



Alameda County Employees' Retirement Association  
BOARD OF RETIREMENT

**RETIRES COMMITTEE/BOARD MEETING  
NOTICE and AGENDA**

**ACERA MISSION:**

To provide ACERA members and employers with flexible, cost-effective, participant-oriented benefits through prudent investment management and superior member services.

**Wednesday, June 3, 2026  
9:30 a.m.**

<b>LOCATION AND TELECONFERENCE</b>	<b>COMMITTEE MEMBERS</b>	
<p>ACERA C.G. "BUD" QUIST BOARD ROOM 475 14<sup>TH</sup> STREET, 10<sup>TH</sup> FLOOR OAKLAND, CALIFORNIA 94612-1900 MAIN LINE: 510.628.3000 FAX: 510.268.9574</p> <p>The public can observe the meeting and offer public comment by using the below Webinar ID and Passcode after clicking on the below link or calling the below call-in number.</p> <p>Link: <a href="https://zoom.us/join">https://zoom.us/join</a> Call-In: 1 (669) 900-6833 US Webinar ID: 879 6337 8479 Passcode: 699406 For help joining a Zoom meeting, see: <a href="https://support.zoom.us/hc/en-us/articles/201362193">https://support.zoom.us/hc/en-us/articles/201362193</a></p>	ELIZABETH ROGERS, CHAIR	ELECTED RETIRED
	KELLIE SIMON, VICE CHAIR	ELECTED GENERAL
	OPHELIA BASGAL	APPOINTED
	KEITH CARSON	APPOINTED
	STEVEN WILKINSON	APPOINTED

The Alternate Retired Member votes in the absence of the Elected Retired Member, or, if the Elected Retired Member is present, then votes if both Elected General members, or the Safety Member and an Elected General member, are absent.

This is a meeting of the Retirees Committee if a quorum of the Retirees Committee attends, and it is a meeting of the Board if a quorum of the Board attends. This is a joint meeting of the Retirees Committee and the Board if a quorum of each attends.

*Note regarding accommodations:* If you require a reasonable modification or accommodation for a disability, please contact ACERA between 9:00 a.m. and 5:00 p.m. at least 72 hours before the meeting at [accommodation@acera.org](mailto:accommodation@acera.org) or at 510-628-3000.

Public comments are limited to four (4) minutes per person in total. The order of items on the agenda is subject to change without notice. Board and Committee agendas and minutes and all documents distributed to the Board or a Committee in connection with a public meeting (unless exempt from disclosure) are posted online at [www.acera.org](http://www.acera.org) and also may be inspected at 475 14<sup>th</sup> Street, 10<sup>th</sup> Floor, Oakland, CA 94612-1900.

# ***RETIREES COMMITTEE/BOARD MEETING***

NOTICE and AGENDA, Page 2 of 3 – Wednesday, June 3, 2026

**Call to Order:** 9:30 a.m.

**Roll Call**

**Public Input (Time Limit: 4 minutes per speaker)**

## **Action Items: Matters for discussion and possible motion by the Committee**

### **1. Approval of Payment for Implicit Subsidy Cost for 2025**

Discussion and possible motion regarding Staff's recommendation that the Committee recommend that the Board authorize Staff to transfer \$9,375,256 from the ACERA Supplemental Retiree Benefit Reserve to the Alameda County Advance Reserve as the Implicit Subsidy for Plan Year 2025.

- Carlos Barrios
- Stephen Murphy, Segal
- Michael Szeto, Segal

### **2. Possible Declaration of Intent to Fund Implicit Subsidy Program for 2027**

Discussion and possible motion regarding Staff's recommendation that the Committee recommend that the Board adopt a Statement of Intent to fund the Implicit Subsidy for Plan Year 2027.

- Carlos Barrios
- Stephen Murphy, Segal
- Michael Szeto, Segal

## **Information Items: These items are not presented for Committee action but consist of status updates and cyclical reports**

### **1. Presentation and Report on Health Care Inflation/Trends**

Staff and Segal, ACERA's Actuary and Benefits Consultant, will provide information and report on health care inflation factors for 2026.

- Carlos Barrios
- Daniel Siblik, Segal
- Stephen Murphy, Segal
- Michael Szeto, Segal

# ***RETIRES COMITTEE/BOARD MEETING***

NOTICE and AGENDA, Page 3 of 3 – Wednesday, June 3, 2026

## **2. Preliminary Report on Projected Benefit Costs Funded through the Supplemental Retiree Benefit Reserve**

Segal, ACERA's Actuary, will provide a preliminary report on the projection of benefit costs, which are funded through the Supplemental Retiree Benefit Reserve.

- Carlos Barrios
- Daniel Siblik, Segal
- Eva Yum, Segal

## **3. Discussion of Monthly Medical Allowance for 2027**

Staff will present for discussion Monthly Medical Allowance for Group and Individual Plans cost comparisons for the 2026 and 2027 Plan Years.

- Carlos Barrios

## **4. Report on Health Reimbursement Account Balances and Reimbursements**

Staff will present a status report on the final 2025 Health Reimbursement Account balances, and total reimbursement amounts for Medicare eligible retirees and early retirees living outside the HMO service area enrolled in medical plans through Via Benefits.

- Jessica Huffman

## **5. Plans for Open Enrollment and Retiree Health and Wellness Fair**

Staff will provide a report on the planning for ACERA's annual Open Enrollment and Retiree Health and Wellness Fair.

- Mike Fara
- Mario Martinez

### **Trustee Remarks**

### **Future Discussion Items**

- Adoption of 2027 Monthly Medical Allowance for Group Plans, Early Retiree Individual Plans and Medicare Eligible Retiree Individual Plans

### **Establishment of Next Meeting Date**

July 1, 2026, at 9:30 a.m.

### **Adjournment**




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MEMORANDUM TO THE RETIREES COMMITTEE

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DATE: June 3, 2026  
TO: Members of the Retirees Committee  
FROM: Carlos Barrios Assistant Chief Executive Officer   
SUBJECT: **Implicit Subsidy for Health Plan Year 2025**

On February 15, 2007, the Board of Retirement adopted a series of resolutions authorizing the establishment of a mechanism to reimburse the County of Alameda (County) for the additional expense associated with the enrollment of pre-65 ACERA retirees in County-sponsored health benefit plans. Specifically, **Resolution 07-30 Use of SRBR Under Article 5.5 and Section 31592.4** states that ACERA is authorized to transfer funds “not greater than such retiree implicit subsidy”.

Attached is a letter from the County providing the final Implicit Subsidy amount for 2025, as calculated by its Consultant, Newfront. Also attached is a letter from ACERA’s Benefits Consultant, Segal, verifying that the correct Implicit Subsidy reimbursement for Plan Year 2025 is \$9,375,256.

Last year, the County determined the final Implicit Subsidy amount for Plan Year 2024 was \$2,453,953 and estimated the 2025 Implicit Subsidy amount to be \$9,390,686, (117.13% higher than the 2024 actual amount).

Recommendation

Staff recommends that the Retirees Committee approve and recommend to the Board of Retirement an authorization for Staff to transfer \$9,375,256 from the Supplemental Retiree Benefit Reserve account to the County Advance Reserve to be amortized over 20 years as the Implicit Subsidy payment for Plan Year 2025.

Attachments (2)

April 20, 2026

**Sent Via US Mail & Email**

Carlos Barrios  
Asst. CEO, Benefits Communications  
ACERA  
475 14th Street, 10<sup>th</sup> Floor  
Oakland, CA 94612

**RE: 2025 Final Implicit Subsidy Calculation and 2026 Estimate**

Dear Carlos:

MMA/McGriff has completed the calculation of the Implicit Subsidy for which the County of Alameda ("County") is responsible on behalf of Alameda County Retiree Association ("ACERA") early retirees for the year 2025.

**2025/2026 Implicit Subsidy Calculation**

Following our established procedure, MMA/McGriff calculated the subsidy based on the total premium cost for the 2025 plan year. For this purpose, enrollment figures were based on the average monthly data from February 2025 through January 2026. The details of our calculations can be found in the attached spreadsheets.

The total 2025 Implicit Subsidy amounts to \$9,375,256, which represents a 282% increase (approximately \$6,921,303) compared to the 2024 subsidy of \$2,453,953.

This change is attributed to the following factors:

- Kaiser: The County's active population was predominantly enrolled in Kaiser for the 2025 plan year (82.1%). The ratio of active unblended to blended rates increased from 1.4% in 2024 to 6.4% in 2025.
- UHC: The ratio of active unblended to blended rates for UHC increased from 1.7% in 2024 to 2.6% in 2025.

Calculation Breakdown for 2025:

1. Total premium for County of Alameda active employees using blended rates:  
\$183,126,955
2. Total premium for County of Alameda active employees using unblended rates:  
\$173,751,699
3. Implicit Subsidy (1) – (2): \$9,375,256

## 2026 Implicit Subsidy Estimate

For 2026, we have applied the same methodology, utilizing the 2026 premium rates and February 2026 enrollment figures. The details of these calculations can also be found in the attached spreadsheets.

Our estimate for the 2026 Implicit Subsidy is \$7,552,893, showing a 19.4% decrease (approximately \$1,822,363) compared to the 2025 subsidy. This change is due to the following:

- Kaiser: The ratio of active unblended to blended rates for Kaiser, where 82.1% of the County's active population is enrolled, decreased from 6.4% in 2025 to 4.5% in 2026.
- UHC: The ratio for UHC decreased from 2.6% in 2025 to 2.3% in 2026.

Calculation Breakdown for 2026:

1. Total premium for County of Alameda active employees using blended rates:  
\$203,977,075
2. Total premium for County of Alameda active employees using unblended rates:  
\$196,424,182
3. Implicit Subsidy (1) – (2): **\$7,552,893**

Once you and your consultant have reviewed this letter and the attached calculations, I would be happy to arrange a Teams call to discuss further and address any questions you may have.

Best regards,

Ava Lavender  
HR Division Manager, Benefits

Copy: Margarita Zamora

Enclosure



Stephen Murphy  
Senior Vice President  
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smurphy@segalco.com

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Glendale, CA 91203-3338  
segalco.com

May 19, 2026

Carlos Barrios  
Assistant Chief Executive Officer  
ACERA  
475 14<sup>th</sup> Steet, Suite 1000  
Oakland, California 94612

**Re: ACERA Final 2025 and Estimated 2026 Implicit Subsidy Analysis**

Dear Carlos:

Segal has completed the review of the County of Alameda's Final 2025 and Estimated 2026 Implicit Subsidies.

The Final 2025 Implicit Subsidy requested by the County is \$9,375,300 for the average active enrollment from February 2025 through January 2026. The 2025 subsidy is requested for the employees enrolled in Kaiser's Premium and Standard plans and United Healthcare's Signature Value and Signature Value Advantage plans.

The 2026 Implicit Subsidy is estimated to be \$7,552,900, based on annualized February 2026 enrollment. The 2026 subsidy is estimated for employees enrolled in Kaiser's Premium and Standard plans and United Healthcare's Signature Value plan.

The plans and enrollment provided by the County and their consultant are consistent with our understanding of the ACERA health plans. We reviewed the enrollment and rates to verify that the effect of blending was revenue neutral over the combined active and retiree population.

In our opinion, the Final 2025 and Estimated 2026 Implicit Subsidies stated in this letter are reasonable given the information provided. We did not find any reason to withhold approval of the requested 2025 Implicit Subsidy.

If you have any questions, feel free to contact me at (310) 749-0969.

Sincerely,

A handwritten signature in blue ink, appearing to read "SM", written over a light blue horizontal line.

Stephen Murphy  
Senior Vice President  
CA Insurance License #0724515

Attachment (5988343)

cc: Jessica Huffman, ACERA  
Mario Martinez, ACERA

Amerae Martinez, ACERA  
Jessica Kuhlman, Segal  
Michael Szeto, Segal

**Disclaimer**

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ACERA  
Implicit Subsidy Summary (2012-2026)

