Alameda County Employees' Retirement Association
BOARD OF RETIREMENT

RETIREES COMMITTEE/BOARD MEETING
NOTICE and AGENDA

THIS MEETING WILL BE CONDUCTED VIA TELECONFERENCE [SEE EXECUTIVE ORDER N-29-20 ATTACHED AT THE END OF THIS AGENDA.]

ACERA MISSION:

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

Wednesday, June 2, 2021
9:30 a.m.

ZOOM INSTRUCTIONS	COMMITTEE MEMBERS	
The public can view the Teleconference and comment via audio during the meeting. To join this Teleconference, please click on the link below. https://zoom.us/join Meeting ID: 863 2393 0009 Password: 803051 For help joining a Zoom meeting, see: https://support.zoom.us/hc/en-us/articles/201362193	**LIZ KOPPENHAVER, CHAIR**	**ELECTED RETIRED**
	HENRY LEVY, VICE CHAIR	**TREASURER**
	KEITH CARSON	**APPOINTED**
	DARRYL L. WALKER	**ELECTED GENERAL[1]**
	GEORGE WOOD	**ELECTED GENERAL**

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

The order of agenda items is subject to change without notice. Board and Committee agendas and minutes, and all documents distributed to the Board or a Committee in connection with a public meeting (unless exempt from disclosure), are available online at www.acera.org.

Note regarding public comments: Public comments are limited to four (4) minutes per person in total.

Note regarding accommodations: The Board of Retirement will provide reasonable accommodations for persons with special needs of accessibility who plan to attend Board meetings. Please contact ACERA at (510) 628-3000 to arrange for accommodation.

[1] Trustee Walker is filling the vacancy created by Trustee Rogers' retirement. See Gov't Code §§ 31524, 31520.1(b).

Call to Order: 9:30 a.m.

Roll Call:

Public Input (Time Limit: 4 minutes per speaker)

Action Items: Matters for Discussion and Possible Motion by the Committee

1. **Approval of Payment for Implicit Subsidy Cost for 2020**
   Motion to approve authorization for Staff to transfer funds in an amount equal to the Implicit Subsidy from the ACERA Supplemental Retiree Benefit Reserve account to the Alameda County Advance Reserve as the Implicit Subsidy reimbursement for Plan Year 2020.

   - Kathy Foster
   - Segal

   Recommendation
   Staff recommends that the Retirees Committee approve and recommend to the Board of Retirement an authorization for Staff to transfer $7,484,411 from the Supplemental Retiree Benefit Reserve account to the County Advance Reserve to be amortized over 20 years as the Implicit Subsidy payment for Plan Year 2020.

2. **Possible Declaration of Intent to Fund Implicit Subsidy Program for 2022**
   Motion to adopt a Statement of Intent to fund the Implicit Subsidy program for Plan Year 2022.

   - Kathy Foster
   - Segal

   Recommendation
   Staff recommends that the Retirees Committee recommend to the Board of Retirement the adoption of a Statement of Intent to continue the Implicit Subsidy Program for health Plan Year 2022, following a determination by ACERA at the end of Plan Year 2022 that the amount is not greater than the actual retiree Implicit Subsidy.

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

1. **Presentation and Report on Health Care Inflation/Trends**
   Staff and ACERA's Benefits Consultant will provide information and report on health care inflation factors for 2021 and 2022.

   – Kathy Foster
   - Segal

2. **Preliminary Report on Projected Benefit Costs Funded through the Supplemental Retiree Benefit Reserve**
   Segal, ACERA's Actuary, will provide a preliminary report on the projection of benefit costs, which are funded through the Supplemental Retiree Benefit Reserve.

   - Kathy Foster
   - Segal

3. **Discussion of Monthly Medical Allowance for 2022**
   Staff will present for discussion Monthly Medical Allowance for Group and Individual Plans cost comparisons for the 2021 and 2022 Plan Years.

   – Kathy Foster

4. **2022 Medical Plans Update/Renewal Requests of ACERA/County of Alameda**
   A report will be presented on medical plan renewal requests of ACERA and the County of Alameda for Plan Year 2022.

   - Kathy Foster
   - Segal

5. **Report on Annual Health Care Planning Meeting with Retiree Groups**
   Staff will provide a report on its annual meeting with retirees regarding ACERA-Sponsored health plan issues.

   - Kathy Foster

6. **Report on Health Reimbursement Arrangement Account Balances and Reimbursements**
   Staff will present a status report on the final 2020 Health Reimbursement Arrangement Account balances, and total reimbursement amounts for Medicare eligible retirees and early retirees living outside the HMO service area enrolled in medical plans through Via Benefits.

   - Ismael Piña

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

   - Ismael Piña

8. **Miscellaneous Updates**
   Staff will update the Committee on any recent benefit issues affecting ACERA retirees.

   - Ismael Piña

<u>Trustee Remarks</u>

Future Discussion Items

- Adoption of 2022 Monthly Medical Allowance for Group Plans
- Adoption of 2022 Monthly Medical Allowance for Early Retiree Individual Plans
- Adoption of 2022 Monthly Medical Allowance for Medicare Eligible Retiree Individual Plans

Establishment of Next Meeting Date

July 7, 2021, at 10:30 a.m.

Adjournment

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

EXECUTIVE ORDER N-29-20

WHEREAS on March 4, 2020, I proclaimed a State of Emergency to exist in California as a result of the threat of COVID-19; and

WHEREAS despite sustained efforts, the virus continues to spread and is impacting nearly all sectors of California; and

WHEREAS the threat of COVID-19 has resulted in serious and ongoing economic harms, in particular to some of the most vulnerable Californians; and

WHEREAS time bound eligibility redeterminations are required for Medi-Cal, CalFresh, CalWORKs, Cash Assistance Program for Immigrants, California Food Assistance Program, and In Home Supportive Services beneficiaries to continue their benefits, in accordance with processes established by the Department of Social Services, the Department of Health Care Services, and the Federal Government; and

WHEREAS social distancing recommendations or Orders as well as a statewide imperative for critical employees to focus on health needs may prevent Medi-Cal, CalFresh, CalWORKs, Cash Assistance Program for Immigrants, California Food Assistance Program, and In Home Supportive Services beneficiaries from obtaining in-person eligibility redeterminations; and

WHEREAS under the provisions of Government Code section 8571, I find that strict compliance with various statutes and regulations specified in this order would prevent, hinder, or delay appropriate actions to prevent and mitigate the effects of the COVID-19 pandemic.

NOW, THEREFORE, I, GAVIN NEWSOM, Governor of the State of California, in accordance with the authority vested in me by the State Constitution and statutes of the State of California, and in particular, Government Code sections 8567 and 8571, do hereby issue the following order to become effective immediately:

IT IS HEREBY ORDERED THAT:

1. As to individuals currently eligible for benefits under Medi-Cal, CalFresh, CalWORKs, the Cash Assistance Program for Immigrants, the California Food Assistance Program, or In Home Supportive Services benefits, and to the extent necessary to allow such individuals to maintain eligibility for such benefits, any state law, including but not limited to California Code of Regulations, Title 22, section 50189(a) and Welfare and Institutions Code sections 18940 and 11265, that would require redetermination of such benefits is suspended for a period of 90 days from the date of this Order. This Order shall be construed to be consistent with applicable federal laws, including but not limited to Code of Federal Regulations, Title 42, section 435.912, subdivision (e), as interpreted by the Centers for Medicare and Medicaid Services (in guidance issued on January 30, 2018) to permit the extension of

otherwise-applicable Medicaid time limits in emergency situations.

2. Through June 17, 2020, any month or partial month in which California Work Opportunity and Responsibility to Kids (CalWORKs) aid or services are received pursuant to Welfare and Institutions Code Section 11200 et seq. shall not be counted for purposes of the 48-month time limit set forth in Welfare an Institutions Code Section 11454. Any waiver of this time limit shall not be applied if it will exceed the federal time limits set forth in Code of Federal Regulations, Title 45, section 264.1.

3. Paragraph 11 of Executive Order N-25-20 (March 12, 2020) is withdrawn and superseded by the following text:

   Notwithstanding any other provision of state or local law (including, but not limited to, the Bagley-Keene Act or the Brown Act), and subject to the notice and accessibility requirements set forth below, a local legislative body or state body is authorized to hold public meetings via teleconferencing and to make public meetings accessible telephonically or otherwise electronically to all members of the public seeking to observe and to address the local legislative body or state body. All requirements in both the Bagley-Keene Act and the Brown Act expressly or impliedly requiring the physical presence of members, the clerk or other personnel of the body, or of the public as a condition of participation in or quorum for a public meeting are hereby waived.

   In particular, any otherwise-applicable requirements that

   (i) state and local bodies notice each teleconference location from which a member will be participating in a public meeting;

   (ii) each teleconference location be accessible to the public;

   (iii) members of the public may address the body at each teleconference conference location;

   (iv) state and local bodies post agendas at all teleconference locations;

   (v) at least one member of the state body be physically present at the location specified in the notice of the meeting; and

   (vi) during teleconference meetings, a least a quorum of the members of the local body participate from locations within the boundaries of the territory over which the local body exercises jurisdiction

   are hereby suspended.

   A local legislative body or state body that holds a meeting via teleconferencing and allows members of the public to observe and address the meeting telephonically or otherwise electronically, consistent with the notice and accessibility requirements set forth below, shall have satisfied any requirement that the body allow

members of the public to attend the meeting and offer public comment. Such a body need not make available any physical location from which members of the public may observe the meeting and offer public comment.

Accessibility Requirements: If a local legislative body or state body holds a meeting via teleconferencing and allows members of the public to observe and address the meeting telephonically or otherwise electronically, the body shall also:

(i) Implement a procedure for receiving and swiftly resolving requests for reasonable modification or accommodation from individuals with disabilities, consistent with the Americans with Disabilities Act and resolving any doubt whatsoever in favor of accessibility; and

(ii) Advertise that procedure each time notice is given of the means by which members of the public may observe the meeting and offer public comment, pursuant to subparagraph (ii) of the Notice Requirements below.

Notice Requirements: Except to the extent this Order expressly provides otherwise, each local legislative body and state body shall:

(i) Give advance notice of the time of, and post the agenda for, each public meeting according to the timeframes otherwise prescribed by the Bagley-Keene Act or the Brown Act, and using the means otherwise prescribed by the Bagley-Keene Act or the Brown Act, as applicable; and

(ii) In each instance in which notice of the time of the meeting is otherwise given or the agenda for the meeting is otherwise posted, also give notice of the means by which members of the public may observe the meeting and offer public comment. As to any instance in which there is a change in such means of public observation and comment, or any instance prior to the issuance of this Order in which the time of the meeting has been noticed or the agenda for the meeting has been posted without also including notice of such means, a body may satisfy this requirement by advertising such means using "the most rapid means of communication available at the time" within the meaning of Government Code, section 54954, subdivision (e); this shall include, but need not be limited to, posting such means on the body's Internet website.

All of the foregoing provisions concerning the conduct of public meetings shall apply only during the period in which state or local public health officials have imposed or recommended social distancing measures.

All state and local bodies are urged to use sound discretion and to make reasonable efforts to adhere as closely as reasonably possible to the provisions of the Bagley-Keene Act and the Brown Act, and other applicable local laws regulating the conduct of public meetings, in order to maximize transparency and provide the public access to their meetings.

IT IS FURTHER ORDERED that as soon as hereafter possible, this Order be filed in the Office of the Secretary of State and that widespread publicity and notice be given of this Order.

This Order is not intended to, and does not, create any rights or benefits, substantive or procedural, enforceable at law or in equity, against the State of California, its agencies, departments, entities, officers, employees, or any other person.

IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 17th day of March 2020.

GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: June 2, 2021

TO: Members of the Retirees Committee

FROM: Kathy Foster, Assistant Chief Executive Officer

SUBJECT: **Implicit Subsidy for Health Plan Year 2020**

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

Attached is a letter from the County providing the final Implicit Subsidy amount for 2020, as calculated by its Consultant, Korn Ferry. Also attached is a letter from ACERA's Benefits Consultant, Segal, verifying that the correct Implicit Subsidy reimbursement for Plan Year 2020 is $7,484,411.

Recommendation

Staff recommends that the Retirees Committee approve and recommend to the Board of Retirement an authorization for Staff to transfer $7,484,411 from the Supplemental Retiree Benefit Reserve account to the County Advance Reserve to be amortized over 20 years as the Implicit Subsidy payment for Plan Year 2020.

Attachments (2)

Human Resource Services
Employee Benefits Center

1405 Lakeside Drive
Oakland, CA 94612-4305
QIC 25701
ph: (510) 891-8991
fax: (510) 891-8976
email: emailEBC@acgov.org

April 15, 2021

Sent Via US Mail & Email

Kathy Foster
Asst. CEO – Benefits
ACERA
475 14th Street
Oakland, CA 94612

RE: 2020 Final Implicit Subsidy Calculation and 2021 Estimate

Dear Kathy:

Korn Ferry has completed the calculation of the amount of Implicit Subsidy being paid by the County of Alameda on behalf of ACERA early retirees for 2020.

2020 Implicit Subsidy Calculation

In accordance with the established procedure, Korn Ferry calculated the subsidy based on the total premium cost for the 2020 plan year. For this purpose, the enrollment is based on the monthly average from February 2020 through January 2021. The results of our calculations follow with more details in the calculation spreadsheets.

The 2020 Implicit Subsidy is $7,484,411, which is 16.1% higher (approximately $1,038,000) than the 2019 $6,446,702 amount.

This variance is due to the increase in the ratio of Kaiser's and UHC's active unblended to blended rates for 2020 versus 2019. For 2020:

- Kaiser's active unblended rates were 5.5% lower than blended rates, compared to 5.3% in 2019.
- UHC's active unblended rates were 4.7% lower than the blended rates, compared to 2.6% in 2019.

This increase in Kaiser's and UHC's ratios of active unblended to blended rates from 2019 to 2020 is due to the more favorable active claims experience used in the 2020 rating in relation to ACERA claims experience when compared to the experience used for the 2019 rating.

1.	Total premium for County of Alameda active employees using blended rates	$	141,406,693
2.	Total premium for County of Alameda active employees using unblended rates (as if active employees were rated separately)	$	133,922,282
3.	Implicit Subsidy (1) – (2)	$	7,484,411

Human Resource Services
Employee Benefits Center

1405 Lakeside Drive
Oakland, CA 94612-4305
QIC 25701
ph: (510) 891-8991
fax: (510) 891-8976
email: emailEBC@acgov.org

2021 Implicit Subsidy Estimate

Our estimate for 2021 is based on the same methodology but uses 2021 premium rates and February 2021 enrollment. The results of our calculations follow with more details in the calculation spreadsheets.

The estimated 2021 Implicit Subsidy is 24.5% lower (approximately $1,832,000) than the 2020 amount. The variance is due to the net impact of the following:

- An increase in the ratio of 2020 and 2021 UHC's active unblended to blended rates (from 4.7% to 5.6%).
- A decrease in the ratio of 2020 and 2021 Kaiser's active unblended to blended rates (from 5.5% to 3.3%).

1.	Total premium for County of Alameda active employees using blended rates	$	144,805,903
2.	Total premium for County of Alameda active employees using unblended rates (as if active employees were rated separately)	$	139,153,290
3.	Implicit Subsidy (1) – (2)	$	5,652,613

Once you and your consultants have a had a chance to review this letter and the accompanying enclosure, I would be more than happy to coordinate a Teams call for further discussion and to answer any questions you may have.

