Alameda County Employees' Retirement Association

Actuarial Valuation of the OPEB and Non-OPEB Benefits Provided by the Supplemental Retiree Benefits Reserve Including Sufficiency of Funds as of December 31, 2022 – REVISED

Segal

Segal

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September 25, 2023

Board of Retirement
Alameda County Employees' Retirement Association
475 14th Street, Suite 1000
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Dear Members of the Board:

We are pleased to submit this report on our actuarial valuation of the sufficiency of funds for benefits provided by the Supplemental Retiree Benefits Reserve (SRBR) as of December 31, 2022. ACERA's accounting disclosure requirements under Statement No. 74 of the Governmental Accounting Standards Board (GASB) for retiree health benefits provided by the SRBR were included in our GASB 74 report dated May 22, 2023. ACERA's accounting disclosure requirements under GASB Statement No. 67 for non-vested supplemental COLA and retired member death benefits provided by the SRBR were included in our GASB 67 report dated May 22, 2023, together with the statutory pension benefits.

The December 31, 2022 census and financial information was prepared by ACERA. We gratefully acknowledge that assistance. The actuarial projections were based on the assumptions and methods described in Exhibit 1 and on the plan of benefits as summarized in Exhibit 2.

The actuarial calculations were completed under the supervision of Eva Yum, FSA, MAAA, Enrolled Actuary and Mary Kirby, FSA, MAAA, FCA. The undersigned are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein.

We look forward to discussing this material with you at your convenience.

Sincerely,

Segal

Andy Yeung, ASA, MAAA, FCA, EA
Vice President amd Actuary

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

Mary Kirby, FSA, MAAA, FCA
Senior Vice President and Consulting Actuary

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Section 1: Introduction

Purpose

Other Postemployment Benefits (OPEB)

This report presents the results of our actuarial valuation as of December 31, 2022 of the Alameda County Employees' Retirement Association (ACERA) postretirement medical, dental and vision benefits provided through ACERA's 401(h) account. ACERA has allocated a portion of the Supplemental Retiree Benefits Reserve (SRBR) to be treated as pension contributions if the employers make contributions to the 401(h) account.[1] The results of this report have been prepared with the goal of determining sufficiency of funds. Actuarial calculations for other purposes may differ significantly from the results reported here.

The actuarial calculations used to prepare this report have been made on a basis consistent with our understanding of the "substantive plan designs" of the OPEB Plan provided by ACERA using guidelines provided by the Board. The most important plan design assumption incorporated in our valuation is that the future monthly medical allowance (MMA) will increase at one-half of our anticipated medical trend assumptions for all years after 2024. However, the SRBR OPEB Plan will reimburse the fully indexed premium required for dental, vision, and enrollment in the Medicare Part B program.

In Section 2 of this report, we show the unlimited OPEB liabilities (i.e., the liabilities not limited by the current SRBR assets). The unlimited liabilities in this report will be used as the basis when we roll forward the liabilities for the next GASB 74 valuation report as of December 31, 2023.

Non-OPEB Benefits

The SRBR currently provides benefits in addition to those that qualify as OPEB. These "non-OPEB" benefits include supplemental COLAs and death benefits related to the underlying statutory defined benefit pension plan.[2]

In Section 2 of this report, we show the unlimited non-OPEB liabilities. The unlimited liabilities in this report will be used as the basis when we roll forward the liabilities for the next GASB 67 valuation report as of December 31, 2023.

[1] It is our understanding that GASB requires such benefits to be reported under GASB Statement No. 74 and, accordingly, they have been included in our December 31, 2022 GASB 74 report dated May 22, 2023.

[2] It is our understanding that GASB requires such benefits to be reported under GASB Statement No. 67 together with the underlying statutory defined benefit pension plan and, accordingly, they have been included in our December 31, 2022 GASB 67 report dated May 22, 2023.

Special Note Pertaining to OPEB and Non-OPEB Benefits

The calculation of benefit obligations pursuant to prescribed accounting requirements included in the above mentioned GASB reports does not, in and of itself, imply that ACERA has any legal liability to provide the benefits valued.

Actuarial valuations involve estimates of benefit amounts and assumptions about the probability of their payment far into the future, and the actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future.

Important Information about Actuarial Valuations

An actuarial valuation is a budgeting tool with respect to the financing of future projected obligations of an OPEB and non-OPEB Plan. It is an estimated forecast – the actual long-term cost of the plan will be determined by the actual benefits and expenses paid and the actual investment experience of the plan.

In order to prepare an actuarial valuation, Segal relies on a number of input items. These include:

Plan provisions	Plan provisions define the rules that will be used to determine benefit payments, and those rules, or the interpretation of them, may change over time. Even where they appear precise, outside factors may change how they operate. It is important to keep Segal informed with respect to plan provisions and administrative procedures, and to review the plan summary in this report (as well as the plan summary included in our funding valuation report) to confirm that Segal has correctly interpreted the plan of benefits.
Participant information	An actuarial valuation for a plan is based on data provided to the actuary by ACERA. Segal does not audit such data for completeness or accuracy, other than reviewing it for obvious inconsistencies compared to prior data and other information that appears unreasonable. It is important for Segal to receive the best possible data and to be informed about any known incomplete or inaccurate data.
Financial information	This valuation is based on the fair value of assets as of the valuation date, as provided by ACERA. The Association uses an "actuarial value of assets" that differs from fair value to gradually reflect six-month changes in the fair value of assets in determining the sufficiency of funds to pay the benefits provided by the SRBR.
Actuarial assumptions	In preparing an actuarial valuation, Segal starts by developing a forecast of the benefits to be paid to existing plan participants for the rest of their lives and the lives of their beneficiaries. This requires actuarial assumptions as to the probability of death, disability, withdrawal, and retirement of participants in each year, as well as forecasts of the plan's benefits for each of those events. In addition, the benefits forecasted for each of those events in each future year reflect actuarial assumptions as to health care trends and member enrollment in retiree health benefits for the OPEB Plan, and actuarial assumptions as to salary increases and cost-of-living adjustments for the non-OPEB Plan. The forecasted benefits are then discounted to a present value, typically based on an estimate of the rate of return that will be achieved on the plan's assets. All of these factors are uncertain and unknowable. Thus, there will be a range of reasonable assumptions, and the results may vary materially based on which assumptions are selected within that range. That is, there is no right answer (except hindsight). It is important for any user of an actuarial valuation to understand and accept this constraint. The actuarial model may use approximations and estimates that will have an immaterial impact on our results. In addition, the actuarial assumptions may change over time, and while this can have a significant impact on the reported results, it does not mean that the previous assumptions or results were unreasonable or wrong.

