Alameda County Employees' Retirement Association
BOARD OF RETIREMENT

RETIREES COMMITTEE/BOARD MEETING
NOTICE and AGENDA

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

Wednesday, December 6, 2023
9:30 a.m.

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

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

The Alternate Safety Member votes in the absence of the Elected Safety Member, either of the two Elected General Members, or both the Retired and Alternate Retired members.

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

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

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

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. Adoption of Medicare Part B Reimbursement Plan Benefit for 2024

Discussion and possible motion to recommend that the Board of Retirement continue to provide Medicare Part B Reimbursement Plan (MBRP) benefits to current eligible retirees at the lowest standard monthly premium rate.

- Carlos Barrios
- Steve Murphy, Segal

Recommendation
Staff recommends that the Retirees Committee recommend to the Board of Retirement to continue to provide the Medicare Part B Reimbursement Plan (MBRP) benefit to eligible retirees in 2024, and approve the reimbursement based on the lowest standard monthly Medicare Part B premium at the rate of $174.70. The MBRP benefit is a non-vested benefit funded by contributions from ACERA Employers to the 401(h) account. After contributions are made, in accordance with the County Employees Retirement Law, ACERA treats an equal amount of Supplemental Retiree Benefit Reserve assets as employer contributions for pensions.

2. Adoption of Updates to Appendix A of 401(h) Account Resolutions

Discussion and possible motion to recommend that the Board of Retirement adopt revisions to 401(h) Account Resolution 07-29, Appendix A, amended to reflect Plan Year 2024 benefit amounts.

- Carlos Barrios

Recommendation
Staff recommends that the Retirees Committee recommend to the Board of Retirement (Board) to adopt the revised and updated Appendix A to Resolution No. 07-29, which reflects the changes approved by the Board to the Monthly Medical Allowance amounts for Group and Individual Plans as well as the Retiree Health Benefit contribution amounts for Plan Year 2024.

3. Review of Possible Policy to Help Members Maximize the Death Benefits Paid to Their Designated Beneficiaries

Discussion and possible motion to recommend that the Board of Retirement adopt a policy to implement a program to make available contingent applications for disability retirement with selection of optional settlement 2 or optional settlement 4, so that members can maximize death benefits for their designated beneficiaries.

- Jeff Rieger

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

1. Annual Retired Member (Lump Sum) Death Benefit Report

Staff will provide a report on the $1,000 Retired Member (lump sum) Death Benefits paid in 2023. This benefit is funded by the Supplemental Retiree Benefit Reserve and is considered a vested benefit, as long as there are funds available.

- Jessica Huffman

2. Medicare Part B Income-Related Monthly Adjustment Amount through Health Reimbursement Arrangement

Staff will provide information regarding the reimbursement of the Medicare Part B premiums income-related monthly adjustment amounts by Via Benefits through the Health Reimbursement Arrangement.

- Carlos Barrios

3. Information on Hearing Aid Benefit Utilization and Reimbursement Options

Staff will present information on hearing aid benefit utilization and possible reimbursement options.

- Carlos Barrios

4. Virtual Retiree Health and Wellness Fair Results and Open Enrollment Activity

Staff will provide results of the Virtual Retiree Health and Wellness Fair and Open Enrollment activity for Plan Year 2024.

- Ismael Piña

5. Silver&Fit Survey Results

Staff will provide the results of the Silver&Fit survey conducted in September 2023.

- Mike Fara

Trustee Remarks

Future Discussion Items

- Annual Supplemental Cost of Living Adjustment (COLA)

Establishment of Next Meeting Date

February 7, 2024, at 9:30 a.m.

Adjournment

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: December 6, 2023

TO: Members of the Retirees Committee

FROM: Carlos Barrios, Assistant Chief Executive Officer

SUBJECT: **Medicare Part B Reimbursement Plan Benefits for 2024**

The Centers for Medicare & Medicaid Services (CMS) announced the 2024 Medicare Part B premiums on October 12, 2023. Based on the Supplemental Retiree Benefit Reserve (SRBR) Policy, ACERA reimburses eligible retirees the lowest standard premium amount. Currently, ACERA is paying $164.90 to eligible retirees as this was the lowest standard premium for all eligible recipients. The standard monthly premium for Medicare Part B enrollees will be $174.70 for 2024, which is an increase of about 5.9%.

The reason for the increase in the 2024 Part B premium provided from the CMS website states: "The increase in the 2024 Part B standard premium and deductible is mainly due to projected increases in health care spending and, to a lesser degree, the remedy for the 340B-acquired drug payment policy for the 2018-2022 period under the Hospital Outpatient Prospective Payment System."