Best regards,

Ava Lavender
HR Division Manager, Benefits

C: Joe Angelo, Human Resources Director

Segal

Paul Sadro
Senior Actuary
T 8189566722
psadro@segalco.com

500 North Brand Boulevard,
Suite 1400
Glendale, CA 91203-3338
segalco.com

May 20, 2021

Kathy Foster
Assistance Chief Executive Officer
ACERA
475 14th Street, Suite 1000
Oakland, California 94612

Re: ACERA Final 2020 and Estimated 2021 Implicit Subsidy Analysis

Dear Kathy:

Segal has completed the review of the County of Alameda's Final 2020 and Estimated 2021 Implicit Subsidies.

The Final 2020 Implicit Subsidy requested by the County is $7,484,400 for the active enrollment from February 2020 through January 2021. The 2020 subsidy is requested for the employees in Premium and Standard plans offered by Kaiser and United Healthcare, which includes the Signature Value and Signature Value Advantage networks of United Healthcare.

The 2021 Implicit Subsidy is estimated to be $5,652,600 assuming February 2021 enrollment for twelve months. The 2021 subsidy is estimated for employees in Premium and Standard plans offered by Kaiser and United Healthcare. The plans offered have not changed from the prior year.

The plans and enrollment provided by the County and their consultant are consistent with our understanding of the ACERA health plans. We reviewed the enrollment and rates to verify that the effect of blending was revenue neutral over the combined active and retiree population. In our opinion, the Final 2020 and Estimated 2021 Implicit Subsidies stated in this memo are reasonable given the information provided. We did not find any reason to withhold approval of the requested 2020 Implicit Subsidy.

If you have any questions, feel free to contact me at (818) 956-6722.

Sincerely,

Paul Sadro
Senior Actuary

cc: Jessica Huffman, ACERA
Ismael Piña, ACERA
Eva Hardy, ACERA
Stephen Murphy, Segal
Jessica Kuhlman, Segal
Michael Szeto, Segal

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: June 2, 2021

TO: Members of the Retirees Committee

FROM: Kathy Foster, Assistant Chief Executive Officer

SUBJECT: **Intent to Fund Implicit Subsidy Program for Plan Year 2022**

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

The Implicit Subsidy cost for the current Plan Year 2021 is estimated by the County to be $5,652,613.

Recommendation

Staff recommends that the Retirees Committee recommend to the Board of Retirement the adoption of a Statement of Intent to continue the Implicit Subsidy Program for health Plan Year 2022, following a determination by ACERA at the end of Plan Year 2022 that the amount is not greater than the actual retiree Implicit Subsidy.

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: June 2, 2021

TO: Members of the Retirees Committee

FROM: Kathy Foster, Assistant Chief Executive Officer

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

Segal has provided ACERA with recommended assumptions to be used for the December 31, 2020 Supplemental Retiree Benefit Reserve (SRBR) Valuation for projecting benefits based on ACERA's substantive plan pursuant to GASB 43. ACERA's substantive plan design incorporates an increase for the Monthly Medical Allowance (MMA) of one-half of anticipated health care inflation assumptions. The Medicare Part B, vision and dental projections are based on the full inflation assumption for those plans.

Attached is a letter dated March 22, 2021 from Segal. As presented on page two of the attachment to Segal's letter, the near term trend assumptions will remain at 6.75% for non-Medicare plans and 6.25% for Medicare Advantage plans. The annual trend assumptions for dental and vision remain at 4.00%. However, due to the three-year 2021 rate guarantee for dental, the first two years of trend will be 0.00%. Likewise, due to the five-year 2021 rate guarantee for vision, the first four years of trend will be 0.00%. The trend used for Medicare Part B is 4.50%.

Segal is using the lowest trend of 6.25% for medical inflation as the most conservative approach. Therefore, based on the substantive plan design, a 3.125% increase would be applied to the projections for the MMA for the December 31, 2020 SRBR Valuation.

Health care trend information has also been provided by Segal's benefit consulting team. Steve Murphy, Vice President, Benefits Consultant, will review the attached presentation at the June 2nd Retirees Committee meeting. Also attached is a 10-year ACERA rate history for the period 2012 through 2021 for Kaiser Permanente and UnitedHealthcare.

Attachments (3)

180 Howard Street,
Suite 1100
San Francisco, CA 94105-6147
T 415.263.8200
segalco.com

Via Email

March 22, 2021

Ms. Kathy Foster
Assistant Chief Executive Officer
Alameda County Employees' Retirement Association
475 14th Street, Suite 1000
Oakland, CA 94612

Re: Alameda County Employees' Retirement Association
Health Trend Assumptions Recommended for the December 31, 2020 SRBR Retiree Health Actuarial Valuation

Dear Kathy:

We have provided in this letter the health trend assumptions that we recommend to the Board for the December 31, 2020 retiree health valuation.

These health trend assumptions will also be used to develop our Governmental Accounting Standards Board (GASB) Statement 74 report with a measurement date of December 31, 2020.

Health Care Trend Assumptions

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

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

1. For the prior December 31, 2019 SRBR valuation, we recommended the following assumptions:

    a. For the non-Medicare plans, we recommended the first year trend rate be set at 6.75%, then graded down by 0.25% each year until an ultimate rate of 4.50% is reached after 9 years. For the Medicare plans, we recommended the first year trend rate be set at 6.25%, then graded down by 0.25% each year until an ultimate rate of 4.50% is reached after 7 years.

In addition, to reflect the repeal[1] of the Health Insurance Tax (HIT) that took effect in 2021, we subtracted 1.20% from the first-year non-Medicare trend and 0.90% from the first-year Medicare trend.

We continued to use the ultimate health care trend assumption of 4.50% for these plans, based on Segal's research and analysis on long-term cost in the health care market as a whole.

b. The ultimate Dental and Vision trend assumptions remained at 4.00% based upon Segal Survey data.

c. Medicare Part B trend assumption was 4.50% based on updated information from the Centers for Medicare & Medicaid Services (CMS) relating to expectations for ultimate Medicare trend and Congressional Budget Office (CBO) trustee reports.

d. Based on past practice, the 5.55% (6.75% minus 1.20% for removal of the HIT) non-Medicare and 5.35% (6.25% minus 0.90% for removal of the HIT) Medicare first year trends were used in the December 31, 2019 "preview" valuation and were applied to the 2020 non-Medicare and Medicare medical premiums to estimate the projected 2021 non-Medicare and Medicare medical premiums. The first year trends were replaced as part of the "final" valuation as of December 31, 2019 to reflect the actual premium renewals for 2021.

e. We continued to assume that the Board's annual Monthly Medical Allowance (MMA) would increase by 50% of the rate of the anticipated medical trend (including 50% of the adjustment due to the HIT) assumption. If different types of medical plans had different initial trend rates, we assumed that the future increase in MMA would be linked to the plan with the lowest projected medical trend (i.e., the Medicare plans). For the Board's subsidies for Medicare Part B, dental and vision plans, we assumed they would increase at the full rate of anticipated trend assumed for each of those plans as provided in Attachment One (4.50% for Medicare Part B and 4.00% for dental/vision to project premiums for calendar year 2021).

2. For the current December 31, 2020 SRBR valuation, we are recommending the following assumptions:

   a. For the non-Medicare plans, we are recommending the first year trend rate be reset to the same 6.75% that we recommended as the first-year trend in the prior year valuation[2], then grading down by 0.25% each year until reaching an ultimate rate of 4.50% after 9 years. For the Medicare plans, we are recommending the first-year trend rate be reset to the same 6.25% that we recommended as the first-year trend in the

[1] The HIT was imposed by the Affordable Care Act (ACA) on each covered entity engaged in the business of providing health insurance for United States health risks. The fees associated with the HIT are collected from the health insurance industry to fund the implementation and ongoing support of the ACA marketplace exchanges. They are based on the health insurance providers' premiums and market shares. These taxes were incorporated into premiums beginning in 2014 and would vary based upon insurer. Congressional budgetary actions placed a moratorium on these fees for calendar years 2017 and 2019. These fees were again reflected in premiums for calendar year 2020. The repeal of the ACA at the end of 2020 removes the HIT from the premiums beginning in calendar year 2021.

[2] We note that in the absence of the above recommendation to reset the assumption, the first-year trend rate that we would use in this year's valuation would equal 6.50%.

prior year valuation[3], then grading down by 0.25% each year until reaching an ultimate rate of 4.50% after 7 years.

We will continue to use the ultimate health care trend assumption of 4.50% for these plans, based on Segal's research and analysis on long-term cost in the health care market as a whole.

b. The Dental and Vision annual trend assumptions will remain at 4.00% based upon Segal Survey data.

However, because of the three-year 2021 rate guarantee for dental, the first-two years of trend will be 0.00%. Likewise, because of the five-year 2021 rate guarantee for vision, the first four years of trend will be 0.00%.

In the prior valuations, we had not reflected any multi-year rate guarantees for dental and vision trend. To reduce potential actuarial gains, we have updated our methodology to reflect any known rate guarantees in our trend assumption.

c. Medicare Part B trend assumptions will remain at 4.50%, based on updated information from the Centers for Medicare & Medicaid Services (CMS) relating to expectations for ultimate Medicare trend and Congressional Budget Office (CBO) trustee reports.

d. Based on past practice, the 6.75% non-Medicare and 6.25% Medicare first year trends will be used in the December 31, 2020 "preview" valuation and applied to the 2021 non-Medicare and Medicare medical premiums to estimate the projected 2022 non-Medicare and Medicare medical premiums. The first year trends will be replaced as part of the "final" valuation as of December 31, 2020 to reflect the actual premium renewals for 2022.

e. We will continue to assume that the Board's annual Monthly Medical Allowance (MMA) will increase by 50% of the rate of the anticipated medical trend assumption. If different types of medical plans have different initial trend rates, we assume that the future increase in MMA will be linked to the plan with the lowest projected medical trend (i.e., the Medicare plans). For the Board's subsidies for Medicare Part B, dental and vision plans, we assume they would increase at the full rate of anticipated trend assumed for each of those plans, as described in (b) and (c) above, and provided in Attachment One.

Segal will prepare a separate letter to address the recommended demographic driven changes to be used in the December 31, 2020 SRBR sufficiency valuation.

[3] We note that in the absence of the above recommendation to reset the assumption, the first-year trend rate that we would use in this year's valuation would equal 6.00%.

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

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

Sincerely,

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

Paul Sadro, ASA, MAAA
Senior Actuary

TJH/bbf
Attachment

Segal

Health Trends Used in the Prior Valuation as of December 31, 2019
(Provided for Comparison Purposes)

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

Calendar Year	United Healthcare HMO & Kaiser HMO Early Retiree[3]	Via Benefits & Kaiser Senior Advantage[4]	Dental & 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) For calendar year 2020, actual trends are below, based on actual premium renewals for 2021, as reported by ACERA. These trends were used in preparing our December 31, 2019 SRBR valuation report dated September 23, 2020.

Kaiser HMO Early Retiree	United Healthcare HMO Early Retiree	Kaiser Senior Advantage	Dental & 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.

Health Trends Recommended for the Current Valuation as of December 31, 2020

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

Calendar Year	United Healthcare HMO & Kaiser HMO Early Retiree[2]	Via Benefits & Kaiser Senior Advantage[3]	Dental[4]	Vision[5]	Medicare Part B
2021	6.75%[1]	6.25%[1]	0.00%	0.00%	4.50%
2022	6.50	6.00	0.00	0.00	4.50
2023	6.25	5.75	4.00	0.00	4.50
2024	6.00	5.50	4.00	0.00	4.50
2025	5.75	5.25	4.00	4.00	4.50
2026	5.50	5.00	4.00	4.00	4.50
2027	5.25	4.75	4.00	4.00	4.50
2028	5.00	4.50	4.00	4.00	4.50
2029	4.75	4.50	4.00	4.00	4.50
2030 & Later	4.50	4.50	4.00	4.00	4.50

(1) Based on past practice, the first year trends will be replaced as part of the "final" valuation as of December 31, 2020 to reflect the actual premium renewals for 2022.

(2) Non-Medicare plans.

(3) Medicare plans.

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

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

Alameda County Employees' Retirement Association (ACERA)

2021 Health Plan Cost Trend Survey

ACERA Retirees Committee Meeting

Presented on June 2, 2021 / Presenters: Stephen Murphy & Paul Sadro

Segal

Segal Health Plan Cost Trend Survey Overview

2021 edition is our 24th annual national survey

More than 100 managed care organizations (MCOs), health insurers, pharmacy benefit managers (PBMs), and third-party administrators (TPAs) participated including:

Aetna
(Acquired by CVS Health in 2018)

Anthem

Blue Shield of California

Cigna

CVS Health

Delta Dental of California

Express Scripts
(Acquired by Cigna in 2018)

Health Net

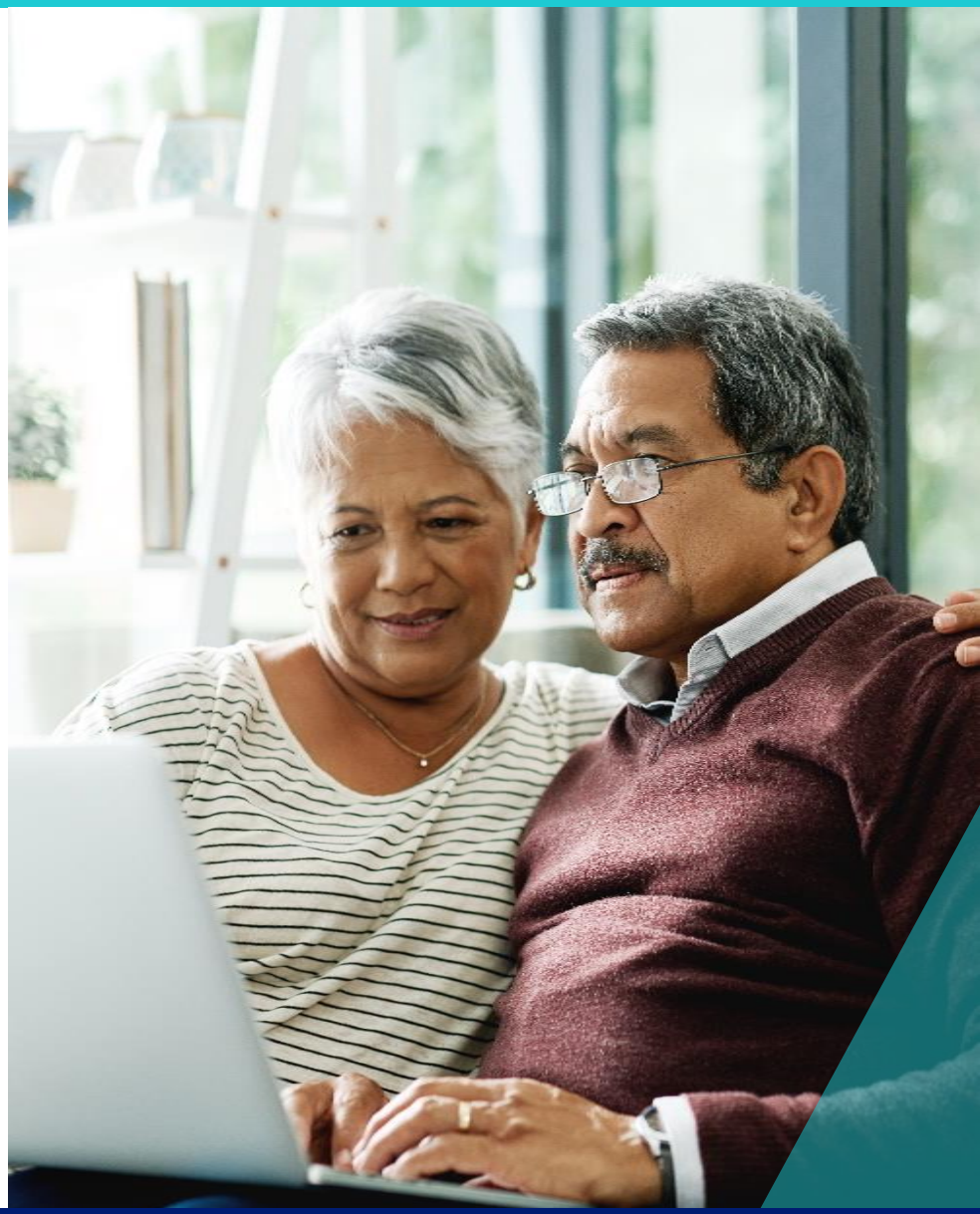
Humana

Kaiser Foundation Health Plan

UnitedHealthcare

Health Care Cost Trend Influencers

- New treatments, therapies and technology
- Provider cost shifting from reduced CMS payments (Medicaid & Medicare)
- Regulations/mandates
- Provider price increase and CPI
- Increased demand from increased health risks due to aging populations or rise in obesity
- Leveraging effect of fixed deductibles and copayments[1]
- Greater emphasis on detection and diagnostics
- Other, including fraud and abuse