Section 1: Introduction

Models	Segal valuation results are based on proprietary actuarial modeling software. The actuarial valuation models generate a comprehensive set of liability and cost calculations that are presented to meet regulatory, legislative and client requirements. 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. Our claims costs assumptions are based on proprietary modeling software as well as models that were developed by others. These models generate per capita claims cost calculations that are used in our valuation software. Our Health Technical Services Unit, comprised of actuaries and programmers, is responsible for the initial development and maintenance of our health models. They are also responsible for testing models that we purchase from other vendors for reasonableness. The client team inputs the paid claims, enrollments, plan provisions and assumptions into these models and reviews the results for reasonableness, under the supervision of the responsible actuary.

The user of Segal's actuarial valuation (or other actuarial calculations) should keep the following in mind:

The valuation is prepared at the request of the Board to determine sufficiency of funds related to the payments of OPEB and non-OPEB benefits out of the SRBR. Segal is not responsible for the use or misuse of its report, particularly by any other party.
An actuarial valuation is a measurement at a specific date - it is not a prediction of a plan's future financial condition. Accordingly, Segal did not perform an analysis of the potential range of future financial measures, except where otherwise noted.
If ACERA is aware of any event or trend that was not considered in this valuation that may materially change the results of the valuation, Segal should be advised, so that we can evaluate it.
Critical events for a plan include, but are not limited to, decisions about changes in benefits and contributions. The basis for such decisions needs to consider many factors such as the risk of changes in plan enrollment, emerging claims experience, health care trend, and investment losses, not just the current valuation results.
Segal does not provide investment, legal, accounting, or tax advice. Segal's valuation is based on our understanding of applicable guidance in these areas and of the plan's provisions, but they may be subject to alternative interpretations. The Board should look to their other advisors for expertise in these areas.
While Segal maintains extensive quality assurance procedures, an actuarial valuation involves complex computer models and numerous inputs. In the event that an inaccuracy is discovered after presentation of Segal's valuation, Segal may revise that valuation or make an appropriate adjustment in the next valuation.
Segal's report shall be deemed to be final and accepted by ACERA upon delivery and review. Trustees should notify Segal immediately of any questions or concerns about the final content.

As Segal has no discretionary authority with respect to the management or assets of ACERA, it is not a fiduciary in its capacity as actuaries and consultants with respect to ACERA.

Section 2: Valuation Results

Highlights of the Valuation

- The actuarial assumptions used in this study are consistent with those assumptions approved by the Retirement Board for the December 31, 2022 pension valuation, including the use of a 7.00% investment return assumption.
- In the last SRBR valuation, we utilized the following medical trend assumptions:
  - All non-Medicare plans: starting at 7.50%, reduced by 0.25% for each year until it reaches 4.50% after 12 years.
  - All Medicare Advantage plans: starting at 6.50%, reduced by 0.25% for each year until it reaches 4.50% after 8 years.

  For this valuation, we recommended to the Board in our letter dated May 17, 2023 that the medical trend assumptions be changed as follows:
  - All non-Medicare plans: starting at 7.50%,[1] reduced by 0.25% for each year until it reaches 4.50% after 12 years.
  - All Medicare Advantage plans: starting at 6.25%[1], reduced by 0.25% for each year until it reaches 4.50% after 7 years.
- The Board approved an increase in the 2024 Monthly Medical Allowance (MMA) on July 20, 2023. The maximum MMA for ACERA sponsored plans and individual (out-of-area) non-Medicare plans has been increased from $616.12 to $635.37 and the maximum MMA for individual Medicare plans has been increased from $471.99 to $486.74 for 2024.
- For years after 2024 we have assumed that the MMA will increase with 50% of the lowest medical trend.
- These and the other OPEB assumptions are provided in Exhibit 1.
- The determination of the "substantive plan" underlying ACERA's OPEB was based upon prior directions provided by ACERA, its auditors, as well as the administrative staff, auditors and consultants representing the County of Alameda, along with changes to the plan adopted by the Board on July 19, 2012 to allow retirees to select medical benefits available through the Medicare Exchange. These directions are provided in Exhibit 3.
- Based on action taken by the Board in February 2014, we continue to exclude the non-OPEB lump sum retiree death benefit from the pension valuation and have included this death benefit in the results presented herein.
- For this valuation, the Association has continued to provide to us the breakdown of the OPEB and non-OPEB assets as of December 31, 2022.

[1] After we released our preliminary high-level summary letter dated May 30, 2023, the Association approved premiums for 2024. We have used those actual 2024 premiums in this study in lieu of estimating those premiums by using the 7.50% assumption for non-Medicare plans and the 6.25% assumption for Medicare plans.

Section 2: Valuation Results

- The terminal year of the SRBR was determined by projecting how long the SRBR can provide for all OPEB and non-OPEB benefits under the substantive plan outlined in Exhibit 3. OPEB benefits can be paid through 2050[1], while non-OPEB benefits can be paid through 2038[1]. Last year, it was projected that OPEB benefits could be paid through 2046 and non-OPEB benefits could be paid through 2043.
- Note that the OPEB sufficiency period included in this report of through 2050 is the same as originally provided in our May 30, 2023 preview letter of through 2050.[1] Our preview letter estimated medical plan premiums and subsidies for 2023 and future years using our trend assumption. Subsequent to our issuing the preview letter, ACERA reported the 2024 medical plan premium renewals and subsidies and we have used the actual 2024 premiums and subsidies in our updated projection shown herein.

  There is an approximate four-year increase in the sufficiency period to pay OPEB benefits between the last study and current study mainly due to the following factors:

  - The demographic and investment experience on an actuarial value of assets basis caused the sufficiency period to increase by 5 months.
  - The unblended non-Medicare premiums (that is, premium rates unblended from the actives) decreased while the blended premiums increased. Additionally, the implicit subsidy was adjusted to the 2023 estimate provided by Newfront. Other changes include updating the 2023 Medicare Part B premium and per capita costs for Via Benefits. The combined effects these changes caused the sufficiency period to increase by 3 years and 11 months.
  - Increasing the first year non-Medicare trend and reflecting actual 2024 premiums lowered the sufficiency period by 8 months.
- There is an approximate five-year decrease in the sufficiency period to pay the non-OPEB benefits between the last study and the current study mainly due to the high actual inflation of 4.88% in the Bay Area for 2022[2] (versus the inflation assumption of 2.75%), which increased the supplemental COLA costs. For supplemental COLA benefits, the excess of inflation over the cost of living allowance (i.e., 3% for Tiers 1 and 3, and 2% for Tiers 2, 2C, 2D, and 4) is banked for future years when inflation may be less than the cost of living allowance. In years when inflation is less than the cost of living allowance, the bank is reduced by the excess of the cost of living allowance over inflation, but to no less than zero percent. A supplemental COLA benefit would be paid whenever a member's COLA bank exceeds 15%. Due to the actual inflation of 4.88% in 2022, the April 1, 2023 COLA banks increased by 2.00% for Tiers 1 and 3 and increased by 3.00% for Tiers 2, 2C, 2D, and 4 over the banks as of the prior year. However, based on the inflation assumption of 2.75%, the April 1, 2023 COLA banks were expected to decrease by 0.25% for Tiers 1 and 3 and to increase by 0.75% for Tiers 2, 2C, 2D and 4. Since the actual April 1, 2023 COLA banks have either increased unexpectedly (for Tiers 1 and 3) or increased by a higher than expected amount (for Tiers 2, 2C, 2D, and 4), it is expected to take less time for members to accumulate a bank in excess of 15%, which results in an increase in the present value of providing supplemental

[1] Assets would only be sufficient to pay benefits for a part of the year indicated.
[2] Based on a comparison of the December 2022 Consumer Price Index (CPI) to the December 2021 CPI, as published by the Bureau of Labor Statistics.

