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, 2019

Segal

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September 23, 2020

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, 2019. 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 27, 2020. 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 27, 2020, together with the statutory pension benefits.

The December 31, 2019 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 I and on the plan of benefits as summarized in Exhibit II.

The actuarial calculations were completed under the supervision of Eva Yum, FSA, MAAA, Enrolled Actuary and Thomas Bergman, ASA, MAAA, Enrolled Actuary. 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 & Actuary

Eva Yum, FSA, MAAA, EA
Senior Actuary

Thomas Bergman, ASA, MAAA, EA
Retiree Health Actuary

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Section 1: Introduction

Purpose

I. Other Postemployment Benefits (OPEB)

This report presents the results of our actuarial valuation as of December 31, 2019 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 2021. 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, 2020.

II. 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, 2020.

[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, 2019 GASB 74 report dated May 27, 2020.

[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, 2019 GASB 67 report dated May 27, 2020.

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 of Benefits	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 data	An actuarial valuation for a plan is based on data provided to the actuary by the Association. 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.
Assets	This valuation is based on the market value of assets as of the valuation date, as provided by the Association. The Association uses a "Valuation Value of Assets" that differs from market value to gradually reflect six-month changes in the Market 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 projects the benefits to be paid to existing plan participants for the rest of their lives and the lives of their beneficiaries. This projection requires actuarial assumptions as to the probability of death, disability, termination, and retirement of each participant for each year. In addition, the benefits projected to be paid 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 projected benefits are then discounted to a present value, based on the assumed rate of return that is expected to be achieved on the plan's assets. There is a reasonable range for each assumption used in the projection and the results may vary materially based on which assumptions are selected. It is important for any user of an actuarial valuation to understand this concept. Actuarial assumptions are periodically reviewed to ensure that future valuations reflect emerging plan experience. While future changes in actuarial assumptions may have a significant impact on the reported results, that does not mean that the previous assumptions were unreasonable.

Section 1: Introduction

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 of the plan's assets and liabilities at a specific date. Accordingly, except where otherwise noted, Segal did not perform an analysis of the potential range of future financial measures. 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.
- If the Association 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.
- 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.

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

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, 2019 pension valuation, including the use of a 7.25% investment return assumption.
- In the last SRBR valuation, we utilized the following medical trend assumptions:
  - All non-Medicare plans: starting at 7.00% (before increasing the first year trend by 1.20% to reflect the reinstatement of the Health Insurance Tax (HIT)[1]) for 2019 to 2020, reduced by 0.25% for each year until it reaches 4.50% after 10 years.
  - All Medicare Advantage plans: starting at 6.50% (before increasing the first year trend by 0.90% to reflect the reinstatement of the HIT[1]) for 2019 to 2020, 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 6, 2020 that the medical trend assumptions be revised to the following:
  - All non-Medicare plans: starting at 6.75% (before decreasing the first year trend by 1.20% to reflect the repeal of the HIT[2]) for 2020 to 2021[3], reduced by 0.25% for each year until it reaches 4.50% after 8 years.
  - All Medicare Advantage plans: starting at 6.25% (before decreasing the first year trend by 0.90% to reflect the repeal of the HIT[2]) for 2020 to 2021[3], reduced by 0.25% for each year until it reaches 4.50% after 6 years.
- The Board acted to leave the 2021 Monthly Medical Allowance (MMA) unchanged from 2020 in July 2020. The maximum MMA for ACERA sponsored plans and individual (out-of-area) non-Medicare plans remains at $578.65 and the maximum MMA for individual Medicare plans remains at $443.28, for 2021.
- For years after 2021 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 I.
- 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

[1] The HIT was imposed by the Affordable Care Act (ACA) on some health insurance companies. Congressional budgetary actions placed a moratorium on these fees for calendar years 2017 and 2019. Segal understands that these fees were reflected in premiums for calendar year 2020.

[2] The repeal of certain aspects of the ACA at the end of 2020 removes the HIT effective calendar 2021.

[3] After we released our preliminary high-level summary letter dated May 6, 2020, the Association approved premiums for 2021. We have used those actual 2021 premiums in this study in lieu of estimating those premiums by using the 5.55% (6.75% minus 1.20% for removal of the HIT) assumption for non-Medicare plans and the 5.35% (6.25% minus 0.90% for removal of the HIT) assumption for Medicare plans.

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 III.