Year *	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
<b>Actual</b>															
Kaiser Permanente	\$ 5,531,428	\$ 3,835,549	\$ 3,800,100	\$ 4,620,708	\$ 7,361,748	\$ 5,131,871	\$ 5,294,803	\$ 5,495,470	\$ 5,736,765	\$ 3,487,076	\$ 6,422,492	\$ 3,133,406	\$ 1,751,862	\$ 8,207,102	N/A
UnitedHealthcare	\$ 1,839,038	\$ 3,157,273	\$ 1,520,853	\$ 1,400,743	\$ 1,425,848	\$ 668,692	\$ 1,604,336	\$ 951,232	\$ 1,747,645	\$ 2,106,846	\$ 1,419,723	\$ 903,904	\$ 702,090	\$ 1,168,153	N/A
<b>Total</b>	<b>\$ 7,370,466</b>	<b>\$ 6,992,822</b>	<b>\$ 5,320,953</b>	<b>\$ 6,021,451</b>	<b>\$ 8,787,596</b>	<b>\$ 5,800,563</b>	<b>\$ 6,899,139</b>	<b>\$ 6,446,703</b>	<b>\$ 7,484,411</b>	<b>\$ 5,593,922</b>	<b>\$ 7,842,215</b>	<b>\$ 4,037,310</b>	<b>\$ 2,453,952</b>	<b>\$ 9,375,255</b>	<b>N/A</b>
% Change Over Prior year	N/A	-5.12%	-23.91%	13.16%	45.94%	-33.99%	18.94%	-6.56%	16.10%	-25.26%	40.19%	-48.52%	-39.22%	282.05%	N/A
\$ Change Over Prior year	N/A	\$ (377,644)	\$ (1,671,869)	\$ 700,498	\$ 2,766,145	\$ (2,987,033)	\$ 1,098,576	\$ (452,436)	\$ 1,037,708	\$ (1,890,489)	\$ 2,248,293	\$ (3,804,905)	\$ (1,583,358)	\$ 6,921,303	N/A
<b>Estimated</b>															
Kaiser Permanente	N/A	\$ 3,836,331	\$ 3,783,943	\$ 3,918,304	\$ 7,429,284	\$ 5,157,389	\$ 5,308,241	\$ 5,549,141	\$ 5,785,530	\$ 3,499,713	\$ 6,508,029	\$ 3,183,005	\$ 1,758,685	\$ 8,205,408	\$ 6,300,015
UnitedHealthcare	N/A	\$ 3,156,701	\$ 1,431,412	\$ 1,406,198	\$ 1,435,991	\$ 672,894	\$ 1,631,567	\$ 961,735	\$ 1,763,154	\$ 2,152,900	\$ 1,473,447	\$ 932,994	\$ 713,660	\$ 1,185,278	\$ 1,252,877
<b>Total</b>	<b>N/A</b>	<b>\$ 6,993,032</b>	<b>\$ 5,215,355</b>	<b>\$ 5,324,502</b>	<b>\$ 8,865,275</b>	<b>\$ 5,830,283</b>	<b>\$ 6,939,808</b>	<b>\$ 6,510,876</b>	<b>\$ 7,548,684</b>	<b>\$ 5,652,613</b>	<b>\$ 7,981,476</b>	<b>\$ 4,115,999</b>	<b>\$ 2,472,345</b>	<b>\$ 9,390,686</b>	<b>\$ 7,552,892</b>
% Change Over Prior year	N/A	N/A	-25.42%	2.09%	66.50%	-34.23%	19.03%	-6.18%	15.94%	-25.12%	41.20%	-48.43%	-39.93%	279.83%	-19.57%
\$ Change Over Prior year	N/A	N/A	\$ (1,777,677)	\$ 109,147	\$ 3,540,773	\$ (3,034,992)	\$ 1,109,525	\$ (428,932)	\$ 1,037,807	\$ (1,896,070)	\$ 2,328,863	\$ (3,865,477)	\$ (1,643,654)	\$ 6,918,341	\$ (1,837,794)
<b>% Change Actual vs. Estimated</b>	<b>N/A</b>	<b>0.0%</b>	<b>2.0%</b>	<b>13.1%</b>	<b>-0.9%</b>	<b>-0.5%</b>	<b>-0.6%</b>	<b>-1.0%</b>	<b>-0.9%</b>	<b>-1.0%</b>	<b>-1.7%</b>	<b>-1.9%</b>	<b>-0.7%</b>	<b>-0.2%</b>	<b>N/A</b>
<b>\$ Change Actual vs. Estimated</b>	<b>N/A</b>	<b>\$ (210)</b>	<b>\$ 105,598</b>	<b>\$ 696,949</b>	<b>\$ (77,679)</b>	<b>\$ (29,720)</b>	<b>\$ (40,669)</b>	<b>\$ (64,173)</b>	<b>\$ (64,273)</b>	<b>\$ (58,691)</b>	<b>\$ (139,261)</b>	<b>\$ (78,689)</b>	<b>\$ (18,393)</b>	<b>\$ (15,431)</b>	<b>N/A</b>

\* Twelve months beginning February 1 of the year stated. For the year 2012, the subsidy is stated for the period from February 1, 2012 through January 31, 2013.



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MEMORANDUM TO THE RETIREES COMMITTEE

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DATE: June 3, 2026

TO: Members of the Retirees Committee

FROM: Carlos Barrios, Assistant Chief Executive Officer 

SUBJECT: **Intent to Fund Implicit Subsidy Program for Plan Year 2027**

In establishing the Implicit Subsidy Program, the Board of Retirement recognized the marked impact on utilization and projected premiums of the participation of pre-65 retirees (early retirees) in the County of Alameda's (County) health plan contracts. As the plan sponsor, the County has a legitimate financial interest in ascertaining whether ACERA will continue to support the Implicit Subsidy Program when negotiating enrollment and premium provisions.

The Implicit Subsidy cost for the current Plan Year 2026 is estimated by the County to be \$7,552,893. The estimated 2026 subsidy is significantly lower than the actual 2025 Implicit Subsidy (\$9,375,256). The reasons stated for the significant decrease compared to the 2025 amount (approximately \$1,822,363) are due to the following:

- “Kaiser: The ratio of active unblended to blended rates for Kaiser, where 82.1% of the County’s active population is enrolled, decreased from 6.4% in 2025 to 4.5% in 2026.
- UHC: The ratio for UHC decreased from 2.6% in 2025 to 2.3% in 2026.”

Recommendation

Staff recommends that the Retirees Committee recommend to the Board of Retirement the adoption of a Statement of Intent to continue the Implicit Subsidy Program for health Plan Year 2027, following a determination by ACERA at the end of Plan Year 2027 that the amount is not greater than the actual retiree Implicit Subsidy.



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MEMORANDUM TO THE RETIREES COMMITTEE

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DATE: June 3, 2026

TO: Members of the Retirees Committee

FROM: Carlos Barrios, Assistant Chief Executive Officer 

SUBJECT: **Report on Health Care Inflation/Trends**

Segal has provided ACERA with recommended assumptions to be used for the December 31, 2025, Supplemental Retiree Benefit Reserve (SRBR) Valuation for projecting benefits based on ACERA's substantive plan pursuant to GASB 43. ACERA's substantive plan design incorporates an increase for the Monthly Medical Allowance (MMA) of one-half of anticipated health care inflation assumptions. The Medicare Part B, vision and dental projections are based on the full inflation assumptions for those plans.

Attached is a letter dated March 11, 2026, from Daniel Siblik, with Segal. As presented on the second page of the attachment to Segal's letter (page 6), the near-term trend assumptions will be set at 8.00% for non-Medicare plans and 7.50% for Medicare Advantage plans. The main considerations that influenced the updated non-Medicare trend rates were: 1) the plan's recent premium experience; and 2) the updated national trend expectations for prescription drug costs. The updated Medicare trend rates were also influenced by the same factors that influenced the non-Medicare trend rates as well as the Calendar Year 2027 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates and Part D Payment Policies (the Advance Notice) released by the Centers for Medicare & Medicaid Services (CMS) on January 26, 2026.

The dental trend rates will be updated to start at 5.00%, based on a review of the plan's recent claims experience and forward-looking expectations from Segal survey data. The vision trend assumption will remain at 3.00%, based mostly on forward-looking expectations from Segal survey data. The Medicare Part B trend assumptions will be increased to 6.75% for calendar years 2026 through 2033. The updated Part B trend assumptions were based on the intermediate Part B premium estimates in Table V.E2. of the 2024 Medicare Trustees report. The proposed 6.75% initial trend assumption represents the average trend shown for years 2026 through 2033 of the Trustees report.

Segal is using the lowest trend of 7.50% for medical inflation as the most conservative approach. Therefore, based on the substantive plan design, a 3.75% increase would be applied to the projections for the MMA for the December 31, 2025, SRBR Valuation.

Report on Health Care Inflation/Trends

June 3, 2026

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Health care trend information has also been provided by Segal's benefit consulting team. Steve Murphy and Michael Szeto will review the attached presentation at the June 3<sup>rd</sup> Retirees Committee meeting. Also attached is a 10-year ACERA rate history for the period 2017 through 2026 for Kaiser Permanente and UnitedHealthcare.

Attachments (3)

March 11, 2026

Carlos Barrios  
Assistant Chief Executive Officer  
Alameda County Employees' Retirement Association  
475 14th Street, Suite 1000  
Oakland, CA 94612

**Re: Alameda County Employees' Retirement Association (ACERA)  
Healthcare trend assumptions recommended for the December 31, 2025  
Supplemental Retiree Benefit Reserve (SRBR) Actuarial Valuation**

Dear Carlos:

We have provided in this letter the healthcare trend assumptions that we recommend to the Board to be used in the December 31, 2025, retiree health valuation for determining sufficiency of assets to provide retiree health benefits. These health trend assumptions will also be used to develop our Governmental Accounting Standards Board (GASB) Statement No. 74 report with a measurement date of December 31, 2025.

## Health care trend assumptions

The health care trend assumptions used in the health valuation are reviewed annually. Every year Segal publishes a set of health care trend assumptions based on the latest research and information available to our health actuaries. The health care trend assumptions take into account factors such as recent and expected premium increases affecting our clients, changes in utilization of health care, and cost shifting from Medicare.

The specific health care trend assumptions we are recommending are outlined in Attachment One.

1. For the prior December 31, 2024, SRBR valuation, we recommended the following assumptions:
  - a. For the non-Medicare plans, we recommended the first-year trend rate be set at 7.75%, then graded down by 0.25% each year for 13 years until reaching an ultimate rate of 4.50%. Key considerations that influenced the updated non-Medicare trend rates were the plan's recent premium experience, updated national trend expectations for prescription drug costs, and concerns about the impact of general inflation on healthcare costs. Based on these assumptions, the non-Medicare plan premiums are expected to increase by an average of 5.63% per year over the next twenty years.

- b. For the Medicare plans, we recommended the first-year trend rate be set at 7.50%, then graded down by 0.25% each year until reaching an ultimate rate of 4.50% after 12 years. In addition to the same key considerations that influenced the updated non-Medicare trend rates, the updated Medicare trend rates were also influenced by the Calendar Year 2026 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (the Advance Notice) released by the Centers for Medicare & Medicaid Services (CMS) on January 10, 2025. Based on these assumptions, the Medicare plan premiums are expected to increase by an average of 5.47% per year over the next twenty years.
  - c. The Dental trend rates started at 6.00%, then decreased to 5.00% and 4.50% before reaching an ultimate rate of 4.00%. The updated Dental trend assumptions were based on a review of the plan's recent claims experience and forward-looking expectations from Segal survey data. The Vision trend assumption was lowered from 4.00% to 3.00%, based mostly on forward-looking expectations from Segal survey data.
  - d. Medicare Part B trend assumptions were increased to 6.20% for calendar years 2025 through 2033, 5.75% for calendar year 2034, then decreased by 0.25% per year until the ultimate trend rate of 4.50% is reached in 2039. The updated Part B trend assumptions were based on the intermediate Part B premium estimates in Table V.E2. of the 2024 Medicare Trustees report. The 6.20% initial trend assumption represented the average trend shown for years 2025 through 2033 of the Trustees report.
  - e. Based on past practice, the 7.75% non-Medicare and 7.50% Medicare first-year trends were used in the December 31, 2024 "preview" valuation and applied to the 2025 non-Medicare and Medicare medical premiums to estimate the projected 2026 premiums. The first-year trends were replaced as part of the "final" valuation as of December 31, 2024, to reflect the actual premium renewals for 2026. Similarly, the initial Dental and Vision trend rates were updated based on the actual premium renewals for 2026.
  - f. We continued to assume that the Board's annual Monthly Medical Allowance (MMA) would increase by 50% of the rate of the anticipated medical trend assumption. If different types of medical plans had different initial trend rates, we assumed that the future increase in MMA would be linked to the plan with the lowest projected medical trend. For the Board's subsidies for dental, vision, and Medicare Part B plans, we assumed they would increase at the full rate of anticipated trend assumed for each of those plans, as described in (c) and (d) above, and provided in Attachment One.
2. For the current December 31, 2025, SRBR valuation, we are recommending the following assumptions:
    - a. For the non-Medicare plans, we recommend the first-year trend rate be set at 8.00%,<sup>1</sup> then grading down by 0.25% each year for 14 years until reaching an ultimate rate of 4.50%. Key considerations that influenced the updated non-Medicare trend rates were the plan's recent premium experience and updated national trend expectations for

<sup>1</sup> We note that in the absence of the above recommendation to reset the assumption, the first-year trend rate that we would use in this year's valuation would equal 7.50%.

medical and prescription drug costs. Based on these assumptions, the non-Medicare plan premiums are expected to increase by an average of 5.81% per year over the next twenty years.

- b. For the Medicare plans, we are recommending the first-year trend rate be set at 7.50%,<sup>2</sup> then grading down by 0.25% each year until reaching an ultimate rate of 4.50% after 12 years. In addition to the same key considerations that influenced the updated non-Medicare trend rates, the updated Medicare trend rates were also influenced by the Calendar Year 2027 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (the Advance Notice) released by the Centers for Medicare & Medicaid Services (CMS) on January 26, 2026. Final guidance, rules and clarifications will be provided by CMS in April of 2026. Based on these assumptions, the Medicare plan premiums are expected to increase by an average of 5.47% per year over the next twenty years.
- c. The Dental trend rates will start at 5.00%, then decrease to 4.50% before reaching an ultimate rate of 4.00%. The updated Dental trend assumptions were based on a review of the plan's recent claims experience and forward-looking expectations from Segal survey data. The Vision trend assumption is 3.00%, based mostly on forward-looking expectations from Segal survey data.
- d. Medicare Part B trend assumptions will be increased to 6.75% for calendar years 2026 through 2033, 6.25% for calendar year 2034, then decreasing by 0.50% per year until the ultimate trend rate of 4.50% is reached in 2038. The updated Part B trend assumptions were based on the intermediate Part B premium estimates in Table V.E2. of the 2025 Medicare Trustees report. The proposed 6.75% initial trend assumption represents the average trend shown for years 2026 through 2033 of the Trustees report.
- e. Based on past practice, the 8.00% non-Medicare and 7.50% Medicare first-year trends will be used in the December 31, 2025 "preview" valuation and applied to the 2026 non-Medicare and Medicare medical premiums to estimate the projected 2027 premiums. The first-year trends will be replaced as part of the "final" valuation as of December 31, 2025, to reflect the actual premium renewals for 2027. Similarly, the initial Dental and Vision trend rates will be updated based on the actual premium renewals for 2027.
- f. We will continue to assume that the Board's annual Monthly Medical Allowance (MMA) will increase by 50% of the rate of the anticipated medical trend assumption. If different types of medical plans have different initial trend rates, we assume that the future increase in MMA will be linked to the plan with the lowest projected medical trend. For the Board's subsidies for dental, vision, and Medicare Part B plans, we assume they would increase at the full rate of anticipated trend assumed for each of those plans, as described in (c) and (d) above, and provided in Attachment One.