COLA benefits. Moreover, the supplemental COLA benefit is increased for retired members and beneficiaries who already have a COLA bank in excess of 15% (i.e., an increase of 2.00% for Tiers 1 and 3 and an increase of 3.00% for Tiers 2, 2C, 2D and 4). These increases are greater than our assumption.

- The funded ratio of the OPEB liabilities is 96.1% and the funded ratio of the non-OPEB liabilities is 29.0% as of December 31, 2022. The comparable funded ratios were 90.8% and 38.7% for the OPEB and non-OPEB liabilities, respectively, as of December 31, 2021.
- The terminal years the SRBR can be paid as well as the funded ratios have been developed to reflect only the actuarial value of assets allocated to the SRBR through December 31, 2022. As we indicated on page 23 of our December 31, 2022 actuarial valuation report for the Pension Plan, the Association had deferred investment losses of $794.1 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 losses of $794.1 million represent 7.7% of the market value of assets as of December 31, 2022. If a proportion of the net deferred loss that is commensurate with the size of the SRBR reserves were recognized immediately in the valuation value of assets, there would be a decrease in the SRBR Reserve of approximately $74.0 million to pay OPEB benefits and $3.6 million to pay non-OPEB benefits.[1]
- The funded ratio for the non-OPEB benefits is lower than for OPEB benefits because the Actuarial Value of Assets was initially allocated based on the benefit outflows for the OPEB and non-OPEB benefits. The benefit outflows for non-OPEB (in particular, the supplemental COLA) are “back loaded”, i.e., they are expected to be larger in later years than in earlier years. This results in a smaller asset allocation relative to liabilities for the non-OPEB benefits.
- Since there is a gap between the sufficiency periods of paying OPEB and non-OPEB benefits, we have addressed in a side letter what action may be considered by the Board before we complete the next sufficiency study as of December 31, 2023.
- Note that in preparing the 401(h) contribution letter for 2023/2024, we had included an additional allocation for expense 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.
- As stated earlier in this report, it is our understanding that GASB requires the OPEB benefits to be reported under GASB Statement No. 74 and accordingly they have been included in our GASB 74 report dated May 22, 2023. Similarly, we understand that GASB requires the non-OPEB benefits to be reported under GASB Statement No. 67 together with the underlying statutory defined benefit pension plan and accordingly they have been included in our GASB 67 report dated May 22, 2023.

[1] It is important to note that this actuarial valuation is based on plan assets as of December 31, 2022. 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. Moreover, this actuarial valuation does not include any possible short-term or long-term impacts on mortality of the covered population that may emerge after December 31, 2022 due to COVID-19. Segal is available to prepare projections of potential outcomes of market conditions and other demographic experience upon request.

Section 2: Valuation Results

- This revised report has been issued to correct typographical errors in the original report. The trend rates for Via Benefits and Kaiser Senior Advantage on page 31, and the trend rates for the Maximum Medical Allowance on page 32 have been updated. These were the only changes to the revised report.

Summary of OPEB Valuation Results

Without Limiting Liabilities to Current Assets	December 31, 2022	December 31, 2021
Actuarial Present Value of Projected Benefits		
• Medical	$1,289,873,000	$1,346,214,000
• Dental and Vision	138,523,000	141,026,000
• **Total**	**$1,428,396,000**	**$1,487,240,000**
Actuarial Accrued Liability[1]		
• Medical[2]	$1,046,564,000	$1,077,575,000
• Dental and Vision[3]	112,883,000	115,152,000
• **Total**	**$1,159,447,000**	**$1,192,727,000**
Actuarial Value of Assets (Exhibit B)	$1,114,705,000	$1,082,704,000
Unfunded Actuarial Accrued Liability	44,742,000	110,023,000
Funded Ratio	96.1%	90.8%
Year Current Assets will be Exhausted[4]	2050	2046

Note: The above results have been calculated using our understanding of the "substantive plan" as described in Exhibits 2 and 3. The liabilities provided in this report will have to be revised if our understanding of the "substantive plan" is inaccurate.

[1] These results will be used as the basis for the next GASB 74 valuation report based on a measurement date of December 31, 2023.

[2] Of the amount shown, $576.1 million is attributable to members currently receiving this benefit as of December 31, 2022 and $571.7 million is attributable to members receiving this benefit as of December 31, 2021. For treatment of implicit subsidy, see page 27.

[3] Of the amount shown, $65.6 million is attributable to members currently receiving this benefit as of December 31, 2022 and $65.5 million is attributable to members receiving this benefit as of December 31, 2021.

[4] Full 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.

Summary of Non-OPEB Valuation Results

Without Limiting Liabilities to Current Assets	December 31, 2022	December 31, 2021
Actuarial Present Value of Projected Benefits		
• Supplemental COLA	$205,679,000	$149,266,000
• Retiree Death Benefit	4,909,000	4,798,000
• **Total**	**$210,588,000**	**$154,064,000**
Actuarial Accrued Liability[1]		
• Supplemental COLA[2]	$184,796,000	$129,614,000
• Retiree Death Benefit	4,518,000	4,409,000
• **Total**	**$189,314,000**	**$134,023,000**
Actuarial Value of Assets (Exhibit B)	$54,901,000	$51,921,000
Unfunded Actuarial Accrued Liability	134,413,000	82,102,000
Funded Ratio	29.0%	38.7%
Year Current Assets will be Exhausted[3]	2038	2043

[1] These results will be used as the basis for the next GASB 67 valuation report based on a measurement date of December 31, 2023.

[2] Of the amount shown, $14.1 million is attributable to members currently receiving this benefit as of December 31, 2022 and $10.4 million is attributable to members receiving this benefit as of December 31, 2021.

[3] Full 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.