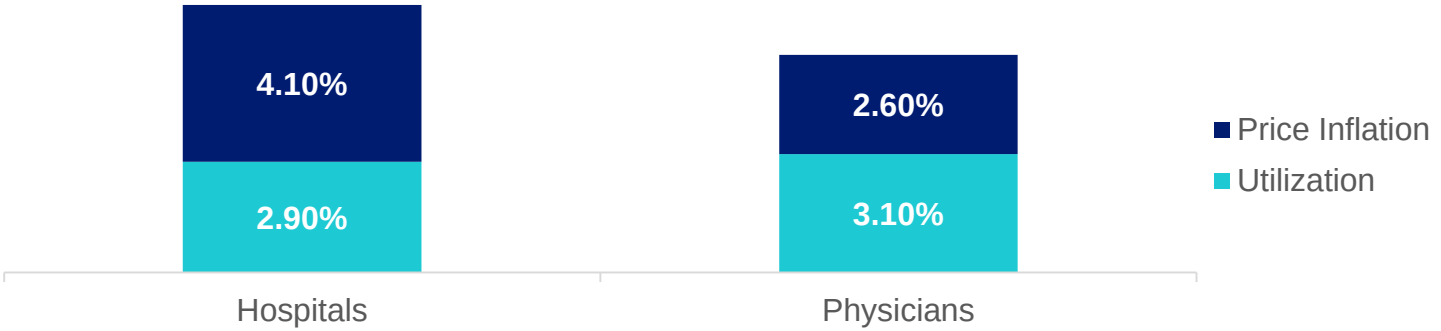


Trend is the forecast of annual gross per capita claims cost increases.

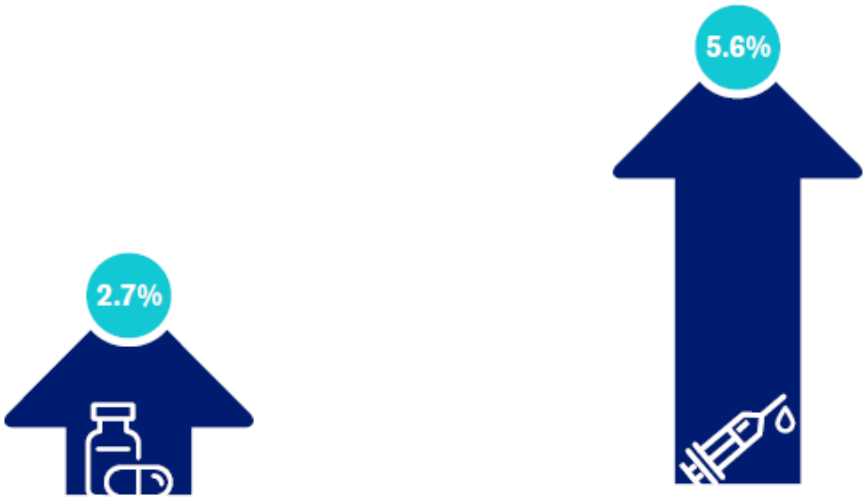
1 This is a driver of net paid claim cost trends, not gross per capita claims cost increases.

Leading Drivers of Trend

Influence of Price Inflation and Utilization on 2021 Projected Medical Trends*



Price Inflation is the leading driver of trend for prescription drugs.

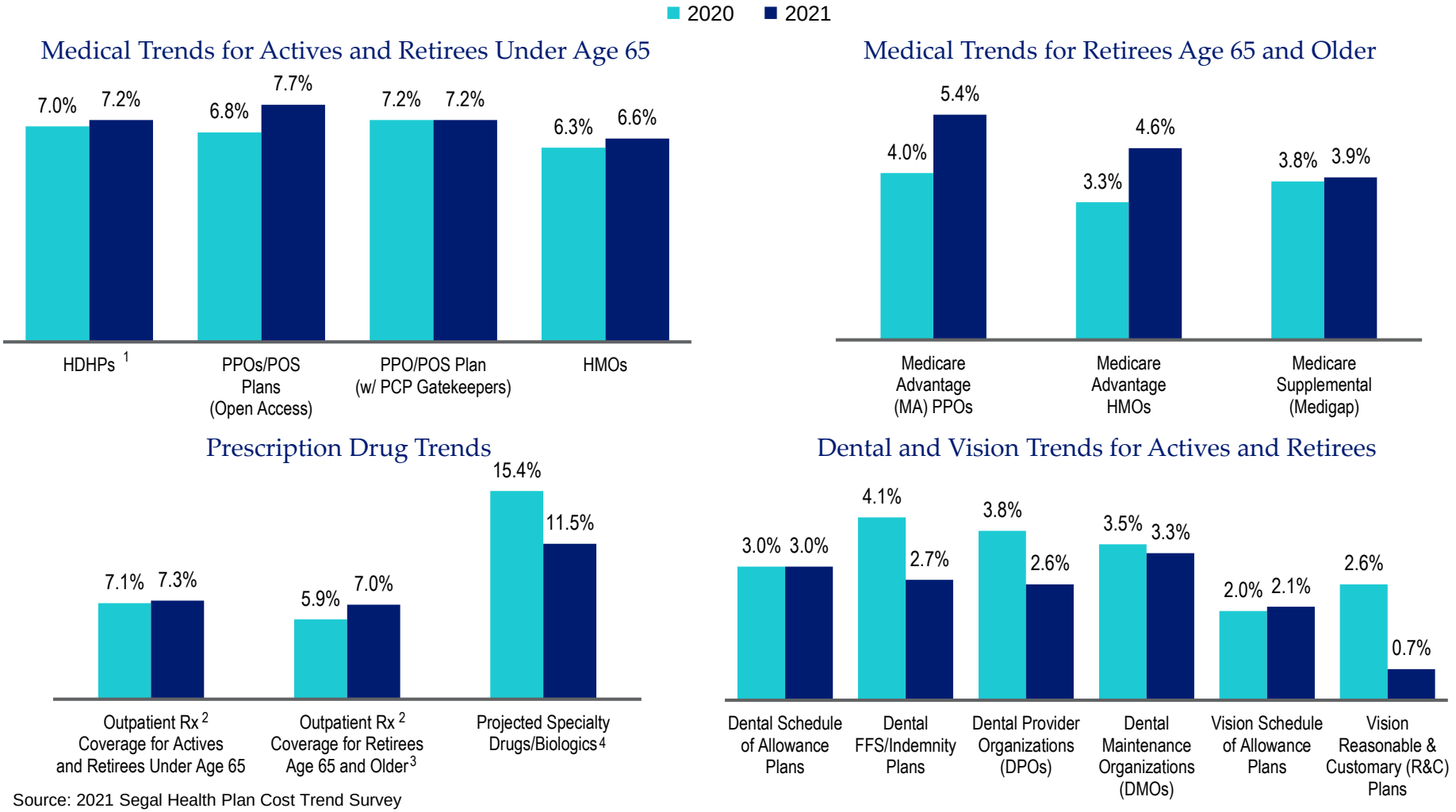


Hospital and physician trends are for open-access PPOs for actives and retirees under age 65. The components do not add up to totals because there are other components of trend not illustrated, reflecting such factors as the impact of cost shifting and technology changes. Not all survey respondents provided a breakdown of trend by component.

Source: Segal, 2021

Projected Health Care Trends

2020 vs. 2021



Source: 2021 Segal Health Plan Cost Trend Survey

1 HDHPs with an employee-directed, tax-advantaged health account—a health savings account (HSA) or a health reimbursement account (HRA)—are referred to as account-based health plans and are designed to encourage consumer engagement, resulting in more efficient use of health care services.

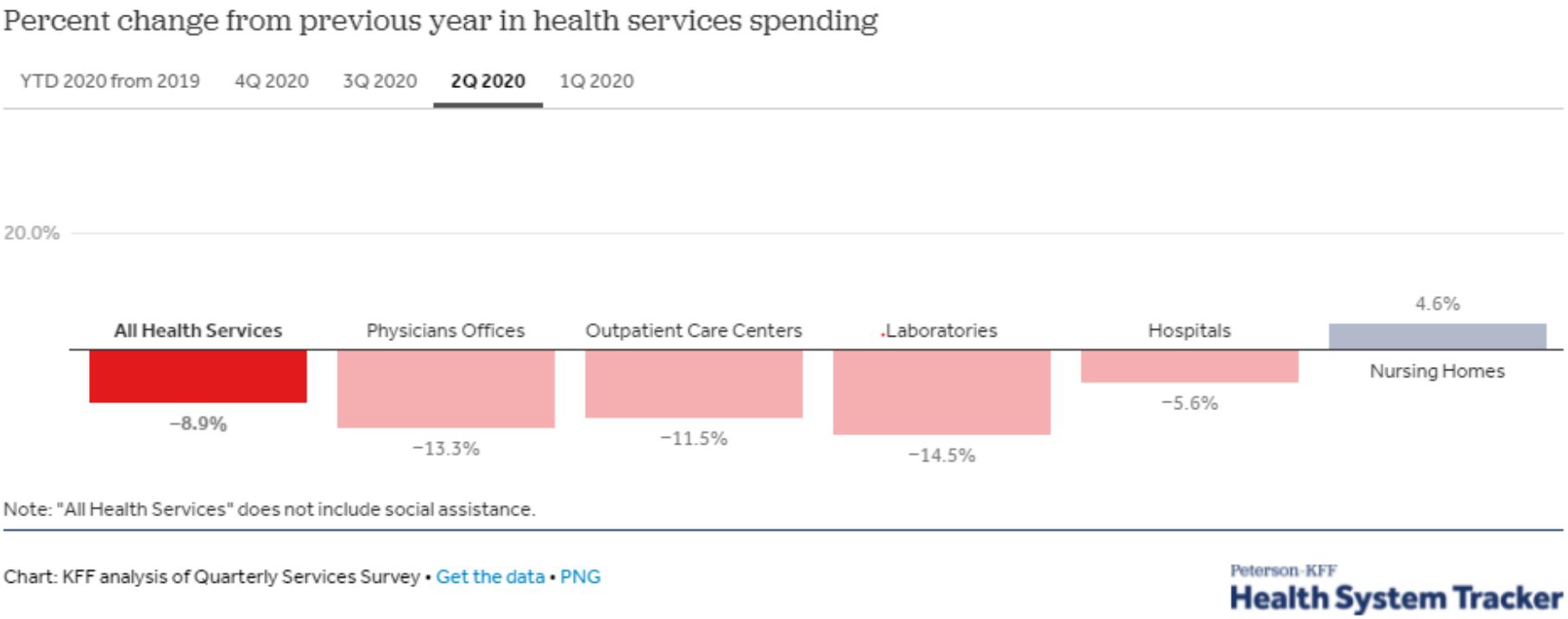
2 These results do not include the impact of rebates from PBMs.

3 This data is for all prescription drugs (non-specialty and specialty drugs combined).

4 This data is for all coverage of specialty drugs and both age groups.

COVID-19 Impact to Health Services Spending

At the onset of the pandemic (2Q 2020), year-over-year spending for all health services nationally declined 8.9%. Spending recovered by year-end, but 2020 spending was still 1.0% less when compared to 2019.



Applying Health Plan Cost Trend Survey Results to ACERA

The *Health Plan Cost Trend Survey* results exclude the potential impact of non-claim factors such as:

- Pharmaceutical manufacturer rebates
- Medicare Star Rating performance bonuses
- Changes in administration fees (i.e., premium taxes, ACA fees, etc.)

When recommending long term health trend assumptions used in ACERA's Other Postemployment Benefits (OPEB) and Supplemental Retiree Benefit Reserve (SRBR) valuations, Segal's Actuarial Team takes into account multiple factors including:

- The annual Health Plan Cost Trend Survey findings
- Consistency of assumptions relative to other large OPEB plans
- Smoothing when changing from prior year assumptions

Medical Rate Comparisons

2012-2021 Rate History

Alameda County Employees' Retirement Association

Kaiser Early Retiree

1,030 Enrolled*

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Rating Structure	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
Retiree	$593.86	$639.26	$658.96	$670.58	$671.82	$729.08	$735.64	$765.06	$785.44	$810.72
Retiree & 1 Dep	$1,187.82	$1,278.52	$1,317.92	$1,341.16	$1,343.64	$1,458.16	$1,471.28	$1,530.12	$1,570.88	$1,621.44
Retiree & 2+ Deps	$1,680.62	$1,809.12	$1,864.86	$1,897.74	$1,901.26	$2,063.30	$2,081.88	$2,165.12	$2,222.80	$2,294.34
% Change over Retiree Monthly Premium		7.64%	3.08%	1.76%	0.18%	8.52%	0.90%	4.00%	2.66%	3.22%

Kaiser Permanente Senior Advantage

4,265 Enrolled*

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Rating Structure	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
Retiree	$298.74	$316.64	$330.96	$330.96	$329.90	$354.73	$367.23	$394.07	$411.54	$382.21
Retiree & Spouse	$597.48	$633.28	$661.92	$661.92	$659.80	$709.46	$734.46	$788.14	$823.08	$764.42
% Change over Retiree Monthly Premium		5.99%	4.52%	0.00%	-0.32%	7.53%	3.52%	7.31%	4.43%	-7.13%

UnitedHealthcare SignatureValue HMO Early Retiree

107 Enrolled*

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Rating Structure	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
Retiree	$827.84	$914.78	$972.34	$972.34	$982.06	$982.06	$1,047.16	$1,047.16	$1,087.80	$1,150.60
Retiree & 1 Dep	$1,655.64	$1,829.48	$1,944.60	$1,944.60	$1,964.06	$1,964.06	$2,094.24	$2,094.24	$2,175.50	$2,301.12
Retiree & 2+ Deps	$2,342.72	$2,588.70	$2,751.60	$2,751.60	$2,779.12	$2,779.12	$2,963.32	$2,963.32	$3,078.30	$3,256.06
% Change over Retiree Monthly Premium		10.50%	6.29%	0.00%	1.00%	0.00%	6.63%	0.00%	3.88%	5.77%

UnitedHealthcare SignatureValue Advantage HMO Early Retiree - Effective 2/1/2019

35 Enrolled*

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Rating Structure	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
Retiree	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$980.94	$831.92	$759.16
Retiree & 1 Dep	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$1,961.80	$1,663.74	$1,518.20
Retiree & 2+ Deps	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$2,775.92	$2,354.18	$2,148.24
% Change over Retiree Monthly Premium	-	-	-	-	-	-	-	-	-15.19%	-8.75%

*As of December 31, 2020

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: June 2, 2021

TO: Members of the Retirees Committee

FROM: Kathy Foster, Assistant Chief Executive Officer

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

Attached is a letter from Segal, ACERA's Actuary, which provides a preliminary report of the Supplemental Retiree Benefit Reserve (SRBR) financial status. This overview of the valuation is based on projections using substantive plan and medical inflation trends, as well as other assumptions consistent with our pension valuation. This information is provided to the Retirees Committee in preparation for setting the Monthly Medical Allowance (MMA), and Vision and Dental subsidies for 2022.