- 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, 2019.
- The terminal year of the SRBR was determined by projecting how long the SRBR can provide for all non-OPEB and OPEB benefits under the substantive plan outlined in Exhibit III. OPEB benefits can be paid through 2040[4], while non-OPEB benefits can be paid through 2037[4]. Last year, it was projected that OPEB benefits could be paid through 2040 and non-OPEB benefits could be paid through 2036.

  Note that the OPEB sufficiency period has changed from that originally shown of through 2039 in our May 6, 2020 preview letter. Our preview letter estimated medical plan premiums and subsidies for 2021 and future years using our trend assumption. Subsequent to our issuing the preview letter, ACERA reported the 2021 medical plan premium renewals and subsidies and we have used the actual 2021 premiums and subsidies in our updated projection shown herein. On average, the premium increases for non-Medicare plans (3.60%) were lower than our expected 5.55% increase from 2020 to 2021, and the premium change (a decrease of 7.13%) for the Medicare plan (Kaiser Senior Advantage) was much lower than our expected 5.35% increase from 2020 to 2021.
- The main reason the terminal year of the SRBR for non-OPEB benefits is projected to be one year later than it was in last year's study is the somewhat low actual inflation of 2.45% in the Bay Area from 2018 to 2019 (versus the inflation assumption of 3.00%), which decreased the supplemental COLA costs. For supplemental COLA benefits, the excess of inflation over the cost of living allowance (i.e., 3.00% for Tiers 1 and 3, and 2.00% for Tiers 2, 2C, 2D, and 4) is banked for future years when inflation may be less than the cost of living allowance. A supplemental COLA benefit would be paid when a member's COLA bank exceeds 15%. Due to the actual inflation of 2.45% in 2019 for the San Francisco-Oakland-Hayward Area, the April 1, 2020 COLA banks decreased by 0.50% for Tiers 1 and 3 and increased by 0.50% for Tiers 2, 2C, 2D, and 4 over the banks as of the prior year. Based on the inflation assumption of 3.00%, the April 1, 2020 COLA banks for Tiers 1 and 3 were expected to remain at the same level and the April 1, 2020 COLA banks for Tiers 2, 2C, 2D and 4 were expected to increase by 1.00%. Since the COLA banks have either decreased (for Tiers 1 and 3) or increased by a lower than expected amount (for Tiers 2, 2C, 2D, and 4), it is expected to take more time for members to accumulate a bank in excess of 15%, which results in a decrease in the present value of providing supplemental COLA benefits. Moreover, the supplemental COLA benefit is decreased for Tiers 1 and 3 retired members and beneficiaries who already have a COLA bank in excess of 15% (i.e., a decrease of 0.50%). For Tiers 2, 2C, 2D and 4 retired

[4] Assets would only be sufficient to pay benefits for a part of the year indicated.

members and beneficiaries who already have a COLA bank in excess of 15%, the supplemental COLA benefit is increased by 0.50%, which is lower than our assumption.

- The funded ratio of the OPEB liabilities is 82.7% The funded ratio of the non-OPEB liabilities is 20.7% The comparable funded ratios were 87.6% and 21.7% for the OPEB and non-OPEB liabilities, respectively, as of December 31, 2018.
- 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, 2019. As we indicated on page 22 of our December 31, 2019 actuarial valuation report for the Pension Plan, the Association had deferred investment gains of $260.7 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 $260.7 million represent 3.0% of the market value of assets as of December 31, 2019. If one-half of the net deferred gain after restoring the Contingency Reserve to 1% of total assets were recognized immediately in the valuation value of assets, there would be an increase in the SRBR Reserve of approximately $82.0 million to pay OPEB benefits and $3.8 million to pay non-OPEB benefits.[5]
- 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.
- Note that in preparing the 401(h) contribution letter for 2020/2021, 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.
- Previously, the projected payments did not include any excise tax on high cost medical plans because we did not believe the amount of MMA subsidy paid by ACERA would be above the threshold for those plans (“Cadillac” plans) imposed by the Affordable Care Act and related statutes. In this year’s calculation, we have continued to exclude such excise tax especially with the recent repeal of that tax for all plans.[6]
- 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 27, 2020. Similarly, we understand

[5] It is important to note that the December 31, 2019 actuarial valuation is based on plan assets as of that same date. Due to the COVID-19 pandemic, market conditions have changed significantly since the valuation 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. While it is impossible to determine how the market will perform over the next several months, and how that will affect the results of next year’s valuation, Segal is available to prepare projections of potential outcomes upon request.