Projected Cash Flow and Present Value of Projected Benefits

Provided by the Supplemental Retiree Benefits Reserve as of December 31, 2022

Year Ending December 31	Annual Benefit Cash Flows			Present Value as of December 31, 2022 of Projected Benefits through Year End		
	Medical[1]	Dental and Vision	Non-OPEB[2]	OPEB[3]	Non-OPEB	Total
2023	$46,149,455	$5,866,797	$1,406,863	$50,286,009	$1,360,066	$51,646,075
2024	50,820,793	5,960,484	1,568,088	101,587,441	2,776,821	104,364,262
2025	54,364,329	6,056,299	1,730,968	152,605,718	4,238,424	156,844,142
2026	58,245,571	6,388,868	2,250,350	203,611,659	6,014,277	209,625,936
2027	62,055,030	6,726,820	2,927,964	254,339,555	8,173,705	262,513,260
2028	65,795,215	7,071,530	3,869,523	304,564,399	10,840,850	315,405,249
2029	69,610,898	7,421,067	4,887,367	354,186,645	13,989,181	368,175,826
2030	73,444,138	7,783,866	6,020,419	403,088,739	17,613,683	420,702,422
2031	77,331,823	8,157,315	7,138,568	451,189,154	21,630,195	472,819,349
2032	81,182,726	8,542,976	8,373,616	498,370,571	26,033,382	524,403,953
2033	85,319,500	8,937,420	9,693,737	544,692,174	30,797,270	575,489,444
2034	89,290,143	9,324,669	11,029,197	589,984,925	35,862,865	625,847,790
2035	93,193,773	9,706,801	12,291,130	634,154,232	41,138,741	675,292,973
2036	96,749,594	10,078,574	13,546,049	677,009,555	46,572,891	723,582,446
2037	100,319,834	10,456,808	15,130,578	718,541,610	52,245,603	770,787,213
2038	104,022,075	10,827,772	7,578,852[4]	758,783,824	54,901,156	813,684,980
2039	107,468,596	11,199,009	-	797,643,560	54,901,156	852,544,716
2040	110,891,118	11,554,163	-	835,117,206	54,901,156	890,018,362
2041	114,249,226	11,911,961	-	871,202,137	54,901,156	926,103,293
2042	117,524,659	12,262,161	-	905,895,542	54,901,156	960,796,698
2043	120,817,633	12,603,099	-	939,227,120	54,901,156	994,128,276
2044	123,904,064	12,934,441	-	971,176,108	54,901,156	1,026,077,264
2045	126,647,267	13,252,948	-	1,001,703,055	54,901,156	1,056,604,211
2046	129,163,309	13,555,749	-	1,030,807,760	54,901,156	1,085,708,916
2047	131,723,128	13,852,198	-	1,058,552,791	54,901,156	1,113,453,947
2048	133,599,488	14,130,672	-	1,084,866,547	54,901,156	1,139,767,703
2049	135,530,425	14,390,459	-	1,109,823,526	54,901,156	1,164,724,682
2050	28,354,062[4]	3,023,137[4]	-	1,114,705,105	54,901,156	1,169,606,261

[1] Includes Medicare Part B and Implicit Subsidy Reimbursement made to the County. For treatment of implicit subsidy, see page 27.
[2] Includes Supplemental COLA and $1,000 Lump Sum Death Benefit.
[3] Includes Medical, Dental and Vision.
[4] 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.

Actuarial Certification

September 25, 2023

This is to certify that Segal has conducted an actuarial valuation of certain benefit obligations of the Alameda County Employees' Retirement Association provided by the Supplemental Retiree Benefits Reserve for the year ending December 31, 2022, in accordance with generally accepted actuarial principles and practices. The actuarial valuation is based on the plan of benefits verified by the ACERA and on participant, claims and expense data provided by ACERA.

The actuarial computations made are for purposes of determining sufficiency of funds. Determinations for other purposes may be significantly different from the results reported here. Accordingly, additional determinations may be needed for other purposes such as judging benefit security at plan termination.

To the best of our knowledge, this report is complete and accurate and in our opinion presents the information necessary to determine the sufficiency of funds with respect to the benefit obligations addressed. The undersigned are members of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to render the actuarial opinion herein.

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

Mary Kirby, FSA, MAAA, FCA
Senior Vice President and Consulting Actuary

Section 3: Valuation Details

Exhibit A – Table of Plan Coverage – Members Receiving SRBR Benefits as of December 31, 2022

	Current Retirees
Category 1 – Medical	
• Number	6,876
• Average in force monthly medical reimbursements for 2023 (excluding Medicare Part B)	$388
• Average maximum (based on service at retirement) monthly medical reimbursements for 2023 (excluding Medicare Part B)	$533
• Monthly Medicare Part B premium reimbursements for 2023	$165
Category 1 - Supplemental COLA	
• Number	508
• Average monthly supplemental COLA for 2023[1]	$156
Category 2 – Dental and Vision	
• Number	8,272
• Average monthly medical reimbursements for 2023	$56
Category 2 – Retiree Death Benefit	
• Number[2]	Not Available
• Average lump sum benefits for 2023	$1,000

[1] Estimate of supplemental COLA payable as of December 31, 2022. The average benefit does not take into account any adjustments to the members' COLA banks as of April 2023.
[2] Beneficiaries who received the $1,000 lump sum retiree death benefit were not separately identified in the data provided for the pension valuation.

Exhibit B – Determination of Actuarial Value of Assets

Reserves Supporting SRBR Benefits	December 31, 2022	December 31, 2021
401(h) Account (Allocated to OPEB)	$8,979,000	$9,229,000
Supplemental Retiree Benefits Reserve		
• OPEB	$1,105,726,000[1]	$1,073,475,000[2]
• Non-OPEB	54,901,000	51,921,000
• SRBR Total	$1,160,627,000	$1,125,396,000
Total	**$1,169,606,000**	**$1,134,625,000**

Total Present Value of Projected SRBR Benefits Payable Through Terminal Year of the SRBR	December 31, 2022	December 31, 2021
Present Value of Projected OPEB Payable Through Terminal Year of the SRBR		
Medical	$1,006,774,000	$979,814,000
Dental and Vision	107,931,000	102,890,000
Total	**$1,114,705,000**	**$1,082,704,000**
Present Value of Projected Non-OPEB Payable Through Terminal Year of the SRBR		
Supplemental COLA	$51,920,000	$48,284,000
Retiree Death Benefit	2,981,000	3,637,000
Total	**$54,901,000**	**$51,921,000**
Grand Total	**$1,169,606,000**	**$1,134,625,000**

[1] Adjusted to reflect estimated transfer of $7,981,476 (provided by ACERA) from SRBR to employer advance reserve for reimbursement of implicit retiree health benefit subsidy for calendar year 2022.

[2] Adjusted to reflect estimated transfer of $5,652,613 (provided by ACERA) from SRBR to employer advance reserve for reimbursement of implicit retiree health benefit subsidy for calendar year 2021.

Section 4: Supporting Information

Exhibit 1 – Actuarial Assumptions and Actuarial Cost Method

Data:	Detailed census data and summary plan descriptions for postretirement benefits were provided by ACERA.
Rationale for Assumptions:	The information and analysis used in selecting each assumption that has a significant effect on this actuarial valuation is shown in the December 1, 2016 through November 30, 2019 Actuarial Experience Study report dated September 9, 2020, the non-trend retiree health assumption letter dated May 22, 2023, and the health trend assumptions letter dated May 17, 2023. Unless otherwise noted, all actuarial assumptions and methods shown below apply to all tiers. These assumptions were adopted by the Board.

