 37.9%

Q13: Would you be willing to absorb a member contribution rate increase to improve pension funding?

- Yes: 39.3%
- No: 60.1%
SUMMARY

Findings indicate that overall members understand the challenges OPERS must address to continue health care.

The vast majority of respondents (95%) want the health care program to continue after watching a video* to inform them of the challenges. In addition:

- An overwhelming majority (84%) would recommend making changes to extend health care rather than allowing the health care fund to decrease to $0 in 7 – 11 years.

- Nearly 90% of respondents across all groups said having a retirement health care plan is either “extremely important” or “very important.”

- This should not be interpreted as meaning members are pleased about the potential changes. This sentiment is reflected in comments such as “I paid for my OPERS throughout my entire career, so how can you take it away now?” and “I depended on this when deciding to retire.”

* Retired 65+ who took the paper survey received written background rather than the video
SUMMARY

Responses to specific potential changes

- **Eligibility:** 74% of all respondents recommend revising health care eligibility requirements for new retirees.

- **Base Allowance:** 58% of all respondents recommend reducing the base allowance to extend the life of the fund. More of those “Actively Working” than “Retired” recommend reducing the base allowance to extend the life of the fund.

- **Grandfathering:** Most members recommend maintaining grandfathering but reducing the allowance to extend fund life.

- **Low-Income Discount Program:** Members split over whether OPERS has responsibility to offer this program.

- **Rate Increase (pension) vs. Working Longer to Extend Fund:** Active Workers prefer a rate increase over working longer.
QUESTIONS
AGENDA

I. Roll Call

II. Consent agenda:
   A. Minutes – August 21, 2019
   B. Disability report

III. Committee Report:
   A. Health Care Committee

IV. Action Items:
   A. Cost of Living Adjustment (COLA) – Karen Carraher and Allen Foster
   B. Health Care 115 Fund Asset Allocation Alignment – Paul Greff, Craig Svendsen, Rob Goldthorpe – NEPC
   C. 2019 Five-year rule review – Debbie McCarthy

V. Discussion Items:
   A. Annual Review of Investment Policies* – Paul Greff, Prabu Kumaran, Craig Svendsen, Chenae Edwards and Suzanne Bernard
      • Staff presentation
      • NEPC presentation
      • AHIC presentation
      • Red-lined Policies
   B. 2nd quarter performance – Paul Greff, Craig Svendsen, Chenae Edwards
   C. Group D – Allen Foster and Debbie McCarthy
   D. Combined/Member Directed Plan changes* - Allen Foster and Debbie McCarthy
   E. Strategic Plan Strategies – Chuck Quinlan
   F. Executive Director report – Karen Carraher

*COULD BE MOVED TO ACTION AT THE BOARD’S REQUEST
MEMORANDUM

DATE:         September 9, 2019

TO:           OPERS Retirement Board Members

FROM:         Karen Carraher, Executive Director
              Allen Foster, Director of Benefits

RE:           IV. Action Items:
              A. Cost of Living Adjustment (COLA)

________________________________________________________________________

Action requested: _______ moved, _______ seconded to approve Option ___ as set forth in this memorandum.

________________________________________________________________________

Purpose – The purpose of this memorandum is to review the various options presented to the Board at the August 2019 meeting regarding changes to the cost of living adjustment (COLA). After additional discussion and deliberation, we are looking for direction from the Board on which option (or “package”) is preferred.

Background – At the August meeting, the Board received background information on the rationale for modifying the COLA. OPERS’ current funding ratio as of year-end 2018 is 78% with an amortization period of 27 years. OPERS is currently using the full 14% employer contribution rate to fund the pension plan and therefore no additional employer contribution is available to re-direct to pension funding. Additionally, OPERS has $2.9 billion in unrealized losses that will be recognized over the next three years. Thus, even if OPERS earns the assumed rate of return for the next three years, the realization of these losses will cause the amortization period to exceed the statutorily required 30-year amortization period.

Significant plan changes were made in 2013 impacting the active members and yielding a reduction in the unfunded liability of over $3 billion. The proposed COLA changes would impact both active and retired members and is expected to
reduce the unfunded liability by $3.0 billion to $4.5 billion, depending on the alternative selected.

**Options** – Last month, the Board discussed various packages. The packages are listed below.

**Package 1 (Cap 2.0%)** – Savings $4.47 billion
- CPI-based COLA capped at 2.0%
- 85% purchasing power restored
- First COLA for future retirees delayed to 2nd pension anniversary

**Package 2 (Cap 2.5%)** – Savings $3.02 billion
- CPI-based COLA capped at 2.5%
- 85% purchasing power restored
- First COLA for future retirees delayed to 2nd pension anniversary

**Package 3 (Freeze 2 years)** – Savings $3.44 billion
- No COLA’s granted during calendar 2022-2023 (2-year freeze)
- Following the freeze, future COLA’s would return to current conditions*
- 85% purchasing power restored
- First COLA for future retirees delayed to 2nd pension anniversary

**Package 4 (Freeze 3 years)** – Savings $4.18 billion
- No COLA’s granted during calendar 2022-2024 (3-year freeze)
- Following the freeze, future COLA’s would return to current conditions*
- 85% purchasing power restored

**“Current conditions”** means that retirees receiving a fixed 3% COLA prior to the freeze would receive a fixed 3% COLA after the freeze period. Retirees receiving a CPI-based COLA, capped at 3%, prior to the freeze would receive a CPI-based COLA, capped at 3%, after the freeze period.

The Board’s discussion last month focused on Package 3 with an estimated savings of $3.44 billion.

**Next Steps** – Once the Board approves a package, staff will begin the legislative process.
MEMORANDUM

DATE: September 9, 2019

TO: OPERS Retirement Board

FROM: Paul Greff, Chief Investment Officer

RE: IV. Action Items: B. Health Care 115 Fund Asset Allocation Alignment

Action requested: __________________________ moved, __________________________ seconded, to approve the Health Care 115 Fund Asset Allocation Alignment, as recommended below by Staff and NEPC.

Background

The OPERS Retirement Board ("Board") conducted the Asset Liability Study for the Defined Benefit Fund ("DB Fund") in the first four months of calendar 2019. At the April 2019 meeting, the new strategic asset allocation targets were approved for the DB Fund. To implement the approved changes, Staff presented a modified DB Fund Policy at the May 2019 Board Meeting and received approval from the Board. Staff is currently in the process of implementing the Board approved changes for the DB Fund. The following table provides a quick summary of the approved changes to the DB Fund asset allocation targets.

<table>
<thead>
<tr>
<th>Source</th>
<th>Current</th>
<th>New</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hedge Funds</td>
<td>8%</td>
<td>5%</td>
<td>-3%</td>
</tr>
<tr>
<td>GTAA</td>
<td>2%</td>
<td>0%</td>
<td>-2%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>-5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target</th>
<th>Current</th>
<th>New</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-U.S. Equity</td>
<td>20%</td>
<td>21%</td>
<td>1%</td>
</tr>
<tr>
<td>U.S. Treasury</td>
<td>1%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Private Equity</td>
<td>10%</td>
<td>12%</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>5%</td>
</tr>
</tbody>
</table>

The Health Care 115 Fund ("HC115 Fund") Asset Liability Study is scheduled to be conducted in early 2020. Staff, in consultation with NEPC, would like to...
recommend alignment in asset allocations between the DB and HC115 Funds until the Asset Liability Study is completed.

**Recommendations**
Staff would like to bring alignment between the DB and HC115 Fund and recommend the following changes in the HC115 Fund:
- Eliminating the 2% allocation to GTAA
- Reducing Hedge Funds allocation by 1% and lowering its target to 5%
- Adding 2% allocation to the U.S. Treasury and increasing target to 3%
- Adding 1% allocation to the Non-U.S. Equity and increasing target to 23%

<table>
<thead>
<tr>
<th>Source</th>
<th>Current</th>
<th>New</th>
<th>Change</th>
<th>Source</th>
<th>Current</th>
<th>New</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hedge Funds</td>
<td>6%</td>
<td>5%</td>
<td>-1%</td>
<td>Non-U.S. Equity</td>
<td>22%</td>
<td>23%</td>
<td>1%</td>
</tr>
<tr>
<td>GTAA</td>
<td>2%</td>
<td>0%</td>
<td>-2%</td>
<td>U.S. Treasury</td>
<td>1%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-3%</td>
<td></td>
<td></td>
<td><strong>Total</strong></td>
<td>-3%</td>
<td></td>
<td>3%</td>
</tr>
</tbody>
</table>

The above-mentioned changes would increase the internally managed assets by 2% to 45% of the Total Fund. The increased allocation to treasuries will add additional liquidity to the HC115 Fund and the increased Non-U.S. Equity exposure will maintain the overall return expectations of the HC115 Fund. These changes are expected to lower the fees for the Fund due to shifting assets from higher fee external managers to lower fee internal management.
MEMORANDUM

DATE: September 9, 2019

TO: OPERS Retirement Board Members

FROM: Eric Harrell, General Counsel
Deborah McCarthy, Government Relations Officer/Legal Counsel

RE: IV. Action Items:
   C. 2019 Five Year Rule Review

Action requested: ________ moved, ________ seconded, to do both of the following:

   (1) Approve for submission to the Joint Committee on Agency Rule Review (JCARR) and the Legislative Service Commission (LSC), the rules set forth in this memorandum;
   (2) Authorize the Executive Director to execute Amendment Three to the Health Reimbursement Arrangement Plan Document, as set forth in this memorandum.

Executive summary – Section 106.03 of the Ohio Revised Code requires OPERS to review each of our administrative rules every five years and determine whether they require amendment, rescission, or to continue without change. This year’s quinquennial review involves the rules in Chapter 145-3 of the Ohio Administrative Code regarding the Combined and Member-Directed Plans. These rules have been reviewed to confirm that they encompass the appropriate purpose, scope, and intent of the governing statutes.