[6] The excise tax on high-cost health plans was repealed effective December 20, 2019.

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 27, 2020.

- The Coronavirus (COVID-19) pandemic is rapidly evolving and is having a significant impact on the US economy in 2020, including most OPEB plans, and will likely continue to have an impact in the future. Our results do not include the impact of the following:
  - Changes in the market value of plan assets since December 31, 2019
  - Changes in interest rates since December 31, 2019
  - Short-term or long-term impacts on mortality of the covered population
  - The potential for federal or state fiscal relief
  - Short-term increases in health plan costs related to the testing or treatment of COVID-19

Each of the above factors could significantly impact these results. The above factors generally will not have an impact on the December 31, 2019 valuation, since that is based on a snapshot of assets and liabilities prior to recent events. Given the high level of uncertainty and fluidity of the current events, you may wish to consider updated estimates to monitor the plan's financial status. We will keep you updated on emerging developments.

Summary of OPEB Valuation Results

Without Limiting Liabilities to Current Assets	December 31, 2019[1]	December 31, 2018
Actuarial Present Value of Projected Benefits		
• Medical	$1,211,903,000	$1,119,902,000
• Dental and Vision	113,758,000	108,777,000
• **Total**	**$1,325,661,000**	**$1,228,679,000**
Actuarial Accrued Liability		
• Medical[2]	$980,968,000	$918,842,000
• Dental and Vision[3]	93,224,000	88,739,000
• **Total**	**$1,074,192,000**	**$1,007,581,000**
Actuarial Value of Assets (Exhibit B)	$888,184,000	$883,013,000
Unfunded Actuarial Accrued Liability	186,008,000	124,568,000
Funded Ratio	82.7%	87.6%
Year Current Assets will be Exhausted[4]	2040	2040

Note: The above results have been calculated using our understanding of the "substantive plan" as described in Exhibits II and III. 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, 2020.

[2] Of the amount shown, $546.3 million is attributable to members currently receiving this benefit as of December 31, 2019 and $517.8 million is attributable to members receiving this benefit as of December 31, 2018. For treatment of implicit subsidy, see page 23.

[3] Of the amount shown, $53.8 million is attributable to members currently receiving this benefit as of December 31, 2019 and $50.8 million is attributable to members receiving this benefit as of December 31, 2018.

[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, 2019[1]	December 31, 2018
Actuarial Present Value of Projected Benefits		
• Supplemental COLA	$231,434,000	$216,613,000
• Retiree Death Benefit	4,621,000	4,510,000
• **Total**	**$236,055,000**	**$221,123,000**
Actuarial Accrued Liability		
• Supplemental COLA[2]	$191,303,000	$177,506,000
• Retiree Death Benefit	4,246,000	4,134,000
• **Total**	**$195,549,000**	**$181,640,000**
Actuarial Value of Assets (Exhibit B)	$40,430,000	$39,366,000
Unfunded Actuarial Accrued Liability	155,119,000	142,274,000
Funded Ratio	20.7%	21.7%
Year Current Assets will be Exhausted[3]	2037	2036

[1] These results will be used as the basis for the next GASB 67 valuation report based on a measurement date of December 31, 2020.

[2] Of the amount shown, $10.9 million is attributable to members currently receiving this benefit as of December 31, 2019 and $9.9 million is attributable to members receiving this benefit as of December 31, 2018.