Section 4: Supporting Information

Post-Retirement Mortality Rates - Healthy	*Healthy* • **General Members:** Pub-2010 General Healthy Retiree Amount-Weighted Above-Median Mortality Tables (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2019. • **Safety Members:** Pub-2010 Safety Healthy Retiree Amount-Weighted Above-Median Mortality Tables (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2019. *Disabled* • **General Members:** Pub-2010 Non-Safety Disabled Retiree Amount-Weighted Mortality Tables (separate tables for males and females) with rates decreased 10% for females, projected generationally with the two-dimensional mortality improvement scale MP-2019. • **Safety Members:** Pub-2010 Safety Disabled Retiree Amount-Weighted Mortality Tables (separate tables for males and females) with rates increased by 5% for males, projected generationally with the two-dimensional mortality improvement scale MP-2019. *Beneficiaries* • **All Beneficiaries:** Pub-2010 General Contingent Survivor Amount-Weighted Above-Median Mortality Tables (separate tables for males and females) with rates increased by 5% for males, projected generationally with the two-dimensional mortality improvement scale MP-2019. The above tables are used for the projection of non-OPEB benefits. The headcount weighted instead of the benefit (or amount) weighted mortality tables were used in the projections of OPEB benefits. The Pub-2010 mortality tables and adjustments as shown above reasonably reflect the mortality experience as of the measurement date. These mortality tables were adjusted to future years using the generational projection to reflect future mortality improvement between the measurement date and those years.

Section 4: Supporting Information

Pre-Retirement Mortality Rates

- **General Members:** Pub-2010 General Employee Amount-Weighted Above-Median Mortality Tables (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2019.
- **Safety Members:** Pub-2010 Safety Employee Amount-Weighted Above-Median Mortality Tables (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2019.

	Rate (%)			
	General[1]		Safety[1]	
Age	Male	Female	Male	Female
20	0.04	0.01	0.04	0.02
25	0.02	0.01	0.03	0.02
30	0.04	0.01	0.04	0.02
35	0.04	0.02	0.04	0.03
40	0.06	0.03	0.05	0.04
45	0.09	0.05	0.07	0.06
50	0.13	0.08	0.10	0.08
55	0.19	0.11	0.15	0.11
60	0.28	0.17	0.23	0.15
65	0.41	0.27	0.35	0.20

All pre-retirement deaths are assumed to be non-service connected.

[1] Generational projections beyond the base year (2010) are not reflected in the above mortality rates.

The above tables are used for the projection of non-OPEB benefits. The headcount weighted instead of the benefit (or amount) weighted mortality tables were used in the projections of OPEB benefits.

Section 4: Supporting Information

Disability Incidence:

Age	Rate (%) General	Rate (%) Safety
20	0.00	0.00
25	0.01	0.03
30	0.03	0.26
35	0.07	0.64
40	0.09	1.22
45	0.16	1.50
50	0.26	2.10
55	0.33	2.65
60	0.38	3.80

65% of General disabilities are assumed to be service connected disabilities. The other 35% are assumed to be non-service connected disabilities.

100% of Safety disabilities are assumed to be service connected disabilities.

Termination:

Years of Service	Rate (%) General	Rate (%) Safety
0-1	12.00	4.00
1-2	9.00	4.00
2-3	8.00	4.00
3-4	6.00	3.50
4-5	6.00	3.00
5-6	6.00	2.00
6-7	5.25	1.80
7-8	4.25	1.70
8-9	3.75	1.60
9-16	3.50	1.50
16-17	3.40	1.40
17-18	3.30	1.30
18-19	3.20	1.20
19-20	3.10	1.10
20 or more	3.00	1.00

For members with less than five years of service, 55% of all terminated members are assumed to choose a refund of contributions and the other 45% are assumed to choose a deferred vested benefit. For members with five or more years of service, 30% of all terminated members are assumed to choose a refund of contributions and the other 70% are assumed to choose a deferred vested benefit.

No termination is assumed after a member is eligible for retirement.

Section 4: Supporting Information

Retirement Rates:

	Rate (%)[1]									
	General					Safety				
		Tier 2[2]					Tier 2, 2D[2]			
Age	Tier 1	< 30	30+	Tier 3	Tier 4	Tier 1[3]	< 30	30+	Tier 2C[3]	Tier 4
49	0.0	0.0	0.0	0.0	0.0	0.0	12.0	18.0	0.0	0.0
50	2.0	2.0	4.0	10.0	0.0	35.0	12.0	18.0	4.0	4.0
51	4.0	2.0	4.0	10.0	0.0	30.0	10.0	24.0	2.0	2.0
52	4.0	2.0	4.0	10.0	4.0	25.0	10.0	24.0	2.0	2.0
53	5.0	2.0	4.0	10.0	2.0	35.0	10.0	25.0	3.0	3.0
54	5.0	2.0	4.0	10.0	2.0	45.0	12.0	27.0	6.0	6.0
55	6.0	2.0	4.0	12.0	5.0	45.0	12.0	29.0	10.0	10.0
56	10.0	2.5	4.5	14.0	2.5	45.0	14.0	32.0	12.0	12.0
57	12.0	4.0	5.0	16.0	3.5	45.0	16.0	32.0	20.0	20.0
58	12.0	4.0	5.0	18.0	3.5	45.0	18.0	30.0	10.0	10.0
59	14.0	4.5	8.0	20.0	4.5	45.0	18.0	30.0	15.0	15.0
60	20.0	8.0	8.5	20.0	5.0	45.0	25.0	30.0	60.0	60.0
61	20.0	9.0	13.5	20.0	5.0	45.0	25.0	30.0	60.0	60.0
62	35.0	15.0	22.5	30.0	18.0	45.0	25.0	30.0	60.0	60.0
63	30.0	15.0	22.5	25.0	15.0	45.0	25.0	30.0	60.0	60.0
64	30.0	18.0	27.0	25.0	17.0	45.0	30.0	30.0	60.0	60.0
65	30.0	25.0	27.5	50.0	25.0	100.0	100.0	100.0	100.0	100.0
66	30.0	30.0	33.0	50.0	30.0	100.0	100.0	100.0	100.0	100.0
67	30.0	30.0	33.0	50.0	30.0	100.0	100.0	100.0	100.0	100.0
68	30.0	30.0	33.0	50.0	30.0	100.0	100.0	100.0	100.0	100.0
69	35.0	35.0	38.5	50.0	35.0	100.0	100.0	100.0	100.0	100.0
70	40.0	40.0	40.0	65.0	25.0	100.0	100.0	100.0	100.0	100.0
71	40.0	40.0	40.0	65.0	25.0	100.0	100.0	100.0	100.0	100.0
72	40.0	40.0	40.0	65.0	25.0	100.0	100.0	100.0	100.0	100.0
73	40.0	40.0	40.0	65.0	25.0	100.0	100.0	100.0	100.0	100.0
74	40.0	40.0	40.0	65.0	25.0	100.0	100.0	100.0	100.0	100.0
75 & Over	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

[1] The retirement rates only apply to members that are eligible to retire at the age shown.