Other Post-Employment Benefits (OPEB)

In the December 31, 2019 valuation, it was projected that the Other Post-Employment Benefits (OPEB) assets would be exhausted in 2040 with full benefits paid through 2039. The results of the December 31, 2020 valuation indicate that the terminal year of OPEB benefits is projected to be 2039, with full benefits paid through 2038 for a total of 18 full years and one partial year. The main reasons the terminal year is projected to be one year earlier are due to the following factors:

- The change in the investment rate of return assumption from 7.25% to 7.00%.
- The change to decrement rates related to the experience study.

Non-OPEB

The terminal year for non-OPEB benefits is projected to be 2044, with full benefits paid through 2043 for a total of 23 full years and one partial year. The main reason the terminal year for the non-OPEB benefits is projected to be seven years later than last year is the change in the actuarial assumptions, in particular the decrease in the inflation assumption from 3.00% to 2.75% per year, and the impacts of that change to the Supplemental COLA benefit.

Also attached are two additional letters from Segal. One letter dated March 22nd is regarding assumptions that are recommended for the SRBR valuation. These assumptions are used for the substantive plan projections. The second letter dated April 15th is regarding recommended parameters to reflect demographic driven changes. This information will be presented in more detail at the June 2nd Retirees Committee meeting, at the same time the MMA costs and recommendations for 2022 will be discussed.

Andy Yeung, with Segal, will present the attached Preview of December 31, 2020 Valuation Results for Benefits Povided by the SRBR report in more detail at the June 2nd Retirees Committee meeting.

Attachments (3)

180 Howard Street,
Suite 1100
San Francisco, CA 94105-6147
T 415.263.8200
segalco.com

May 25, 2021

Ms. Kathy Foster
Assistant Chief Executive Officer
Alameda County Employees' Retirement Association
475 14th Street, Suite 1000
Oakland, California 94612-1900

Re: Alameda County Employees' Retirement Association (ACERA)
Preview of December 31, 2020 Valuation Results for Benefits Provided by the Supplemental Retiree Benefits Reserve (SRBR)

Dear Kathy:

This letter is intended to provide a preview of the December 31, 2020 valuation results for benefits provided by the SRBR, before we issue a full valuation report. The results in this letter are based on our understanding of the Other Postemployment Benefits (OPEB) "substantive plan" design and on the current benefits provided by the SRBR that are in addition to the OPEB benefits (i.e., "non-OPEB").

Results

As of December 31, 2020, the OPEB-related assets in the SRBR are projected to be sufficient to pay OPEB benefits through 2039 (18 full years and 1 partial year) and non-OPEB benefits through 2044 (23 full years and 1 partial year).

Background and Discussion

The determination of the "substantive plan" underlying ACERA's OPEB was based upon prior directions provided by ACERA and its auditors, as well as the administrative staff, auditors, and consultants representing the County of Alameda, along with other features of the plan, as we stated in our December 31, 2019 valuation report dated September 23, 2020.

The actuarial assumptions used in this valuation are consistent with those assumptions applied by the Retirement Board for the December 31, 2020 pension valuation for funding purposes, including the use of a 7.00% investment return assumption. When projecting OPEB payments, for the purposes of anticipating death, we use the headcount weighted instead of the benefit (or amount) weighted mortality tables used in the pension funding valuation. We have also used the

additional OPEB-related assumptions/parameters that were provided in our letter dated April 15, 2021.[1]

This includes applying the health trend assumption in projecting that the 2022 Monthly Medical Allowance will increase from the 2021 level by 3.125% (i.e., 1/2 of the lowest 2021 to 2022 calendar year medical trend assumed in the December 31, 2020 SRBR valuation.[2] Copies of our March 22 and April 15, 2021 letters are attached for your reference.

MMA Amounts for Group and Via Benefits Individual Medical Insurance Exchange

In 2021, the maximum Monthly Medical Allowance (MMA) for retirees with 20 or more years of service and enrolled in an ACERA sponsored group medical plan, or for eligible out-of-area non-Medicare retirees enrolled in Via Benefits Exchange, is $578.65. For Medicare retirees with 20 or more years of service and purchasing individual plan Medicare insurance through Via Benefits Exchange (including out-of-area retirees), the maximum MMA for 2021 is $443.28.

At the end of this letter, we provide an exhibit that shows the projected cash flow and present value of projected benefits for the OPEB and non-OPEB plans. The present values calculated represent the amount of benefits payable through the date of exhaustion of the assets in the SRBR. The exhibit also indicates the years in which the assets in the SRBR are expected to be exhausted, shown separately for OPEB and non-OPEB. Note that the assets used herein reflect the estimated implicit subsidy transfer of $7,548,683 from the SRBR to the Employer Advance Reserve for 2020 previously provided by ACERA, consistent with the transfer amount used in the December 31, 2020 funding valuation report for the Pension Plan.

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

OPEB

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

Note that in preparing the 401(h) contribution letter for 2021/2022, we had included an additional allocation for expenses related to the administration of the health benefits for retirees. However, as we previously demonstrated to the Association during our discussion with the Board on SB 1479, the values in both the employer reserves and the SRBR would remain unchanged relative to the values prior to that allocation, through the operation of SB 1479. For that reason, we have not included the explicit payment of administrative expense out of the 401(h) in preparing the cash flow requirements of the SRBR.

[1] Note that we issued a separate health trend assumptions letter dated March 22, 2021 due to the timing of the GASB 74 valuation report as of December 31, 2020.

[2] This corresponds to the medical trend assumption we recommend for the Medicare Advantage Plans in the December 31, 2020 valuation. This trend assumption has been reset to the first year increase of 6.25% that we used to adjust medical plan costs from 2020 to 2021 as used in the December 31, 2019 valuation.

In order to determine the cost of the retiree medical benefits, we estimated the average per capita premium for retirees under age 65. Because these premiums include active participants for purposes of underwriting, the retirees receive an implicit subsidy. Had the retirees under age 65 been underwritten as a separate group, their aggregate premiums would be higher. The excess of the retiree only costs over the active/retiree composite premiums currently charged makes up the implicit subsidy. In preparing the cash flow requirements, we have included amounts that are estimated to be reimbursed by ACERA to the County out of the SRBR for this implicit subsidy, estimated by Segal based on 2020 premium data and 2020 implicit subsidy estimate provided to ACERA by the County's health consultant of $7,548,683. At this time we have not received the 2021 implicit subsidy estimate from the County's health consultant and therefore we have projected the 2020 implicit subsidy costs to 2021 with assumed trend.

We have assumed that the Medicare Part B, dental and vision subsidies will increase at the full rate of the trend assumption for those plans. The trend assumption for dental reflects the rate guarantees for 2022 and 2023 maintaining premiums at 2021 levels. The trend assumption for vision reflects the rate guarantees for 2022 through 2025 maintaining premiums at 2021 levels.

In the December 31, 2019 valuation, it was projected that the OPEB assets would be exhausted in 2040, with full benefits paid through 2039, for a total of 20 full years and 1 partial year. The results of the December 31, 2020 valuation indicate that the terminal year of OPEB benefits is projected to be 2039, with full benefits paid through 2038, for a total of 18 full years and 1 partial year.

After accounting for the 1 year of benefit payments made in 2020, there is an approximate shortening of the sufficiency period by another 8 months mainly due to the following factors:

- The change in the investment rate of return assumption from 7.25% to 7.00% caused the sufficiency period to drop by about 7 months.
- The change to decrement rates related to the experience study caused the sufficiency period to drop about 4 months.
- The lower than expected Via Benefits per capita costs for Medicare retirees, and lower than expected increase in the 2021 Medicare Part B premium, caused the sufficiency period to increase by about 3 months.

These results are based on the amount of OPEB assets available as of December 31, 2020, which were provided by ACERA.[3]

[3] The OPEB assets used in this valuation (i.e., $891.6 million) are on an actuarial value of assets basis. Note that in our recently issued Governmental Accounting Standards Board (GASB) Statement No. 74 financial reporting valuation report as of December 31, 2020 of the OPEB benefits provided by the SRBR, we utilized the Plan's Fiduciary Net Position, or market value of OPEB assets, of $1,184.9 million, as required by that Statement. The increase in assets used in the GASB 74 valuation of $293.3 million represents one-half of the net deferred investment gains (under the actuarial value of assets method used by ACERA in the Retirement Plan valuation, and after replenishing the Contingency Reserve from $69.0 million to $98.7 million (1% of total assets)) that is commensurate with the size of the OPEB SRBR reserve to total SRBR and 401(h) reserve to valuation and 401(h) reserve. These deferred investment gains have not been utilized in this December 31, 2020 SRBR sufficiency valuation, similar to how the deferred investment gains as of December 31, 2019 were not used in last year's sufficiency valuation. For informational purposes only, the deferred investment gains as of December 31, 2020 represent about 11 years more of projected OPEB benefit payment.

Non-OPEB

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

In the December 31, 2019 valuation, it was projected that the non-OPEB assets would be exhausted in 2037, with full benefits paid through 2036, for a total of 17 full years and 1 partial year. The results of the December 31, 2020 valuation indicate that the terminal year of benefits is projected to be 2044, with full benefits paid through 2043, for a total of 23 full years and 1 partial year.

The main reason the terminal year of the SRBR for non-OPEB benefits is projected to be seven years later than it was in last year's study is the change in the actuarial assumptions, in particular the decrease in the inflation assumption from 3.00% to 2.75% per year. 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%. With the reduction in the assumed inflation rate from 3.00% to 2.75% per year, it is expected to take longer for members in Tiers 2, 2C, 2D, and 4 to accumulate a COLA bank in excess of 15%. In addition, for retired members and beneficiaries in Tiers 1 and 3 with COLA banks currently exceeding 15%, it is expected that their banks will eventually fall below the 15% threshold as the banks are used to provide for the difference between the cost of living allowance of 3% and the assumed inflation assumption of 2.75%. These changes result in a decrease in the present value of providing supplemental COLA benefits.

These results are based on the amount of non-OPEB assets available as of December 31, 2020, which were provided by ACERA.[4]

Other Considerations

Note that the terminal years through which the SRBR can be paid have been developed to reflect only the actuarial value of assets allocated to the SRBR through December 31, 2020. As we indicated on page 23 of our December 31, 2020 actuarial valuation report for the Pension Plan, the Association had deferred investment gains of $643.3 million that were not yet

[4] The non-OPEB SRBR assets used in this valuation (i.e., $41.7 million) are on an actuarial value of assets basis. Note that in our recently issued Governmental Accounting Standards Board (GASB) Statement No. 67 financial reporting valuation report as of December 31, 2020 for the Pension Plan and non-OPEB benefits provided by the SRBR, we utilized the Plan's Fiduciary Net Position, or market value of assets, of $55.5 million in non-OPEB SRBR assets. as required by that Statement. The increase in non-OPEB SRBR assets used in the GASB 67 valuation of $13.8 million represents one-half of the net deferred investment gains (under the actuarial value of assets method used by ACERA in the Retirement Plan valuation, and after replenishing the Contingency Reserve from $69.0 million to $98.7 million (1% of total assets)) that is commensurate with the size of the non-OPEB SRBR reserve to total SRBR reserve. These deferred investment gains have not been utilized in this December 31, 2020 SRBR sufficiency valuation, similar to how the deferred investment gains as of December 31, 2019 were not used in last year's sufficiency valuation. For informational purposes only, the deferred investment gains as of December 31, 2020 represent about 4 years more of projected non-OPEB benefit payment.

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 $643.3 million represent 6.7% of the market value of assets as of December 31, 2020. 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 $293.3 million to pay OPEB benefits and $13.8 million to pay non-OPEB benefits.[5]

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

These calculations were prepared under the supervision of Andy Yeung, ASA, MAAA, Enrolled Actuary; Eva Yum, FSA, MAAA, Enrolled Actuary; and Thomas Bergman, ASA, MAAA, Enrolled Actuary. We are members of the American Academy of Actuaries and we meet the Qualifications of the American Academy of Actuaries to render the actuarial opinion herein.

Please let us know if you have any questions.

Sincerely,

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

Eva Yum, FSA, MAAA, EA
Senior Actuary

Thomas Bergman, ASA, MAAA, EA
Senior Actuary

JB/bbf
Enclosures (5672927, 5684695)

[5] It is important to note that the December 31, 2020 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 onset of the Public Health Emergency. 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, 2020. While it is impossible to determine how the pandemic will affect market conditions and other demographic experience of the Plan in future valuations, Segal is available to prepare projections of potential outcomes upon request.

Alameda County Employees' Retirement Association
Projected Cash Flow and Present Value of Projected Benefits Provided by the Supplemental Retirees Benefit Reserve as of December 31, 2020

Year Ending December 31	Annual Benefit Cash Flows			Present Value as of December 31, 2020 of Projected Benefits through Year End		
	Medical[1]	Dental and Vision	Non-OPEB[2]	OPEB[3]	Non-OPEB	Total
2021	$49,876,435	$4,850,597	$1,131,472	$52,906,619	$1,093,835	$54,000,454
2022	53,488,725	4,956,332	1,101,201	105,711,263	2,088,762	107,800,025
2023	57,419,920	5,049,860	1,073,433	158,459,814	2,995,152	161,454,966
2024	61,272,386	5,330,629	1,069,944	211,019,246	3,839,493	214,858,739
2025	65,262,987	5,613,007	1,070,774	263,291,613	4,629,209	267,920,822
2026	69,426,079	5,917,810	1,078,356	315,223,877	5,372,487	320,596,364
2027	73,550,143	6,229,099	1,090,304	366,615,857	6,074,836	372,690,693
2028	77,420,358	6,546,750	1,164,190	417,166,986	6,775,719	423,942,705
2029	81,043,238	6,864,919	1,347,490	466,628,461	7,533,884	474,162,345
2030	84,911,352	7,196,438	1,638,001	515,062,477	8,395,211	523,457,688
2031	88,933,429	7,540,150	2,152,533	562,473,434	9,453,052	571,926,486
2032	92,731,165	7,884,006	2,935,203	608,684,930	10,801,160	619,486,090
2033	96,783,802	8,227,547	3,871,337	653,760,270	12,462,902	666,223,172
2034	100,530,594	8,564,122	4,855,748	697,524,845	14,410,840	711,935,685
2035	104,052,975	8,891,373	5,875,774	739,869,610	16,613,768	756,483,378
2036	107,219,759	9,211,791	6,894,957	780,666,037	19,029,691	799,695,728
2037	110,321,682	9,530,342	7,946,846	819,913,631	21,632,022	841,545,653
2038	113,672,865	9,844,738	9,098,043	857,715,454	24,416,423	882,131,877
2039	108,904,453[4]	9,493,447[4]	10,153,656	891,579,911	27,320,597	918,900,508
2040			11,111,468	891,579,911	30,290,811	921,870,722
2041			12,080,282	891,579,911	33,308,744	924,888,655
2042			13,266,996	891,579,911	36,406,316	927,986,227
2043			14,501,468	891,579,911	39,570,611	931,150,522
2044			10,329,875[4]	891,579,911	41,677,183	933,257,094

[1] Includes Medicare Part B and Implicit Subsidy Reimbursement made to the County.