[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, 2019

	Annual Benefit Cash Flows			Present Value as of December 31, 2019 of Projected Benefits through Year End		
Year Ending December 31	Medical[1]	Dental and Vision	Non-OPEB[2]	OPEB[3]	Non-OPEB	Total
2020	$50,491,551	$4,558,913	$1,279,969	$53,157,229	$1,235,950	$54,393,179
2021	51,017,914	4,831,244	1,253,808	103,440,171	2,364,797	105,804,968
2022	54,389,529	5,115,547	1,250,242	153,393,077	3,414,341	156,807,418
2023	58,203,351	5,408,661	1,263,801	203,183,817	4,403,550	207,587,367
2024	61,965,084	5,713,725	1,269,333	252,576,754	5,329,927	257,906,681
2025	65,796,411	6,020,941	1,286,020	301,446,968	6,205,037	307,652,005
2026	69,665,279	6,336,489	1,534,688	349,668,526	7,178,765	356,847,291
2027	73,507,816	6,658,181	2,015,419	397,093,864	8,371,065	405,464,929
2028	77,086,134	6,986,210	2,889,875	443,468,029	9,965,115	453,433,144
2029	80,591,816	7,316,764	4,172,782	488,680,361	12,111,222	500,791,583
2030	84,199,511	7,660,832	5,601,044	532,731,425	14,797,169	547,528,594
2031	87,978,062	8,008,122	7,089,573	575,649,454	17,967,109	593,616,563
2032	91,390,153	8,348,811	8,735,371	617,230,804	21,608,901	638,839,705
2033	95,103,780	8,696,035	10,570,616	657,579,827	25,717,906	683,297,733
2034	98,544,977	9,031,101	12,338,814	696,569,971	30,190,017	726,759,988
2035	101,708,635	9,364,250	14,069,535	734,106,135	34,944,700	769,050,835
2036	104,712,293	9,688,568	16,007,240	770,153,526	39,988,537	810,142,063
2037	107,524,141	10,006,907	1,501,838[4]	804,683,785	40,429,772	845,113,557
2038	110,509,662	10,315,540	-	837,782,221	40,429,772	878,211,993
2039	113,022,770	10,620,636	-	869,363,055	40,429,772	909,792,827
2040	72,205,877[4]	6,826,047[4]	-	888,184,713	40,429,772	928,614,485

[1] Includes Medicare Part B and Implicit Subsidy Reimbursement made to the County. For treatment of implicit subsidy, see page 23.
[2] Includes Supplemental COLA and $1,000 Lump Sum Death Benefit.
[3] Includes Medical, Dental, and Vision.
[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.

Actuarial Certification

September 23, 2020

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, 2019, 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 the 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. The health assumptions were selected under the supervision of Paul Sadro, ASA, MAAA.

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
Senior Actuary

Thomas Bergman, ASA, MAAA, EA
Retiree Health Actuary

Section 3: Valuation Details

Exhibit A – Table of Plan Coverage – Members Receiving SRBR Benefits as of December 31, 2019

	Current Retirees
Category 1 – Medical	
• Number	6,575
• Average in force monthly medical reimbursements for 2020 (excluding Medicare Part B)	$427
• Average maximum (based on service at retirement) monthly medical reimbursements for 2020 (excluding Medicare Part B)	$501
• Monthly Medicare Part B premium reimbursements for 2020	$145
Category 1 - Supplemental COLA	
• Number	476
• Average monthly supplemental COLA for 2020[1]	$203
Category 2 – Dental and Vision	
• Number	7,741
• Average monthly medical reimbursements for 2020	$46
Category 2 – Retiree Death Benefit	
• Number[2]	Not Available
• Average lump sum benefits for 2020	$1,000

[1] Estimate of supplemental COLA payable as of December 31, 2019. The average benefit does not take into account any adjustments to the members' COLA banks as of April 2020.
[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, 2019	December 31, 2018
401(h) Account (Allocated to OPEB)	$10,415,000	$9,830,000
Supplemental Retiree Benefits Reserve		
• OPEB	$877,769,000[1]	$873,183,000[2]
• Non-OPEB	40,430,000	39,366,000
• SRBR Total	$918,199,000	$912,549,000
Total	**$928,614,000**	**$922,379,000**

Total Present Value of Projected SRBR Benefits Payable Through Terminal Year of the SRBR	December 31, 2019	December 31, 2018
Present Value of Projected OPEB Payable Through Terminal Year of the SRBR		
Medical	$813,352,000	$808,482,000
Dental and Vision	74,832,000	74,531,000
Total	**$888,184,000**	**$883,013,000**
Present Value of Projected Non-OPEB Payable Through Terminal Year of the SRBR		
Supplemental COLA	$37,325,000	$36,297,000
Retiree Death Benefit	3,105,000	3,069,000
Total	**$40,430,000**	**$39,366,000**
Grand Total	**$928,614,000**	**$922,379,000**

[1] Adjusted to reflect estimated transfer of $6,510,876 (provided by ACERA) from SRBR to employer advance reserve for reimbursement of implicit retiree health benefit subsidy for calendar year 2019.

[2] Adjusted to reflect estimated transfer of $6,939,808 (provided by ACERA) from SRBR to employer advance reserve for reimbursement of implicit retiree health benefit subsidy for calendar year 2018.