[2] Different retirement rates are assumed for General Tier 2 and Safety Tier 2 & 2D members who have accrued less than 30 years of service and those who have accrued at least 30 years of service.

[3] Retirement rate is 100% after a member accrues a benefit of 100% of final average earnings.

Section 4: Supporting Information

Retirement Age and Benefit for Deferred Vested Members:	General Retirement Age: 61 Safety Retirement Age: 55 Future deferred vested members who terminate with less than five years of service and are not vested are assumed to retire at age 70 for both General and Safety if they decide to leave their contributions on deposit. 25% of future General and 50% of future Safety deferred vested members are assumed to continue to work for a reciprocal employer. For reciprocals, 3.65% and 4.05% compensation increases are assumed per annum for General and Safety, respectively.
Measurement Date:	December 31, 2022
Discount Rate:	7.00%
Future Benefit Accruals:	1.0 year of service per year of employment, plus 0.003 years of additional service for General members and 0.007 years of additional service for Safety members, to anticipate conversion of unused sick leave for each year of employment.
Unknown Data for Members:	Same as those exhibited by members with similar known characteristics. If not specified, members are assumed to be male.
Inclusion of Deferred Vested Members:	All deferred vested members are included in the valuation.
Data Adjustments:	Data as of November 30 has been adjusted to December 31 by adding one month of age and, for active members, one month of service.
Percent Married for Pension:	70% of male members; 50% of female members.
Age and Gender of Spouse for Pension:	For all active and inactive 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 2 years older than the member.
Consumer Price Index:	Increase of 2.75% per year. Retiree COLA increases due to CPI are subject to a 2.75% maximum change per year for General Tier 1, General Tier 3, and Safety Tier 1, and 2% maximum change per year for General Tier 2, General Tier 4, Safety Tier 2, Safety Tier 2C, Safety Tier 2D, and Safety Tier 4. (For General Tier 1, General Tier 3, and Safety Tier 1 members with a sufficient COLA bank, withdrawals from the bank can be made to increase the retiree COLA up to 3% per year.) The actual COLA granted by ACERA on April 1, 2023 has been reflected in the December 31, 2022 valuation for nonactive members.
Increase in Internal Revenue Code Section 401(a)(17) Compensation Limit:	Increase of 2.75% per year from the valuation date.

Section 4: Supporting Information

Increase in Section 7522.10 Compensation Limit:

Increase of 2.75% per year from the valuation date.

Actuarial Cost Method:

Entry Age Actuarial Cost Method.

Salary Increases:

The annual rate of compensation increase includes:

- Inflation at 2.75%, plus
- "Across the board" salary increases of 0.50% per year, plus
- The following merit and promotion increases:

Years of Service	Rate (%)	
	General	Safety
0-1	5.10	8.00
1-2	5.10	8.00
2-3	4.50	8.00
3-4	2.90	4.90
4-5	2.10	3.70
5-6	1.60	2.10
6-7	1.50	1.30
7-8	1.50	1.20
8-9	1.00	0.90
9-10	0.90	0.90
10-11	0.70	0.80
11 & Over	0.40	0.80

Additional Cashout Assumptions:

Additional pay elements are expected to be received during a member's final average earnings period. The percentages, added to the final average salary, used in this valuation are:

	Service Retirement	Disability Retirement
General Tier 1	7.5%	6.5%
General Tier 2	3.0%	1.4%
General Tier 3	7.5%	6.5%
General Tier 4	N/A	N/A
Safety Tier 1	7.5%	6.4%
Safety Tier 2	2.5%	1.9%
Safety Tier 2C	2.5%	1.9%
Safety Tier 2D	2.5%	1.9%
Safety Tier 4	N/A	N/A

Section 4: Supporting Information

Per Capita Health Costs:

The combined monthly per capita dental and vision claims cost for plan year 2023 was assumed to be $55.87. The monthly Medicare Part B premium reimbursement for 2023 is $164.90. For calendar year 2023, medical costs for a retiree were assumed to be as follows:

Medical Plan[1]	Election Assumption	Monthly Premium	Maximum Monthly Medical Allowance[2]
Under Age 65[3]			
Kaiser HMO	75%	$909.74	$616.12
Via Benefits Individual Insurance Exchange[4]	13%	N/A	616.12
United Healthcare HMO Current Network	7%	1,290.92	616.12
United Healthcare HMO SVA Network	5%	843.94	616.12
Age 65 and Older			
Kaiser Senior Advantage	75%	$316.81	$616.12
Via Benefits Individual Insurance Exchange	25%	323.40[5]	471.99

(1) There are other plans available to retirees under age 65, and age 65 and older, that have a range of premiums. We have assumed the same costs as Kaiser HMO and Kaiser Senior Advantage for current non-Medicare and Medicare retirees, respectively.

(2) The Maximum Monthly Medical Allowance of $616.12 ($471.99 for retirees purchasing individual insurance from the Medicare exchange) is subject to the following subsidy schedule:

Completed Years of Service	Percentage Subsidized
10-14	50%
15-19	75%
20+	100%

(3) Current retirees under age 65 as well as future retirees are assumed to elect medical plans in the same proportion upon age 65 as current retirees who are age 65 and over.

(4) Via Benefits individual insurance coverage is available to retirees under age 65 residing outside of ACERA medical plans' coverage area. We have assumed that these current retirees under 65 will draw the Maximum Monthly Subsidy ($616.12).

(5) Derivation of the amount expected to be paid in 2022 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.

Section 4: Supporting Information

Per Capita Health Costs (continued):

		Derivation of Via Benefits Monthly Per Capita Costs		
	(Years of Service Category)	**10-14**	**15-19**	**20+**
1.	Maximum MMA for 2022	$228.57	$342.85	$457.13
2.	Total of Maximum MMA (From Jan. 2022 to Dec. 2022)	$511,893	$815,401	$5,136,604
3.	Total of Actual Reimbursement (From Jan. 2022 to Dec. 2022)	$374,455	$564,457	$3,101,877
4.	Ratio of Actual Reimbursement to Maximum 2022 MMA [(3) / (2)]	73.15%	69.22%	60.39%
5.	Average Monthly Per Capita Cost for 2022 [(1) x (4)]	$167.20	$237.32	$276.06
6.	Maximum MMA for 2023	$236.00	$353.99	$471.99
7.	Increase for Expected Medical Trend (6.50%) from 2022 to 2023 [(7) x 1.0650]	$178.07	$252.75	$294.00
8.	Increase for Additional 10% Margin for 2022 Expenses Incurred in 2022 but Reimbursed after December 2022 [(8) x 1.10]	**$195.88**	**$278.03**	**$323.40**

Section 4: Supporting Information

Per Capita Health Costs (continued):

Implicit Subsidy

We have estimated the average per capita premium for retirees under age 65 to be $11,240 per year. Because premiums for retirees under age 65 include active participants for purposes of underwriting, the retirees receive an implicit subsidy from the actives. Had the retirees under age 65 been underwritten as a separate group, their age-based premiums would be higher for most individuals. The excess of the age-based premium over the per capita premium charged makes up the subsidy. Below is a sample of the age-based costs for the retirees under age 65.