I. Summary of Five Year Review Rules – No Changes

1. Rule 145-3-01 – Plan documents
2. Rule 145-3-02 – Combined and member-directed plan provisions
3. Rule 145-3-04 – Impact of weekend or holiday on initial plan selection
4. Rule 145-3-06 – Procedure for additional deposits
5. Rule 145-3-08 – Active/inactive administrative fee
6. Rule 145-3-10 – Application by a participant for refund of contributions
7. Rule 145-3-11 – Waiver of spousal consent
8. Rule 145-3-13 – Beneficiary and payment plan changes after retirement
9. Rule 145-3-14 – Designation of beneficiaries under the multiple-life plan
10. Rule 145-3-15 – Calculation of amount due retirant with multiple beneficiaries under the multiple-life plan
11. Rule 145-3-16 – Priority of multiple court orders under the multiple-life plan
12. Rule 145-3-21 – Purchase of service credit by combined plan members
13. Rule 145-3-22 – Restored service
14. Rule 145-3-23 – Additional liability for service purchases in the combined plan
15. Rule 145-3-24 – Purchase of workers’ compensation service
16. Rule 145-3-27 – Purchase of service credit pursuant to section 145.293 of the Revised Code
17. Rule 145-3-28 – Free military service credit
18. Rule 145-3-29 – Purchase of military service credit
19. Rule 145-3-31 – Purchase of additional service credit under section 145.201 of the Revised Code
20. Rule 145-3-32 – Purchase of school board member service
21. Rule 145-3-34 – Purchase of exempted service credit
22. Rule 145-3-35 – Police and fire or highway patrol service
23. Rule 145-3-36 – Purchase of optional service
24. Rule 145-3-37 – Purchase of leave of absence
25. Rule 145-3-39 – Purchase of firefighter service
26. Rule 145-3-40 – Service credit in the combined plan for participation in the member-directed plan
27. Rule 145-3-50 – Designation of beneficiary prior to retirement
28. Rule 145-3-51 – Survivor benefits
29. Rule 145-3-52 – Proof of dependency
30. Rule 145-3-53 – Validity of marriage
31. Rule 145-3-71 – Actuarial reduction factors
32. Rule 145-3-73 – Cost of living adjustment
33. Rule 145-3-75 – Death benefit payment
34. Rule 145-3-77 – Annual interest credited to contributor accounts in the employee savings fund
35. Rule 145-3-81 – Military service
36. Rule 145-3-82 – Purchase of service credit by member-directed plan members

II. Summary of Five Year Rule Review Amendments

1. Rule 145-3-38 – Cincinnati retirement system. This rule contains a technical correction.
2. Rule 145-3-41 – Application for a disability benefit
   Rule 145-3-43 – Disability appeals. The amendments to these rules are consistent with the rule amendments described in item 4 below.

III. Other Amendments

1. Rule 145-1-01 – Organization. The amendments to this rule effect three changes. First, the amendments provide the Board with the flexibility to decide in which month the first regular meeting of the year will be held. Second, the amendments authorize the Board, at the call of the chair, to schedule regular meetings to begin on the Tuesday before the third Wednesday of any month. Lastly, the amendments eliminate the
Investment Committee as a standing committee of the whole Board now that investment items will be part of
the regular Board meeting agenda.

2. **Rule 145-1-31 – Payment for periods of non-contributing service.** The rule amendments remove
obsolete language regarding properly executed written exemption forms and add language clarifying that
refunds from the Money Purchase Program to individuals under age 65 will be treated the same as regular
refunds when non-contributing service has been granted.

3. **Rule 145-1-71 – Withdrawal of benefit application.** The amendment to this rule clarifies that a
retirement application may not be withdrawn if health care claims have been paid for an eligible benefit
recipient. This change makes this rule consistent with OAC 145-4-32 regarding the effective date of pre-
Medicare health care coverage.

   **Rule 145-2-23 – Disability appeals.** The amendments to these rules will allow disability applicants and
benefit recipients to be notified of medical determinations regarding approvals, denials, and terminations of
benefits prior to the Board’s monthly consent to the medical determination. Currently, this notification process
is only used in the months that the Board does not have a regular meeting. These amendments would allow this
notification process to apply in all months while continuing the Board’s current role of ratifying (or consenting)
to the medical determination.

5. **Amendment Three to the Ohio PERS Health Reimbursement Arrangement Plan –
   Section 4.7.** This plan document amendment gives effect to the policy change presented to the
Board during the August meeting regarding the forfeiture period for a deceased participant’s HRA account.
(A) Offices

(1) The general offices of the public employees retirement board and its address of record is “277 East Town Street, Columbus, Ohio 43215-4642.”

(2) The location of the office may be changed or additional offices may be established or closed by appropriate board resolution.

(B) Meetings

(1) **Regular** Except as provided in this paragraph, regular meetings shall be held at nine a.m. on the third Wednesday of each calendar month. At the call of the chair, or in the event of the chair’s incapacity, at the call of the vice chair, a regular meeting may be held on the Tuesday preceding the third Wednesday of a month at a time determined by the chair or vice chair. The date and hour of a regular meeting may be changed by appropriate board resolution.

(2) Special meetings may be held at the call of the chair, or in the event of the chair’s incapacity, at the call of the vice chair. Should both the chair and vice chair be incapacitated, a special meeting of the board may be called by any two members of the board.

(3) The January first meeting in each calendar year shall be the annual meeting, at which time as the first order of new business the board shall elect from its members a chair and a vice chair who shall take office immediately following their election. The chair-elect shall announce committee appointments for the coming year no later than the next regular February meeting. The composition of the committees shall remain the same until the new appointments. New board members and re-elected board members shall be sworn in at the annual meeting.

(4) The director of administrative services may designate a member of such individual’s staff to act on the board in such individual’s absence, provided the person designated is not disqualified by operation of law to act as such a representative.

(5) A majority of the actual number of members that have been elected or appointed to and are serving on the board at the time of a meeting where official action is to be taken constitutes a quorum to conduct a meeting. A majority of those members present and voting yes on a proposal shall constitute a favorable vote. An abstention from voting shall not be counted as either an affirmative or negative vote, and a member who abstains shall not be counted as a member present to determine whether a majority needed for a favorable vote has been reached. A roll call shall occur if there is a division in the vote. Any board member may request a roll call on any vote.

(6) The regular order of business for any meeting of the board shall be as follows:

(a) Roll call. An employee or retirant member of the board not able to be present may request to be excused. A request to be excused shall be moved by the chair and voted on by the board.

(b) Items of business as presented on a written agenda sent to each board member, and made available to the public, prior to the meeting and such other items that may arise between the release date of the written agenda and the meeting date.

(c) Announcement of next regular or special meeting date, hour and place.
Adjournment.

Without objection, the regular order of business may be changed by the chair or upon the request of a board member. If there is an objection, a motion, second and vote to consider an item out of turn is in order.

When a question of parliamentary procedure arises, the most current edition of “Robert’s Rules of Order” shall be followed unless in conflict with Chapter 145 of the Revised Code, or this rule.

The minutes shall be the record of the proceedings of the board. Draft copies of the written minutes shall be circulated to the board in advance of each meeting. After approval, the final form shall be inserted in the minutes book of the board.

Officers and their duties

The chair shall be elected and take office at the annual meeting in January of each year for a one-year term or until a successor is elected, whichever occurs first. The chair shall be the voice of the board and shall preside at all board meetings. The chair may call upon the vice chair to preside during a meeting. The chair shall appoint committees; make the determination whether a special meeting of the board is required; and when required, call the meeting. The chair shall present to the board for a vote the member’s request to be excused for members unable to attend meetings.

The vice chair shall be elected and take office at the annual meeting in January of each year for a one-year term. The vice chair shall succeed to the chair in the event of the resignation, retirement or death of the chair. The vice chair shall preside in the event of the absence or incapacity of the chair or upon the request of the chair.

Under the direction of the chair, the executive director or other designated person shall keep the minutes of board proceedings.

Other officers of the board shall include the chairs of standing or special committees.

Committees

The investment committee shall consist of all board members. The chair of the investment committee shall be appointed by the board chair. The investment committee shall, through its chair and its written reports, make recommendations to the board on investment related policies and actions.

The personnel and salary review committee shall consist of an odd number of board members up to a maximum of seven members. The exact number of members on the committee, the committee chair, and members shall be determined and appointed by the board chair. This committee shall meet at the call of its chair as occasion requires, to review compensation and personnel matters and to make recommendations through its chair and reports to the board on these matters.
(3)(2) The audit committee shall consist of five members: the board chair, the director of administrative services, an employee member appointed by the board chair, a retirant member appointed by the board chair, and one additional member appointed by the board chair. The board chair shall make appointments to the committee by considering the accounting, finance, or business management background of the board members. This committee shall meet twice annually, and at any other time at the call of the board chair, to review audit plans and audit findings of the retirement system’s independent and/or internal auditors. The committee shall, through the board chair, make its reports to the board. The committee shall prepare and submit an annual report of its activities to the Ohio Retirement Study Council.

(4)(3) Appointments of the committee chairs and appointments of members to the regular committees listed are concurrent with the board chair who makes the appointment.

(5)(4) The chair of the board may, at times as required, appoint temporary or special committees for such purposes as the chair deems necessary. The chair of a temporary or special committee shall be announced when the members are named. Unless otherwise stated for a shorter period in the appointment, temporary or special committee appointments shall be concurrent with the board chair who makes such appointment.

(6)(5) The minutes shall be the record of the proceedings of a committee or subcommittee. Draft copies of the written minutes shall be circulated to the committee or subcommittee for approval. After approval, the final form shall be inserted in the minutes book of the board.

Promulgated Under: 111.15
Authorized By: 145.09
Rule Amplifies: 145.04, 145.05, 145.06, 145.07, 145.08, 145.09
Rule Review Date: 10/29/97, 9/14/07, 10/15/02, 9/29/12, 9/14/17, 9/21/22
Effective Date History: 3/29/76, 12/12/76, 2/1/88; 5/9/88, 10/11/88, 4/5/93, 4/30/94, 6/1/96, 7/6/00, 1/5/01, 3/22/02, 12/24/04, 11/30/07, 10/1/09 (Emer.), 1/1/10, 1/1/14, 4/1/18
145-1-31  Payment for periods of noncontributing service

(A) This rule amplifies section 145.483 of the Revised Code.

(B) For purposes of this rule:

(1) “Exempt” means exempt from membership in the public employees retirement system pursuant to Chapter 145. of the Revised Code as effective during the period of noncontributing service and for which there is a properly executed written exemption.