Segal will prepare a separate letter to address the recommended demographic driven changes to be used in the December 31, 2025, SRBR sufficiency valuation.

<sup>2</sup> We note that in the absence of the above recommendation to reset the assumption, the first-year trend rate that we would use in this year's valuation would equal 7.25%.

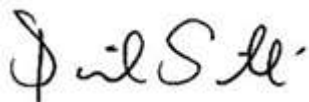
## Statement of actuarial opinion

This document has been prepared for the exclusive use and benefit of ACERA, based upon information provided by the Plan or otherwise made available to Segal at the time this document was created. Segal makes no representation or warranty as to the accuracy of any forward-looking statements and does not guarantee any particular outcome or result. This document should only be copied, reproduced, or shared with other parties in its entirety as necessary for the proper administration of the Plan. This document does not constitute legal, tax, or investment advice or create or imply a fiduciary relationship. You are encouraged to discuss any issues raised with your legal, tax and other advisors before taking, or refraining from taking, any action.

Mehdi Riazi is a member of the American Academy of Actuaries and meets the qualification requirements to render the actuarial opinion contained herein.

We look forward to discussing this with you. Please let us know if you have any questions.

Sincerely,



Daniel Siblik, ASA, MAAA, EA  
Vice President and Actuary



Mehdi Riazi, FSA, MAAA, FCA, EA  
Vice President and Actuary

/bbf

## Prior and Current Recommended Trend Assumptions for the December 31, 2025, Retiree Health Valuations

### Health Trends Used in the Prior Valuation as of December 31, 2024 (Provided for Comparison Purposes)

Trends to be applied to premium for shown calendar year to calculate next calendar year's projected premium for all health plans are as follows:

Calendar Year	United Healthcare (UHC) HMO & Kaiser HMO Early Retiree <sup>3</sup>	Via Benefits & Kaiser Senior Advantage <sup>4</sup>	Dental <sup>5</sup>	Vision <sup>6</sup>	Medicare Part B
2025	7.75%	7.50%	6.00%	3.00%	6.20%
2026	7.50	7.25	5.00	3.00	6.20
2027	7.25	7.00	4.50	3.00	6.20
2028	7.00	6.75	4.00	3.00	6.20
2029	6.75	6.50	4.00	3.00	6.20
2030	6.50	6.25	4.00	3.00	6.20
2031	6.25	6.00	4.00	3.00	6.20
2032	6.00	5.75	4.00	3.00	6.20
2033	5.75	5.50	4.00	3.00	6.20
2034	5.50	5.25	4.00	3.00	5.75
2035	5.25	5.00	4.00	3.00	5.50
2036	5.00	4.75	4.00	3.00	5.25
2037	4.75	4.50	4.00	3.00	5.00
2038	4.50	4.50	4.00	3.00	4.75
2039 & Later	4.50	4.50	4.00	3.00	4.50

The 2025 assumed trend rates were replaced with the actual premium increases shown below, based on premium renewals for 2026 as reported by ACERA. These premium increases were used in preparing our December 31, 2024, SRBR valuation report dated September 19, 2025:

Kaiser HMO Early Retiree	UHC HMO Signature Value Early Retiree	UHC HMO Signature Value Advantage Early Retiree	Kaiser Senior Advantage	Dental	Vision

<sup>3</sup> Non-Medicare plans.

<sup>4</sup> Medicare plans.

<sup>5</sup> We are aware of the 3-year rate guarantee of the 2026 dental premium, but for the purpose of the long-term measurement, we will focus on the underlying trend.

<sup>6</sup> We are aware of the 5-year rate guarantee of the 2026 vision premium, but for the purpose of the long-term measurement, we will focus on the underlying trend.

## Prior and Current Recommended Trend Assumptions for the December 31, 2025, Retiree Health Valuations

### Health Trends Recommended for the Current Valuation as of December 31, 2025

Trends to be applied to premium for shown calendar year to calculate next calendar year's projected premium for all health plans are as follows:

Calendar Year	United Healthcare HMO & Kaiser HMO Early Retiree <sup>7</sup>	Via Benefits & Kaiser Senior Advantage <sup>8</sup>	Dental	Vision	Medicare Part B
2026	8.00% <sup>9</sup>	7.50% <sup>9</sup>	5.00% <sup>9</sup>	3.00% <sup>9</sup>	6.75% <sup>10</sup>
2027	7.75	7.25	4.50	3.00	6.75
2028	7.50	7.00	4.00	3.00	6.75
2029	7.25	6.75	4.00	3.00	6.75
2030	7.00	6.50	4.00	3.00	6.75
2031	6.75	6.25	4.00	3.00	6.75
2032	6.50	6.00	4.00	3.00	6.75
2033	6.25	5.75	4.00	3.00	6.75
2034	6.00	5.50	4.00	3.00	6.25
2035	5.75	5.25	4.00	3.00	5.75
2036	5.50	5.00	4.00	3.00	5.25
2037	5.25	4.75	4.00	3.00	4.75
2038	5.00	4.50	4.00	3.00	4.50
2039	4.75	4.50	4.00	3.00	4.50
2040 & Later	4.50	4.50	4.00	3.00	4.50

<sup>7</sup> Non-Medicare plans.

<sup>8</sup> Medicare plans.

<sup>9</sup> Based on past practice, the initial trend rates will be replaced as part of the "final" valuation as of December 31, 2025 to reflect the actual premium renewals for 2027.

<sup>10</sup> If available, first year trend may be replaced to reflect actual 2026 calendar year premium at time of valuation.



Alameda County Employees'  
Retirement Association (ACERA)

# 2026 Health Plan Cost Trend Survey

ACERA Retirees Committee Meeting  
June 3, 2026

Presenter: Michael Szeto



# Segal Health Plan Cost Trend Survey Overview

**2026 edition is our 29th annual national survey**

Survey respondents represent more than 80 percent of the commercially insured and self-insured market and include:

**Aetna**

**Blue Shield of California**

**Cigna**

**Elevance Health (a.k.a. Anthem)**

**Health Net**

**Kaiser Permanente**

**United Healthcare**

# Health Care Cost Trend Influencers

- New treatments, therapies and technologies
- Medical price inflation, which impacts the cost of delivering care
- Provider consolidation
- Increased treatment burden due to the aging population and rise in chronic conditions
- Provider cost shifting
- Greater emphasis on detection and diagnoses
- Social and economic factors, which can influence utilization or care decisions
- Regulatory changes
- Erosion effect of fixed-dollar deductibles and copayments<sup>1</sup>
- Reduced payment by Medicare and Medicaid

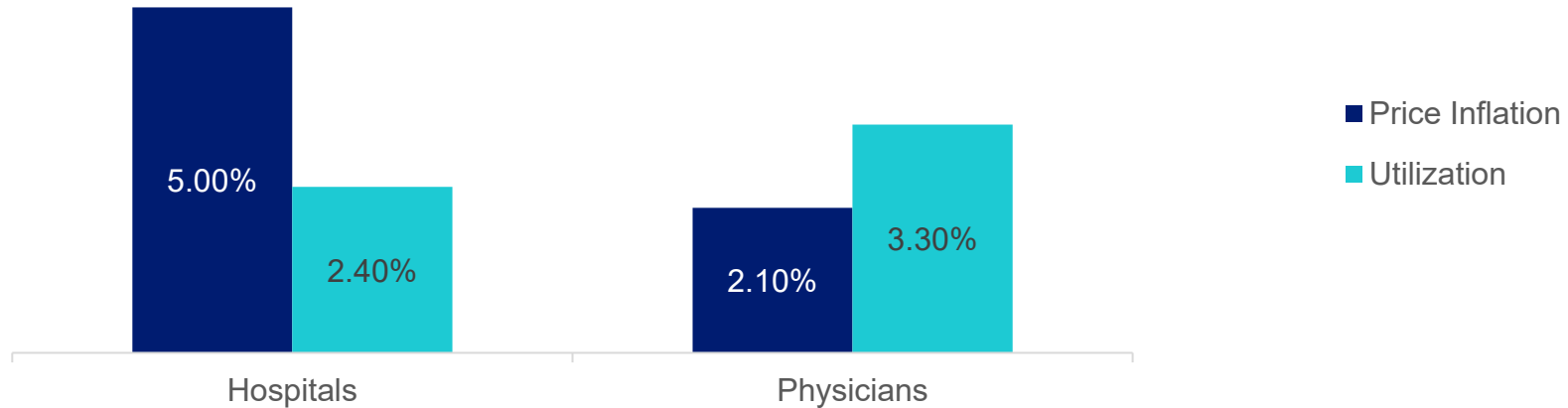


Trend is the forecast of increases in allowed gross per capita claims cost.

<sup>1</sup> This is a driver of net paid claim cost trends, not gross per capita claims cost increases.

# Leading Drivers of Trend

Influence of Price Inflation on 2026 Projected Medical Trends<sup>1</sup>



## Medical Trend Observations

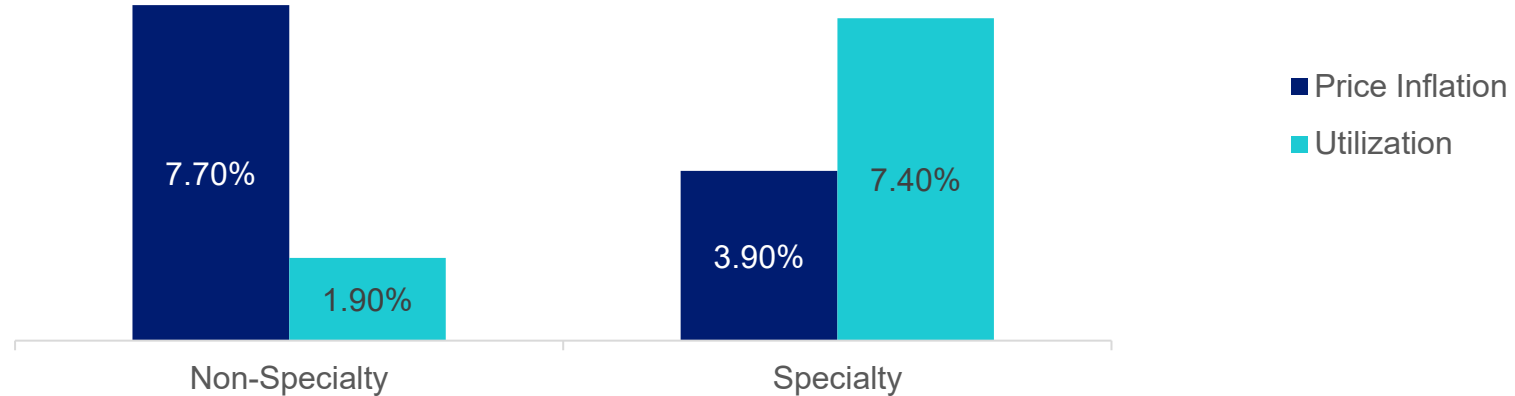
- Overall medical price inflation is driven up by rising labor costs, regulatory changes and ongoing workforce shortages.
- For physician services, utilization increases may be due to increased rates in common seasonal illnesses or general market conditions (i.e. providers ordering additional tests and procedures to offset inflationary pressures).

Source: 2026 Segal Health Plan Cost Trend Survey

<sup>1</sup> "Hospital services" includes inpatient and outpatient hospital services combined.

# Leading Drivers of Trend

High-Cost New Drugs are the Leading Driver of Rx trend<sup>1</sup>



## Rx Trend Observations

- Pharmacy price inflation drive by demand, supply chain dynamics, manufacturing costs, and policy-related factors.
- Utilization changes account for 62% of the gross trend, to treat prevalent conditions such as atopic dermatitis and psoriasis

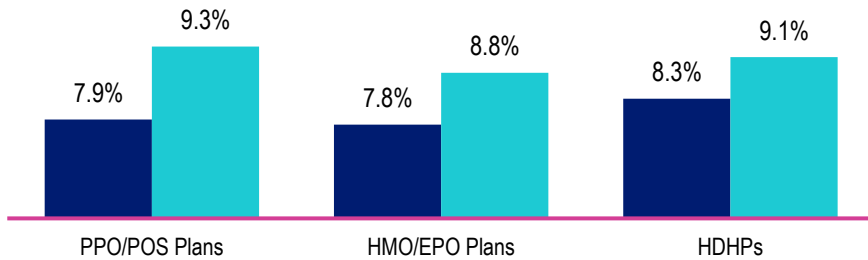
Source: 2026 Segal Health Plan Cost Trend Survey

<sup>1</sup> The components do not add up to totals because there are other components of trend not illustrated, reflecting such factors as the impact of mandates, technology changes and drug mix. Not all survey respondents provided a breakdown of trend by component, which may produce results that vary from the overall Rx plan cost survey results..