[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.

Segal

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Via Email

March 22, 2021

Ms. Kathy Foster
Assistant Chief Executive Officer
Alameda County Employees' Retirement Association
475 14th Street, Suite 1000
Oakland, CA 94612

Re: Alameda County Employees' Retirement Association
Health Trend Assumptions Recommended for the December 31, 2020 SRBR Retiree Health Actuarial Valuation

Dear Kathy:

We have provided in this letter the health trend assumptions that we recommend to the Board for the December 31, 2020 retiree health valuation.

These health trend assumptions will also be used to develop our Governmental Accounting Standards Board (GASB) Statement 74 report with a measurement date of December 31, 2020.

Health Care Trend Assumptions

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

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

1. For the prior December 31, 2019 SRBR valuation, we recommended the following assumptions:

    a. For the non-Medicare plans, we recommended the first year trend rate be set at 6.75%, then graded down by 0.25% each year until an ultimate rate of 4.50% is reached after 9 years. For the Medicare plans, we recommended the first year trend rate be set at 6.25%, then graded down by 0.25% each year until an ultimate rate of 4.50% is reached after 7 years.

In addition, to reflect the repeal[1] of the Health Insurance Tax (HIT) that took effect in 2021, we subtracted 1.20% from the first-year non-Medicare trend and 0.90% from the first-year Medicare trend.

We continued to use the ultimate health care trend assumption of 4.50% for these plans, based on Segal's research and analysis on long-term cost in the health care market as a whole.

b. The ultimate Dental and Vision trend assumptions remained at 4.00% based upon Segal Survey data.

c. Medicare Part B trend assumption was 4.50% based on updated information from the Centers for Medicare & Medicaid Services (CMS) relating to expectations for ultimate Medicare trend and Congressional Budget Office (CBO) trustee reports.

d. Based on past practice, the 5.55% (6.75% minus 1.20% for removal of the HIT) non-Medicare and 5.35% (6.25% minus 0.90% for removal of the HIT) Medicare first year trends were used in the December 31, 2019 "preview" valuation and were applied to the 2020 non-Medicare and Medicare medical premiums to estimate the projected 2021 non-Medicare and Medicare medical premiums. The first year trends were replaced as part of the "final" valuation as of December 31, 2019 to reflect the actual premium renewals for 2021.

e. We continued to assume that the Board's annual Monthly Medical Allowance (MMA) would increase by 50% of the rate of the anticipated medical trend (including 50% of the adjustment due to the HIT) assumption. If different types of medical plans had different initial trend rates, we assumed that the future increase in MMA would be linked to the plan with the lowest projected medical trend (i.e., the Medicare plans). For the Board's subsidies for Medicare Part B, dental and vision plans, we assumed they would increase at the full rate of anticipated trend assumed for each of those plans as provided in Attachment One (4.50% for Medicare Part B and 4.00% for dental/vision to project premiums for calendar year 2021).

2. For the current December 31, 2020 SRBR valuation, we are recommending the following assumptions:

   a. For the non-Medicare plans, we are recommending the first year trend rate be reset to the same 6.75% that we recommended as the first-year trend in the prior year valuation[2], then grading down by 0.25% each year until reaching an ultimate rate of 4.50% after 9 years. For the Medicare plans, we are recommending the first-year trend rate be reset to the same 6.25% that we recommended as the first-year trend in the

[1] The HIT was imposed by the Affordable Care Act (ACA) on each covered entity engaged in the business of providing health insurance for United States health risks. The fees associated with the HIT are collected from the health insurance industry to fund the implementation and ongoing support of the ACA marketplace exchanges. They are based on the health insurance providers' premiums and market shares. These taxes were incorporated into premiums beginning in 2014 and would vary based upon insurer. Congressional budgetary actions placed a moratorium on these fees for calendar years 2017 and 2019. These fees were again reflected in premiums for calendar year 2020. The repeal of the ACA at the end of 2020 removes the HIT from the premiums beginning in calendar year 2021.

[2] We note that in the absence of the above recommendation to reset the assumption, the first-year trend rate that we would use in this year's valuation would equal 6.50%.

prior year valuation[3], then grading down by 0.25% each year until reaching an ultimate rate of 4.50% after 7 years.

We will continue to use the ultimate health care trend assumption of 4.50% for these plans, based on Segal's research and analysis on long-term cost in the health care market as a whole.

b. The Dental and Vision annual trend assumptions will remain at 4.00% based upon Segal Survey data.

However, because of the three-year 2021 rate guarantee for dental, the first-two years of trend will be 0.00%. Likewise, because of the five-year 2021 rate guarantee for vision, the first four years of trend will be 0.00%.

In the prior valuations, we had not reflected any multi-year rate guarantees for dental and vision trend. To reduce potential actuarial gains, we have updated our methodology to reflect any known rate guarantees in our trend assumption.

c. Medicare Part B trend assumptions will remain at 4.50%, based on updated information from the Centers for Medicare & Medicaid Services (CMS) relating to expectations for ultimate Medicare trend and Congressional Budget Office (CBO) trustee reports.

d. Based on past practice, the 6.75% non-Medicare and 6.25% Medicare first year trends will be used in the December 31, 2020 "preview" valuation and applied to the 2021 non-Medicare and Medicare medical premiums to estimate the projected 2022 non-Medicare and Medicare medical premiums. The first year trends will be replaced as part of the "final" valuation as of December 31, 2020 to reflect the actual premium renewals for 2022.

e. We will continue to assume that the Board's annual Monthly Medical Allowance (MMA) will increase by 50% of the rate of the anticipated medical trend assumption. If different types of medical plans have different initial trend rates, we assume that the future increase in MMA will be linked to the plan with the lowest projected medical trend (i.e., the Medicare plans). For the Board's subsidies for Medicare Part B, dental and vision plans, we assume they would increase at the full rate of anticipated trend assumed for each of those plans, as described in (b) and (c) above, and provided in Attachment One.

Segal will prepare a separate letter to address the recommended demographic driven changes to be used in the December 31, 2020 SRBR sufficiency valuation.

[3] We note that in the absence of the above recommendation to reset the assumption, the first-year trend rate that we would use in this year's valuation would equal 6.00%.

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

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

Sincerely,

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

Paul Sadro, ASA, MAAA
Senior Actuary

TJH/bbf
Attachment

Segal

Health Trends Used in the Prior Valuation as of December 31, 2019
(Provided for Comparison Purposes)

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

Calendar Year	United Healthcare HMO & Kaiser HMO Early Retiree[3]	Via Benefits & Kaiser Senior Advantage[4]	Dental & 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) For calendar year 2020, actual trends are below, based on actual premium renewals for 2021, as reported by ACERA. These trends were used in preparing our December 31, 2019 SRBR valuation report dated September 23, 2020.

Kaiser HMO Early Retiree	United Healthcare HMO Early Retiree	Kaiser Senior Advantage	Dental & 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.

Health Trends Recommended for the Current Valuation as of December 31, 2020

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

Calendar Year	United Healthcare HMO & Kaiser HMO Early Retiree[2]	Via Benefits & Kaiser Senior Advantage[3]	Dental[4]	Vision[5]	Medicare Part B
2021	6.75%[1]	6.25%[1]	0.00%	0.00%	4.50%
2022	6.50	6.00	0.00	0.00	4.50
2023	6.25	5.75	4.00	0.00	4.50
2024	6.00	5.50	4.00	0.00	4.50
2025	5.75	5.25	4.00	4.00	4.50
2026	5.50	5.00	4.00	4.00	4.50
2027	5.25	4.75	4.00	4.00	4.50
2028	5.00	4.50	4.00	4.00	4.50
2029	4.75	4.50	4.00	4.00	4.50
2030 & Later	4.50	4.50	4.00	4.00	4.50

(1) Based on past practice, the first year trends will be replaced as part of the "final" valuation as of December 31, 2020 to reflect the actual premium renewals for 2022.

(2) Non-Medicare plans.

(3) Medicare plans.

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

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

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VIA E-MAIL

April 15, 2021

Ms. Kathy Foster
Assistant Chief Executive Officer
Alameda County Employees' Retirement Association
475 14th Street, Suite 1000
Oakland, CA 94612-1900

Re: Alameda County Employees' Retirement Association
Recommended Parameters to Reflect Demographic Driven Changes
for the December 31, 2020 SRBR Retiree Health Actuarial Valuation

Dear Kathy:

We have provided in this letter the recommended parameters to reflect the demographic driven changes in the membership data for use in the December 31, 2020 retiree health valuation.

The health care cost trend assumptions used in the health valuation are reviewed annually and the recommended assumptions for the December 31, 2020 valuation (that we have used earlier to prepare our Governmental Accounting Standards Board Statement 74 report with a measurement date as of the same date) were provided in a separate letter dated March 22, 2021.

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

Following are our recommended assumptions for the December 31, 2020 health plan valuation:

1. Per capita medical costs – These costs are used to project the premiums for current active members when they retire. Based on the percentage of retired members, spouses and beneficiaries electing health coverage and the proportion of members enrolled in each available medical plan, we will project the per capita health premium costs for a member who is covered in calendar year 2021. They are provided in Item 2a of the Attachment.

2. Election rates – Based on the January 1, 2021 enrollment data, we have provided in Item 2a of the Attachment the observed and recommended election rates among the

different medical plans. Based on this enrollment data, we propose maintaining the percent of newly eligible retirees who will elect medical coverage in the future. The recommended election assumption is shown in Item 3j of the Attachment.

3. The per capita costs and election rates for the dental and vision plans that we recommend for use in the December 31, 2020 valuation are provided in Item 2b of the Attachment.

4. For retirees enrolled in a Group Medical Plan, ACERA provides a monthly subsidy of $578.65 for retirees with 20 or more years of service, $433.99 for retiree with 15-19 years of service, and $289.33 for retirees with 10-14 years of service. We have assumed that the MMA subsidy for the Group Medical Plans available will increase with 50% of medical trend[1] after 2021.

5. Via Benefits Individual Medical Insurance Exchange – Beginning in 2013, retirees eligible for Medicare have the option to purchase individual Medicare insurance from plans through the Via Benefits Individual Medicare Insurance Exchange. Item 2a of the Attachment shows the percentage of retirees enrolled in Via Benefits as of January 2021. To assist with purchasing insurance through Via Benefits, the Board adopted a monthly subsidy of $443.28 for Medicare retirees with 20 or more years of service, $332.46 for retirees with 15-19 years of service, and $221.64 for retirees with 10-14 years of service. We have assumed that the MMA subsidy for the individual plans available through Via Benefits will increase with 50% of medical trend[1] after 2021, consistent with the increase anticipated for the MMA for the group plans.

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

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

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

   To derive the average monthly per capita cost, we have analyzed the actual Via Benefits reimbursement data available from January 1, 2020 through December 31, 2020, adjusted for expected medical trend to 2021 and have included an estimate of the

[1] As noted in Item 3d(i) of the Attachment, if different types of medical plans have different initial trend rates, we assume that the future increase in MMA will be linked to the plan with the lowest projected medical trend.

additional cost to account for the lag in reporting and reimbursing any unused amount in the retirees' Health Reimbursement Account through March 2021. That calculation is provided in Item 2a of the Attachment.

6. Other assumptions – The other assumptions and methods will be consistent[2] with those used in our December 31, 2020 pension funding valuation. These include the economic and non-economic assumptions.

We are members of the American Academy of Actuaries and collectively meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein.

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

Sincerely,

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

Thomas Bergman ASA, MAAA, EA
Senior Actuary

TJH/bbf
Attachment

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

1. Health Care Cost Trend Rates

The health care cost trend assumptions recommended for the December 31, 2020 valuation to be applied to all health plans were provided in a separate letter dated March 22, 2021.

2. (a) Medical Plan - Per Capita Costs and Election Rates for Calendar Year 2021

UNDER AGE 65[1]

Medical Plan	Recommended Election Assumption	Observed Election	Monthly Premium (Self)	Maximum Monthly Subsidy (20+ YOS)
Kaiser HMO	80%	77.0%	$810.72	$578.65
United Healthcare HMO Current Network	10%	7.3%	1,150,60	578.65
Via Benefits Individual Insurance Exchange[2]	10%	12.0%	N/A[2]	578.65
United Healthcare HMO SVA Network	0%	3.1%	759.16	578.65
Other Plans	0%	0.6%	810.72[3]	578.65

AGE 65 AND OLDER

Medical Plan	Recommended Election Assumption	Observed Election	Monthly Premium (Self)	Maximum Monthly Subsidy (20+ YOS)
Kaiser, non-Medicare[4]	0%	1.8%	$810.72	$578.65
Kaiser Senior Advantage	75%	72.0%	382.21	578.65
Via Benefits Individual Insurance Exchange	25%	26.1%	309.27[5]	443.28
Other Plans	0%	0.1%	382.21[3]	578.65

(1) *Current retirees under age 65 are assumed to elect medical plans in the same proportion as future retirees upon age 65.*

(2) *Via Benefits individual insurance coverage is available to retirees under age 65 residing outside of ACERA medical plans' coverage areas. We have assumed that these current retirees under age 65 will draw the Maximum Monthly Subsidy ($578.65).*

(3) *We assumed the same costs as Kaiser HMO and Kaiser Senior Advantage for current non-Medicare and Medicare retirees, respectively.*

(4) *Closed to future retirees.*

(5) *Derivation of the amount expected to be paid in 2021 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.*

		Derivation of Via Benefits Monthly Per Capita Costs		
	(Years of Service Category)	**10-14**	**15-19**	**20+**
1.	Maximum MMA for 2020	$221.64	$332.46	$443.28
2.	Total of Maximum MMA (From Jan. 2020 to Dec. 2020)	$506,447	$805,741	$5,138,819
3.	Total of Actual Reimbursement (From Jan. 2020 to Dec. 2020)	$377,103	$577,016	$3,093,872
4.	Ratio of Actual Reimbursement to Maximum 2020 MMA [(3) / (2)]	74.46%	71.61%	60.21%
5.	Average Monthly Per Capita Cost for 2020 [(1) x (4)]	$165.03	$238.07	$266.90
6.	Maximum MMA for 2021	$221.64	$332.46	$443.28
7.	Increase in Average Monthly Per Capita Cost due to the Change in Maximum MMA from 2020 to 2021 [(6) / (1)] x (5)	$165.03	$238.07	$266.90
8.	Increase for Expected Medical Trend (5.35%[6]) from 2020 to 2021 [(7) x 1.0535]	$173.86	$250.81	$281.18
9.	Increase for Additional 10% Margin for 2020 Expenses Incurred in 2020 but Reimbursed after December 2020 [(8) x 1.10]	**$191.25**	**$275.89**	**$309.30**

2. (b) Dental and Vision Plans - Per Capita Costs and Election Rates for Calendar Year 2021

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

a. 10 or more years of ACERA service credit; or

b. Service-connected disability; or

c. Non-service-connected disability with retirement prior to February 1, 2014.