Section 4: Supporting Information

Exhibit I – 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, 2013 through November 30, 2016 Actuarial Experience Study report dated September 6, 2017, and in our letters both dated May 6, 2020 regarding the health trend assumptions and regarding the recommended parameters to reflect the demographic driven changes, for the December 31, 2019 SRBR retiree health actuarial valuation. Unless otherwise noted, all actuarial assumptions and methods shown below apply to all tiers. These assumptions were adopted by the Board.
Post-Retirement Mortality Rates - Healthy	*Healthy* • **General Members and All Beneficiaries:** Headcount-Weighted RP-2014 (RPH-2014) Healthy Annuitant Mortality Tables, with no setback for males and females, projected generationally with the two-dimensional MP-2016 projection scale. • **Safety Members:** Headcount-Weighted RP-2014 (RPH-2014) Healthy Annuitant Mortality Tables, with no setback for males and females, projected generationally with the two-dimensional MP-2016 projection scale. *Disabled* • **General Members:** Headcount-Weighted RP-2014 (RPH-2014) Healthy Annuitant Mortality Tables, set forward seven years for males and set forward four years for females, projected generationally with the two-dimensional MP-2016 projection scale. • **Safety Members:** Headcount-Weighted RP-2014 (RPH-2014) Healthy Annuitant Mortality Tables, set forward two years for males and with no set forward for females, projected generationally with the two-dimensional MP-2016 projection scale. The RPH-2014 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 and Safety Members:** Headcount-Weighted RP-2014 (RPH-2014) Employee Mortality Tables multiplied by 80%, projected generationally with the two-dimensional MP-2016 projection scale.

	Rate (%)			
	General[1]		Safety[1]	
Age	Male	Female	Male	Female
20	0.05	0.02	0.05	0.02
25	0.05	0.02	0.05	0.02
30	0.05	0.02	0.05	0.02
35	0.05	0.03	0.05	0.03
40	0.06	0.04	0.06	0.04
45	0.10	0.07	0.10	0.07
50	0.17	0.11	0.17	0.11
55	0.27	0.17	0.27	0.17
60	0.45	0.24	0.45	0.24
65	0.78	0.36	0.78	0.36

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

[1] Generational projections beyond the base year (2014) are not reflected in the above mortality rates.

Disability Incidence:

	Rate (%)	
Age	General	Safety
20	0.00	0.00
25	0.01	0.03
30	0.03	0.26
35	0.05	0.58
40	0.08	0.73
45	0.19	0.78
50	0.31	1.52
55	0.38	2.00
60	0.43	2.60

60% of General disabilities are assumed to be service connected disabilities. The other 40% are assumed to be non-service connected disabilities.

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

Section 4: Supporting Information

Termination:

Less Than Five Years of Service

Years of Service	Rate (%)	
	General	Safety
0-1	11.00	4.00
1-2	9.00	3.50
2-3	8.00	3.50
3-4	6.00	2.50
4-5	6.00	2.00

60% of all terminated members with less than 5 years of service are assumed to choose a refund of contributions. The other 40% are assumed to choose a deferred vested benefit.

Five or More Years of Service

Age	Rate (%)	
	General	Safety
20	6.00	2.00
25	6.00	2.00
30	5.40	2.00
35	4.40	1.70
40	3.40	1.20
45	3.00	1.00
50	3.00	1.00
55	3.00	1.00
60	3.00	0.40

35% of all terminated members with 5 or more years of service are assumed to choose a refund of contributions. The other 65% are assumed to choose a deferred vested benefit.

No termination is assumed after a member is eligible for retirement (as long as a retirement rate is present).

Section 4: Supporting Information

Retirement Rates:

	Rate (%)[1]							
	General				Safety			
Age	Tier 1	Tier 2	Tier 3	Tier 4	Tier 1[2]	Tier 2, 2D[2]	Tier 2C[2]	Tier 4
49	0.00	0.00	0.00	0.00	0.00	10.00	0.00	0.00
50	4.00	2.00	6.00	0.00	35.00	15.00	4.00	4.00
51	4.00	2.00	3.00	0.00	30.00	15.00	2.00	2.00
52	4.00	2.00	5.00	4.00	25.00	15.00	2.00	2.00
53	4.00	2.00	6.00	1.50	35.00	15.00	3.00	3.00
54	4.00	2.00	6.00	1.50	45.00	15.00	6.00	6.00
55	6.00	2.00	12.00	2.00	45.00	15.00	10.00	10.00
56	8.00	3.00	13.00	2.50	45.00	15.00	12.00	12.00
57	10.00	4.00	13.00	3.50	45.00	15.00	20.00	20.00
58	12.00	4.00	14.00	3.50	45.00	20.00	10.00	10.00
59	14.00	5.00	16.00	4.50	45.00	20.00	15.00	15.00
60	20.00	7.00	21.00	6.00	45.00	30.00	60.00	60.00
61	20.00	9.00	20.00	8.00	45.00	30.00	60.00	60.00
62	35.00	15.00	30.00	18.00	45.00	30.00	60.00	60.00
63	30.00	16.00	25.00	15.00	45.00	30.00	60.00	60.00
64	30.00	18.00	25.00	17.00	45.00	50.00	60.00	60.00
65	35.00	25.00	30.00	22.00	100.00	100.00	100.00	100.00
66	35.00	25.00	25.00	25.00	100.00	100.00	100.00	100.00
67	30.00	25.00	25.00	25.00	100.00	100.00	100.00	100.00
68	30.00	30.00	25.00	30.00	100.00	100.00	100.00	100.00
69	35.00	35.00	50.00	35.00	100.00	100.00	100.00	100.00
70	65.00	50.00	65.00	50.00	100.00	100.00	100.00	100.00
71	65.00	50.00	65.00	50.00	100.00	100.00	100.00	100.00
72	65.00	50.00	65.00	50.00	100.00	100.00	100.00	100.00
73	65.00	50.00	65.00	50.00	100.00	100.00	100.00	100.00
74	65.00	50.00	65.00	50.00	100.00	100.00	100.00	100.00
75	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

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

[2] 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: 56 Future deferred vested members who terminate with less than five years of service and who are not vested are assumed to retire at age 70 for both General and Safety if they decide to leave their contributions on deposit. 30% of future General and 60% of future Safety deferred vested members are assumed to continue to work for a reciprocal employer. For reciprocals, 3.90% and 4.30% compensation increases are assumed per annum for General and Safety, respectively.
Measurement Date:	December 31, 2019
Discount Rate:	7.25%
Future Benefit Accruals:	1.0 year of service per year of employment, plus 0.003 years of additional service for General members and 0.006 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.
Consumer Price Index:	Increase of 3.00% per year. Retiree COLA increases due to CPI are subject to a 3% 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.
Increase in Internal Revenue Code Section 401(a)(17) Compensation Limit:	Increase of 3.00% per year from the valuation date.
Increase in Section 7522.10 Compensation Limit:	Increase of 3.00% per year from the valuation date.
Actuarial Cost Method:	Entry Age Actuarial Cost Method.

Section 4: Supporting Information

Salary Increases:

The annual rate of compensation increase includes:

- Inflation at 3.00%, 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	4.80	7.80
1-2	4.80	7.80
2-3	3.90	7.00
3-4	2.40	4.40
4-5	1.90	3.50
5-6	1.60	2.30
6-7	1.50	1.60
7-8	1.10	1.00
8-9	0.80	1.00
9-10	0.80	0.90
10-11	0.50	0.80
11 & Over	0.40	0.80

Terminal Pay Assumptions:

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

	Service Retirement	Disability Retirement
General Tier 1	8.0%	6.5%
General Tier 2	3.0%	1.4%
General Tier 3	8.0%	6.5%
General Tier 4	N/A	N/A
Safety Tier 1	8.5%	6.4%
Safety Tier 2	3.5%	2.1%
Safety Tier 2C	3.5%	2.1%
Safety Tier 2D	3.5%	2.1%
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 2020 was assumed to be $46.28. The monthly Medicare Part B premium reimbursement for 2020 is $144.60. For calendar year 2020, 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	80%	$785.44	$578.65
United Healthcare HMO Current Network	10%	$1,087.80	$578.65
Via Benefits Individual Insurance Exchange[4]	10%	N/A[4]	$578.65
United Healthcare HMO SVA Network	0%	$831.92	$578.65
Age 65 and Older			
Kaiser Senior Advantage	75%	$411.54	$578.65
Via Benefits Individual Insurance Exchange	25%	$326.61[5]	$443.28

(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 $578.65 ($443.28 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 65 are assumed to elect medical plans in the same proportion as future retirees upon age 65.

(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 ($578.65).