(2) “Excluded” means excluded from membership in the retirement system because Chapter 145. of the Revised Code specifically excludes a person, or the person is not a public employee.

(3) “Noncontributing service” means a period of employment or service for which employee contributions pursuant to section 145.47 of the Revised Code were due, but not deducted by an employer, because the service was neither exempt nor excluded.

(4) “Properly executed written exemption” means:

(a) For employment which began before November 20, 1973, an exemption form provided by the retirement system which was signed by both the employee and employer and received by the retirement system within one month from the date employment began.

(b) For employment beginning on or after November 20, 1973, an exemption form provided by the retirement system, which was signed by both the employee and employer, received by the retirement system within one month from the date employment began, and approved by the retirement system.

(C) An employer that failed to deduct employee contributions from a public employee during a period of employment, after January 1, 1935, for state employees or after July 1, 1938, for all other employees, for which employee contributions were required shall certify the earnable salary for such noncontributing service period on a form provided by the retirement system. This certification must be based on records available to the employer.

(D) (1) After receipt of the employer’s certification, the retirement system shall prepare an employer billing statement for employee and employer contributions and interest for the period of noncontributing service.

(2) Interest shall be calculated through the end of the year preceding the date of the employer billing statement.

(3) The amount of employee contributions shall be calculated using the employee contribution rate, earnable salary and maximum contribution limits in effect during the period of noncontributing service.

(4) The amount of employer contributions shall be calculated using the employer contribution rate in effect during the period of noncontributing service.

(5) The employer is liable for the total amount due in the employer billing statement.

(5) If the amount contained in the employer billing statement is not paid, it shall be added to the employer’s monthly billing summary.

145-1-31  (continued)
(7) Service credit for the period of non-contributing service shall be granted to the member on the
earlier of the date the system receives payment in full from the employer or the due date of the
employer billing statement described in paragraph (D)(5) of this rule.

(E) (1) An employer shall not be billed for a period of noncontributing service that occurred before a
period of contributing service for which a member received a refund of the member’s accumulated
contributions, pursuant to section 145.40 of the Revised Code or article VIII of the combined plan
document, until the member has made a redeposit of the refund, pursuant to section 145.31 of the
Revised Code or rule 145-3-22 of the Administrative Code.

(2) The following applies when an employee who is or was exempt from membership pursuant to
section 145.03 of the Revised Code with a public employer also has noncontributing service and is
an employee with the same public employer.

(a) Absent a written exemption, the period of noncontributing service shall be billed to the
employer pursuant to section 145.483 of the Revised Code and this rule.

(b) An employer shall not be billed for periods of exempt service that are subsequent to a
period of noncontributing service unless the subsequent period of exempt service begins
within three months from the last date of compensation for the noncontributing service.

(c) Once the service credit is granted to the member as described in paragraph (D)(7) of this
rule, a properly executed written exemption will no longer be accepted by the retirement
system.

(3) A member who has service that was exempt and not billed to an employer may purchase such
exempt service pursuant to section 145.28 of the Revised Code and PERS rules.

(F) Except as provided in paragraph (F)(4) of this rule:

(1) Employee contributions paid by the employer pursuant to section 145.483 of the Revised Code
and this rule shall be held in the employers’ accumulation fund as defined in division (B) of
section 145.23 of the Revised Code.

(2) Employee contributions paid by the employer, pursuant to section 145.483 of the Revised Code
and this rule, shall be refunded to such employer in the event the member receives a refund of the
member’s accumulated contributions pursuant to section 145.40 of the Revised Code, or a
distribution under article VIII of the combined plan document, or a payment under division (H) of
section 145.384 of the Revised Code. Amounts paid for employer contributions, interest or other
fees, pursuant to section 145.483 of the Revised Code, shall remain with the retirement system.

(3) The employer which received employee contributions, pursuant to paragraph (F)(2) of this
rule, shall be liable for a return of such employee contributions if the employee again becomes a
member of the retirement system and either makes a redeposit pursuant to section 145.31 of the
Revised Code or rule 145-3-22 of the Administrative Code. The retirement system shall bill the
employer for the employee contributions plus interest calculated from the date of the refund
through the end of the year preceding the date of the statement.
(4) (a) For members participating in the member-directed plan, employee contributions and interest paid by the employer pursuant to section 145.483 and this rule shall be held in the member’s employer contribution account, as defined in section 1.19 of the member-directed plan document. The amount credited to the member’s employer contribution account pursuant to section 145.483 of the Revised Code shall vest in accordance with section 7.02 of the member-directed plan document. If the member receives a distribution under article VII of the member-directed plan document, the non-vested portion of the employee contributions shall be refunded to the employer.

(b) For members participating in the member-directed plan, employer contributions and interest paid by the employer pursuant to section 145.483 of the Revised Code and this rule shall be credited to the member’s employer contribution account, as defined in section 1.19 of the member-directed plan document, and the retiree medical account, as defined in rule 145-4-01 of the Administrative Code, in the percentages determined by the OPERS board. The amount credited shall vest in accordance with the relevant provisions of the member-directed and retiree medical account plan documents. If the member receives a distribution under article VIII of the member-directed plan document, the non-vested portion of the amounts paid for employer contributions, corresponding interest or other fees pursuant to section 145.483 of the Revised Code shall be transferred as described in section 7.04 of the member-directed plan document or section 4.02 of the retiree medical account plan document, as applicable.

(G) If a member has contributions in more than one retirement plan, the contributions paid by the employer pursuant to section 145.483 of the Revised Code shall be credited to the plan in which the noncontributing service would have been earned, if it were remitted at the time the service occurred. If the member no longer has contributions in the retirement plan in which the noncontributing service would have been earned, the contributions paid by the employer pursuant to section 145.483 of the Revised Code shall be credited to the plan in which the member is now contributing.
Withdrawal of benefit application

(A) Except as provided in paragraph (F) of this rule, a member or contributor of the public employees retirement system may withdraw an application for retirement, disability, or annuity payments pursuant to section 145.384 or 145.64 of the Revised Code by either of the following methods:

(1) Returning to the retirement system not later than thirty days after issuance of the initial benefit payment, all uncashed payments, along with a written request over the member’s or retirant’s signature to withdraw the application;

(2) Remitting to the retirement system a personal check or money order repaying the benefit payment(s) transmitted by or on behalf of the retirement system to the member’s or retirant’s financial institution not later than thirty days after the institution’s receipt of the initial benefit payment, along with a written request over the member’s or retirant’s signature to withdraw the application.

(B) Except as provided in division (C)(1) of section 145.45 of the Revised Code or paragraph (F) of this rule, a beneficiary eligible for monthly benefits pursuant to division (A) or (B) of section 145.45 of the Revised Code may withdraw an application for those benefits by either of the following methods:

(1) Returning to the retirement system not later than thirty days after issuance of the initial benefit payment, all uncashed payments, along with a written request over the beneficiary’s signature to withdraw the application and a completed application for a lump sum payment of the member’s accumulated account;

(2) Remitting to the retirement system a personal check or money order repaying the benefit payment(s) transmitted by the retirement system to the beneficiary’s financial institution, not later than thirty days after the institution’s receipt of the initial benefit payment, along with a written request over the beneficiary’s signature to withdraw the application and a completed application for a lump sum payment of the member’s accumulated account.

(C) If a member participating in the member-directed or combined plan, or the member’s beneficiary, withdraws an application as provided in this rule and all or any portion of the member’s individual defined contribution account is used to pay the benefit, the member or the beneficiary is not entitled to any investment gains or losses on the amount that was used to pay the benefit for the period beginning on the date the retirement system converts the units in the account for payment and ending on the date the account is reestablished by the retirement system as provided in this rule. The amount used to pay the benefit as provided in this rule shall be credited to the member’s individual defined contribution account and invested in the same OPERS investment options and in the same proportion as the account existed immediately prior to the payment.

(D) Any non-vested amounts that were forfeited by a member participating in the member-directed plan or the member’s beneficiary who withdraws a retirement application under this rule shall be restored to the member’s individual defined contribution account or retiree medical account as defined in rule 145-4-01 of the Administrative Code. Investment gains or losses shall not be applied to the amounts for the period that the amounts were not in the member’s individual defined contribution account.

(E) (1) If a member or contributor participating in the traditional pension plan withdraws an application as provided in this rule, the application of the member or contributor for an
additional annuity payment under section 145.64 of the Revised Code, if any, shall also be withdrawn.

(2) All payments issued pursuant to section 145.64 of the Revised Code shall be returned to the retirement system in accordance with paragraph (A) of this rule.

(3) A member is not entitled to any investment gains or losses on the additional annuity account for the period beginning on the date the retirement system converts the units in the account for payment and ending on the date the account is reestablished by the retirement system. The member’s additional annuity account shall be credited based on the daily value of the OPERS stable value fund on the date the account is reestablished by the retirement system.

(F) A member, contributor, or beneficiary may not withdraw an application as described in this rule if any of the following have occurred:

(1) The retirement system has made a distribution from the health reimbursement arrangement, retiree medical account or wellness retiree medical account or the retirement system or third-party health care administrator has paid claims for health care coverage for an eligible benefit recipient or eligible dependent, as those terms are defined in rule 145-4-01 of the Administrative Code.

(2) The retirement system has paid a portion of the benefit to satisfy a court order.

(3) The retirement system has made a distribution in accordance with paragraph (E) of rule 145-1-21 of the Administrative Code.

(4) In the case of an application for an additional annuity payment under section 145.64 of the Revised Code, the member, contributor, or beneficiary fails to also withdraw the individual’s application for retirement, disability, or annuity payments under section 145.384 of the Revised Code.
145-2-22 Receipt of disability benefits

(A) After the board has acted on a member’s application, the public employees retirement system shall notify, by regular mail, the member and the member’s last employer reporting to the retirement system or other retirement system, as applicable, of its action of an approval or denial of an application for a disability benefit.

(B) The board may require a member to submit to subsequent medical examination(s) by an examining physician(s) provided the medical consultant recommends such examination(s) in order to evaluate continued eligibility for disability benefits. The board’s consideration shall remain limited to the disabling condition(s) described in paragraph (B)(2) of rule 145-2-21 of the Administrative Code or as described in paragraph (G) of this rule.