# Projected Health Care Trend 2025 vs. 2026

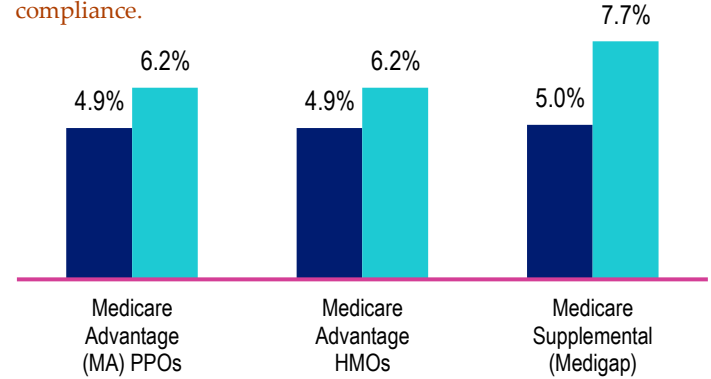
■ 2025 ■ 2026

## Medical Trends<sup>1</sup> for Actives and Retirees Under Age 65

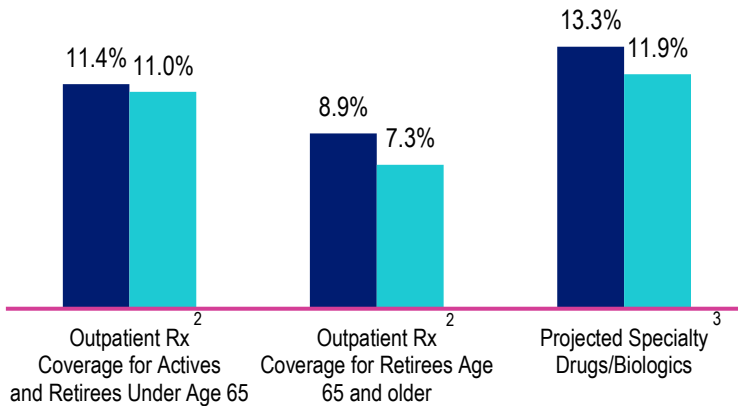


## Medical Trends for Retirees Age 65 and Older

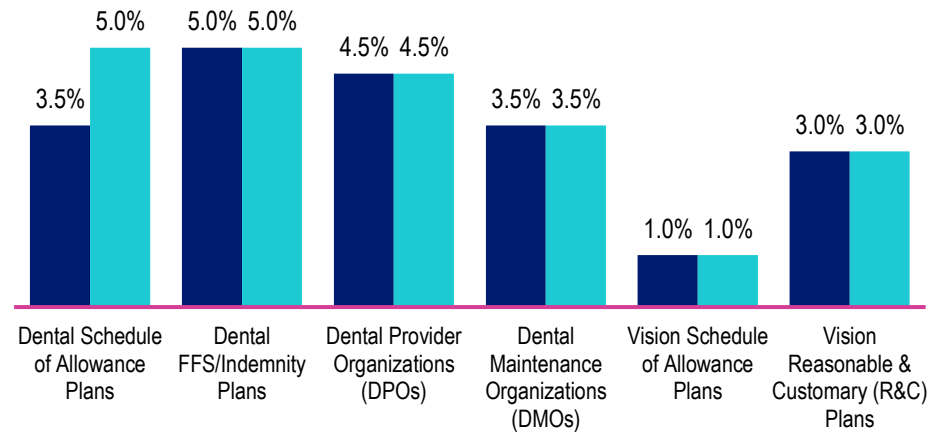
Projected MA trends reflect national averages, which are subject to regional variability and the impact of Inflation Reduction Act compliance.



## Prescription Drug Trends



## Dental and Vision Trends for Actives and Retirees



Source: 2026 Segal Health Plan Cost Trend Survey

<sup>1</sup> Trend projections are for actives and non-Medicare retirees and exclude prescription drugs.

<sup>2</sup> This data is for all prescription drugs (non-specialty and specialty drugs combined).

<sup>3</sup> Specialty drug/biologics trend is for outpatient specialty coverage. This data is for all coverage of specialty drugs for actives and non-Medicare retirees.

# Medical Rate Comparisons

2017-2026 Rate History



## Kaiser Early Retiree

747 Enrolled\*

	2017	2018	2019	2020	2021	2022	2023	2024	2025
Rating Structure	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
Retiree	\$729.08	\$735.64	\$765.06	\$785.44	\$810.72	\$843.16	\$909.74	\$1,037.76	\$1,097.88
Retiree & 1 Dep	\$1,458.16	\$1,471.28	\$1,530.12	\$1,570.88	\$1,621.44	\$1,686.32	\$1,819.48	\$2,075.52	\$2,195.76
Retiree & 2+ Deps	\$2,063.30	\$2,081.88	\$2,165.12	\$2,222.80	\$2,294.34	\$2,386.22	\$2,574.60	\$2,936.90	\$3,107.04
<b>% Change over Retiree Monthly Premium</b>		<b>8.52%</b>	<b>0.90%</b>	<b>4.00%</b>	<b>2.66%</b>	<b>3.22%</b>	<b>4.00%</b>	<b>14.07%</b>	<b>5.79%</b>

## Kaiser Permanente Senior Advantage

4,587 Enrolled\*

	2017	2018	2019	2020	2021	2022	2023	2024	2025
Rating Structure	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
Retiree	\$354.73	\$367.23	\$394.07	\$411.54	\$382.21	\$344.44	\$316.81	\$354.31	\$375.22
Retiree & Spouse	\$709.46	\$734.46	\$788.14	\$823.08	\$764.42	\$688.88	\$633.62	\$708.62	\$750.44
<b>% Change over Retiree Monthly Premium</b>		<b>7.53%</b>	<b>3.52%</b>	<b>7.31%</b>	<b>4.40%</b>	<b>-7.10%</b>	<b>-9.88%</b>	<b>11.84%</b>	<b>5.90%</b>

## UnitedHealthcare SignatureValue HMO Early Retiree

72 Enrolled\*

	2017	2018	2019	2020	2021	2022	2023	2024	2025
Rating Structure	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
Retiree	\$982.06	\$1,047.16	\$1,047.16	\$1,087.80	\$1,150.60	\$1,184.32	\$1,290.92	\$1,464.90	\$1,594.36
Retiree & 1 Dep	\$1,964.06	\$2,094.24	\$2,094.24	\$2,175.50	\$2,301.12	\$2,368.56	\$2,581.72	\$2,929.64	\$3,189.80
Retiree & 2+ Deps	\$2,779.12	\$2,963.32	\$2,963.32	\$3,078.30	\$3,256.06	\$3,351.46	\$3,653.08	\$4,145.40	\$4,514.06
<b>% Change over Retiree Monthly Premium</b>		<b>0.00%</b>	<b>6.63%</b>	<b>0.00%</b>	<b>3.88%</b>	<b>5.77%</b>	<b>2.93%</b>	<b>13.48%</b>	<b>8.84%</b>

## UnitedHealthcare SignatureValue Advantage HMO Early Retiree - Effective 2/1/2019, Terminated 1/31/2026

107 Enrolled\*

	2017	2018	2019	2020	2021	2022	2023	2024	2025
Rating Structure	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
Retiree	N/A	N/A	\$980.94	\$831.92	\$759.16	\$781.42	\$843.94	\$957.68	\$1,042.48
Retiree & 1 Dep	N/A	N/A	\$1,961.80	\$1,663.74	\$1,518.20	\$1,562.70	\$1,687.72	\$1,915.18	\$2,085.04
Retiree & 2+ Deps	N/A	N/A	\$2,775.92	\$2,354.18	\$2,148.24	\$2,211.18	\$2,388.08	\$2,709.92	\$2,950.20
<b>% Change over Retiree Monthly Premium</b>		<b>-</b>	<b>-</b>	<b>-15.19%</b>	<b>-8.75%</b>	<b>2.93%</b>	<b>8.00%</b>	<b>13.48%</b>	<b>8.85%</b>

\*As of December 31, 2025



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MEMORANDUM TO THE RETIREES COMMITTEE

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DATE: June 3, 2026

TO: Members of the Retirees Committee

FROM: Carlos Barrios, Assistant Chief Executive Officer 

SUBJECT: **Preliminary Report on Projected Benefit Costs Funded through Supplemental Retiree Benefit Reserve**

Attached is a letter from Segal, ACERA's Actuary, which provides a preliminary report of the Supplemental Retiree Benefit Reserve (SRBR) financial status. This overview of the valuation is based on projections using substantive plan and medical inflation trends, as well as other assumptions consistent with our pension valuation. This information is provided to the Retirees Committee in preparation for setting the Monthly Medical Allowance (MMA), and Vision and Dental subsidies for 2027.

**Other Post-Employment Benefits (OPEB)**

In the December 31, 2024, valuation, it was projected that the Other Post-Employment Benefits (OPEB) assets would be exhausted in 2045 with full benefits paid through 2044. The results of the December 31, 2025, valuation indicate that the terminal year of OPEB benefits is projected to be 2044, with full benefits paid through 2043 for a total of 18 full years and one partial year. The five main reasons which resulted in the decrease in the sufficiency period by approximately 0.92 years (11 months) are due to the following factors:

- Updated per capita health costs for the year 2026 decreased the sufficiency period by approximately 8 months. This was mainly the result of new implicit subsidy estimates that are greater than expected from last year.
- Updated trend assumptions described in the March 11, 2026, trend assumptions letter decreased the sufficiency period by 6 months. Key changes include higher anticipated increases to Part B premiums.
- On April 16, 2026, the ACERA Board of Retirement adopted an increase to the Monthly Medical Allowance (MMA) for retirees enrolled in Individual Plans through the Medicare Exchange to coincide with the MMA of retirees enrolled in the Group Plans effective January 1, 2027. This benefit enhancement decreased the sufficiency period by approximately 7 months.
- Favorable investment experience produced actuarial gains which increased the sufficiency period by 8 months.
- Demographic experience gains and the assumption change related to the use of premiums without age-adjustments for the Kaiser Senior Advantage MAPD plan combined to increase the sufficiency period by 2 months.

## **Non-OPEB**

The terminal year for non-OPEB benefits is projected to be 2048, with full benefits paid through 2047, again for a total of 22 full years and one partial year. The main reason for the decrease in the sufficiency period for non-OPEB benefits is the higher-than-expected actual inflation of 3.04% (before it is rounded to 3.00% at the nearest 0.50% increment) in the Bay Area for 2025 (versus the COLA assumption of 2.75%), which increased the supplemental COLA costs.

Also attached are two additional letters from Segal. One letter dated March 11, 2026, is regarding assumptions that are recommended for the SRBR valuation. These assumptions are used for the substantive plan projections. The second letter dated April 29, 2026, is regarding recommended parameters to reflect demographic driven changes. This information will be presented in more detail at the June 3<sup>rd</sup> Retirees Committee meeting, at the same time the MMA costs and recommendations for 2027 will be discussed.

Daniel Siblik and Eva Yum, with Segal, will present the attached Preview of December 31, 2025, Valuation Results for Benefits Provided by the SRBR report in more detail at the June 3<sup>rd</sup> Retirees Committee meeting.

Attachments (3)

May 20, 2026

Mr. Carlos Barrios  
Assistant Chief Executive Officer, Benefits  
Alameda County Employees' Retirement Association  
475 14th Street, Suite 1000  
Oakland, California 94612-1900

**Re: Alameda County Employees' Retirement Association (ACERA)  
Preview of December 31, 2025 valuation results for benefits provided by the  
Supplemental Retiree Benefits Reserve (SRBR)**

Dear Carlos:

This letter provides a preview of the December 31, 2025 valuation results for benefits provided by the SRBR, before we issue a full valuation report later this year. The results in this letter are based on our understanding of the Other Postemployment Benefits (OPEB) "substantive plan" design, as well as the benefits provided by the SRBR that are in addition to the OPEB benefits (i.e., "non-OPEB").

## Results

### OPEB

In the December 31, 2024 valuation, the OPEB assets were projected to become exhausted in 2045, with full benefits paid through 2044, for a total of 20 full years and 1 partial year. In the December 31, 2025 valuation, the OPEB assets are projected to become exhausted in 2044, with full benefits paid through 2043, for a total of 18 full years and 1 partial year. After accounting for the 1 year of benefit payments made in 2025, there is an approximate decrease in the sufficiency period of 0.92 years (11 months). The decrease to the OPEB sufficiency period was the net result of several changes. Updated estimates of the plan's implicit subsidies, new health care trend assumptions and the Medicare Exchange Monthly Medical Allowance (MMA) benefit enhancement each lowered the sufficiency period by 6 to 8 months (combined impact of 21 months). The impact of these changes was partially offset by investment gains and demographic experience gains, which combined to increase the sufficiency period by 10 months.<sup>1</sup>

<sup>1</sup> For informational purposes only, the deferred investment gains as of December 31, 2025 that have not been utilized in the December 31, 2025 SRBR sufficiency valuation represent an approximate 98-month increase in the sufficiency period. Explained in detail in footnote 4.

## Non-OPEB

In the December 31, 2024 valuation, the non-OPEB assets were projected to become exhausted in 2048, with full benefits paid through 2047, for a total of 23 full years and 1 partial year. In the December 31, 2025 valuation, the non-OPEB assets are again projected to become exhausted in 2048, with full benefits paid through 2047, for a total of 22 full years and 1 partial year. After accounting for the 1 year of benefit payments made in 2025, there is an approximate decrease in the sufficiency period of 0.42 years (5 months). The main cause of the decrease to the non-OPEB sufficiency period was the higher-than-expected actual inflation in the Bay Area for 2025.

## Background and discussion

The determination of the “substantive plan” underlying ACERA’s OPEB was based upon prior directions provided by ACERA and its auditors, as well as the administrative staff, auditors, and consultants representing the County of Alameda, along with other features of the plan, as we stated in our December 31, 2024 valuation report dated September 19, 2025.