2021 Plan Year Monthly Subsidy
$44.15 + $3.97 = $48.12

(6) *6.25% medical trend for Medicare Plans (lowest medical trend) minus 0.90% to reflect the repeal of the Health Insurance Tax (HIT).*

3. Other Assumptions

In the December 31, 2020 valuation, we will also apply the following assumptions and methodologies:

a. Economic assumptions: These include discount rate, inflation rate and salary scale assumptions. We will apply the same assumptions approved by the Board for the December 31, 2020 pension funding valuation.

b. Demographic assumptions: These include the incidence of service retirement, disability retirement, withdrawal and deferred vested retirement. We will apply the same assumptions that we use for the December 31, 2020 pension funding valuation. For the purposes of anticipating death, we use the headcount weighted instead of the benefit (or amount) weighted mortality tables used in the pension funding valuation.

c. Funding methodologies: The Entry Age Actuarial Cost Method will continue to be used in this valuation. For the purpose of the Sufficiency Study, SRBR is assumed to pay benefits until the current assets are exhausted.

d. Expected annual rate of increase in the Board's health subsidy amount:

   i. Maximum Monthly Medical Allowances (MMA) will increase with 50% of medical trend.

      If different types of medical plans have different initial trend rates, we assume that the future increase in MMA will be linked to the plan with the lowest projected medical trend.

   ii. Dental and vision premium reimbursement will increase with full dental/vision trend.

   iii. Medicare B premium reimbursement will increase with full Medicare Part B trend.

e. We will assume 100% of future retirees will be covered by Medicare Parts A and B, and receive Medicare Part B premium reimbursement. We will further assume all current retirees under age 65 receiving a MMA will also receive a Medicare Part B premium reimbursement upon age 65.

f. Assets: We will use the current value of assets in the SRBR in our valuation.

3. Other Assumptions (continued)

g. Implicit Subsidy: Our understanding is that the under age 65 retiree premium[7] rates are pooled together with active premium rates and an implicit subsidy does exist. For GASB 74/75 purposes, we will include the total cost of the implicit subsidy. For purposes of sufficiency of funds for benefits provided by the SRBR, the implicit subsidy will be adjusted to match the County health actuary's estimated amount of TBD[8] for 2021, to reflect that ACERA is not reimbursing all employers' implicit subsidy costs.

h. Spouse Age Difference in Years for Retirees with Medical Coverage (Spousal Coverage will only affect costs due to implicit subsidy):

Member Gender	Average Observed Age Difference for Spouse	Current Assumption	Recommended Assumption
Male	-3	-3	-3
Female	1	2	1

i. Spousal Coverage:

Member Gender	Observed for Current Retirees	Current Assumption for Future Retirees	Recommended Assumption for Future Retirees
Male	40.7%	40%	40%
Female	16.6%	20%	20%

j. Retiree Medical Coverage Election:
The table below summarizes the figures for retirees eligible for ACERA retiree medical coverage.

	Observed for Current Retirees	Current Assumption for Future Retirees	Recommended Assumption for Future Retirees
Under Age 65*	75.1%	80%	80%
Age 65 and Older	87.1%	90%	90%

***** 50% of eligible retirees under age 65 without medical coverage are assumed to elect medical coverage upon reaching age 65.

(7) *Only ACERA group plans (not individual plan premiums purchased through Via Benefits) generate an implicit subsidy liability.*

(8) *The 2021 implicit subsidy estimate is not yet available.*

3. Other Assumptions (continued)

k. Age-Based Costs for Retirees Under Age 65

Since 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. The annual age-based per capita costs for retirees and spouses under age 65 for 2021 are shown below:

	Retiree		Spouse	
Age	**Male**	**Female**	**Male**	**Female**
50	$10,981	$12,508	$7,670	$10,043
55	13,042	13,465	10,264	11,625
60	15,488	14,513	13,741	13,483
64	17,769	15,396	17,346	15,175

l. Adjustment of Per Capita Medical Costs for Age and Gender for Retirees Age 65 and Over. The following factors were applied to age 65 and over per capita costs in Table 2(a) for 2021:

	Retiree		Spouse	
Age	**Male**	**Female**	**Male**	**Female**
65	0.9478	0.8056	N/A*	N/A*
70	1.0985	0.8682	N/A*	N/A*
75	1.1838	0.9345	N/A*	N/A*
80+	1.2748	1.0075	N/A*	N/A*

* *We do not value any implicit subsidy for spouses over age 65.*

m. Changes in eligibility requirements since the prior valuation:

Please let us know of any changes.

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: June 2, 2021

TO: Members of the Retirees Committee

FROM: Kathy Foster, Assistant Chief Executive Officer

SUBJECT: **Monthly Medical Allowance for 2022**

This memo provides background information on the Monthly Medical Allowance benefit paid from the Supplemental Retiree Benefit Reserve Policy (SRBR), and the substantive plan definition. Staff will review the attached presentation, which summarizes the information contained in this memo.

Each year, the Retirees Committee recommends to the Board of Retirement (Board) a suggested dollar amount to be contributed towards retiree health care costs. This dollar contribution is known as the Monthly Medical Allowance (MMA). The MMA is a non-vested retiree health benefit provided in agreement with ACERA's Participating Employers through the use of Internal Revenue Code 401(h) accounts. 401(h) benefits are funded by employer contributions. After contributions are made, in accordance with the County Employees Retirement Law of 1937, ACERA treats an equal amount of SRBR assets as employer contributions available for paying pension benefits.

GROUP PLAN OPTIONS AND MONTHLY MEDICAL ALLOWANCE

Non-Medicare eligible retirees (early retirees) have the option of enrolling in Kaiser Permanente or UnitedHealthcare SignatureValue HMO or UnitedHealthcare SignatureValue Advantage HMO group plans. Medicare eligible retirees have the option of enrolling in the Kaiser Senior Advantage group plan. Group plan premiums are deducted from the retirees' monthly payroll amounts and offset by the MMA subsidy amount, which is based on years of service.

For early retirees, the premium exceeds the current MMA, which results in an out-of-pocket cost (see attached charts). For Medicare eligible retirees, the MMA covers the group plan premium for those with 15 years or more of service. Those with less than 15 years of service pay an out-of-pocket cost (see attached charts).

INDIVIDUAL PLAN MONTHLY MEDICAL ALLOWANCE

In 2012 ACERA offered individual Medicare Exchange plan coverage, replacing a former group plan. Retirees may enroll in an individual plan on the Medicare Exchange and receive an MMA based on years of service. The individual plan MMA provides reimbursement through a Health Reimbursement Arrangement (HRA) for premiums, co-pays and deductibles, but is limited to an annual amount.

Effective January 1, 2016, ACERA offered individual plan coverage to early retirees who live outside ACERA's HMO service areas through the Health Exchange. Also effective January 1, 2016, ACERA terminated the group multi-site contracts with Kaiser Permanente, and instead provided individual medical coverage for impacted retirees through the Health Exchange, or an individual plan offered directly through Kaiser.

The MMA amounts provided through the HRAs are based on years of service. Retirees are reimbursed for premiums, co-pays and deductibles up to their annual MMA amount. Premium amounts depend on the plan chosen by the retiree through Via Benefits. Some retirees will use their entire allotment if they incur higher costs, such as the early retiree plan premiums or high drug costs for Medicare eligible retirees.

SUBSTANTIVE PLAN DEFINITION

To complete ACERA's substantive plan definition under GASB 43, the Board in 2007 adopted a formula which bases future MMA contribution increases on an amount equal to 50% of the rate of health care inflation assumptions provided by ACERA's actuary.

ACERA's Actuary, Segal, has provided ACERA with its recommended assumptions to be used for the December 31, 2020 retiree health plan valuation. These assumptions reset the near-term trend assumption for non-Medicare to 6.75% and Medicare Advantage plans to 6.25% in calendar year 2020. Based on our substantive plan definition under GASB, we would use 3.125% as an increase to the 2022 MMA should an increase be considered. When more than one trend is provided, the lowest number is used.

For Plan Years 2011, 2012, 2013, 2014 and 2015, the Board decided not to increase the MMA. However, for Plan Year 2016, the Board decided to follow the substantive plan definition adopted under GASB and increased the MMA by one-half the rate of anticipated health care inflation assumptions. For the 2017 and 2018 Plan Years, the Board decided not to increase the MMA. For Plan Years 2019 and 2020, the Board decided to follow the substantive plan definition adopted under GASB and increased the MMA by one-half the rate of anticipated health care inflation assumptions. For the 2021 Plan Year, the Board decided not to increase the MMA.

GROUP PLANS COSTS

Attached are three charts. One provides the current MMA costs and premiums for 2021; another with estimated trend percentage increases to premiums with no increase to the MMA; and a third with projected increases to premiums and a 3.125% increase to the MMA. A summary of total costs is provided below:

Plan Year	20+ Years MMA	Annual Cost Summary	
2021	$578.65	Current premiums and MMA:	$25,322,221
2022	$578.65	Increase in premiums only:	$26,349,109
2022	$596.73	Increase in premiums and MMA:	$26,626,981

If no increase is applied to the MMA, we assume premiums will still increase and the total cost will go up by approximately $1,026,888. If 3.125% is added to the MMA, we assume the annual cost to provide this benefit will increase by $1,304,760 ($1,026,888 due to premium increase and $277,872 due to 3.125% MMA increase) for 2022.

The above projected annual costs reflect enrollment in the main group plans (Kaiser California and UnitedHealthcare). If we included the Operating Engineers, the additional projected annual cost is $192,690.

INDIVIDUAL PLAN COSTS – Early (Non-Medicare) Retirees Living Outside ACERA's HMO Service Area

The following chart shows the current MMA amounts approved for 2021, and estimated costs based on the entire maximum MMA for the current number of enrollments. The actual cost is determined based on the amount reimbursed to each retiree. Based on the actual reimbursements for the 2020 Plan Year (as of May 4, 2021), the total reimbursements were $813,111.40.

Years of Service Category	Number of Members	Monthly MMA Amount	Annual MMA Amount	Maximum Annual MMA Amount
10 - 14 Years	24	$ 289.33	$ 3,471.96	$ 83,327.04
15 - 19 Years	33	$ 433.99	$ 5,207.88	$ 171,860.04
20 + Years	185	$ 578.65	$ 6,943.80	$ 1,284,603.00
Totals	**242**			**$ 1,539,790.08**

The Board may also consider increasing the reimbursement amounts for the early retirees in the individual plans, which would result in the amounts stated in the chart below.

Years of Service Category	Number of Members	Monthly MMA Amount	Annual MMA Amount	Maximum Annual MMA Amount
10 - 14 Years	24	$ 298.37	$ 3,580.44	$ 85,930.56
15 - 19 Years	33	$ 447.55	$ 5,370.60	$ 177,229.80
20 + Years	185	$ 596.73	$ 7,160.76	$ 1,324,740.60
Totals	**242**			**$ 1,587,900.96**

Based on a 3.125% increase, which is 50% of the medical plan trend, the estimated annual increase would be $48,111.

INDIVIDUAL PLAN COSTS – Medicare Eligible Retirees

The following chart shows the current MMA amounts approved for 2021, and estimated costs based on the entire maximum MMA for the current number of enrollments. The actual cost is determined based on the amount reimbursed to each retiree. Based on the actual reimbursements for the 2020 Plan Year (as of May 4, 2021), the total reimbursements were $4,306,220.89.

Years of Service Category	Number of Members	Monthly MMA Amount	Annual MMA Amount	Maximum Annual MMA Amount
10 - 14 Years	197	$ 221.64	$ 2,659.68	$ 523,956.96
15 - 19 Years	204	$ 332.46	$ 3,989.52	$ 813,862.08
20 + Years	982	$ 443.28	$ 5,319.36	$ 5,223,611.52
Totals	**1,383**			**$ 6,561,430.56**

The Board may also consider increasing the reimbursement amounts for the Medicare eligible retirees in the individual plans, which would result in the amounts stated in the chart below.

Years of Service Category	Number of Members	Monthly MMA Amount	Annual MMA Amount	Maximum Annual MMA Amount
10 - 14 Years	197	$ 228.57	$ 2,742.84	$ 540,339.48
15 - 19 Years	204	$ 342.85	$ 4,114.20	$ 839,296.80
20 + Years	982	$ 457.13	$ 5,485.56	$ 5,386,819.92
Totals	**1,383**			**$ 6,766,456.20**

Based on a 3.125% increase, which is 50% of the medical plan trend, the estimated annual increase would be $205,026.

CONSIDERATIONS FOR SETTING 2022 MMA

- A history of the MMA amounts for the 10-year period 2012 through 2021 is shown in the attached presentation.
- Health care premium costs for 2022 are unknown; however, a history of the premiums for the 10-year period 2012 through 2021 is shown in the attached presentation.
- In 2020, $60,294,406 was credited to the SRBR (includes interest credited at the assumed rate of return of 3.6250%).
- On a preliminary basis, Segal projects 18 years of benefits payable from the SRBR, which is one year less than last year's projection. Projections have exceeded the SRBR Policy's 15-year goal since 2013.

- The Implicit Subsidy for 2021 is estimated to be about $1,831,798 lower than the cost for 2020.
- Annual payee numbers are increasing by about 3% on average.
- ACERA's overall SRBR costs increased by 3.77% in 2020 compared to an 8.02%increase in 2019.
- Also attached for informational purposes is a 10-year history of the SRBR (deductions and additions) fund balances.

RECOMMENDATIONS TO CONSIDER FOR JULY RETIREES COMMITTEE MEETING

1. Do not increase MMA amount for 2022. Current annual cost plus potential increase due to premium increase is $34,450,330.
2. Increase MMA by 50% of health care trend, 3.125% for potential increased cost of $34,981,338. This is an annual cost difference of $531,008.