(C) The board may waive the periodic medical examination as described in section 145.362 of the Revised Code upon the recommendation of the board’s medical consultant or when the recipient of a disability allowance is within twelve months of becoming eligible for a benefit under section 145.331 of the Revised Code. A waiver of the periodic medical examination does not prohibit the board from requiring the member to submit to future medical examinations.

(D) Continued medical treatment

(1) A member whose disability benefit is approved with the requirement of continued medical treatment must submit required medical treatment reports on a form provided by the retirement system. If the member fails to submit a required report or does not continue the required treatment, the member’s disability benefit shall be suspended until such report is received by the retirement system or the member resumes treatment. If such failure continues for one year, the disability benefit shall be terminated in accordance with section 145.35 of the Revised Code and is not subject to appeal to the public employees retirement board.

(2) The medical consultant may waive the requirement for continued medical treatment if the medical consultant determines that the treatment is no longer helpful or advisable.

(3) A disability benefit recipient enrolled in the rehabilitative services program shall comply with the continued medical treatment as described in paragraph (F) of this rule.

(E) Reemployment of or public service provided by a disability benefit recipient

(1) If a disability benefit recipient is restored to service as defined in this rule, the disability benefit shall cease in accordance with section 145.362 of the Revised Code and is not subject to appeal to the public employees retirement board.

(2) Subject to paragraph (E)(3) of this rule, “restored to service” means holding elective office or service as a public employee with any public employer covered by Chapter 145. of the Revised Code, regardless of whether the service is similar or dissimilar to the public employment from which the recipient was found disabled, the amount or type of compensation, if any, or whether the compensation is earnable salary.

(3) “Restored to service” does not include either of the following:

(a) On and after July 1, 2015, service the disability benefit recipient terminates immediately upon notice from the retirement system as described in this paragraph.

Upon receipt of notice that the disability benefit recipient has been restored to service, the
system shall notify the recipient on a form provided by the system. The form shall require an affirmation by the recipient that either the service will be terminated in order to continue to receive a disability benefit or the service will continue, which will cause the disability benefit to be terminated. The recipient shall return to the retirement system the signed and notarized form not later than forty-five days after the date it was mailed by the retirement system. If the recipient affirms a continuation of service or the recipient fails to return the form to the retirement system within forty-five days, the disability benefit shall be terminated on the date the recipient was restored to service and any overpayment of disability benefits shall be collected as authorized in Chapter 145. of the Revised Code. If the recipient affirms a termination of service, the termination of service shall be effective on receipt of the notice from the retirement system and any employee contributions remitted for the service shall be unauthorized and returned to the employer. The corresponding employer contributions shall be unauthorized and shall be credited against future employer liabilities.

(b) Service performed as an election worker, as defined in rule 145-1-44 of the Administrative Code, who is not a public employee pursuant to section 145.012 of the Revised Code.

(4) The retirement board shall review the employment of a disability benefit recipient who seeks employment or is employed or compensated by an employer other than a public employer in a position similar to the position the recipient held as a public employee to determine if the recipient must undergo a medical examination to determine if the disability is ongoing or whether the benefit should be terminated.

(F) Rehabilitative services program

(1) A disability benefit recipient whose application for a disability benefit was received by the retirement system on or after January 7, 2013, and who was not a law enforcement officer at the time contributing service terminated, may elect to participate in the rehabilitative services program. If the recipient withdraws from the rehabilitative services program, the recipient is eligible to make one additional election to participate. A recipient may elect to participate in the rehabilitative services program under this paragraph not later than six months prior to the beginning of the third year following the benefit effective date.

(2) For a disability benefit recipient who has elected to participate in the rehabilitative services program, the continued treatment requirement will be satisfied by the recipient’s participation in the case management treatment plan through the rehabilitative services program. Prior to the conclusion of the third year following the benefit effective date, non-compliance with the case management treatment plan shall be treated as described in paragraph (D) of this rule. After the conclusion of the third year following the benefit effective date, non-compliance with the case management treatment plan irrevocably terminates the disability benefit recipient’s participation in the rehabilitative services program and thereafter the medical examination of the recipient shall be conducted under the standard described in division (B) of section 145.362 of the Revised Code.

(3) If the recipient has been receiving the benefit for less than five years and the medical consultant determines that there are no rehabilitative services acceptable to the board’s medical consultant, the recipient shall be considered on leave of absence and the standard for termination of the benefit is that the recipient is not physically or mentally incapable of resuming the service from which the recipient was found disabled.
(G) Disability from the duties of any position

(1) Consideration of a recipient’s ability to perform any position that meets the criteria in division (B) of section 145.362 of the Revised Code shall include the recipient’s physical and mental functionality as based on the recipient’s disability record.

(2) For purposes of evaluating the ability to perform the duties of any position described in division (B) of section 145.362 of the Revised Code, all criteria described in that division shall be determined at the beginning of each review.

(H) Information gathered or obtained regarding the disabling condition(s) under this rule becomes part of the disability record that is available for review by the medical examiner and medical consultant.

Promulgated Under: 111.15
Statutory Authority: 145.09
Rule Review Date: 9/29/16, 9/29/21
Effective Date History: 6/30/61, 2/1/93, 10/4/93, 9/27/98, 1/5/01, 1/1/03, 12/24/04, 1/1/07, 2/1/11 (Emer.), 4/18/11, 12/10/12, 1/7/13 (Emer.), 3/24/13, 7/7/13 (Emer.), 9/16/13, 11/6/14, 3/23/15 (Emer.), 6/6/15, 1/1/17, 9/1/17
145-2-23 Disability appeals

(A) Except as provided in this paragraph, this rule applies when the public employees retirement board either denies an application for a disability benefit filed pursuant to section 145.35 of the Revised Code is denied or terminates a disability benefit pursuant to section 145.362 of the Revised Code is terminated due to the recipient no longer being disabled. The termination of a disability benefit due to any of the following are not subject to the discretion of nor appeal to the board:

(1) The disability benefit recipient being restored to service, refusing to undergo medical examination, or noncompliance with the annual statement requirement as provided in section 145.362 of the Revised Code and rule 145-2-22 of the Administrative Code;

(2) The disability benefit recipient’s failure to obtain treatment or submit a medical report as provided in division (F) of section 145.35 of the Revised Code and rule 145-2-22 of the Administrative Code.

(B) (1) After the board has either denied an application for, is denied or terminated, a disability benefit is terminated, the member shall be notified in writing of such action.

(2) The notice shall be sent by regular mail.

(3) The notice shall include the following information:

(a) The board’s denial or termination of the disability benefit.

(b) The member’s right to file a written request to appeal. Such written request to appeal must be received by the board public employees retirement system no later than thirty days from the date of the notice of denial or termination.

(c) Failure of a member to submit a written request to appeal shall make the board’s action final as to such application or benefit.

(d) In addition to the written request to appeal, the member must also submit additional objective medical evidence. For appeals under the own occupation standard of review, such additional evidence shall be current medical evidence documented by a licensed physician specially trained in the field of medicine covering the illness or injury for which the disability is claimed and such evidence has not been considered previously by the board examining physician or medical consultant. For appeals under the any occupation standard of review, such additional medical evidence shall be current medical evidence documented by a licensed physician specially trained in the field of medicine covering the illness or injury that supports the member’s inability to perform the duties of any occupation described in division (B) of section 145.362 of the Revised Code. Such additional medical evidence shall be presented on a form provided by the retirement system.

(e) Failure to provide the additional medical evidence within forty-five days of the member’s appeal request shall make the board’s action final to such application or benefit unless an extension for submission of such evidence has been requested and granted within the forty-five days. Only one extension, not to exceed forty-five days, may be granted by the board’s staff retirement system.

(f) All medical costs of physicians selected by the member and incident to the appeal shall be at the expense of the member.
Returning to public employment covered by Chapter 145. of the Revised Code during an appeal process that follows a termination of benefits automatically voids the member’s appeal and the board’s termination of disability benefits is final.

(C) (1) After submission of any additional medical evidence as described in paragraph (B)(3)(d) of this rule, all evidence shall be reviewed by the board’s medical consultant(s) who shall recommend action for concurrence by the board.

(2) If the board concurs with a recommendation for approval of the appeal, disability benefits shall be paid from the date that was established when the original application for a disability benefit was filed. If a recommendation for termination of a disability benefit was appealed and the appeal is approved by the board, the payments shall be resumed from the date of termination. The member shall be notified by regular mail of the board’s decision.

(3) If the board concurs with a recommendation for denial of the appeal, the member shall be notified by regular mail of the board’s decision and such decision shall be final.

(D) The following apply to disability appeals or applications after the board’s decision on an appeal is final:

(1) If two years have elapsed since the date the member’s contributing service terminated, no subsequent application shall be accepted.

(2) Any subsequent applications for a disability benefit filed after the board’s decision on a denial of an appeal and within the two years following the date the member’s contributing service terminated shall be submitted with medical evidence supporting progression of the disabling condition or a new disabling condition. The board shall not consider an application under this paragraph if the medical consultant or examining physician concludes there is no evidence of progression or a new disabling condition and the application shall be voided.

(3) Notwithstanding paragraph (D)(2) of this rule, a member may file a new disability application without showing progression or a new condition if the member has changed his or her position of public employment since the board’s decision on the appeal became final.

(E) If an appeal is pending, the retirement system shall void the appeal of a member who returns to public employment covered by Chapter 145. of the Revised Code or files a new disability application and the board’s denial or termination of disability benefits is final.
This rule amplifies sections 145.2910 and 145.2911 of the Revised Code as applicable to members participating in the combined plan.

Except as provided in paragraph (C) of this rule, a member participating in the combined plan may purchase service credit under sections 145.2910 and 145.2911 of the Revised Code in accordance with rule 145-2-15 of the Administrative Code.

Any payments made by a member to purchase credit pursuant to section 145.2910 or 145.2911 of the Revised Code shall not be refunded to a member except as authorized or required under those sections, article VIII of the combined plan document, as amended on January 7, 2013, or rule 145-2-15 of the Administrative Code.

For purchases and transfers described in paragraph (E) of rule 145-2-15 of the Administrative Code, if the payment was transmitted to the retirement system by a financial institution, the amount received by the retirement system shall be returned to the financial institution.
145-3-41  Application for a disability benefit

(A)  This rule amplifies division (C) of section 145.82 of the Revised Code and sections 10.02 and
10.03 of the combined plan document.