	Average Medical[1]	
	Retiree and Spouse	
Age	Male	Female
50	$11,435	$12,075
55	12,904	13,108
60	14,857	14,209
64	18,056	15,426

(1) Not all ACERA employers are receiving an implicit subsidy reimbursement from the Association. For SRBR sufficiency purposes, we have applied an adjustment of 0.86 (14% reduction of the costs shown above) for our projected implicit subsidy payments to account for this fact, based on data provided by the County of Alameda's health consultant. For calculating the Actuarial Present Value of Projected Benefits and Actuarial Accrued Liability, we have not applied the adjustment.

Section 4: Supporting Information

Per Capita Health Costs (continued):

2023 medical and prescription drug age-based claims costs for retirees age 65 and over are shown below at selected ages:

	Kaiser Senior Advantage			
	Retiree		Spouse	
Age	Male	Female	Male	Female
65	$3,614	$3,002	N/A[2]	N/A[2]
70	4,059	3,358	N/A[2]	N/A[2]
75	4,484	3,530	N/A[2]	N/A[2]
80+	4,695	3,768	N/A[2]	N/A[2]

	Via Benefits			
	Retiree		Spouse	
Age	Male	Female	Male	Female
65	$3,613	$3,001	N/A[2]	N/A[2]
70	4,058	3,357	N/A[2]	N/A[2]
75	4,483	3,529	N/A[2]	N/A[2]
80+	4,694	3,767	N/A[2]	N/A[2]

[2] Spouses are only eligible for the implicit subsidy while under age 65.

Section 4: Supporting Information

Participation and Coverage Election Retired Members & Beneficiaries:

MMA

MMA on Record

	Under Age 65	Upon Attaining Age 65
Current Retirees Under 65 on Valuation Date	100%	100% and assumed to choose carrier in same proportion as future retirees
Current Retirees 65 & Over on Valuation Date	N/A	100%

No MMA on Record

	Under Age 65	Upon Attaining Age 65
Less than 10 Years of Service	0%	0%
10+ Years of Service		
• Current Retirees Under 65 on Valuation Date	0%	50%
• Current Retirees 65 & Over on Valuation Date	N/A	0%

Medicare Part B Premium Subsidy

MMA on Record

	Under Age 65	Upon Attaining Age 65
Current Retirees Under 65 on Valuation Date	N/A	100%
Current Retirees 65 & Over on Valuation Date	N/A	100% if Part B reimbursement on record or purchasing individual insurance from the Medicare exchange

No MMA on Record

	Under Age 65	Upon Attaining Age 65
Less than 10 Years of Service	N/A	0%
10+ Years of Service		
• Current Retirees Under 65 on Valuation Date	N/A	50%
• Current Retirees 65 & Over on Valuation Date	N/A	0%

Implicit Subsidy

Current retirees, married dependents and surviving beneficiaries under age 65 and enrolled in an ACERA non-Medicare plan are assumed to have an implicit subsidy liability.

Dental and Vision Subsidy

Current retirees not self-paying ("Voluntary" or "Under 10 YOS" dental or vision code).

Section 4: Supporting Information

Participation and Coverage Election – Active & Inactive Vested Members:		
Medical Plan Subsidy (i.e., MMA)	**Under Age 65**	**Upon Attaining Age 65**
	80% of eligible members	90% of eligible members
Part B Subsidy	**Under Age 65**	**Upon Attaining Age 65**
	80% of eligible members (disabled only)	90% of eligible members
Implicit Subsidy	70% of eligible members under age 65 are assumed to have an implicit subsidy liability. In other words, 87% of the non-Medicare retirees who receive a Medical Plan Subsidy (which equals the sum of the percentages of members enrolled in all except the Via Benefits Individual Exchange of 13% as provided on page 25) were assumed to enroll in an ACERA sponsored health plan.	
Dental and Vision Subsidy	100% of eligible members.	

Section 4: Supporting Information

Health Care Cost Trend Rates:

Health care trend measures the anticipated overall rate at which health plan costs are expected to increase in future years. The rates shown below are "net" and are applied to the net per capita costs shown above. The trend shown for a particular plan year is the rate that is to be applied to the premium for the shown calendar year to calculate the next calendar year's projected premium. For example, the projected 2024 calendar year premium for Kaiser (under age 65) is $1,037.76 per month ($909.74 increased by 14.07%).

Calendar Year	United Healthcare HMO & Kaiser HMO Early Retiree[2]	Via Benefits & Kaiser Senior Advantage[3]	Dental[4]	Vision[5]	Medicare Part B
2023	7.50%[1]	6.25%[1]	4.00%[1]	0.00%	4.50%
2024	7.25	6.00	0.00	0.00	4.50
2025	7.00	5.75	4.00	4.00	4.50
2026	6.75	5.50	4.00	4.00	4.50
2027	6.50	5.25	4.00	4.00	4.50
2028	6.25	5.00	4.00	4.00	4.50
2029	6.00	4.75	4.00	4.00	4.50
2030	5.75	4.50	4.00	4.00	4.50
2031	5.50	4.50	4.00	4.00	4.50
2032	5.25	4.50	4.00	4.00	4.50
2033	5.00	4.50	4.00	4.00	4.50
2034	4.75	4.50	4.00	4.00	4.50
2035 & Later	4.50	4.50	4.00	4.00	4.50

(1) The actual trends are shown below, based on premium renewals for 2024 as reported by ACERA.

Kaiser HMO Early Retiree	United Healthcare HMO Signature Value Early Retiree	United Healthcare HMO Signature Value Advantage Early Retiree	Kaiser Senior Advantage	Dental	Vision
14.07%	18.02%	18.01%	11.84%	-0.37%	0.00%

(2) Non-Medicare plans.

(3) Medicare plans.

(4) Second year reflects two-year rate guarantee, premiums fixed at 2024 level.

(5) First two years reflect five-year rate guarantee, premiums fixed at 2021 level.