Attachments (6)

ACERA

Out-of-Pocket Expenses for Retirees in Group Plans - *PLAN YEAR 2021*

Current Premiums and MMA

Plan	Years of Service	Under 10 Years	10 - 14 Years	15 - 19 Years	20 + Years	Total Enrolled
	2021 MMA	**$ -**	**$ 289.33**	**$ 433.99**	**$ 578.65**	
Early Retirees Plans						
Kaiser Permanente HMO (Early Retirees)	Projected # Enrolled (2021 plan year)	2	54	72	827	955
	Total Premium (2021)	$ 810.72	$ 810.72	$ 810.72	$ 810.72	
	Projected Subsidy Paid by ACERA	$ -	$ 289.33	$ 433.99	$ 578.65	
	Projected Premium Paid by Retiree	**$ 810.72**	**$ 521.39**	**$ 376.73**	**$ 232.07**	
UnitedHealthcare SignatureValue HMO (Early Retirees)	Projected # Enrolled (2021 plan year)	2	3	7	82	94
	Total Premium (2021)	$ 1,150.60	$ 1,150.60	$ 1,150.60	$ 1,150.60	
	Projected Subsidy Paid by ACERA	$ -	$ 289.33	$ 433.99	$ 578.65	
	Projected Premium Paid by Retiree	**$ 1,150.60**	**$ 861.27**	**$ 716.61**	**$ 571.95**	
UnitedHealthcare SignatureValue Advantage HMO (Early Retirees)	Projected # Enrolled (2021 plan year)	1	2	6	39	48
	Total Premium (2021)	$ 759.16	$ 759.16	$ 759.16	$ 759.16	
	Projected Subsidy Paid by ACERA	$ -	$ 289.33	$ 433.99	$ 578.65	
	Projected Premium Paid by Retiree	**$ 759.16**	**$ 469.83**	**$ 325.17**	**$ 180.51**	
					Total Plan Enrollees (Early Retirees)	**1097**
Kaiser Senior Advantage Medicare Plan						
Kaiser Senior Advantage	Projected # Enrolled (2021 plan year)	35	479	553	3029	4096
	Total Premium (2021)	$ 382.21	$ 382.21	$ 382.21	$ 382.21	
	Projected Subsidy Paid by ACERA	$ -	$ 289.33	$ 382.21	$ 382.21	
	Projected Premium Paid by Retiree	**$ 382.21**	**$ 92.88**	**0.00**	**0.00**	
					Total Kaiser Senior Advantage Medicare Plan Enrollees	**4096**

Total Projected Annual Cost: $25,322,221

ACERA

Out-of-Pocket Expenses for Retirees in Group Plans - *PLAN YEAR 2022*

Assumes 0% Increase to MMA and Projected Increase to Premiums

Plan	Years of Service	Under 10 Years	10 - 14 Years	15 - 19 Years	20 + Years	Total Enrolled
	Projected (2022) MMA	**$ -**	**$ 289.33**	**$ 433.99**	**$ 578.65**	
Early Retirees Plans						
Kaiser Permanente HMO (Early Retirees) **Assumes 6.75% Increase**	Projected # Enrolled (2021 plan year)	2	54	72	827	955
	Total Premium (2022)	$ 865.44	$ 865.44	$ 865.44	$ 865.44	
	Projected Subsidy Paid by ACERA	$ -	$ 289.33	$ 433.99	$ 578.65	
	Projected Premium Paid by Retiree	**$ 865.44**	**$ 576.11**	**$ 431.45**	**$ 286.79**	
UnitedHealthcare SignatureValue HMO (Early Retirees) **Assumes 6.75% Increase**	Projected # Enrolled (2021 plan year)	2	3	7	82	94
	Total Premium (2022)	$ 1,228.27	$ 1,228.27	$ 1,228.27	$ 1,228.27	
	Projected Subsidy Paid by ACERA	$ -	$ 289.33	$ 433.99	$ 578.65	
	Projected Premium Paid by Retiree	**$ 1,228.27**	**$ 938.94**	**$ 794.28**	**$ 649.62**	
UnitedHealthcare SignatureValue Advantage HMO (Early Retirees) **Assumes 6.75% Increase**	Projected # Enrolled (2021 plan year)	1	2	6	39	48
	Total Premium (2022)	$ 810.40	$ 810.40	$ 810.40	$ 810.40	
	Projected Subsidy Paid by ACERA	$ -	$ 289.33	$ 433.99	$ 578.65	
	Projected Premium Paid by Retiree	**$ 810.40**	**$ 521.07**	**$ 376.41**	**$ 231.75**	
					Total Plan Enrollees (Early Retirees)	**1097**
Kaiser Senior Advantage Medicare Plan						
Kaiser Senior Advantage **Assumes 6.25% Increase**	Projected # Enrolled (2021 plan year)	35	479	553	3029	4096
	Total Premium (2022)	$ 406.10	$ 406.10	$ 406.10	$ 406.10	
	Projected Subsidy Paid by ACERA	$ -	$ 289.33	$ 406.10	$ 406.10	
	Projected Premium Paid by Retiree	**$ 406.10**	**$ 116.77**	**0.00**	**0.00**	
					Total Kaiser Senior Advantage Medicare Plan Enrollees	**4096**

Total Projected Annual Cost: $26,349,109

ACERA

Out-of-Pocket Expenses for Retirees in Group Plans - *PLAN YEAR 2022*

Assumes 3.125% Increase to MMA and Projected Increase to Premiums

Plan	Years of Service	Under 10 Years	10 - 14 Years	15 - 19 Years	20 + Years	Total Enrolled
	Projected (2022) MMA	**$ -**	**$ 298.37**	**$ 447.55**	**$596.73**	
Early Retirees Plans						
Kaiser Permanente HMO (Early Retirees) Assumes 6.75% Increase	Projected # Enrolled (2021 plan year)	2	54	72	827	955
	Total Premium (2022)	$ 865.44	$ 865.44	$ 865.44	$ 865.44	
	Projected Subsidy Paid by ACERA	$ -	$ 298.37	$ 447.55	$ 596.73	
	Projected Premium Paid by Retiree	**$ 865.44**	**$ 567.07**	**$ 417.89**	**$ 268.71**	
UnitedHealthcare SignatureValue HMO (Early Retirees) Assumes 6.75% Increase	Projected # Enrolled (2021 plan year)	2	3	7	82	94
	Total Premium (2022)	$ 1,228.27	$ 1,228.27	$ 1,228.27	$ 1,228.27	
	Projected Subsidy Paid by ACERA	$ -	$ 298.37	$ 447.55	$ 596.73	
	Projected Premium Paid by Retiree	**$ 1,228.27**	**$ 929.90**	**$ 780.72**	**$ 631.54**	
UnitedHealthcare SignatureValue Advantage HMO (Early Retirees) Assumes 6.75% Increase	Projected # Enrolled (2021 plan year)	1	2	6	39	48
	Total Premium (2022)	$ 810.40	$ 810.40	$ 810.40	$ 810.40	
	Projected Subsidy Paid by ACERA	$ -	$ 298.37	$ 447.55	$ 596.73	
	Projected Premium Paid by Retiree	**$ 810.40**	**$ 512.03**	**$ 362.85**	**$ 213.67**	
					Total Plan Enrollees (Early Retirees)	**1097**
Kaiser Senior Advantage Medicare Plan						
Kaiser Senior Advantage Assumes 6.25% Increase	Projected # Enrolled (2021 plan year)	35	479	553	3029	4096
	Total Premium (2022)	$ 406.10	$ 406.10	$ 406.10	$ 406.10	
	Projected Subsidy Paid by ACERA	$ -	$ 298.37	$ 406.10	$ 406.10	
	Projected Premium Paid by Retiree	**$ 406.10**	**$ 107.73**	**0.00**	**0.00**	
					Total Kaiser Senior Advantage Medicare Plan Enrollees	**4096**

Total Projected Annual Cost: $26,626,981

Monthly Medical Allowance for 2022

Kathy Foster, ACERA Assistant CEO
June 2, 2021

Group Plan Options and Monthly Medical Allowance (MMA)

Non-Medicare eligible retirees
(early retirees)

- Kaiser Permanente
- UnitedHealthcare SignatureValue HMO
- UnitedHealthcare SignatureValue Advantage HMO

Medicare eligible retirees

- Kaiser Senior Advantage group plan

Plan	10 - 14 Years	15 - 19 Years	20 + Years
	$ 289.33	$ 433.99	$ 578.65
Early Retirees Plans			
Kaiser Permanente HMO (Early Retirees)	54	72	827
	$ 810.72	$ 810.72	$ 810.72
	$ 289.33	$ 433.99	$ 578.65
	$ 521.39	**$ 376.73**	**$ 232.07**
UnitedHealthcare SignatureValue HMO (Early Retirees)	3	7	82
	$ 1,150.60	$ 1,150.60	$ 1,150.60
	$ 289.33	$ 433.99	$ 578.65
	$ 861.27	**$ 716.61**	**$ 571.95**
UnitedHealthcare SignatureValue Advantage HMO (Early Retirees)	2	6	39
	$ 759.16	$ 759.16	$ 759.16
	$ 289.33	$ 433.99	$ 578.65
	$ 469.83	**$ 325.17**	**$ 180.51**
Kaiser Senior Advantage Medicare Plan			
Kaiser Senior Advantage	479	553	3029
	$ 382.21	$ 382.21	$ 382.21
	$ 289.33	$ 382.21	$ 382.21
	$ 92.88	**0.00**	**0.00**

Individual Plan MMA

- Individual Medicare plan coverage
- Individual plan coverage for early retirees who live outside ACERA's HMO service areas

MMA for Individual Plans			
	10-14 yrs	15-19 yrs	20+ yrs
Individual Medicare Plans	$221.64	$332.46	$443.28
Individual Non-Medicare Plans	$289.33	$433.99	$578.65

- Monthly premiums depend on chosen individual plan
- MMA is provided through Health Reimbursement Arrangement

Substantive Plan Definition under GASB 43

- In 2007, the Board adopted a formula which bases future MMA contribution increases on an amount equal to 50% of the rate of health care inflation assumptions provided by ACERA's actuary
- Segal provided assumptions to be used for the December 31, 2020 retiree health plan valuation. These assumptions reset the near-term trend assumptions in the calendar year 2021:
  - 6.75% for non-Medicare plans
  - 6.25% for Medicare Advantage Plans
- Based on our substantive plan definition, we would use 3.125% as an increase to the 2022 MMA should an increase be considered
  - When more than one trend is provided, the lowest number is used

Group Plans Costs

- If no increase is applied to the MMA, we assume premiums will still increase and the total cost will go up by approximately $1,026,888

- If 3.125% is added to the MMA, we assume the annual cost to provide this benefit will increase by $1,304,760 ($1,026,888 due to premium increase and $277,872 due to 3.125% MMA increase) for 2022

Plan Year	20+ Years MMA	Annual Cost Summary	
2021	$578.65	Current premiums and MMA:	$25,322,221
2022	$578.65	Increase in premiums only:	$26,349,109
2022	$596.73	Increase in premiums and MMA:	$26,626,981

Note: If we included the Operating Engineers, the additional projected annual cost is $192,690

Early Retiree Individual Plan Costs – Outside HMO Service Area

Years of Service Category	Number of Members	2021			2022
		Monthly MMA Amount	Annual MMA Amount	Maximum Annual MMA Amount	Maximum Annual MMA Amount with Increase
10 - 14 Years	24	$ 289.33	$ 3,471.96	$ 83,327.04	$ 85,930.56
15 - 19 Years	33	$ 433.99	$ 5,207.88	$ 171,860.04	$ 177,229.80
20 + Years	185	$ 578.65	$ 6,943.80	$ 1,284,603.00	$ 1,324,740.60
Totals	**242**			**$ 1,539,790.08**	**$ 1,587,900.96**

The 3.125% increase in the MMA results in an estimated amount of $48,111

Note: Based on the actual reimbursements for the 2020 Plan Year (as of May 4, 2021), the total reimbursements were $813,111

Individual Plan Costs – Medicare Eligible Retirees

Years of Service Category	Number of Members	2021			2022
		Monthly MMA Amount	Annual MMA Amount	Maximum Annual MMA Amount	Maximum Annual MMA Amount with Increase
10 - 14 Years	197	$ 221.64	$ 2,659.68	$ 523,956.96	$ 540,339.48
15 - 19 Years	204	$ 332.46	$ 3,989.52	$ 813,862.08	$ 839,296.80
20 + Years	982	$ 443.28	$ 5,319.36	$ 5,223,611.52	$ 5,386,819.92
Totals	**1,383**			**$6,561,430.56**	**$6,766,456.20**

- The 3.125% increase in the MMA results in an estimated amount of $205,026
- Note: Based on the actual reimbursements for the 2020 Plan Year (as of May 4, 2021), the total reimbursements were $4,306,221

Considerations for Setting 2022 MMA

1. 10-Year History of MMA - 2012 through 2021

Group & Individual Early Retiree* Plan MMA:										
Year	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
10 to 14 Years of Service	$ 261.08	$ 261.08	$ 261.08	$ 261.08	$ 270.22	$ 270.22	$ 270.22	$ 279.00	$ 289.33	$ 289.33
15 to 19 Years of Service	$ 391.62	$ 391.62	$ 391.62	$ 391.62	$ 405.33	$ 405.33	$ 405.33	$ 418.50	$ 433.99	$ 433.99
20 or more Years of Service	$ 522.16	$ 522.16	$ 522.16	$ 522.16	$ 540.44	$ 540.44	$ 540.44	$ 558.00	$ 578.65	$ 578.65
Individual Plan MMA for Medicare Eligible Retirees - Effective 2/1/2013:										
Year	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
10 to 14 Years of Service	$ -	$ 200.00	$ 200.00	$ 200.00	$ 207.00	$ 207.00	$ 207.00	$ 213.73	$ 221.64	$ 221.64
15 to 19 Years of Service	$ -	$ 300.00	$ 300.00	$ 300.00	$ 310.50	$ 310.50	$ 310.50	$ 320.59	$ 332.46	$ 332.46
20 or more Years of Service	$ -	$ 400.00	$ 400.00	$ 400.00	$ 414.00	$ 414.00	$ 414.00	$ 427.46	$ 443.28	$ 443.28

**Effective 1/1/2016*

Considerations for Setting 2022 MMA (continued)

2. Ten-Year Premium Rate History - 2012 through 2021

Medical Plans	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
Kaiser Permanente HMO (Early Retirees)	$ 639.26	$ 658.96	$ 670.58	$ 671.82	$ 729.08	$ 735.64	$ 765.06	$ 765.06	$ 785.44	$ 810.72
% Change over Monthly Premium		3.08%	1.76%	0.18%	8.52%	0.90%	4.00%	4.00%	2.66%	3.22%
Kaiser Permanente Senior Advantage	$ 298.74	$ 316.64	$ 330.96	$ 330.96	$ 329.90	$ 354.73	$ 367.23	$ 394.07	$ 411.54	$ 382.21
% Change over Monthly Premium		5.99%	4.52%	0.00%	-0.32%	7.53%	3.52%	7.31%	4.43%	-7.13%
UnitedHealthcare SignatureValue HMO (Early Retiree)	$ 827.84	$ 914.78	$ 972.34	$ 972.34	$ 982.06	$ 982.06	$1,047.16	$1,047.16	$1,087.80	$ 1,150.60
% Change over Monthly Premium		10.50%	6.29%	0.00%	1.00%	0.00%	6.63%	0.00%	3.88%	5.77%
UnitedHealthcare SignatureValue Advantage HMO (Early Retiree)*	-	-	-	-	-	-	-	$980.94	$831.92	$759.16
% Change over Monthly Premium		-	-	-	-	-	-	-	-15.19%	-8.75%

**Effective 1/1/2019*

Considerations for Setting 2022 MMA (continued)

3. In 2020, $60,294,406 was credited to the SRBR (includes interest at the rate of return of 3.6250%). Since 2013, more dollars have been added to the SRBR than what has been deducted. See attached 10-year history of SRBR fund balances.

4. On a preliminary basis, Segal projects 18 years of benefits payable from the SRBR. Projections have exceeded the SRBR Policy's 15-year goal since 2013. Although a reduction of one year occurred due to market losses, we anticipate gains to be realized next year resulting in an increase.