(5) The derivation of amount expected to be paid in 2020 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):

	(Years of Service Category)	Derivation of Via Benefits Monthly Per Capita Costs 10-14	15-19	20+
1.	Maximum MMA for 2019	$213.73	$320.59	$427.46
2.	Total of Maximum MMA (From Jan. 2019 to Dec. 2019)	$479,281	$784,907	$4,958,001
3.	Total of Actual Reimbursement (From Jan. 2019 to Dec. 2019)	$368,871	$573,300	$3,092,110
4.	Ratio of Actual Reimbursement to Maximum 2019 MMA [(3) / (2)]	76.96%	73.04%	62.37%
5.	Average Monthly Per Capita Cost for 2019 [(1) x (4)]	$164.49	$234.16	$266.59
6.	Maximum MMA for 2020	$221.64	$332.46	$443.28
7.	Increase in Average Monthly per Capita Cost due to the Change in Maximum MMA from 2019 to 2020 [(6) / (1)] x (5)	$170.58	$242.83	$276.46
8.	Increase for Expected Medical Trend (7.40%[(1)]) from 2019 to 2020 [(7) x 1.074]	$183.20	$260.80	$296.91
9.	Increase for Additional 10% Margin for 2019 Expenses Incurred in 2019 but Reimbursed after December 2019 [(8) x 1.10]	**$201.52**	**$286.88**	**$326.61**

[(1)] 6.50% medical trend for Medicare Plans plus 0.90% for the Health Insurance Tax (HIT).

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 $9,828 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			
	Retiree		Spouse	
Age	Male	Female	Male	Female
50	$11,635	$13,252	$8,127	$10,641
55	13,817	14,265	10,874	12,317
60	16,409	15,376	14,558	14,285
64	18,826	16,312	18,377	16,078

Not all ACERA employers are receiving an implicit subsidy reimbursement from the Association. For SRBR sufficiency purposes, we have adjusted (by about a 17% reduction of the costs shown above) 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

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**: 80% of eligible members **Upon Attaining Age 65**: 90% of eligible members
Part B Subsidy	**Under Age 65**: 80% of eligible members (disabled only) **Upon Attaining Age 65**: 90% of eligible members
Implicit Subsidy	80% of eligible members under age 65 are assumed to have an implicit subsidy liability.
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 2021 calendar year premium for Kaiser (under age 65) is $810.72 per month ($785.44 increased by 3.22%).

Calendar Year	United Healthcare HMO & Kaiser HMO Early Retiree[3]	Via Benefits & Kaiser Senior Advantage[4]	Dental and Vision	Medicare Part B
2020	6.75%[1],[2]	6.25%[1],[2]	4.00%[1]	4.50%
2021	6.50	6.00	4.00	4.50
2022	6.25	5.75	4.00	4.50
2023	6.00	5.50	4.00	4.50
2024	5.75	5.25	4.00	4.50
2025	5.50	5.00	4.00	4.50
2026	5.25	4.75	4.00	4.50
2027	5.00	4.50	4.00	4.50
2028	4.75	4.50	4.00	4.50
2029 & Later	4.50	4.50	4.00	4.50

(1) The actual trends are shown below, based on premium renewals for 2021 as reported by ACERA.

Kaiser HMO Early Retiree	United Healthcare HMO Early Retiree	Kaiser Senior Advantage	Dental and Vision
3.22%	5.77%	-7.13%	3.98%

(2) Before reducing the first-year non-Medicare trend by 1.20% and the first-year Medicare trend by 0.90% to reflect the repeal of the Health Insurance Tax (HIT).

(3) Non-Medicare plans.

(4) Medicare plans.

Assumed Increase in Annual Maximum Benefits:

For the "substantive plan design" shown in this report, we have assumed:

1. Maximum medical allowance for 2021 will remain unchanged from $578.65 per month, then increase with 50% of trend for medical plans, or 3.00%, graded down to the ultimate rate of 2.25% over 6 years.
2. Dental and vision premium reimbursement will increase with full trend.
3. Medicare B premium reimbursement will increase with full trend.

Section 4: Supporting Information

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 two years 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. 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 II and III.
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 II – 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 $578.65 per month is provided, effective January 1, 2020 and through December 31, 2020. For the period January 1, 2021 through December 31, 2021, the maximum allowance will remain at $578.65 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 will be $443.28 per month for 2020 and 2021. 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 will be $46.28 in 2020 and $48.12 in 2021. 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 III – 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 employer 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 employer 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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