(B)  Subject to paragraph (C) of this rule, a member participating in the combined plan who has
disability coverage under section 10.01 of the combined plan document may apply for disability
benefits in accordance with rule 145-2-21 of the Administrative Code.

(C)  In addition to the agreement required under paragraph (C)(1)(d)(4) of that rule, a member
participating in the combined plan shall, prior to the public employees retirement board’s approval
of the member’s application, elect one of the options listed in section 10.03 of the combined plan
document.

Promulgated Under: 111.15
Statutory Authority: 145.80
Rule Amplifies: 145.81, 145.82
Rule Review Date: 10/7/09, 9/24/14, 9/24/19
Effective Date History: 1/1/03
145-3-43 Disability appeals

(A) This rule applies when the public employees retirement board denies an application for a disability benefit filed under rule 145-3-41 of the Administrative Code is denied.

(B) After the board has denied an application under rule 145-3-41 of the Administrative Code is denied, the board shall comply with rule 145-2-23 of the Administrative Code.

Promulgated Under: 111.15
Statutory Authority: 145.80
Rule Amplifies: 145.81, 145.82
Rule Review Date: 9/29/04, 10/7/09, 9/24/14, 9/24/19
Effective Date History: 1/1/03
Amendment Three to the
Public Employees Retirement System of Ohio
Health Reimbursement Arrangement Plan

WHEREAS, the Public Employees Retirement System of Ohio Health Reimbursement Arrangement Plan ("Plan") was originally effective October 1, 2015;

WHEREAS, the Ohio Public Employees Retirement Board, as Trustees of the Plan ("Trustees"), reserved the right to amend the Plan pursuant to Section 9.1 of the Plan;

WHEREAS, the Trustees now desire to amend the Plan;

NOW, THEREFORE, the Plan is hereby amended as follows, effective on September 3, 2019:

1. Section 4.7 of the Plan, [describe section] is hereby amended to be and read as follows:

4.7 Death.

(a) Participant Who Is An Eligible Retiree.

(1) Upon the death of a Participant who is an Eligible Retiree, the deceased Participant’s Spouse or Dependent, as applicable, may waive COBRA continuation coverage and elect to continue coverage under the Plan pursuant to this Section 4.7 as alternative coverage to COBRA continuation coverage. Upon the death of a Participant who is an Eligible Retiree, such Participant’s Spouse or Dependents, as applicable, shall be eligible to submit claims for: (i) Qualifying Medical Expenses which are incurred by the Participant through his date of death, and (ii) Qualifying Medical Expenses which are incurred by such Spouse or Dependents provided the Spouse or Dependent has waived COBRA continuation coverage. Such Qualifying Medical Expenses shall be reimbursed only from the balance in the deceased Participant’s HRA Account determined as of the date of his death, and as subsequently debited for reimbursements for such Qualifying Medical Expenses. Claims for reimbursement of such Qualifying Medical Expenses must be submitted to the Third Party Administrator pursuant to Article V Section 4.4.

(2) Notwithstanding Section 4.7(a)(1), an authorized representative (including the deceased Participant’s Spouse or Dependent) of a deceased Participant who is an Eligible Retiree may submit a claim for reimbursement for any Qualifying Medical Expenses incurred by such deceased Participant prior to the deceased Participant’s termination of participation as set forth in Section 2.4. Such Qualifying Medical Expenses shall be reimbursed only from the balance in the deceased Participant’s HRA Account determined as of the date of his death, and as subsequently debited for reimbursements for such Qualifying Medical Expenses. Claims for reimbursement of such Qualifying Medical Expenses must be submitted to the Third Party Administrator pursuant to Section 4.4.

(3) The balance in a deceased Participant’s HRA Account shall be forfeited upon the later of: (i) Failure of a deceased Participant’s Spouse, Dependent, or authorized representative, as applicable, to submit to the Plan a claim for reimbursement of any Qualifying Medical Expenses pursuant to Sections
4.7(a)(2) within a consecutive twenty-four (24) month period following months after the deceased Participant’s date of death, or (ii) Failure of deceased Participant’s Spouse, Dependent, or authorized representative, as applicable, to make a claim for reimbursement of any Qualifying Medical Expense pursuant to Sections 4.7(a)(1) at least once within the twenty-four (24) month period following the date the most recent claim was submitted by the Spouse, Dependent, or authorized representative. In the case of a deceased Participant whose death occurred prior to the effective date of this amendment and whose HRA Account was not forfeited on that date, the balance in the deceased Participant’s HRA Account shall be forfeited twenty-four months after the effective date of this amendment.

2. **In all other respects**, the Plan shall be and remain unchanged.

IN WITNESS WHEREOF, the undersigned has executed this Amendment on the date indicated:

___________________    ______________________________
Date       Karen E. Carraher, Executive Director
MEMORANDUM

DATE: September 9, 2019

TO: OPERS Retirement Board Members

FROM: Paul Greff, Chief Investment Officer
Prabu Kumaran, Fund Manager

RE: V. Discussion Items:
A. Staff Presentation - Annual Review of Investment Policies

Purpose
Investment Policies are a significant component of the OPERS Retirement Board’s (“Board”) governance and oversight of OPERS investment activities. This memorandum is a summary review of proposed changes to OPERS Policies that instruct Staff in the implementation of the Board’s asset allocation in 2019.

Background
The Board has adopted 28 Policies relating to investment activities. Two of those Policies, Proxy Voting and Corporate Governance, will be presented to the Board at its October 2019 meeting by Corporate Governance team.

This memorandum discusses proposed changes to the other 26 existing Investment Policies. All such changes are highlighted in redlined copies of these Policies, which follow this memorandum in a separate booklet.

Issues
Key proposed changes to existing Policies are grouped by: (A) General Changes; (B) Fund Policy Changes; (C) Asset Class and Sub-Asset Class Policy Changes; and (D) other Investment Related Policies.

Next Steps
OPERS will provide a final version of the Policies to all Board members upon approval.
A. General Changes (editorial)
- Removed all references to The Retirement Board’s Investment Committee (IC) reflecting the recent changes adopted by the Board. The responsibilities of the IC have been included back into the responsibility of the Board
- Roles and Responsibilities: Added the phrase “and any changes to it” to expand on the Board’s role and responsibility for all applicable policies
- Roles and Responsibilities - Investment Compliance: Removed the references related to the sub-committees reflecting the recent changes adopted by the Board.
- Monitoring and Reporting: Removed the references related to the sub-committees reflecting the recent changes adopted by the Board.
- Monitoring and Reporting: The Leadership team evaluated the current compliance reporting time lines and concluded to streamline the Compliance reporting timelines from monthly to quarterly
- Removed all references to the Core Plus Sub-Asset Class from all the Policies.
- Removed all references to the GTAA Asset Class
- Changed title of “Assistant Director of Investment Accounting” to Assistant Director of Investment Accounting/Compliance & Risk”
- Remove the GTAA Policy from the approved list of Investments Governing Policies by December 31, 2019.

B. Key Changes to Fund Policies

Investment Objectives and Asset Allocation Policies for Defined Benefit (“DB”) Fund and Health Care 115 Trust (“HC”) Fund
- Section VI. Asset Allocation
  - A. Purpose (Health Care Only)
    ▪ Added language to highlight unique characteristics of the HC Fund.
  - B. Targets and Ranges (Health Care Only)
    ▪ Added the missing word “and” to distinguish between the target and range.
  - D. Periodic Review
    ▪ Modified language describing the frequency of The Board’s strategic asset allocation review to include: “or when material changes to the liabilities take place (e.g., plan design changes, material changes in underlying assumptions, etc.)”.
- Section IX. Roles and Responsibilities
  - A. OPERS Retirement Board
    ▪ 4. Monitoring and Evaluation
      ▪ Changed the title of the Section to “Monitoring, Evaluation, and Approval” to reflect added duties that were under the purview of the Investment Committee
  - G. Actuary
    ▪ Modified language describing the frequency of The Board’s asset liability study to include: “or when material changes to the liabilities take place (e.g., plan design changes, material changes in underlying assumptions, etc.)”.

Investment Objectives and Asset Allocation Policies for Defined Contribution (“DC”) Fund

- Section V. Investment Options
  - A. OPERS Funds and OPERS Target Date Funds
    - Removed the wording “and Other Commission Arrangements” to reflect the correct title of the Soft Dollar Policy.
- Section X. Appendix A
  - Removed 2018 TDF allocation tables and added the 2020 and 2021 tables.
    - Yellow highlights reflect YoY changes in targets and ranges

C. Key Changes to Asset Class and Sub-Asset Class Policies

Private Equity Policy

- Section VIII. Risk Management
  - C. Single Investment Risk
    - For primary funds, the commitment limit to any single closed-end commingled fund was increased to $600 million, given the increased allocation to Private Equity
  - D. Co-Investment/Direct Investment Risk
    - Increased the maximum allowable co-investment or direct investment in any single company to $100 million (or 1% of the portfolio’s market value based on total cost)

Real Estate Policy

- Section VIII. Risk Management
  - A. Private Markets
    - 1. Property Type Risk
      - Removed language constraining the portfolio to have at least 80% invested in certain property types.
      - Added language which elaborates on the “Diversified” property type
      - Modified allocation ranges for three property types
      - Changed the “Sector” heading on the table to “Property Type”
      - Table updated to reflect current ODCE Weights as of 06/30/2019
    - 5. Single Investment Risk
      - For separate accounts, lowered the amount of equity in any single direct property to 10% limit from 15%. Removed the statement with regards to multiple buildings in geographic proximity.

Opportunistic Policy

- Section III. Philosophy
  - Moved portion of paragraph as its own stand-alone section
  - Replaced the word “must” with “should” when discussing the eventual outcome of the opportunistic strategy/instrument
- Section IV. Allocation
  - Added language stating the allocation discretion of the strategies
• Section V. Permissible Instruments
  o Added a clause referencing the role of the governing documents
  o Removed portion of paragraph due to redundancy.
• Section VI. Performance Objectives
  o Modified section to discuss the perceived benefits of the sub-asset class
• Section VIII. Risk Management
  o Modified section to clarify the allocation limit for Public and Private Market strategies or portfolios

D. Other Investment Related Policies
   Derivatives Policy
• Section VIII. Risk Management
  o H. Liquidity Risk
    Increased the maximum combined gross notional exposure for Category II and III derivatives to 25% from 20% of the total net asset value of public market assets held in separate accounts.