The actuarial assumptions used in this valuation are consistent with those assumptions applied by the Retirement Board for the December 31, 2025 pension valuation for funding purposes, including the use of a 7.00% investment return assumption. When projecting OPEB payments, for the purposes of anticipating death, we use the headcount-weighted mortality tables instead of the benefit (or amount)-weighted tables used in the pension funding valuation. We have also used the additional OPEB-related assumptions/parameters that were provided in our letter dated April 29, 2026.<sup>2</sup> As described in the letter, the impact of the Medicare Exchange Monthly Medical Allowance (MMA) plan change reflects assumptions regarding higher per-capita costs for Medicare retirees participating on the Exchange, along with a slight shift in future enrollment toward Exchange-based coverage. Copies of our April 29, 2026 and March 11, 2026 letters are attached for your reference.

In 2026, the maximum Monthly Medical Allowance (MMA) for retirees with 20 or more years of service and enrolled in an ACERA-sponsored group medical plan, or for eligible out-of-area non-Medicare retirees enrolled in Via Benefits Exchange, is \$687.21. For Medicare retirees with 20 or more years of service and purchasing individual plan Medicare insurance through Via Benefits Exchange (including out-of-area retirees), the maximum MMA for 2026 is \$526.46. Service-connected disabled retirees with any years of service are eligible for the same MMA as those with 20 or more years of service. On April 16, 2026, the ACERA Board of Retirement adopted an increase to the Monthly Medical Allowance (MMA) for retirees enrolled in Individual Plans through the Medicare Exchange to coincide with the MMA of retirees enrolled in the Group Plans effective January 1, 2027.

The exhibits at the end of this letter provide the projected cash flow and present value of projected benefits for the OPEB and non-OPEB plans. The present values calculated represent the amount of benefits payable through the date of exhaustion of the assets in the SRBR. The exhibits also indicate the years in which the assets in the SRBR are expected to be exhausted,

<sup>2</sup> Note that we issued a separate health trend assumptions letter dated March 11, 2026 due to the timing of the GASB 74 valuation report as of December 31, 2025.

shown separately for OPEB and non-OPEB. Note that the assets used herein reflect the estimated implicit subsidy transfer of \$9,390,686 as of December 31, 2025 from the SRBR to the Employer Advance Reserve for calendar year 2025 previously provided by ACERA, consistent with the transfer amount used in the December 31, 2025 funding valuation report for the Pension Plan.<sup>3</sup>

A brief discussion on background information and results is provided below for each of the plans.

## OPEB

OPEB benefits, including postretirement medical, dental, and vision benefits, are provided by the employer's contributions made to ACERA's 401(h) account. Once the employer makes those contributions to the 401(h) account, ACERA transfers a like amount from the SRBR to the employer's reserve account.

Note that in preparing the 401(h) contribution letter for 2026/2027, we had included an additional allocation for expenses related to the administration of the health benefits for retirees. However, as we previously demonstrated to the Association during our discussion with the Board on SB 1479, the values in both the employer reserves and the SRBR would remain unchanged relative to the values prior to that allocation, through the operation of SB 1479. For that reason, we have not included the explicit payment of administrative expense out of the 401(h) in preparing the cash flow requirements of the SRBR.

We have assumed the Medicare Part B, dental and vision subsidies will increase at the full rate of the trend assumption for those plans. The maximum Monthly Medical Allowance (MMA) was assumed to increase at 50% of the trend rate for the medical plans with lowest projected trend.

To determine the cost of the retiree medical benefits, we estimated the average per capita premium for retirees under age 65. Because these premiums include active participants for purposes of underwriting, the retirees receive an implicit subsidy. Had the retirees under age 65 been underwritten as a separate group, their aggregate premiums would be higher. The excess of the retiree-only costs over the active/retiree composite premiums currently charged makes up the implicit subsidy. Between the prior and the current valuation, there has been a decrease in the implicit subsidy provided by the County's health consultant from \$9.4 million in 2025 to \$7.6 million in 2026 (a decrease of roughly 19.6%). As shown in the table below, the implicit subsidy estimate provided by the County's health consultant can fluctuate from year to year.

<b>Calendar Year</b>	<b>County's Implicit Subsidy</b>
2022	\$7,981,476
2023	4,116,000
2024	2,472,346

<sup>3</sup> After we were instructed by ACERA to use the estimated transfer amount (i.e., \$9,390,686) in our December 31, 2025 valuation for the Pension Plan, we understand that the calculation of the actual transfer amount (i.e., \$9,375,256) was subsequently finalized. For consistency purposes, we have continued to use the estimated transfer amount in this letter.

<b>Calendar Year</b>	<b>County's Implicit Subsidy</b>
2025	9,390,686
2026	7,552,892

This volatility is not unusual, as claims for the smaller group of non-Medicare retirees are typically more volatile than the overall combined active and retiree experience.

Starting with the December 31, 2024 valuation, we recommended methodology changes that will reduce the volatility of the implicit subsidy estimates used to project the long-term liabilities for SRBR funding sufficiency measurements. Instead of calculating the implicit subsidy based on a single year's estimate, the new approach incorporates a 3-year average of the plan's unblended retiree rates. In preparing the cash flow requirements for this year's valuation, we have started our projection by including an initial smoothed implicit subsidy estimate of \$7,172,100 for 2026, a 25% increase over the 2025 smoothed implicit subsidy estimate of \$5,732,645. This year's smoothed value of \$7,172,100 is in line with the health consultants' 2026 estimate of \$7,552,892. As requested by the Board, our full valuation will include an estimate of the sufficiency period under the prior implicit subsidy methodology for comparison.

In the December 31, 2024 valuation, the OPEB assets were projected to become exhausted in 2045, with full benefits paid through 2044, for a total of 20 full years and 1 partial year. The results of the December 31, 2025 valuation indicate that the terminal year of OPEB benefits is projected to be 2044, with full benefits paid through 2043, for a total of 18 full years and 1 partial year.

After accounting for the 1 year of benefit payments made in 2025, there is an approximate decrease in the sufficiency period of 0.92 years (11 months) mainly due to the following factors:

1. Updated per capita health costs for the year 2026 decreased the sufficiency period by approximately 8 months. This was mainly the result of new implicit subsidy estimates that are greater than expected from last year.
2. Updated trend assumptions described in the March 11, 2026 trend assumptions letter decreased the sufficiency period by 6 months. Key changes include higher anticipated increases to Part B premiums.
3. On April 16, 2026, the ACERA Board of Retirement adopted an increase to the Monthly Medical Allowance (MMA) for retirees enrolled in Individual Plans through the Medicare Exchange to coincide with the MMA of retirees enrolled in the Group Plans effective January 1, 2027. This benefit enhancement decreased the sufficiency period by approximately 7 months.
4. Favorable investment experience produced actuarial gains which increased the sufficiency period by 8 months.
5. Demographic experience gains and the assumption change related to the use of premiums without age-adjustments for the Kaiser Senior Advantage MAPD plan combined to increase the sufficiency period by 2 months.

These results, as provided in the Attachment, are based on the amount of OPEB assets available as of December 31, 2025, which were provided by ACERA.<sup>4</sup>

## Non-OPEB

The SRBR currently provides benefits in addition to those that qualify as OPEB. These non-OPEB benefits include supplemental COLA and death benefits.

In the December 31, 2024 valuation, the non-OPEB assets were projected to become exhausted in 2048, with full benefits paid through 2047, for a total of 23 full years and 1 partial year. The results of the December 31, 2025 valuation indicate that the terminal year of non-OPEB benefits is again projected to be 2048, with full benefits paid through 2047, for a total of 22 full years and 1 partial year.

After accounting for the 1 year of benefit payments made in 2025, there is an approximate decrease in the sufficiency period of 0.42 years (5 months). The main reason for the decrease in the sufficiency period for non-OPEB benefits is the higher than expected actual inflation of 3.04%<sup>5</sup> (before it is rounded to 3.00% at the nearest 0.50% increment) in the Bay Area for 2025 (versus the COLA assumption of 2.75%), which increased the supplemental COLA costs.

These results, as provided in the Attachment, are based on the amount of non-OPEB assets available as of December 31, 2025, which were provided by ACERA.<sup>6</sup>

## Other considerations

Note that the terminal years through which the SRBR can be paid have been developed to reflect only the actuarial value of assets allocated to the SRBR through December 31, 2025. As we indicated on page 25 of our December 31, 2025 actuarial valuation report for the Pension Plan, the Association had deferred investment gains of \$761.8 million that were not yet recognized in determining the combined actuarial value of assets for the Pension Plan and the SRBR Plan as of that date. The deferred gains of \$761.8 million represent 5.4% of the market

<sup>4</sup> The OPEB assets used in this valuation (i.e., \$1.148 billion) are on an actuarial value of assets basis. Note that in our recently issued Governmental Accounting Standards Board (GASB) Statement No. 74 financial reporting valuation report as of December 31, 2025 of the OPEB benefits provided by the SRBR, we utilized the Plan's Fiduciary Net Position, or market value of OPEB assets, of \$1.491 billion, as required by that Statement. The increase in assets used in the GASB 74 valuation of \$342.9 million represents the net deferred investment gains (under the actuarial value of assets method used by ACERA in the Retirement Plan valuation) that is commensurate with the size of the OPEB SRBR reserve and 401(h) reserve. These deferred investment gains have not been utilized in this December 31, 2025 SRBR sufficiency valuation, similar to how the deferred investment losses as of December 31, 2024 were not used in last year's sufficiency valuation. For informational purposes only, the deferred investment gains as of December 31, 2025 represent approximately 98 more months of projected OPEB benefit payments.

<sup>5</sup> Based on a comparison of the December 2025 Consumer Price Index (CPI) to the December 2024 CPI for the San Francisco-Oakland-Hayward Area, as published by the Bureau of Labor Statistics.

<sup>6</sup> The non-OPEB SRBR assets used in this valuation (i.e., \$127.4 million) are on an actuarial value of assets basis. Note that in our recently issued Governmental Accounting Standards Board (GASB) Statement No. 67 financial reporting valuation report as of December 31, 2025 for the Pension Plan and non-OPEB benefits provided by the SRBR, we utilized the Plan Fiduciary Net Position, or market value of assets, of \$165.8 million in non-OPEB SRBR assets, as required by that Statement. The increase in non-OPEB SRBR assets used in the GASB 67 valuation of \$38.4 million represents the net deferred investment gains (under the actuarial value of assets method used by ACERA in the Retirement Plan valuation) that is commensurate with the size of the non-OPEB SRBR reserve. These deferred investment gains have not been utilized in this December 31, 2025 SRBR sufficiency valuation, similar to how the deferred investment losses as of December 31, 2024 were not used in last year's sufficiency valuation. For informational purposes only, the deferred investment gains as of December 31, 2025 represent about 6 years and 6 months more of projected non-OPEB benefit payment.

value of assets as of December 31, 2025. If one-half of the deferred gains that are commensurate with the size of the pension reserves were recognized immediately in the valuation value of assets, there would be an increase in the SRBR Reserve of approximately \$342.9 million to pay OPEB benefits and \$38.4 million to pay non-OPEB benefits.<sup>7</sup>

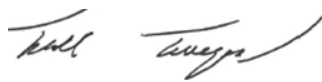
These projections are based on proprietary actuarial modeling software. Our Actuarial Technology and Systems unit, comprised of both actuaries and programmers, is responsible for the initial development and maintenance of these models. The models have a modular structure that allows for a high degree of accuracy, flexibility and user control. The client team programs the assumptions and the plan provisions, validates the models, and reviews test lives and results, under the supervision of the responsible actuary.

These calculations were prepared under the supervision of Eva Yum, FSA, MAAA, Enrolled Actuary and Mehdi Riazi, FSA, MAAA, FCA, Enrolled Actuary. We are members of the American Academy of Actuaries and we meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein.

This document has been prepared for the exclusive use and benefit of ACERA, based upon information provided by ACERA or otherwise made available to Segal at the time this document was created. Segal makes no representation or warranty as to the accuracy of any forward-looking statements and does not guarantee any particular outcome or result. This document should only be copied, reproduced or shared with other parties in its entirety as necessary for the proper administration of the Plan. This document does not constitute legal, tax or investment advice or create or imply a fiduciary relationship. You are encouraged to discuss any issues raised with your legal, tax and other advisors before taking, or refraining from taking, any action.

Please let us know if you have any questions.

Sincerely,



Todd Tauzer, FSA, MAAA, FCA, CERA  
Senior Vice President and Actuary



Eva Yum, FSA, MAAA, EA  
Vice President and Actuary



Mehdi Riazi, FSA, MAAA, FCA, EA  
Vice President and Actuary



Daniel Siblik, ASA, MAAA, FCA, EA  
Vice President and Actuary

DNA/jl

Enclosures (5979218, 5977317)

cc: Lisa Johnson

<sup>7</sup> It is important to note that the December 31, 2025 actuarial valuation is based on plan assets as of that same date. The Plan's actuarial status does not reflect short-term fluctuations of the market but rather is based on the market values on the last day of the Plan Year. Segal is available to prepare projections of potential outcomes of market conditions and other demographic experience upon request.