5. The Implicit Subsidy for 2021 is estimated to be about $1,831,798 lower than the cost for 2020

6. Annual payee numbers continue to increase by about 3% on average. (2019 increased by 3.60% and 2020 increased by 2.71%)

7. ACERA's overall SRBR costs increased by 3.77% in 2020 versus an increase in 2019 of 8.02%. We anticipate 2021 costs will remain low with reduced Kaiser Senior Advantage costs and reduced Implicit Subsidy cost. (See attached SRBR cost history)

Recommendations to Consider for July Retirees Committee Meeting

1. Do not increase MMA amount for 2022
   - Current annual cost plus potential increase due to premium increase is $34,450,330

2. Increase MMA by 50% of health care trend, 3.125%
   - Potential increased cost of $34,981,338
   - An annual cost difference of $531,008

History of Payments Made Out of the SRBR

2011-2020

Benefit Paid from SRBR	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
	Payment Made	Payment Made	Payment Made	Payment Made	Payment Made	Payment Made	Payment Made	Payment Made	Payment Made	Payment Made
Monthly Medical Allowance	24,132,779.01	$24,545,762.50	$21,716,496.34	$23,993,028.81	$24,511,217.41	$25,385,381.36	$27,256,486.00	$28,078,180.27	$30,163,755.94	$31,895,818.80
% Change over a Year		1.71%	-11.53%	10.48%	2.16%	3.57%	7.37%	3.01%	7.43%	5.74%
Dental	3,216,915.62	$3,443,497.64	$3,635,230.64	$3,076,961.42	$3,332,341.54	$3,310,861.36	$3,675,572.97	$3,885,918.92	$4,058,743.79	$3,957,491.59
% Change over a Year		7.04%	5.57%	-15.36%	8.30%	-0.64%	11.02%	5.72%	4.45%	-2.49%
Vision	441,760.34	$460,566.72	$357,478.16	$344,129.93	$351,757.60	$361,086.88	$371,252.25	$383,148.70	$395,767.62	$404,992.08
% Change over a Year		4.26%	-22.38%	-3.73%	2.22%	2.65%	2.82%	3.20%	3.29%	2.33%
MBRP	3,763,057.78	$4,242,443.76	$4,859,988.99	$5,176,062.67	$5,490,533.92	$5,870,137.63	$6,600,279.24	$8,531,422.36	$8,943,882.71	$9,762,403.02
% Change over a Year		12.74%	14.56%	6.50%	6.08%	6.91%	12.44%	29.26%	4.83%	9.15%
Implicit Subsidy	4,402,603	$4,411,206.00	$7,370,466.00	$6,992,822.00	$5,320,953.00	$6,021,451.00	$8,787,596.00	$5,800,563.00	$6,899,139.00	$6,446,702.00
% Change over a Year		0.20%	67.09%	-5.12%	-23.91%	13.16%	45.94%	-33.99%	18.94%	-6.56%
Supplemental COLA	2,556,221	$2,345,527.00	$2,067,218.00	$1,849,140.00	$1,555,924.00	$1,350,784.00	$1,231,500.00	$1,134,613.00	$1,181,244.00	$1,116,523.00
% Change over a Year		-8.24%	-11.87%	-10.55%	-15.86%	-13.18%	-8.83%	-7.87%	4.11%	-5.48%
Death Benefit	746,102	$791,492.00	$5,525.00	$223,529.00	$213,909.00	$187,081.00	$187,060.00	$196,576.00	$216,834.00	$230,747.00
% Change over a Year		6.08%	-99.30%	3945.77%	-4.30%	-12.54%	-0.01%	5.09%	10.31%	6.42%
TOTAL DEDUCTED FROM SRBR	**$39,259,438.75**	**$40,240,495.62**	**$40,012,403.13**	**$41,655,673.83**	**$40,776,636.47**	**$42,486,783.23**	**$48,109,746.46**	**$48,010,422.25**	**$51,859,367.06**	**$53,814,677.49**
% Change over a Year		2.50%	-0.57%	4.11%	-2.11%	4.19%	13.23%	-0.21%	8.02%	3.77%

*As of December 31, 2020

ALAMEDA COUNTY EMPLOYEES' RETIREMENT ASSOCIATION
SUPPLEMENTAL RETIREES' BENEFIT RESERVE (SRBR)
For the Ten Years Ended December 31, 2011 - December 31, 2020

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Beginning Balance	$624,166,664	$ 602,906,726	$570,878,929	$643,056,500	$789,826,877	$853,842,371	$874,385,246	$893,770,614	$919,488,617	$924,709,823
Deductions:										
Transferred to Employers Advance Reserve	31,858,291	33,353,151	32,240,449	34,039,593	36,528,264	33,818,832	38,327,914	43,777,409	44,858,371	45,456,100
Employers Implicit Subsidy	4,402,603	4,411,206	7,370,466	6,992,822	5,320,953	6,021,451	8,787,596	5,800,563	6,899,139	6,446,702
Supplemental Cost of Living	2,556,221	2,345,527	2,067,218	1,849,140	1,555,924	1,350,784	1,231,500	1,134,613	1,181,244	1,116,523
Death Benefit - Burial - SRBR	746,102	791,492	5,525	223,529	213,909	187,081	187,060	196,576	216,834	230,747
ADEB (Active Death)	936,133	426,640	-	-	-	-	-	-	-	-
Total Deductions	40,499,351	41,328,016	41,683,658	43,105,084	43,619,050	41,378,148	48,534,070	50,909,161	53,155,588	53,250,072
Additions:										
Interest Credited to SRBR	19,239,412	9,300,219	38,786,516	54,031,947	62,722,797	60,730,023	66,715,938	64,827,682	57,022,294	58,878,406
Excess Earnings Allocation	-	-	75,074,713 (1)	132,455,002	43,770,247	-	-	10,574,982	-	-
Transferred from Employers Advance Reserve	-	-	-	3,388,512 (2)	1,141,500	1,191,000	1,203,500	1,224,500	1,354,500	1,416,000
Total Additions	19,239,412	9,300,219	113,861,229	189,875,461	107,634,544	61,921,023	67,919,438	76,627,164	58,376,794	60,294,406
Ending Balance	$602,906,726	$ 570,878,929	$643,056,500	$789,826,877	$853,842,371	$874,385,246	$893,770,614	$919,488,617	$924,709,823	$931,754,157

Notes

(1) The Excess Earnings allocation of $75,074,713.03 is a total of $72,013,436.53 from investment earning above the assumed rate of return and $3,061,276.50 from additional excess earning made available from the dispersal of the Death Benefit-Burial Reserve as of 12/31/13.

(2) These amounts include reclassification of OPEB Administrative Expense contribution reimbursement activities and interest from January 2012 through June 2014; and normal activities for the six month period of July 2014 through December 2014. The SB 1479 reimbursements from the Employer Advance Reserve were inadvertently booked to the 401(h) account instead of SRBR. A total misclassified balance of $2,649,500 and regular credited interest of $182,511.54 were transferred from the 401(h) account to SRBR.

Amounts are rounded to the nearest dollar and include <$1 rounding differences.

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: June 2, 2021

TO: Members of the Retirees Committee

FROM: Kathy Foster, Assistant Chief Executive Officer

SUBJECT: **2022 Medical Plans Update/Renewal Requests of ACERA/County**

Staff provided the County of Alameda (County) with our annual medical plans renewal request letter on March 15th. Listed below are some of the highlights of our renewal requests for Kaiser and UnitedHealthcare coverages.

Disease Management/Wellness:

- Wellness resources for in-person and virtual wellness events and mailings
- At least two one-hour sessions on wellness in-person or virtually
- Promote and monitor ACERA's utilization of Kaiser's Mindfulness apps (i.e., MyStrength, Calm, etc.)
- Confirm the unused wellness funds with UnitedHealthcare will be credited back to the plan for future wellness events because of events cancelled in 2020 due to COVID-19

Other:

- Any mandatory benefit changes for 2022, in addition to the following:
    - Detail the impact of COVID-19 (i.e., testing, treatment, vaccinations, etc.) on 2022 premium rates
    - Provide a list of COVID-19 resources educating members related to prevention, testing, treatment, and vaccination
- Any recent member survey results that may be shared
- Summarize the impact of recent and anticipated CMS rule changes to Medicare Advantage and Medicare Part D prescription drug programs in 2022 that may affect ACERA plans

Performance Guarantees:

- Provide routine performance monitoring reports comparing ACERA's direct experience with mutually agreed upon benchmarks
- Place a percentage of premiums at risk for failing to meet or exceed mutually agreed upon performance standards

Prescription Drugs:

- Identify all drugs coming off the formulary and converting to generic effective January 1, 2022, and provide an estimate of projected annual savings
- Project annualized savings associated with brand name drugs losing patent protection and migrating to generic equivalent as of January 1, 2022
- Detail the annual costs associated with the top ten highest cost medications on a per script basis, and the strategies utilized by Kaiser to manage treatment adherence/outcomes and costs

Pricing:

- Indicate additional premium costs to provide the Silver&Fit® Exercise and Healthy Aging Program
- Indicate cost of providing the current hearing aid benefit as a portion of the premium
- UnitedHealthcare HMO plans and/or design change options and cost impact

Providers/Medical Groups/Hospitals:

- Provide updates on anticipated network provider (e.g., hospitals, ambulatory centers, medical groups, etc.) expansion and contractions
- Report on virtual care cost and utilization trends, and plans to promote virtual care in the future

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: June 2, 2021

TO: Members of the Retirees Committee

FROM: Kathy Foster, Assistant Chief Executive Officer

SUBJECT: **Report on Annual Health Care Planning Meeting with Retiree Groups**

On April 7, 2021, ACERA hosted the Annual Health Care Planning meeting with Board representatives from the Alameda County Retired Employees (ACRE) and Retired Employees of Alameda County, Inc. (REAC) Retiree Associations. Also present at this meeting, were representatives from the County of Alameda (County), ACERA's Benefits Consultant, Segal, Via Benefits, as well as Liz Koppenhaver, Nancy Reilly and Dale Amaral from ACERA's Board of Retirement.

The agenda consisted of the following items:

- Presentation by Segal regarding legislative/regulatory updates:
  - Families First and CARES Acts, Medicare Response to COVID-19, Consolidated Appropriations of 2021, No Surprises Act, Transparency, American Rescue Plan Act of 2021, Temporary 100% COBRA Subsidy and HIPAA Security Update

- Presentation by Segal regarding the following:
  - COVID-19 Vaccination Update
  - Health Care Trend Influencers
  - Historic Projected vs. Actual Medical Cost Trends
  - Projected Health Care Trends (2020 and 2021)

- Presentation by Staff regarding ACERA's wellness program:
  - No in-person wellness events in 2021
  - Focus on upgrading retiree virtual resources and communication
  - Financial wellness webinar presented by Elder Protection Unit of the DA's Office
  - Delta Dental's Toothpic smartphone teledentistry app
  - Virtual Health and Wellness Fair
  - Website enhancements demonstration

- Presentation by Staff regarding Electronic Signatures/Automation of Submitting Forms:
  - 1,000 medical, dental and vision forms received/processed annually
  - Current ways to submit forms
  - Optimization with DocuSign

- Presentation by Staff regarding New Call Center Phone System:
  - Received 14,257 member calls and responded to 8,110 info@acera inquires in 2020
  - In August 2020, implemented 8x8 Virtual Call Center

- Presentation by Via Benefits regarding Medicare and Individual and Family Plan (Pre-65):
  - Enrollment statistics
  - Customer support
  - Funding account activity
  - Process enhancements

- Information on ACERA-sponsored plans for 2021/2022:
  - Current medical, dental and vision plans options and rates
  - Utilization, enrollment, and 10-year history of single party premiums for dental and vision plans
  - 2020 Via Benefits average premiums for individual medical plans

- ACRE/REAC Discussion Topics:
  - There were no retiree concerns from ACRE or REAC that were brought to ACERA's attention prior to or during the meeting.

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: June 2, 2021

TO: Members of the Retirees Committee

FROM: Ismael Piña, Assistant Benefits Manager

SUBJECT: **Health Reimbursement Arrangement Account Balances for 2020**

Retirees enrolled in individual medical plans through Via Benefits were able to submit claims for 2020 reimbursements through May 31, 2021. Due to COVID-19, the deadline to submit claims was extended from March 31, 2021 to May 31, 2021. The total amount of reimbursements paid for the 2020 Plan Year as of May 4, 2021 and the average monthly cost per retiree are shown below.

Plan Year 2020		
Plans	Total Reimbursement Paid as of May 4, 2021	Average Monthly Cost Per Retiree
Medicare eligible retirees	$4,306,220.89	$259.47
Early (Pre-65) retirees	$813,111.40	$280.00

Provided below are the unused balances of the Health Reimbursement Arrangement (HRA) Accounts from lowest to highest as of May 4, 2021. The balances are categorized by years of service (YOS) contribution levels.

2020 Health Reimbursement Arrangement Account Balances
for Medicare Eligible Retirees as of May 4, 2021

20 + Years of Service **$5,319.36 Annual MMA**		15 through 19 Years of Service **$3,989.52 Annual MMA**		10 through 14 Years of Service **$2,659.68 Annual MMA**	
Number of Retirees	Balance	Number of Retirees	Balance	Number of Retirees	Balance
110	$ 0	61	$ 0	111	$ 0
80	Under $500	42	Under $500	28	Under $500
101	$500 - $1,000	24	$500 - $1,000	13	$500 - $1,000
139	$1,000 - $1,500	31	$1,000 - $1,500	11	$1,000 - $1,500
172	$1,500 - $2,000	11	$1,500 - $2,000	7	$1,500 - $2,000
123	$2,000 - $2,500	35	$2,000 +	27	$2,000 +
82	$2,500 - $3,000				
59	$3,000 - $4,000				
116	$4,000 +				
982 Total Number of Retirees		***204 Total Number of Retirees***		***197 Total Number of Retirees***	

Observations of Medicare eligible retirees' HRA accounts in 2020:

- There were 1,383 HRA's reported as active accounts at the end of 2020.
- 282 retirees used all of their funds – 20.4% of Medicare eligible retirees.
- Out of the 982 retirees with 20 + YOS, 725 have used half of their balances – 73.8% of the group.

2020 Health Reimbursement Arrangement Account Balances
for Early (Pre-65) Retirees as of May 4, 2021

20 + Years of Service **$6,943.80 Annual MMA**		15 through 19 Years of Service **$5,207.88 Annual MMA**		10 through 14 Years of Service **$3,471.96 Annual MMA**	
Number of Retirees	Balance	Number of Retirees	Balance	Number of Retirees	Balance
67	$ 0	15	$ 0	10	$ 0
17	Under $500	3	Under $500	3	Under $500
8	$500 - $1,000	1	$500 - $1,000	4	$500 - $1,000
5	$1,000 - $1,500	2	$1,000 - $1,500	0	$1,000 - $1,500
11	$1,500 - $2,000	3	$1,500 - $2,000	0	$1,500 - $2,000
10	$2,000 - $2,500	9	$2,000 +	7	$2,000 +
8	$2,500 - $3,000				
24	$3,000 - $4,000				
35	$4,000 +				
185 Total Number of Retirees		***33 Total Number of Retirees***		***24 Total Number of Retirees***	

Observations of early (pre-65) retirees' HRA accounts in 2020:

- There were 242 HRA's reported as active accounts at the end of 2020.
- 92 retirees used all of their funds – 38.0% of early retirees.
- Out of the 185 retirees with 20 + YOS, 126 have used half of their balances – 68.1% of the group.

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: June 2, 2021

TO: Members of the Retirees Committee

FROM: Ismael Piña, Assistant Benefits Manager

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

Staff are in the beginning stages of planning for Open Enrollment and our Annual Health and Wellness Fair. Provided below are preliminary plans in these areas.

Retiree Health and Wellness Fair
Although restrictions are easing, the Annual Retiree Health and Wellness Fair will again be a virtual event allowing our members access to the information and presentations from any internet enabled device.

Carrier Participation
We are meeting with our carriers and vendors regarding the many virtual programs offered to best interest our members and provide them resources to stay active and well.

Open Enrollment Planning
Open Enrollment Guides including all ACERA-sponsored plan information and changes will be disseminated in October with Open Enrollment occurring in November for those plans. Medical premiums and any plan changes will be provided to ACERA by the County of Alameda and carriers in August.

Electronic Signatures
The introduction of DocuSign will ensure documents are completed with the required information to process. The release of our new ACERA Medical, Dental, and Vision Enrollment forms will also provide an easy to follow format, allowing for easier selection or change of coverage for enrollees. The new forms are digitally fillable and will allow for electronic signatures.

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: June 2, 2021

TO: Members of the Retirees Committee

FROM: Ismael Piña, Assistant Benefits Manager

SUBJECT: **Miscellaneous Updates**

An oral report will be provided on any recent benefit issues at the Retirees Committee meeting.