Iran & Sudan Divestment Policy
• Section IV. Investment Philosophy
  o A. Removed the word “will” and replaced with “may” when explaining the potential restriction of new investments on scrutinized companies.
• Section VIII. Roles and Responsibilities
  o A. Added a new section for the role of Executive Director.

Leverage Policy
• Section VI. Risk Management
  o A. Volatility Risk
    ▪ Updated the leverage limit for the Core Fixed sub asset class to 1.2x.
    ▪ Updated the leverage limit for the Securitized Debt sub asset class to 1.45x.
    ▪ Updated the leverage limit for the Hedge Fund sub asset class to 9x.
    ▪ Removed the example leverage calculations in footnote #1.

Liquidity Policy
• Section VI. Risk Management
  o Modified the opening statement without a specific reference (number) to the funding status of the Fund.

Material Non-Public Information Policy
• Section V. Securities Laws
  o B. Material Nonpublic Information
    ▪ Removed the phrase “on an exchange” when defining material information
    ▪ Included divestments, entering into or cancelling significant contracts, significant litigation, claims, and changes to a company’s capital structure as examples of material non-public information
Section VII. Managing Material Nonpublic Information
  o B. Reporting Requirements
    ▪ Replaced Investment Compliance with General Counsel as the party to
      immediately notify when any OPERS employee becomes aware of material
      non-public information
    ▪ Inserted language explaining General Counsel will notify Investment
      Compliance if General Counsel determines information is material and non-
      public
  o D. Removal of Trading Restrictions
    ▪ Inserted language clarifying that Investment Compliance will not permit
      the trading or removal of a security or commodity from the Restricted List until
      General Counsel confirms the information is both public and known to the
      market.
Section IX. Roles and Responsibilities
  o F. Investment Compliance
    ▪ Modified language to permit a restricted trade in lieu of temporarily removing
      the security from the Restricted List.
Section X. Monitoring and Reporting
  o A. Continuously
    ▪ Modified section to clarify that OPERS employees will notify General
      Counsel of MNPI

Office of Foreign Assets Control Policy
  • Section V. Process
    o Reworded section to clarify which party creates and develops the OFAC
      procedure, and the manner in which it’s reviewed.
    o Removed the specific countries and included all nations which appear on the
      OFAC list when assuming which countries are under an embargo.

Personal Trading Policy
  • Section VI. Assets To Which This Policy Applies
    o Included holdings in non-publicly traded limited liability companies and/or
      corporations, and cryptocurrencies in the exception list for covered assets
  • Section VIII. Transactions To Which This Policy Applies
    o Inserted language removing assets acquired by inheritance or survivorship
      from covered assets, as long as the covered person promptly informs
      Investment Compliance of the inheritance or survivorship
  • Section X. Other Requirements
    o A. Pre-Clearance of Covered Transactions
      ▪ Changed the time that pre-clearance approvals expire from 4:15 p.m. EST
        to market close on the day granted.
      1. Pre-clearance for Options
        o Removed requirement that option transactions have separate pre-
          clearance of the underlying security
    o C. Material Inside and Non-Public Information
- Included commodities as an asset which pertains to material inside and non-public information
- Included divestments, entering into or cancelling significant contracts, significant litigation, claims, and changes to a company’s capital structure as examples of material inside and non-public information

- Section XIII. Monitoring and Reporting
  - B. Annually
    - Changed “OPERS employees” to “Covered Persons” as the party who General Counsel and Investment Compliance will review the securities laws with.

**Securities Lending Policy**
- Section V. Eligible Assets
  - Added language prohibiting the lending of securities which are part of the scrutinized list published by the Corporate Governance team.
- Section VII. Risk Management
  - C. Collateral Risk
    - Added section enumerating the methods to minimize risk for non-cash collateral.
- Section VIII. Roles and Responsibilities
  - F. Corporate Governance
    - Added new section describing the role of Corporate Governance with respect to publishing a scrutinized and focus list of companies.
To: OPERS Board Members  
From: Craig Svendsen, CFA  
Date: August 28, 2019  
Subject: Annual Review of Investment Policies

The investment related Policies that are being presented to the Board for approval have been reviewed by NEPC. Please note that 26 of the 28 investment policies have been reviewed. The remaining two policies – Corporate Governance and Proxy Voting – will be reviewed at the October 2019 Board meeting by the Corporate Governance team. The majority of the changes are intended to improve the clarity of or the consistency across the various Policies. Several changes of note include:

- Removal of all references to the Retirement Board’s Investment Committee
- Updating of the Leverage Policy to reflect several new leverage limits including the increase to 9X for the Hedge Fund sub asset class
- If HC 115 Trust Fund (HC Fund) proposed asset allocation is approved:
  o HC Fund Policy updated to reflect new target asset allocation and ranges
  o Elimination of Global Tactical Asset Allocation Policy

NEPC believes the Policy review process was thorough and is comfortable with each Policy currently being proposed to the Board. NEPC also believes that each Policy provides the necessary freedom to implement strategies effectively yet still provides appropriate guidelines and constraints to ensure fiduciary standards are met and best practices are maintained. Please note that the Staff Memo on this topic describes in detail all the changes to the various Policies.
Memo

To: Board of Trustees of the
   Ohio Public Employees Retirement System

From: Suzanne M. Bernard, CFA, CAIA

Date: September 1, 2019

Re: Investment Policies for Alternatives

Background
Annually, Aon Hewitt Investment Consulting (AHIC) works with OPERS Investment Staff to review and make modifications to the Alternative Investment Policy Statements. In our early years working with you, the recommended changes were relatively robust. As the program has evolved, recent changes have been less substantial. Below are the changes being recommended this year by Staff and AHIC. We support these changes.

Assessment
We are comfortable with the changes made to the Investment Policies. We believe all necessary elements of a good investment policy are included:

- They are specific and unambiguous
- Roles and responsibilities elements are delineated
- Appropriate risk measures are addressed
- Performance metrics are clear
- Investment parameters are defined

Also, we continue to stress that these are “living” documents and that we anticipate working with Staff in the future to continue to refine the investment policies as market opportunities and “best practices” in risk assessment and performance measurement continue to evolve. We fully expect to come back to the Board in the future with continued evolutionary modifications to these documents.

On the following pages we summarize the main investment elements modified in the policies this year:
Hedge Funds

Most of the changes in the Hedge Fund policy were presented at the August meeting. Our comments below reflect our thoughts on those changes. We are comfortable with all changes being proposed.

There are three material changes to the Hedge Funds Policy dated August 21, 2019, each of which is interrelated and a continuation of the changes to the long-term asset allocation targets that were approved by the Board in April 2019:

- The role of the Hedge Funds portfolio
- The strategy composition of the Hedge Funds portfolio
- The leverage constraint of the Hedge Funds portfolio

All of the above reflect a desire to improve the Hedge Funds portfolio composition, with a greater emphasis on strategies that exhibit lower correlation to equity markets. We support each of these initiatives.

- In the “Investment Philosophy” section, “long term return enhancement” was removed to clarify the role of the Hedge Funds portfolio, which is to provide diversification to traditional asset classes and reduce overall volatility, while generating positive returns.

- The composition changes required to meet these objectives are reflected in the “Structure” section, where the upper end of the range for the Equity Hedge strategy is reduced from 35% to 15%, while the upper ends of the Relative Value and Macro/Tactical strategies are increased from 35% to 50%. While it is intuitive that Equity Hedge strategies would have a stronger relationship with equity market moves, Staff and Aon conducted separate analyses to confirm this quantitatively using historical data obtained from the risk management system utilized by OPERS, which is sophisticated enough to aggregate exposures from every position in every fund across the entire portfolio. Meanwhile, the Relative Value and Macro/Tactical have been stronger diversifiers as less consistent sources of equity market beta

- Under the “Leverage Risk” section, the expectation for leverage to fall “within a range of 3 to 5 times, with a maximum level of 6 times” was removed and replaced with a maximum level of “9” times. In our opinion, increasing the leverage cap is necessary in order to refocus the strategy mix aimed at performance with lower equity market correlation. Based on the fund and strategy composition changes noted above, Staff estimated that leverage would be higher under a Proposed portfolio compared to the Current portfolio, and that an increase to 9 times was appropriate. Aon analyzed both returns-based and holdings-based data to
evaluate the impact that a transition to the Proposed portfolio would have on the risk profile of the Hedge Funds portfolio. We found no relationship between funds and strategies with higher leverage and the volatility of their returns. Furthermore, there has been no relationship between leverage and the Value at Risk ("VaR") measure based on the actual securities holdings. This is because of the nature of the Relative Value and Macro/Tactical strategies, which utilize more leverage—in terms of gross notional exposure—due to derivatives positions that increase economic exposure but do not necessarily add more risk to the portfolio. In our experience, Hedge Funds utilize derivatives as essential portfolio management tools for the following reasons:

- Access certain markets, such as currencies, commodities, and interest rates
- Create custom trade structures and exploit arbitrage opportunities
- Express views more efficiently
- Manage risks

**Private Equity**

The only investment- or risk-related changes made in the Private Equity guidelines relate to the maximum size of investments as measured by dollars invested in single investment. By necessity, these dollar values rise over time as the Total Fund and the markets both expand. Both changes were within the “Risk Management” section. They are as follows:

- Under “C. Single Investment Risk” the amount that can be invested in a single closed-end fund increased from $400 million to $600 million. The maximum amount able to be invested in a single fund of fund remained constant at $800 million. Both of these limits are reasonable given the size, maturity and diversification level of the private equity portfolio.
- Under “D. Co-Investments” the maximum investment size had been the greater of $75 million or 1% of the private equity program’s market value. The maximum dollar value is being increased to $100 million, but the 1% maximum is static. We find this reasonable as well.

**Real Estate**

- Three risk management guidelines were changed to provide additional mitigation of risk, as defined by deviation from the benchmark, while preserving Staff’s ability to manage a large diversified real estate portfolio. The three items are as follows:
Under “Property Type Risk,” removal of the long-term goal to have 80% of real estate invested in the four “Core” property types (Apartment, Industrial, Office, and Retail). There is a redundancy here because the guidelines include specific maximum and minimum ranges for these four sectors. The minimum exposure is essentially set through the sector-specific guidelines.