Alameda County Employees' Retirement Association  
Attachment – Projected Cash Flows

Provided by the Supplemental Retirees Benefit Reserve as of December 31, 2025

Year Ending December 31	Medical <sup>8</sup> Annual Benefit Cash Flows	Dental and Vision Annual Benefit Cash Flows	Non-OPEB <sup>9</sup> Annual Benefit Cash Flows
2026	\$58,396,124	\$6,461,811	\$2,090,733
2027	64,923,309	6,883,008	2,689,347
2028	70,311,407	7,281,126	3,536,603
2029	75,850,976	7,647,365	4,549,915
2030	81,759,336	8,025,324	5,640,351
2031	88,056,635	8,417,437	6,758,352
2032	94,226,294	8,820,044	7,952,258
2033	100,856,542	9,228,211	9,224,652
2034	107,438,991	9,642,852	10,574,219
2035	113,765,298	10,065,278	11,862,776
2036	119,411,511	10,485,374	13,079,414
2037	125,020,070	10,912,173	14,547,041
2038	130,490,440	11,330,024	16,206,478
2039	135,744,941	11,758,505	17,748,893
2040	140,890,760	12,169,685	19,314,492
2041	146,022,606	12,589,613	20,813,337
2042	151,095,316	13,005,618	22,153,477
2043	156,189,693	13,410,095	23,312,130
2044	89,917,341 <sup>10</sup>	7,703,498 <sup>10</sup>	24,430,704
2045	0	0	25,680,654
2046	0	0	26,779,336
2047	0	0	27,977,983
2048	0	0	6,994,915 <sup>10</sup>

<sup>8</sup> Includes Medicare Part B and Implicit Subsidy Reimbursement made to the County.

<sup>9</sup> Includes Supplemental COLA and \$1,000 Lump Sum Death Benefit.

<sup>10</sup> Benefits will be paid through the year prior to the year shown in the table. Full benefits will be paid for part of the year indicated.

Alameda County Employees' Retirement Association  
Attachment – Present Value of Projected Benefits

Provided by the Supplemental Retirees Benefit Reserve as of December 31, 2025

Year Ending December 31	OPEB <sup>11</sup> Present Value as of December 31, 2025 of Projected Benefits through Year End	Non-OPEB Present Value as of December 31, 2025 of Projected Benefits through Year End	Total Present Value as of December 31, 2025 of Projected Benefits through Year End
2026	\$62,700,532	\$2,021,188	\$64,721,720
2027	127,576,969	4,450,992	132,027,961
2028	193,094,947	7,437,246	200,532,193
2029	258,987,240	11,027,789	270,015,029
2030	325,205,100	15,187,653	340,392,753
2031	391,701,760	19,845,980	411,547,740
2032	458,081,877	24,968,645	483,050,522
2033	524,356,740	30,522,207	554,878,947
2034	590,232,773	36,471,786	626,704,559
2035	655,347,917	42,709,715	698,057,632
2036	719,184,417	49,137,460	768,321,877
2037	781,616,675	55,818,763	837,435,438
2038	842,492,054	62,775,274	905,267,328
2039	901,664,725	69,895,442	971,560,167
2040	959,049,699	77,136,775	1,036,186,474
2041	1,014,625,802	84,429,556	1,099,055,358
2042	1,068,363,458	91,684,091	1,160,047,549
2043	1,120,268,458	98,818,628	1,219,087,086
2044	1,148,190,209	105,806,358	1,253,996,567
2045	1,148,190,209	112,671,072	1,260,861,281
2046	1,148,190,209	119,361,168	1,267,551,377
2047	1,148,190,209	125,893,454	1,274,083,663
2048	1,148,190,209	127,419,780	1,275,609,989

<sup>11</sup> Includes Medical, Dental and Vision.

March 11, 2026

Carlos Barrios  
Assistant Chief Executive Officer  
Alameda County Employees' Retirement Association  
475 14th Street, Suite 1000  
Oakland, CA 94612

**Re: Alameda County Employees' Retirement Association (ACERA)  
Healthcare trend assumptions recommended for the December 31, 2025  
Supplemental Retiree Benefit Reserve (SRBR) Actuarial Valuation**

Dear Carlos:

We have provided in this letter the healthcare trend assumptions that we recommend to the Board to be used in the December 31, 2025, retiree health valuation for determining sufficiency of assets to provide retiree health benefits. These health trend assumptions will also be used to develop our Governmental Accounting Standards Board (GASB) Statement No. 74 report with a measurement date of December 31, 2025.

## Health care trend assumptions

The health care trend assumptions used in the health valuation are reviewed annually. Every year Segal publishes a set of health care trend assumptions based on the latest research and information available to our health actuaries. The health care trend assumptions take into account factors such as recent and expected premium increases affecting our clients, changes in utilization of health care, and cost shifting from Medicare.

The specific health care trend assumptions we are recommending are outlined in Attachment One.

1. For the prior December 31, 2024, SRBR valuation, we recommended the following assumptions:
  - a. For the non-Medicare plans, we recommended the first-year trend rate be set at 7.75%, then graded down by 0.25% each year for 13 years until reaching an ultimate rate of 4.50%. Key considerations that influenced the updated non-Medicare trend rates were the plan's recent premium experience, updated national trend expectations for prescription drug costs, and concerns about the impact of general inflation on healthcare costs. Based on these assumptions, the non-Medicare plan premiums are expected to increase by an average of 5.63% per year over the next twenty years.

- b. For the Medicare plans, we recommended the first-year trend rate be set at 7.50%, then graded down by 0.25% each year until reaching an ultimate rate of 4.50% after 12 years. In addition to the same key considerations that influenced the updated non-Medicare trend rates, the updated Medicare trend rates were also influenced by the Calendar Year 2026 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (the Advance Notice) released by the Centers for Medicare & Medicaid Services (CMS) on January 10, 2025. Based on these assumptions, the Medicare plan premiums are expected to increase by an average of 5.47% per year over the next twenty years.
  - c. The Dental trend rates started at 6.00%, then decreased to 5.00% and 4.50% before reaching an ultimate rate of 4.00%. The updated Dental trend assumptions were based on a review of the plan's recent claims experience and forward-looking expectations from Segal survey data. The Vision trend assumption was lowered from 4.00% to 3.00%, based mostly on forward-looking expectations from Segal survey data.
  - d. Medicare Part B trend assumptions were increased to 6.20% for calendar years 2025 through 2033, 5.75% for calendar year 2034, then decreased by 0.25% per year until the ultimate trend rate of 4.50% is reached in 2039. The updated Part B trend assumptions were based on the intermediate Part B premium estimates in Table V.E2. of the 2024 Medicare Trustees report. The 6.20% initial trend assumption represented the average trend shown for years 2025 through 2033 of the Trustees report.
  - e. Based on past practice, the 7.75% non-Medicare and 7.50% Medicare first-year trends were used in the December 31, 2024 "preview" valuation and applied to the 2025 non-Medicare and Medicare medical premiums to estimate the projected 2026 premiums. The first-year trends were replaced as part of the "final" valuation as of December 31, 2024, to reflect the actual premium renewals for 2026. Similarly, the initial Dental and Vision trend rates were updated based on the actual premium renewals for 2026.
  - f. We continued to assume that the Board's annual Monthly Medical Allowance (MMA) would increase by 50% of the rate of the anticipated medical trend assumption. If different types of medical plans had different initial trend rates, we assumed that the future increase in MMA would be linked to the plan with the lowest projected medical trend. For the Board's subsidies for dental, vision, and Medicare Part B plans, we assumed they would increase at the full rate of anticipated trend assumed for each of those plans, as described in (c) and (d) above, and provided in Attachment One.
2. For the current December 31, 2025, SRBR valuation, we are recommending the following assumptions:
    - a. For the non-Medicare plans, we recommend the first-year trend rate be set at 8.00%,<sup>1</sup> then grading down by 0.25% each year for 14 years until reaching an ultimate rate of 4.50%. Key considerations that influenced the updated non-Medicare trend rates were the plan's recent premium experience and updated national trend expectations for

<sup>1</sup> We note that in the absence of the above recommendation to reset the assumption, the first-year trend rate that we would use in this year's valuation would equal 7.50%.

medical and prescription drug costs. Based on these assumptions, the non-Medicare plan premiums are expected to increase by an average of 5.81% per year over the next twenty years.

- b. For the Medicare plans, we are recommending the first-year trend rate be set at 7.50%,<sup>2</sup> then grading down by 0.25% each year until reaching an ultimate rate of 4.50% after 12 years. In addition to the same key considerations that influenced the updated non-Medicare trend rates, the updated Medicare trend rates were also influenced by the Calendar Year 2027 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (the Advance Notice) released by the Centers for Medicare & Medicaid Services (CMS) on January 26, 2026. Final guidance, rules and clarifications will be provided by CMS in April of 2026. Based on these assumptions, the Medicare plan premiums are expected to increase by an average of 5.47% per year over the next twenty years.
- c. The Dental trend rates will start at 5.00%, then decrease to 4.50% before reaching an ultimate rate of 4.00%. The updated Dental trend assumptions were based on a review of the plan's recent claims experience and forward-looking expectations from Segal survey data. The Vision trend assumption is 3.00%, based mostly on forward-looking expectations from Segal survey data.
- d. Medicare Part B trend assumptions will be increased to 6.75% for calendar years 2026 through 2033, 6.25% for calendar year 2034, then decreasing by 0.50% per year until the ultimate trend rate of 4.50% is reached in 2038. The updated Part B trend assumptions were based on the intermediate Part B premium estimates in Table V.E2. of the 2025 Medicare Trustees report. The proposed 6.75% initial trend assumption represents the average trend shown for years 2026 through 2033 of the Trustees report.
- e. Based on past practice, the 8.00% non-Medicare and 7.50% Medicare first-year trends will be used in the December 31, 2025 "preview" valuation and applied to the 2026 non-Medicare and Medicare medical premiums to estimate the projected 2027 premiums. The first-year trends will be replaced as part of the "final" valuation as of December 31, 2025, to reflect the actual premium renewals for 2027. Similarly, the initial Dental and Vision trend rates will be updated based on the actual premium renewals for 2027.
- f. We will continue to assume that the Board's annual Monthly Medical Allowance (MMA) will increase by 50% of the rate of the anticipated medical trend assumption. If different types of medical plans have different initial trend rates, we assume that the future increase in MMA will be linked to the plan with the lowest projected medical trend. For the Board's subsidies for dental, vision, and Medicare Part B plans, we assume they would increase at the full rate of anticipated trend assumed for each of those plans, as described in (c) and (d) above, and provided in Attachment One.

Segal will prepare a separate letter to address the recommended demographic driven changes to be used in the December 31, 2025, SRBR sufficiency valuation.

<sup>2</sup> We note that in the absence of the above recommendation to reset the assumption, the first-year trend rate that we would use in this year's valuation would equal 7.25%.

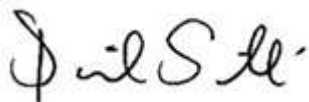
## Statement of actuarial opinion

This document has been prepared for the exclusive use and benefit of ACERA, based upon information provided by the Plan or otherwise made available to Segal at the time this document was created. Segal makes no representation or warranty as to the accuracy of any forward-looking statements and does not guarantee any particular outcome or result. This document should only be copied, reproduced, or shared with other parties in its entirety as necessary for the proper administration of the Plan. This document does not constitute legal, tax, or investment advice or create or imply a fiduciary relationship. You are encouraged to discuss any issues raised with your legal, tax and other advisors before taking, or refraining from taking, any action.

Mehdi Riazi is a member of the American Academy of Actuaries and meets the qualification requirements to render the actuarial opinion contained herein.

We look forward to discussing this with you. Please let us know if you have any questions.

Sincerely,



Daniel Siblik, ASA, MAAA, EA  
Vice President and Actuary



Mehdi Riazi, FSA, MAAA, FCA, EA  
Vice President and Actuary

/bbf

## Prior and Current Recommended Trend Assumptions for the December 31, 2025, Retiree Health Valuations

### Health Trends Used in the Prior Valuation as of December 31, 2024 (Provided for Comparison Purposes)

Trends to be applied to premium for shown calendar year to calculate next calendar year's projected premium for all health plans are as follows:

Calendar Year	United Healthcare (UHC) HMO & Kaiser HMO Early Retiree <sup>3</sup>	Via Benefits & Kaiser Senior Advantage <sup>4</sup>	Dental <sup>5</sup>	Vision <sup>6</sup>	Medicare Part B
2025	7.75%	7.50%	6.00%	3.00%	6.20%
2026	7.50	7.25	5.00	3.00	6.20
2027	7.25	7.00	4.50	3.00	6.20
2028	7.00	6.75	4.00	3.00	6.20
2029	6.75	6.50	4.00	3.00	6.20
2030	6.50	6.25	4.00	3.00	6.20
2031	6.25	6.00	4.00	3.00	6.20
2032	6.00	5.75	4.00	3.00	6.20
2033	5.75	5.50	4.00	3.00	6.20
2034	5.50	5.25	4.00	3.00	5.75
2035	5.25	5.00	4.00	3.00	5.50
2036	5.00	4.75	4.00	3.00	5.25
2037	4.75	4.50	4.00	3.00	5.00
2038	4.50	4.50	4.00	3.00	4.75
2039 & Later	4.50	4.50	4.00	3.00	4.50

The 2025 assumed trend rates were replaced with the actual premium increases shown below, based on premium renewals for 2026 as reported by ACERA. These premium increases were used in preparing our December 31, 2024, SRBR valuation report dated September 19, 2025:

Kaiser HMO Early Retiree	UHC HMO Signature Value Early Retiree	UHC HMO Signature Value Advantage Early Retiree	Kaiser Senior Advantage	Dental	Vision

<sup>3</sup> Non-Medicare plans.

<sup>4</sup> Medicare plans.

<sup>5</sup> We are aware of the 3-year rate guarantee of the 2026 dental premium, but for the purpose of the long-term measurement, we will focus on the underlying trend.

<sup>6</sup> We are aware of the 5-year rate guarantee of the 2026 vision premium, but for the purpose of the long-term measurement, we will focus on the underlying trend.