Section 4: Supporting Information

Assumed Increase in Annual Maximum Benefits:	For the "substantive plan design" shown in this report, we have assumed: 1. Maximum medical allowance for ACERA sponsored plans and individual out-of-area non-Medicare plans for 2024 will increase to $635.37 per month ($486.74 for individual Medicare plans), then increase with 50% of trend for medical plans, or 3.00%, graded down to the ultimate rate of 2.25% over 6 years. 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 trend. 3. Medicare B premium reimbursement will increase with full trend.
Dependents:	Demographic data was available for spouses of current retirees. For future retirees, male members were assumed to be three years older than their wives, and female members were assumed to be one year younger than their husbands. Of the future retirees who elect to continue their medical coverage at retirement, 40% males and 20% females were assumed to have an eligible spouse who also opts for health coverage at that time. These assumptions are based on historical and current demographic data, adjusted to reflect the plan design, estimated future experience and professional judgment. Please note that these assumptions are only used to determine the cost of the implicit subsidy.
Plan Design:	Development of plan liabilities was based on the plan of benefits in effect as described in Exhibits 2 and 3.
Administrative Expenses:	An administrative expense load was not added to projected incurred claim costs in developing per capita health costs.
Missing Participant Data:	Any missing census items for a given participant was set to equal to the average value of that item over all other participants of the same membership status for whom the item is known.

Exhibit 2 – Summary of Benefits

This exhibit summarizes the major benefit provisions as included in the valuation. To the best of our knowledge, the summary represents the substantive plan provisions as of the measurement date. It is not intended to be, nor should it be interpreted as, a complete statement of all benefit provisions.

Eligibility:	
Service Retirees:	Retired with at least 10 years of service (including deferred vested members who terminate employment and receive a retirement benefit from ACERA).
Disabled Retirees:	A minimum of 10[1] years of service is required for non-duty disability. There is no minimum service requirement for duty disability.
Other Postemployment Benefits (OPEB):	
Monthly Medical Allowance	
Service Retirees:	For retirees, a Maximum Monthly Medical Allowance of $616.12 per month is provided, effective January 1, 2023 and through December 31, 2023. For the period January 1, 2024 through December 31, 2024, the maximum allowance will increase to $635.37 per month for retirees who are not purchasing individual insurance through the Medicare exchange. For those purchasing individual insurance through the Medicare exchange, the Monthly Medical Allowance is $471.99 per month for 2023 and will increase to $486.74 per month in 2024. These Allowances are subject to the following subsidy schedule:

Completed Years of Service	Percentage Subsidized
10-14	50%
15-19	75%
20+	100%

Disabled Retirees:	Non-duty disabled retirees receive the same Monthly Medical Allowance as service retirees. Duty disabled retirees receive the same Monthly Medical Allowance as those service retirees with 20 or more years of service.

[1] The 10 years of service requirement is only used for determining eligibility for health benefits. For pension benefits, the eligibility requirements is 5 years of service.

Section 4: Supporting Information

Medicare Benefit Reimbursement Plan:	The SRBR reimburses the full Medicare Part B premium to qualified retired members. To qualify for reimbursement, a retiree must: • Have at least 10 years of ACERA service, • Be eligible for Monthly Medical Allowance, • Provide proof of enrollment in Medicare Part B.
Dental and Vision Plans:	The SRBR provides dental and vision benefits for retirees only. The maximum combined monthly dental and vision premiums are $55.87 in 2023 and $55.68 in 2024. The eligibility for these premiums is as follows.
Service Retirees:	Retired with at least 10 years of service.
Disabled Retirees:	For non-duty disabled retirees, 10 years of service is required. For grandfathered non-duty disabled retirees (with effective retirement dates on or before January 31, 2014), there is no minimum service requirement. For duty disabled retirees, there is no minimum service requirement.
Note about Monthly Medical Allowance:	The maximum levels of subsidy are reviewed by the Board annually and are not indexed to increase automatically. In addition, the Monthly Medical Allowance can only be used to pay for retiree medical benefits. There is no benefit payable to beneficiaries, current spouses, former spouses or dependents. If the actual cost of coverage is less than the Monthly Medical Allowance, the difference is not paid in cash or applied towards the coverage for beneficiaries, current spouses, former spouses or dependents.
Deferred Benefit:	Members who terminate employment with 10 or more years of service before reaching Pension eligibility commencement age may elect deferred MMA and/or dental/vision benefits.
Death Benefit:	Surviving spouses/domestic partners of members who die before the member commences retiree health benefits may enroll in an ACERA group medical plan on the date that the member would have been eligible to commence benefits. The surviving spouse/domestic partner must pay 100% of the premium. Because premiums for surviving spouses/domestic partners under age 65 include active participants for purposes of underwriting, the surviving spouses/domestic partners receive an implicit subsidy from the actives, which creates a liability for the SRBR.

Section 4: Supporting Information

Non-OPEB Benefits:	
Supplemental COLA	When inflation is higher than the ACERA cost of living allowance for a year, the excess of inflation over the cost of living allowance (3% for Tier 1 and Tier 3, and 2% for Tier 2, Tier 2C, Tier 2D, and Tier 4) is banked for future years when inflation may be less than the cost of living allowance. In 1998, the Board of Retirement approved a supplemental COLA payable through the SRBR for members whose COLA banks exceeded 15%. The supplemental COLA for a year is equal to the percentage of excess of the member's COLA bank over 15% times the member's current annual retirement allowance. The cost of living adjustment and any supplemental COLA must be approved yearly by the ACERA Board of Retirement. For this valuation, we have assumed the Board will maintain its current level of supplemental COLA (i.e., COLA banks will not exceed 15%) during the projection period.
Retired Member Death Benefit	A one-time $1,000 lump sum retiree death benefit is payable to the beneficiary of a retiree. This benefit is only paid upon the death of a retiree; it is not paid upon the death of a beneficiary.

Exhibit 3 – Assumptions About the "Substantive Plan"

The determination of the "substantive plan" underlying ACERA's OPEB was based upon prior directions provided by ACERA, its auditors, as well as the administrative staff, auditors and consultants representing the County of Alameda. Those directions are provided below.

1. **Commitment to provide benefits currently paid out of the SRBR**

   We understand that health and other supplemental benefits currently paid out of the SRBR will continue to be paid as long as there are assets available in the SRBR. However, when the assets in the SRBR are fully depleted, no additional health and other supplemental benefits will be paid by the Association and the employer. To our knowledge, the employer has not made any implicit or explicit commitment to continue those benefits.

2. **Continuation of coverage in the employer's active employee medical plans for the Association's retirees**

   Currently, the Association's retirees are enrolled in the same medical plans as the employer's active employees. The retiree experience is pooled and used in setting the medical plan premium rates for active employee. The Association has begun in 2007 to reimburse the County for the adverse premium experience created by the retirees.

   In this study, for purposes of determining sufficiency of funds we have included the liability associated with reimbursing the County for the adverse premium experience but only through the period up to the exhaustion of assets in the SRBR. In other words, there may be a residual liability to the employer if the Association's retirees continue to participate, and are rated together in the employer's active employee medical plans.

3. **Fully indexed subsidies for dental, vision and Medicare Part B premium and increase at one-half of the rate of increase for monthly medical allowance (MMA)**

   Following guidelines provided by the Board and ACERA, we have assumed in this study that the OPEB Plan will reimburse the fully indexed premium required for dental, vision and for a retiree to enroll in Medicare Part B. In addition, we have assumed in this study that future MMA will increase at one-half of the rate of our anticipated medical inflation assumptions.

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