The addition of a “Diversified” property type category. We have observed an increase in mixed use investments. Common examples would include a lifestyle center that may include retail, office, apartment and hotel. We have also observed a greater incidence of investment managers reporting exposure by property type as “diversified,” in particular, secondary fund managers. Aon made additional adjustments, beyond Staff’s, to various category limits. In addition, the “Hotel/Other” and “Diversified” combined were capped at 50% of the real estate portfolio.

Reducing “Single Investment Risk” from 15% to 10% of the real estate allocation. Such a limit on equity exposure is common practice. The new 10% limit mitigates concentration risk, but allows flexibility for property management, such as the ability to deleverage a mortgaged property in the event credit markets become less liquid. We recommended a focus upon individual property exposure, rather than the term “investment” that could be subject to various interpretations. For example, we recommended deleting the application of this restriction on programmatic investments that include multiple divisible properties, where the optionality of being able to split off and sell individual properties can reduce risk.
To: OPERS Board Members  
Ohio Public Employees’ Retirement System  

From: Craig Svendsen, CFA, Partner  

Date: August 30, 2019  

Subject: Second Quarter 2019 Market and Fund Performance Review  

---

**General Market Overview**

**Equities**

Global equities broadly increased during the quarter as the market perceived a more dovish policy stance from the Fed. In domestic markets, the S&P 500 gained 4.3% in the three months ended June 30. International developed market equities returned 3.7%, according to the MSCI EAFE, and emerging market equities returned 0.6%, according to the MSCI EM.

**Fixed Income**

In fixed income, global yields continued to decline, reflecting concerns over the global growth outlook. Spreads on investment-grade credit were little changed amid steady demand; in contrast, spreads on the riskier CCC-rated segment of high-yield debt widened as much as 70 basis points, underscoring investor concerns around credit risk associated with the late stage of an economic cycle. The Bloomberg Barclays US High Yield index gained 2.5% for the three months ended June 30. The Bloomberg Barclays Aggregate index and the Bloomberg Barclays US Long Treasury index rose 3.1% while the S&P LSTA Leveraged Loan index returned 1.6% in the second quarter. Outside the US, emerging market debt rallied with local currency-denominated debt posting a return of 5.6% for the quarter. External emerging market sovereign debt continued its strong run, returning 4.4% for the quarter. Valuations and fundamentals remain favorable for emerging economies given the Federal Reserve’s more dovish stance.

**Real Assets**

Publicly-traded real assets were volatile in the second quarter with a modest retreat by the Bloomberg Commodity Index. The price of WTI Crude Oil was moderately down and natural gas posted losses of 13% for the three months ended June 30. Industrial metals gave up gains on concerns around the ongoing trade dispute between the United States and China. Equities in the energy, agriculture, and metals and mining sectors were up 0.4%, 1.3% and 2.0%, respectively. Midstream energy was modestly positive for the quarter as investors weighed improving fundamentals with compressing yields after a strong showing in the first quarter. Meanwhile, in real estate, REITs were up 1.7% in the second quarter, according to the FTSE NAREIT Equity REITS Index, bolstered by strong fundamentals and softening long-term interest rates. All subsectors were in the black, with the exceptions of retail and office. Property types with strong secular trends, for instance, industrial and data centers, remain...
to be strong performers. Overall, REITs ended the second quarter trading at a 14% premium to net asset values; however, a wide dispersion in valuations within property types remains.

**Fund Reviews**

**Defined Benefit (DB) Fund Review**

The DB Fund had a strong quarter, returning 3.2% on a net of fee basis, underperforming the Policy index return by 0.2%. This return ranked in the 29th percentile of the peer universe (Public Funds w/ more than $1 billion in assets). The DB Fund has now returned 6.9% over the past year, 9.3% over the past three years and 6.4% over the past five years (all on a net of fee basis). These returns, when compared to peers, rank in the 18th percentile over the past year, in the 27th percentile over the past three years and in the 18th percentile over the past five years.

Most asset classes posted positive returns in the quarter. The DB Fund returns were driven by risk parity (+6.9%), emerging markets debt (+4.6%) and domestic equity (+4.0). As mentioned earlier, the Fund underperformed its Policy Index by 0.2% in the quarter. Over the past three- and five-year periods, the DB Fund has outperformed its Policy Index on a net of fee basis by 30 basis points for both time periods.

**Health Care 115 (HC 115) Fund Review**

The HC 115 Fund returned 3.2% on a net of fee basis, performing in-line with the Policy index. The HC 115 Fund has now returned 6.2% over the past year, 7.9% over the past three years and 4.8% over the past five years (all on a net of fee basis).

**Defined Contribution (DC) Fund Review**

The DC Fund assets increased by $69.4 million during the quarter. All index funds performed as expected relative to their benchmarks while the only active strategy, the Stable Value fund, returned 0.6%. Longer term Target Date Funds outperformed nearer term dated Target Date Funds due to their higher allocation to domestic equity which outperformed fixed income during the quarter. As a point of comparison, the 2020 Fund returned 2.9% while the 2055 Fund returned 3.2%.
MEMORANDUM

DATE: September 9, 2019

TO: OPERS Retirement Board Members

FROM: Allen Foster, Director – Benefits
       Deborah McCarthy, Government Relations Officer/Legal Counsel

RE: V. Discussion Items:
    C. Group D

Purpose – The purpose of this memorandum is to provide the Board with a summary of the plan design components of Group D and a description of each. Staff is seeking the Board’s feedback on each of the Group D components.

Background – At last month’s meeting, the Board reviewed a detailed outline of the Group D proposal, which would impact members hired after January 1, 2022. That review included a summary of the rationale for Group D and its plan design components.

When the Group D proposal was first presented to the Board at the July Strategic Planning retreat, staff outlined several core issues that continue to exist despite many efforts to address them. The core issues are as follows:

(1) Investment market volatility continues to be a risk to the retirement system due to the system’s dependency on investment returns to fund benefits;

(2) The needs/interests of the future generations of our members are changing;

(3) The Traditional Pension Plan’s unfunded actuarial accrued liability (UAAL) is at the highest level it has been ($24B) and needs all the employer contribution rate to fund it;

(4) Funding health care continues to be an issue.
In summary, Group D is an opportunity to address these core issues. Group D is a new tier of the Traditional Pension (defined benefit) Plan that will retain a strong defined benefit pension plan while positioning it for the future and give the retirement system more flexibility to manage market fluctuations. Group D is an opportunity to create a plan design that is attractive to the future generations of our members. A plan design that allows us to continue to fund the UAAL of the Traditional Pension Plan and, under current conditions, fund its own defined benefit. Group D is a new tier that will allow members to share when the investment markets are good and that will provide greater flexibility without seeking benefit reductions during market downturns.

Finally, Group D is an opportunity to address the lack of available funding for health care with a new tier of the Traditional Pension Plan that includes a retiree medical account to fund this group’s health care in retirement. Group D will create a strong defined benefit plan that provides the benefits members want with the retirement security they have come to expect.

**Group D Plan Design** – Below is a detailed description of the plan design components of the proposed Group D tier of the Traditional Pension Plan.

<table>
<thead>
<tr>
<th>Group D Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution Rates</td>
<td>Members contribute 11% of their earnable salary to OPERS. Of the 11%, 10% would fund the defined benefit plan and 1% to fund their Pension Plus Account. (Benefit formula multiplier is contingent on the contribution rate).</td>
</tr>
</tbody>
</table>
| Benefit Eligibility & Final Average Salary | Unreduced benefit age/service requirements – 62/35, 67/25 or 70/5  
Reduced benefit age/service requirements – 57/30, 62/20 or 65/5  
Final average salary – average of the 10 highest years of salary  
Benefit formula multiplier – 2.0% assuming an 11% contribution rate (lower if 10% contribution rate). |
| Pension Plus Account      | A separate account that allows for 1% of member contributions to be deposited into an investment account. Members would have immediate vesting and manage their own investment portfolio. |
| Gainsharing Account       | Active members share investment earnings in accordance with the policy. Group D members who have accrued 5 years and 1) Investment return is over 7.2% and 2) Funded ratio has exceeded the specified target. |
| Funded ratio threshold    | The funded ratio threshold may range from 90% to 120%.                                                                                     |
| Retiree Medical Account (RMA) | A portion of the employer contribution allocated to fund an individual account to reimburse retiree for qualified medical expenses. Initial contribution allocation is 2%. |
| COLA                      | Simple COLA – CPI up to 2.0% starting at the later of age 62 or 24 months from retirement effective date  
Any future changes to COLA may include Group D. |
| Stabilization Fund        | A fund that allows for 0.5% of employer contributions to be used as a reserve for future funding needs.                                       |
| Discount Rate             | For Group D valuation purposes only, the discount rate would be 7%.                                                                        |
| Portability Refunds       | Money in  
- Members can roll money into the plan from other eligible retirement plans.                                                           |
Service Purchases

- Service purchases would continue the same as practiced today. In addition, members could purchase a maximum of 5 years of “Air Time” service credit (with no associated public employment) at the full actuarial cost.

Money out

- Refunds would include member contributions, interest, enhanced refund (if applicable), Pension Plus account and Gainsharing account (if applicable).
- After termination of employment, funds could be rolled to another eligible retirement plan.

Proposed Protective Services Division

- An occupational classification truly based on public safety job duties (Correction officers, EMS workers, etc.).
- Member contribution rate estimated to be 13% and employer at 16%.

Earnable Salary Survivor Benefits Disability Benefits

- Earnable salary – based on minimum wage instead of current requirement of $660 per month to earn full-time service credit.
- Survivor benefits – discontinue current program for Group D and continue to offer life insurance product OPERS implemented in 2018.
- Disability – Use “any occupation” standard for initial determination (same as Social Security).

Group D Plan Design - Law Enforcement/Public Safety

Below is a detailed description of the plan design components of the proposed Group D tier for Law Enforcement and Public Safety divisions of the Traditional Pension Plan.