## Prior and Current Recommended Trend Assumptions for the December 31, 2025, Retiree Health Valuations

### Health Trends Recommended for the Current Valuation as of December 31, 2025

Trends to be applied to premium for shown calendar year to calculate next calendar year's projected premium for all health plans are as follows:

Calendar Year	United Healthcare HMO & Kaiser HMO Early Retiree <sup>7</sup>	Via Benefits & Kaiser Senior Advantage <sup>8</sup>	Dental	Vision	Medicare Part B
2026	8.00% <sup>9</sup>	7.50% <sup>9</sup>	5.00% <sup>9</sup>	3.00% <sup>9</sup>	6.75% <sup>10</sup>
2027	7.75	7.25	4.50	3.00	6.75
2028	7.50	7.00	4.00	3.00	6.75
2029	7.25	6.75	4.00	3.00	6.75
2030	7.00	6.50	4.00	3.00	6.75
2031	6.75	6.25	4.00	3.00	6.75
2032	6.50	6.00	4.00	3.00	6.75
2033	6.25	5.75	4.00	3.00	6.75
2034	6.00	5.50	4.00	3.00	6.25
2035	5.75	5.25	4.00	3.00	5.75
2036	5.50	5.00	4.00	3.00	5.25
2037	5.25	4.75	4.00	3.00	4.75
2038	5.00	4.50	4.00	3.00	4.50
2039	4.75	4.50	4.00	3.00	4.50
2040 & Later	4.50	4.50	4.00	3.00	4.50

<sup>7</sup> Non-Medicare plans.

<sup>8</sup> Medicare plans.

<sup>9</sup> Based on past practice, the initial trend rates will be replaced as part of the "final" valuation as of December 31, 2025 to reflect the actual premium renewals for 2027.

<sup>10</sup> If available, first year trend may be replaced to reflect actual 2026 calendar year premium at time of valuation.

April 29, 2026

Carlos Barrios  
Assistant Chief Executive Officer  
Alameda County Employees' Retirement Association  
475 14th Street, Suite 1000  
Oakland, CA 94612-1900

**Re: Alameda County Employees' Retirement Association (ACERA)  
Recommended parameters other than healthcare trend assumptions for the  
December 31, 2025 SRBR Retiree Health Actuarial Valuation**

Dear Carlos:

This letter provides the recommended parameters to reflect the demographic driven changes in the membership data for use in the December 31, 2025 retiree health valuation. The health care cost trend assumptions used in the health valuation are reviewed annually and the recommended assumptions for the December 31, 2025 valuation (which were also used to prepare the December 31, 2025 Governmental Accounting Standards Board Statement No. 74 report) were provided in a separate letter dated March 11, 2026. **This year's letter also provides the recommended assumptions for valuing the impact of the Medicare Exchange Monthly Medical Allowances (MMA) plan change adopted by the ACERA Board on April 16, 2026.**

Other parameters (or assumptions) such as the proportion of members expected to be covered by each health benefit provider (e.g. Kaiser) can sometimes be volatile due to the dynamic nature of the health care marketplace. Those assumptions are typically based on enrollment experience among the current retirees as of the most recent annual open enrollment.

Following are our recommended assumptions for the December 31, 2025 health plan valuation:

1. Per capita medical costs – These costs are used to project the costs for current active members when they retire. Based on the percentage of retired members, spouses and beneficiaries electing health coverage and the proportion of members enrolled in each available medical plan, we will project the per capita health costs for a member who is covered in calendar year 2026. They are provided in Item 2a of the Attachment.
2. Election rates – Based on the January 1, 2026 enrollment data, we have provided in Item 2a of the Attachment the observed and recommended election rates among the different medical plans.
3. The per capita costs and election rates for the dental and vision plans that we recommend for use in the December 31, 2025 valuation are provided in Item 2b of the Attachment.

4. For retirees enrolled in a Group Medical Plan in 2026, ACERA provides a monthly subsidy of \$687.21 for retirees with 20 or more years of service, \$515.41 for retirees with 15-19 years of service, and \$343.61 for retirees with 10-14 years of service. We have assumed that the MMA subsidy for the Group Medical Plans available will increase with 50% of medical trend<sup>1</sup> after 2026.
5. Via Benefits Individual Medical Insurance Exchange – Beginning in 2013, retirees eligible for Medicare have the option to purchase individual Medicare insurance from plans through the Via Benefits Individual Medicare Insurance Exchange. Item 2a of the Attachment shows the percentage of retirees enrolled in Via Benefits as of January 2025. To assist with purchasing insurance through Via Benefits, the Board adopted a 2026 monthly subsidy of \$526.46 for Medicare retirees with 20 or more years of service, \$394.85 for retirees with 15-19 years of service, and \$263.23 for retirees with 10-14 years of service. Please see the following section for a discussion of the plan change which will increase the maximum MMA for Medicare Eligible Retiree Individual Plans to coincide with the maximum MMA for the Group Medical Plans effective January 1, 2027. We have assumed the MMA subsidy for the individual plans available through Via Benefits will increase with 50% of medical trend<sup>1</sup> after 2027, consistent with the increase anticipated for the MMA for the group plans.

Retirees under age 65 residing outside of ACERA medical plans' coverage areas are also eligible to enroll in Via Benefits and eligible to receive a maximum MMA subsidy equal to the Group Plan MMA described in (4). We have assumed their reimbursements will equal the maximum MMA.

For members enrolled in Via Benefits, ACERA establishes a tax-free Health Reimbursement Account and provides credit up to the amount of Monthly Medical Allowance for which the retiree is eligible to receive. The retiree will be reimbursed from the Health Reimbursement Account for the periodic premiums required to receive health coverage and to pay medical deductible and medical and prescription co-pays. Any monthly medical allowance left over in the retiree's account from the prior calendar year will be forfeited if not claimed by the end of March in the following calendar year.

Via Benefits enrollees have a number of plan options available to them. The actual premiums required to receive coverage as well as amounts available to pay deductibles, etc., vary from retiree to retiree. For our valuation, we will use an average per capita cost.

To derive the average monthly per capita Via Benefits subsidy cost, we analyzed the actual Via Benefits reimbursement data available from January 1, 2025 through December 31, 2025, adjusted for expected medical trend to 2026 and have included an estimate of the additional cost to account for the lag in reporting and reimbursing any unused amount in the retirees' Health Reimbursement Account. That calculation is provided in Item 2a of the Attachment.

This year's development of the average monthly per capita Via Benefits subsidy was adjusted to reflect a lower percentage of retirees with zero HRA utilization than currently observed. As a result of this change, the reserve margin for unused subsidy was lowered

<sup>1</sup> As noted in Item 4d(1) of the Attachment, if different types of medical plans have different initial trend rates, we assume that the future increase in MMA will be linked to the plan with the lowest projected medical trend.

from 10% to 5%. While these methodology changes combined to increase the per capita assumption, the assumed 2026 per capita exchange costs are 7.0% higher than the assumed 2025 costs (slightly lower than last year's assumed increase of 7.5%).

6. Plan change – On April 16, 2026, the ACERA Board of Retirement adopted an increase to the Monthly Medical Allowance (MMA) for retirees enrolled in Individual Plans through the Medicare Exchange to coincide with the MMA of retirees enrolled in the Group Plans effective January 1, 2027. As discussed in our April 1, 2026 analysis, the increased MMA in conjunction with clarifications made to the eligible HRA expenses covered by the Individual Plan MMA in June of 2025, are expected to increase the average subsidy received by retirees on the Via Benefits exchange and could potentially lead to a greater percentage of retirees enrolling in the Exchange than currently observed. To assess the possible impact, our April 1, 2026 letter analyzed several scenarios with varying assumptions regarding increases to the average exchange subsidies and potential shifts in the Group versus Individual plan enrollment elections. Our recommended assumptions for valuing the impact of the plan change in the December 31, 2025 SRBR valuation are provided in Item 3 of the Attachment. These assumptions were based on discussions with ACERA and are meant to incorporate a slight margin for conservatism until data becomes available.
7. Use of premiums without age-specific assumptions - ASOP 6, *Measuring Retiree Group Benefit Obligations and Determining Retiree Group Benefits Program Periodic Costs or Actuarially Determined Contributions*, generally requires actuaries to use age-specific costs in the development of per capita costs. However, exceptions are provided for cases where the use of age-adjusted costs would not be material. Because the net benefit costs, after reflecting revenue from the Centers for Medicare & Medicaid Services (CMS), do not vary significantly by age, Medicare Advantage Prescription Drug (MAPD) plans are among the benefit plans that qualify for this exception. In other words, it is permissible to model the 2026 per-capita costs for the Kaiser Senior Advantage plan by using the same \$398.08 monthly premium rate for all ages. CMS revenue to MAPD plans is based, in part, on the risk profile of the plan's members. These risk-based revenue adjustments work to offset the impact of aging on health care costs and effectively flatten the "aging-curve". More details on this aging exception can be found in the American Academy of Actuaries ASOP 6 Practice Note, *Development of Age-Specific Retiree Health Cost Assumptions, Including Applications to Pooled and Non-Pooled Health Plans*.

Starting with the December 31, 2025 valuation, we recommend valuing the Kaiser Senior Advantage plan per-capita costs based on the plan's premiums without any adjustments for differences in age. This change is expected to lower the actuarial liabilities.

8. Other assumptions – The other actuarial assumptions and methods will be consistent<sup>2</sup> with those used in our December 31, 2025 pension funding valuation. These include the economic and non-economic assumptions. The demographic assumptions under items 4 (h), (i), and (j) are reviewed (and updated if necessary) as part of the triennial experience study. These assumptions include spouse/domestic partner demographic assumptions, and retiree medical coverage election percentages. The December 31, 2025 valuation will

<sup>2</sup> For the purposes of anticipating death, we use the headcount weighted instead of the benefit (or amount) weighted mortality tables used in the pension funding valuation.

reflect the assumptions that were based on the December 1, 2019 – November 30, 2022 experience study dated January 8, 2024 and approved by the Board for use starting with the December 31, 2023 valuation.

## Statement of actuarial opinion

This document has been prepared for the exclusive use and benefit of ACERA, based upon information provided by the Plan or otherwise made available to Segal at the time this document was created. Segal makes no representation or warranty as to the accuracy of any forward-looking statements and does not guarantee any particular outcome or result. This document should only be copied, reproduced, or shared with other parties in its entirety as necessary for the proper administration of the Plan. This document does not constitute legal, tax or investment advice or create or imply a fiduciary relationship. You are encouraged to discuss any issues raised with your legal, tax and other advisors before taking, or refraining from taking, any action.

The undersigned are Members of the American Academy of Actuaries and meet the qualification requirements to render the actuarial opinion contained herein.

We look forward to discussing this with you. Please let us know if you have any questions.

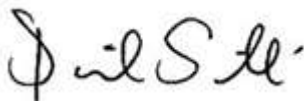
Sincerely,



Todd Tauzer, FSA, MAAA, FCA, CERA  
Senior Vice President and Actuary



Mehdi Riazi, FSA, MAAA, FCA, EA  
Vice President and Actuary



Daniel Siblik, ASA, MAAA, FCA, EA  
Vice President and Actuary



Eva Yum, FSA, MAAA, EA  
Vice President and Actuary

JL/jl/bbf

Attachment

## Recommended Actuarial Assumptions for the December 31, 2025 Health Valuation

### 1. Health Care Cost Trend Rates

The health care cost trend assumptions recommended for the December 31, 2025 valuation to be applied to all health plans were provided in a separate letter dated March 11, 2026.

### 2. Per Capita Costs and Election Rates for Calendar Year 2026

#### a. Medical Plan

#### Under Age 65

Medical Plan	Recommended Election Assumption	Observed Election <sup>1</sup>	Monthly Premium (Self)	Maximum Monthly Medical Allowance (20+ YOS)
Kaiser HMO	72%	71.8%	\$1,133.80	\$687.21
Via Benefits Individual Insurance Exchange <sup>2</sup>	19%	19.6%	N/A	687.21
UHC Signature Value HMO Current Network	9%	8.5%	1,840.38	687.21
Other Plans	0%	0.1%	1,133.80 <sup>3</sup>	687.21

#### Age 65 and Over

Medical Plan	Recommended Election Assumption	Observed Election <sup>1</sup>	Monthly Premium (Self)	Maximum Monthly Medical Allowance (20+ YOS)
Kaiser Senior Advantage	72%	71.5%	\$398.08	\$687.21
Via Benefits Individual Insurance Exchange	28%	28.0%	407.58 <sup>4</sup>	526.46 <sup>5</sup>
Kaiser, non-Medicare <sup>6</sup>	0%	0.5%	1,133.80	687.21
Other Plans	0%	0.0%	398.08 <sup>3</sup>	687.21

<sup>1</sup> The observed election percentages are based on retiree health census data as of January 1, 2026 and pension membership data as of November 30, 2025.

<sup>2</sup> Via Benefits individual insurance coverage is available to retirees under age 65 residing outside of ACERA medical plans' coverage areas. We have assumed that these current retirees under age 65 will draw the maximum MMA subsidy (\$687.21).

<sup>3</sup> We assumed the same costs as Kaiser HMO and Kaiser Senior Advantage for current non-Medicare and Medicare retirees, respectively.

<sup>4</sup> Derivation of the amount expected to be paid in 2026 from the Health Reimbursement Account for members with 20 plus years of service is shown in the table on the following page. We have also derived the amount expected to be paid for members with 10-14 and 15-19 years of service.

<sup>5</sup> The maximum MMA for the Exchange will coincide with the Group Plan maximum MMA starting January 1, 2027.

<sup>6</sup> Closed to future retirees.

Derivation of Via Benefits Monthly Per Capita Costs<sup>7</sup>

Line Description	10-14 Years of Service	15-19 Years of Service	20+ Years of Service
1. Maximum MMA for 2025	\$253.72	\$380.57	\$507.43
2. Total of Maximum MMA (From Jan. 2025 to Dec. 2025)	598,293	938,866	6,386,026
3. Total of Actual Reimbursement (From Jan. 2025 to Dec. 2025)	494,264	733,028	4,544,560
4. Ratio of Actual Reimbursement to Maximum 2025 MMA [(3) / (2)]	82.61%	78.08%	71.16%
5. Average Monthly Per Capita Cost for 2025 [(1) x (4)]	\$209.60	\$297.15	\$361.09
6. Maximum MMA for 2026	263.23	394.85	526.46
7. Increase for Expected Medical Trend (7.50%) from 2025 to 2026 [(5) x 1.075]	225.32	319.44	388.17
<b>8. Increase for Additional 5% Margin for 2025 Expenses Incurred in 2025 but Reimbursed after December 2025 [(7) x 1.05]</b>	<b>\$236.59</b>	<b>\$335.41</b>	<b>\$407.58</b>

## b. Dental and Vision Plans

We assume that 100% of future retirees with mandatory dental and vision coverages will receive the maximum subsidy. Dental and vision coverages are provided for retirees who have:

- 1) 10 or more years of ACERA service credit; or
- 2) Service-connected disability; or
- 3) Non-service-connected disability with retirement prior to February 1, 2014.

2026 Plan Year

Monthly Dental and Vision Subsidy

$$\underline{\$54.35 + \$4.63 = \$58.98}$$

<sup>7</sup> Starting with the December 31, 2025 valuation, rows 2 and 3 exclude retirees with zero HRA subsidies paid in 2025. As a result, the margin in row 8 was reduced from 10% to 5%.

### 3. Plan Change

To measure the impact of the increase to the Monthly Medical Allowance (MMA) for retirees enrolled in Individual Plans effective January 1, 2027, we recommend the following assumption changes:

- a. Increasing the assumed per-capita Exchange subsidy by 16.1%, in addition to the calendar year 2026 assumed trend of 7.50%. For example, the \$407.58 per capita assumption for retirees with over 20 years of service would increase by  $1.075 \times 1.161$  on January 1, 2027. The 16.1% increase was based on the following assumptions:
  - 1) Retirees currently receiving the maximum subsidy will continue to receive the maximum subsidy after the increase to the maximum MMA.
  - 2) The percentage of exchange retirees receiving the maximum subsidy was assumed to increase by 6 percentage points as a result of the 2025 plan clarifications regarding HRA covered expenses.
- b. Maintaining the current 72% Group Plan & 28% Exchange plan election assumption for current Medicare retirees but changing the assumed distribution to 67% Group Plan & 33% Exchange (5% shift) for future Medicare retirees.

These assumptions will be monitored closely in the coming years and adjusted as data becomes available.

### 4. Other Assumptions

In the December 31, 2025 valuation, we will also apply the following assumptions and methodologies:

- a. Economic assumptions: These include discount rate, inflation rate and salary scale assumptions. We will apply the same assumptions approved by the Board for the December 31, 2025 pension funding valuation.
- b. Demographic assumptions: These include the incidence of service retirement, disability retirement, withdrawal and deferred vested retirement. We will apply the same assumptions that we use for the December 31, 2025 pension funding valuation. For the purposes of anticipating death, we use the headcount weighted instead of the benefit (or amount) weighted mortality tables used in the pension funding valuation.
- c. Funding methodologies: The Entry Age Actuarial Cost Method will continue to be used in this valuation. For the purpose of the Sufficiency Study, SRBR is assumed to pay benefits until the current assets are exhausted.
- d. Expected annual rate of increase in the Board's health subsidy amount:
  - 1) Maximum MMA will increase with 50% of medical trend.  
If different types of medical plans have different initial trend rates, we assume that the future increase in MMA will be linked to the plan with the lowest projected medical trend.
  - 2) Dental and vision premium reimbursement will increase with full dental/vision trend.
  - 3) Medicare B premium reimbursement will increase with full Medicare Part B trend.

*Recommended Actuarial Assumptions for the December 31, 2025 Health Valuation*

- e. We will assume 100% of future retirees will be covered by Medicare Parts A and B, and receive Medicare Part B premium reimbursement. We will further assume all current retirees under age 65 receiving a MMA will also receive a Medicare Part B premium reimbursement upon age 65.
- f. Assets: We will use the current value of assets in the SRBR in our valuation.
- g. Implicit Subsidy: Our understanding is that the under age 65 retiree premium<sup>8</sup> rates are blended or pooled together with active premium rates and an implicit subsidy does exist. Starting with the December 31, 2024 valuation, we suggested methodology changes that will reduce the volatility of the implicit subsidy estimates used to project the long-term liabilities in the GASB 74 and 75 accounting valuations and the SRBR funding sufficiency measurements. As shown in the table below, the implicit subsidy estimates provided by the County's health consultant can be quite volatile.

Calendar Year	County's Implicit Subsidy
2021	\$5,652,613
2022	7,981,476
2023	4,116,000
2024	2,472,346
2025	9,390,686
2026	7,552,892

This volatility is not unusual, as claims for the smaller group of non-Medicare retirees are typically more volatile than the overall, combined active and retiree experience. For the December 31, 2025 valuation, we recommend maintaining the smoothing approach developed last year for the December 31, 2024 SRBR valuation. Similar to the December 31, 2024 SRBR valuation, we will also provide the sufficiency period based on the health consultant's 2026 implicit subsidy estimate without any smoothing. This smoothing methodology is only used for the purposes of measuring the long-term liabilities as we are not suggesting any change to the methodology the Association uses to administer the implicit subsidy reimbursements.

- h. Spouse Age Difference in Years for Retirees with Medical Coverage (Spousal Coverage will only affect costs due to implicit subsidy):<sup>9</sup> For all non-retired members, male members are assumed to have a female spouse who is 3 years younger than the member and female members are assumed to have a male spouse who is 1 year older than the member.

<sup>8</sup> Only ACERA group plans (not individual plan premiums purchased through Via Benefits) generate an implicit subsidy liability.

<sup>9</sup> These assumptions were reviewed as part of the December 1, 2019 – November 30, 2022 experience study dated January 8, 2024 and approved by the Board for use starting with the December 31, 2023 valuation.

*Recommended Actuarial Assumptions for the December 31, 2025 Health Valuation*

- i. Spousal Coverage<sup>10</sup>: For all active and inactive members who elect to continue their medical coverage at retirement, 35% of males and 15% of females were assumed to have an eligible spouse who also opts for health coverage at that time.
- j. Aging Exceptions: Starting with the December 31, 2025 valuation, the Kaiser Senior Advantage plan per-capita costs will be based on the plan's premiums without any adjustments for differences by age.
- k. Retiree Medical Coverage Election:<sup>10</sup>  
The table below summarizes the participation assumptions for future retirees eligible for ACERA retiree medical plan subsidy (MMA) and Medical Part B premium subsidy.

<b>Age Group</b>	<b>Percent (%) Covered</b>
Under Age 65 <sup>11</sup>	75
Age 65 and Older	90

<sup>10</sup> These assumptions were reviewed as part of the December 1, 2019 – November 30, 2022 experience study dated January 8, 2024 and approved by the Board for use starting with the December 31, 2023 valuation.

<sup>11</sup> 60% of eligible retirees under age 65 without medical coverage are assumed to elect medical coverage upon reaching age 65.



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MEMORANDUM TO THE RETIREES COMMITTEE

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DATE: June 3, 2026

TO: Members of the Retirees Committee

FROM: Carlos Barrios, Assistant Chief Executive Officer 

SUBJECT: **Monthly Medical Allowance for 2027**

An updated memo, presentation and attachments for this agenda item will be distributed before the meeting.




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MEMORANDUM TO THE RETIREES COMMITTEE


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DATE: June 3, 2026

TO: Members of the Retirees Committee

FROM: Jessica Huffman, Retirement Benefits Manager 

SUBJECT: **Health Reimbursement Arrangement Account Balances for 2025**

Retirees enrolled in individual medical plans through Via Benefits were able to submit claims for 2025 reimbursements through March 31, 2026. The total amount of reimbursements paid for the 2025 Plan Year as of May 14, 2026, and the average monthly cost per retiree are shown below.

Plan Year 2025		
Plans	Total Reimbursement Paid as of May 14, 2026	Average Monthly Cost Per Retiree
Medicare eligible retirees	\$6,288,977.56	\$291.64
Early (Pre-65) retirees	\$872,283.48	\$397.21

Provided below are the unused balances of the Health Reimbursement Arrangement (HRA) Accounts from lowest to highest as of May 14, 2026. The balances are categorized by years of service (YOS) contribution levels.

2025 Health Reimbursement Arrangement Account Balances  
for Medicare Eligible Retirees as of May 14, 2026

20 + Years of Service <b>\$6,089.16 Annual MMA</b>		15 through 19 Years of Service <b>\$4,566.84 Annual MMA</b>		10 through 14 Years of Service <b>\$3,044.64 Annual MMA</b>	
Number of Retirees	Balance	Number of Retirees	Balance	Number of Retirees	Balance
360	\$ 0	107	\$ 0	143	\$ 0
122	Under \$500	31	Under \$500	22	Under \$500
114	\$500 - \$1,000	17	\$500 - \$1,000	10	\$500 - \$1,000
105	\$1,000 - \$1,500	13	\$1,000 - \$1,500	16	\$1,000 - \$1,500
79	\$1,500 - \$2,000	18	\$1,500 - \$2,000	4	\$1,500 - \$2,000
60	\$2,000 - \$2,500	14	\$2,000 - \$2,500	9	\$2,000 - \$2,500
64	\$2,500 - \$3,000	8	\$2,500 - \$3,000	38	\$2,500 +
107	\$3,000 - \$4,000	8	\$3,000 - \$4,000		
73	\$4,000 - \$5,000	34	\$4,000 +		
221	\$5,000 +				
<b><i>1,305 Total Number of Retirees</i></b>		<b><i>250 Total Number of Retirees</i></b>		<b><i>242 Total Number of Retirees</i></b>	

Health Reimbursement Arrangement Account Balances for 2025

June 3, 2026

Page 2 of 2

Observations of Medicare eligible retirees’ HRA accounts in 2025:

- There were 1,797 HRAs reported as active accounts at the end of 2025.
- 610 retirees used all of their funds – 33.9% of Medicare eligible retirees.

2025 Health Reimbursement Arrangement Account Balances  
for Early (Pre-65) Retirees as of May 14, 2026

20 + Years of Service <b>\$7,948.44 Annual MMA</b>		15 through 19 Years of Service <b>\$5,961.36 Annual MMA</b>		10 through 14 Years of Service <b>\$3,974.28 Annual MMA</b>	
Number of Retirees	Balance	Number of Retirees	Balance	Number of Retirees	Balance
70	\$ 0	9	\$ 0	10	\$ 0
10	Under \$500	3	Under \$500	2	Under \$500
5	\$500 - \$1,000	0	\$500 - \$1,000	2	\$500 - \$1,000
3	\$1,000 - \$1,500	0	\$1,000 - \$1,500	0	\$1,000 - \$1,500
5	\$1,500 - \$2,000	0	\$1,500 - \$2,000	1	\$1,500 - \$2,000
2	\$2,000 - \$2,500	0	\$2,000 - \$2,500	3	\$2,000 - \$2,500
1	\$2,500 - \$3,000	0	\$2,500 - \$3,000	0	\$2,500 - \$3,000
2	\$3,000 - \$3,500	0	\$3,000 - \$3,500	4	\$3,000 +
4	\$3,500 - \$4,000	1	\$3,500 - \$4,000		
8	\$4,000 - \$5,000	0	\$4,000 - \$5,000		
5	\$5,000 - \$6,000	6	\$5,000 +		
4	\$6,000 - \$7,000				
23	\$7,000 +				
<b>142 Total Number of Retirees</b>		<b>19 Total Number of Retirees</b>		<b>22 Total Number of Retirees</b>	

Observations of early (pre-65) retirees’ HRA accounts in 2025:

- There were 183 HRAs reported as active accounts at the end of 2025.
- 89 retirees used all of their funds – 48.6% of early retirees.



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MEMORANDUM TO THE RETIREES COMMITTEE

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DATE: June 3, 2026

TO: Members of the Retirees Committee

FROM: Mike Fara, Communications Manager *mf*  
Mario Martinez, Retirement Assistant Benefits Manager *mm*

SUBJECT: **Plans for Open Enrollment and Retiree Health and Wellness Fair**

The Benefits Team is actively preparing for Open Enrollment and the 2026 Retiree Health and Wellness Fair. Below are key updates on our preliminary planning efforts.

**Retiree Health and Wellness Fair**

Following the success of last year's hybrid event, which drew 417 attendees (234 in person and 183 via online), we will once again host the fair in a hybrid format in 2026. This approach continues to support broad accessibility for retirees, including those outside the local area, by allowing them to attend presentations and access valuable health information from any internet-enabled device.

Attendees responded positively to the Fair, with the venue providing additional space that allowed for more exhibitors and enabled attendees to move comfortably throughout the Main Ballroom. ACERA also partnered with Kaiser to offer an interactive "Ask the Expert" Stretching Station, where attendees could participate in light stretching and receive a free exercise band for continued use at home.

The 2026 Fair is scheduled for Thursday, October 22, 2026, returning to the DoubleTree by Hilton Hotel Pleasanton at the Club. With ample parking and enhanced facilities, this location will continue to support a smooth in-person experience for members while maintaining the accessibility of our virtual format.

**Carrier Participation**

We are meeting with our carriers and vendors regarding newly offered programs and informational flyers to best interest our members and provide them the key to resources and education to live well.

**Open Enrollment Planning**

The annual Retiree Enrollment Guide, which includes all plan information and premiums for ACERA-sponsored plans, will be mailed out early October with ACERA's Open Enrollment period occurring in November. Medical premiums and any plan changes will be provided to ACERA by the County of Alameda and carriers in August.