<table>
<thead>
<tr>
<th>Group D Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution Rates</td>
<td>Members continue to contribute current 12% for public safety and 13% for law enforcement. Employer contribution rate would increase from current 18.1% to 19.5% for both public safety and law enforcement.</td>
</tr>
</tbody>
</table>
| Benefit Eligibility & Final Average Salary | Unreduced benefit age/service requirements  
  - Public safety - 56/25 or 65/15 (increase from 64/15)  
  - Law enforcement – 54/25 or 65/15 (increase from 52/25 and 64/15)  
  Reduced benefit age/service requirements  
  - Public safety – 56/15 or 54/25 (increase from 52/25)  
  - Law enforcement – 56/15 or 50/25 (increase from 48/25)  
  Final average salary – average of the 10 highest years of salary  
  Benefit formula multiplier – 2.2% or 1.5% for 15 years of service |
| Pension Plus Account                   | A separate account that allows for 1% of member contributions to be deposited into an investment account. Members would have immediate vesting and manage their own investment portfolio.                          |
| Gainsharing Account                   | Active members share investment earnings in accordance with the policy. Group D members who have accrued 5 years and 1) Investment return is over 7.2% and 2) Funded ratio has exceeded the specified target.             |
| Funded ratio threshold                | The funded ratio threshold may range from 90% to 120%.                                                                                                                                                      |
| Retiree Medical Account (RMA)         | A portion of the employer contribution allocated to fund an individual account to reimburse retiree for qualified medical expenses. Initial contribution allocation is 4%.                                         |
| COLA                        | • Simple COLA – CPI up to 2.0% starting at the later of age 62 or 24 months after retirement  
<table>
<thead>
<tr>
<th></th>
<th>• Any future changes to COLA may include Group D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stabilization Fund</td>
<td>• A fund that allows for 0.5% of employer contributions to be used as a reserve for future funding needs.</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Discount Rate</td>
<td>• For Group D valuation purposes only, the discount rate would be 7%.</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------------------------------------------</td>
</tr>
</tbody>
</table>
| Portability               | Money in  
| Refunds                   | • Members can roll money into the plan from other eligible retirement plans.  
| Service Purchases         | • Service purchases would continue the same as practiced today. In addition, members could purchase a maximum of 5 years of “Air Time” service credit (with no associated public employment) at the full actuarial cost. |
| Money out                 | • Refunds would include member contributions, interest, enhanced refund (if applicable), Pension Plus account and Gainsharing account (if applicable).  
|                           | • After termination of employment, funds could be rolled to another eligible retirement plan. |

**Next Steps** – Based on the Board’s feedback from this month’s meeting, staff will present some additional details on the Group D proposal at the October meeting and will address any outstanding questions of the Board. Although the Group D proposal will be presented as a discussion item at the October meeting, the Board may choose to approve Group D recommendations at any time.
MEMORANDUM

DATE: September 9, 2019

TO: OPERS Retirement Board Members

FROM: Allen Foster, Director – Benefits
       Deborah McCarthy, Government Relations Officer/Legal Counsel

RE: V. Discussion Items:
       D. Combined/Member Directed Plan changes

Purpose – The purpose of this memorandum is to provide the Board with an overview of the proposed changes to both the Member Directed and Combined Plans, as presented at the July 2019 Strategic Planning Retreat. Staff is seeking feedback from the Board on the proposed changes and guidance for future action.

Background – Since its inception, OPERS has offered a defined benefit retirement plan—known today as the Traditional Pension Plan. The Traditional Pension Plan offers retirement, disability, survivor and death benefits to its members and their beneficiaries. In the year 2000, legislation was passed to require OPERS to establish one or more defined contribution plans (HB 628 – 123 G.A.). After many months of research and discussion, the Board approved the establishment of two new retirement plans. In January 2003, OPERS began offering a choice of three retirement plans—the Traditional Pension Plan and two new plans—the Member-Directed Plan (a defined contribution plan) and the Combined Plan (a hybrid defined contribution/defined benefit plan).

Since their inception, the Member-Directed and Combined Plans have been subject to periodic review and amendment. In the case of the Combined Plan, it underwent significant amendment after the enactment of S.B. 343 in 2012. The intent of the amendments was to maintain consistency between the defined benefit provisions of the Combined Plan and the provisions of the Traditional Pension Plan. In contrast, the Member-Directed Plan experienced almost no changes as a result of S.B. 343. Instead, there have been only minor amendments to the Member-Directed Plan since that time.
**Issues – Defining the Problem.** In light of the proposed Group D changes to the Traditional Pension Plan, the Alternative Plan Design work group—a group of staff committed to reviewing the retirement plans offered by OPERS—began an in-depth review of the Member-Directed and Combined Plans to ensure that parity remains among the plans. The ongoing goal of the APD work group is to periodically review all three retirement plans in order to reduce/eliminate subsidization; ensure plan sustainability; evaluate plan appropriateness and attractiveness; ensure plan purpose is achieved in light of changing environment; maintain intergenerational equity; and advance planning to minimize member impact.

After 16 years of experience in administering the three retirement plans, staff took the opportunity to do a “plan-level” review and took into consideration the principles listed above. Based on this review, staff is recommending changes to both the Member-Directed and Combined Plans. At the July retreat, the staff presented the recommendations to the Board and agreed to bring the changes back to the Board at a future date.

**Options for Consideration – Member-Directed Plan.** Below is a chart that summarizes the proposed changes to the Member-Directed Plan, which would apply to members who elect this plan on or after January 1, 2022:

<table>
<thead>
<tr>
<th>Option</th>
<th>Current MD Plan</th>
<th>Future MD Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vesting schedule (Employer Contributions)</td>
<td>100% at 5 years (20% at year 1)</td>
<td>100% at 10 years (starting year 3 at 30%)</td>
</tr>
<tr>
<td>Mitigating rate</td>
<td>2.44%*</td>
<td>4-10%</td>
</tr>
<tr>
<td>Eligibility to annuitize</td>
<td>55</td>
<td>62</td>
</tr>
<tr>
<td>Cost of living adjustment on lifetime annuity</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Retiree Medical Account (RMA) Contribution Rate</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>RMA Interest Crediting</td>
<td>4%, if DB investment return is positive*</td>
<td>Stable value rate*</td>
</tr>
<tr>
<td>Plan Changes</td>
<td>1 Plan Change – anytime during career</td>
<td>1 Plan Change – Within first 5 years</td>
</tr>
</tbody>
</table>

* In April 2019, the Board approved increasing the mitigating rate to 3.5% to be funded by plan forfeitures.

**In April 2019, the Board approved crediting the Stable Value rate of return to RMA accounts to be implemented in January 2020.
Options for Consideration – Combined Plan. In consideration of the proposed changes to the Member-Directed and Traditional Pension Plan (e.g. Group D), staff reviewed the plan design features of the Combined Plan and the participation rates since its establishment.

The Combined Plan includes all of the same plan design features as the Traditional Pension Plan. As a hybrid plan, the employee and employer contributions are used to fund both a defined contribution portion and a defined benefit portion of the plan. Historically, the Combined Plan has had the lowest percentage (8.25%) of plan selection compared to the Member-Directed (15.46%) and Traditional Pension (76.29%) Plans.

Due to the plan design features of the proposed Group D, staff are recommending that the Combined Plan be merged into the Traditional Pension Plan. The Combined Plan would be closed to new members but would continue with its own plan design features. The Combined Plan would function as its own division within the Traditional Pension Plan. Members currently participating in the Combined Plan will experience no changes.

From an administrative perspective, a merger would present little, if any, administrative burden because the plan design features of the Combined and Traditional Pension Plans are identical, with the exception of the defined benefit formula. The chart below compares the plan design features of the Combined and Traditional Pension Plans:

<table>
<thead>
<tr>
<th>Plan design feature</th>
<th>Traditional Pension</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%/14% Contribution rates</td>
<td>✔</td>
<td>Same</td>
</tr>
<tr>
<td>Refund</td>
<td>✔</td>
<td>Same</td>
</tr>
<tr>
<td>100% plus interest (TP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% plus value (CO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 yrs. – 33% additional</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>10 yrs. – 67% additional</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Survivor benefits at 18 months</td>
<td>✔</td>
<td>Same</td>
</tr>
<tr>
<td>Disability benefits at 60 months</td>
<td>✔</td>
<td>Same</td>
</tr>
<tr>
<td>Retirement eligibility</td>
<td>2.2% of FAS</td>
<td>1.0% of FAS</td>
</tr>
<tr>
<td>Cost of living adjustment</td>
<td>✔</td>
<td>Same</td>
</tr>
<tr>
<td>Death benefit</td>
<td>✔</td>
<td>Same</td>
</tr>
</tbody>
</table>

Next Steps – Based on the feedback received at this month’s meeting, staff will bring this topic back at next month’s meeting and will address any outstanding questions of the Board.
MEMORANDUM

DATE: September 9, 2019

TO: OPERS Retirement Board Members

FROM: Chuck Quinlan, Director - Information Technology

RE: V. Discussion Items: E. Strategic Plan Strategies

Purpose – To share with the board the strategies that were developed from the discussions at the July strategic planning retreat. These strategies will be incorporated into the 2020-2022 OPERS Strategic Plan.

Background – The OPERS strategic plan is based on a rolling three-year time horizon. Each year staff evaluates trends, opportunities, and threats and makes recommendations to the board prior to publishing an updated plan. The process includes interaction with the board during a summer strategic planning retreat followed by final recommendations each fall. This presentation (attached) summarizes the strategic direction within each business domain of the plan.

The OPERS Strategic Plan is based upon our mission, vision, and nine guiding principles.

Mission: To provide secure retirement benefits for our members

Vision: To be a trustworthy retirement partner delivering responsive, high-quality service

Guiding Principles:
- Operational Excellence
- Inter-generational Equity
- Self-sustaining Pension Plans
- Stewardship of Plans
- Health Care Access
Five pillar goals provide direction.

Pillar Goals:

1. Maintain Financial Stability
2. Offer Valued and Self-sustaining Retirement Products
3. Provide Quality Service to Our Members and Retirees
4. Maintain Organizational Excellence
5. Promote OPERS as an Asset

Next Steps -- Incorporate final content and publish new strategic plan by end of year.
I. Action Item:

   A. Review and Discussion of Investment Incentive Compensation Plan Design
      Mindy Bailey, Director – Human Resources; Mr. Mike Oak, Associate Partner, McLagan