Attached is a letter from Richard Ward with Segal, ACERA's Benefits Consultant, which provides additional information regarding the 2024 Medicare Parts A and B premiums and deductibles. In addition, the table on page 3 of Segal's letter regarding the number of retirees at the CMS income levels is provided to give Trustees a sense of the impact of setting the Medicare Part B Reimbursement Plan (MBRP) amount at the lowest standard premium. Note that the income is only based on ACERA benefit amounts (for 2022), but provides figures reflecting out-of-pocket numbers the higher income groups may incur for their Medicare Part B premiums.

The number of current retirees receiving the MBRP benefit as of November 2023 is 6,040. If ACERA pays the MBRP benefit of $174.70 for all retirees currently receiving this benefit, the estimated annual cost for 2024 is $12,662,256. The estimated annual cost based on the same number of retirees and the 2023 benefit amount of $164.90 is $11,951,952. The difference in the estimated annual cost is $710,304. These amounts will change for 2024 based on the number of eligible retirees receiving this benefit each payroll.

Recommendation

Staff recommends that the Retirees Committee recommend to the Board of Retirement to continue to provide the Medicare Part B Reimbursement Plan (MBRP) benefit to eligible retirees in 2024, and approve the reimbursement based on the lowest standard monthly Medicare Part B premium at the rate of $174.70. The MBRP benefit is a non-vested benefit funded by contributions from ACERA Employers to the 401(h) account. After contributions are made, in accordance with the County Employees Retirement Law, ACERA treats an equal amount of Supplemental Retiree Benefit Reserve assets as employer contributions for pensions.

Attachment

Segal

Richard Ward, FSA, FCA, MAAA
West Region Market Director, Public Sector
T 956.818.6714
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Glendale, CA 91203-3338
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October 27, 2023

Carlos Barrios
Assistant Chief Executive Officer
ACERA
475 14th Street, Suite 1000
Oakland, CA 94612

Re: Medicare Part A and B Premiums and Deductibles

Dear Carlos:

Medicare Part A Premiums

Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. About 99% of Medicare beneficiaries do not pay a Part A premium since they have at least 40 quarters of Medicare-covered employment. If retirees need to purchase Part A, they will pay up to $505 each month in 2024 versus up to $506 in 2023.

Medicare Part A Deductibles

Part A Deductible and Coinsurance Amounts for Calendar Years 2023 and 2024 Type of Cost Sharing

Year	2023	2024
Inpatient hospital deductible	$1,600	$1,632
Daily coinsurance for 61st – 90th Day	$400	$408
Daily coinsurance for lifetime reserve days	$800	$816
Skilled Nursing Facility coinsurance (Days 21-100)	$200.00	$204.00

Medicare Part B Premiums

Retirees pay a premium each month for Medicare Part B medical insurance, which covers physicians' services, outpatient hospital services, certain home health services, durable medical equipment, and certain other items not covered by Part A. The final rates for Medicare Part B were announced by CMS on October 12, 2023 and will take effect January 1, 2024.

CMS announced that the annual deductible for all Part B beneficiaries will be $240.00 in 2024, an increase of $14.00 from the annual deductible of $226.00 in 2023. Premiums for Medicare

Advantage and Medicare Prescription Drug plans are already finalized and unaffected by this announcement.

In years where the Social Security Cost of Living Adjustment (COLA) is less than the dollar increase in Medicare Part B Premium there is a statutory "hold harmless" provision meant to protect retirees from the full increase of Part B premiums. Medicare Part B standard premiums are increasing by $9.80 from $164.90 in 2023 to $174.70 in 2024, about a 5.9% increase. The COLA increase is 3.2% for 2024, averaging $59 per month nationally, as reported by the Social Security National Press Office. The average monthly COLA increase is over 6 times the standard Part B premium increase for 2024.

Since 2007, beneficiaries with higher incomes have paid higher Part B monthly premiums. These income-related monthly adjustment amounts (IRMAA) affect roughly 8% of people nationally with Medicare. The 2024 Part B total premiums for high income beneficiaries are shown in the following table.

2022 File Individual Tax Return	2022 File Joint Tax Return	2022 File Married & Separate Tax Return	2024 Monthly Premium
$103,000 or less	$206,000 or less	$103,000 or less	$174.70
Above $103,000 to $129,000	Above $206,000 to $258,000	N/A	$244.60
Above $129,000 to $161,000	Above $258,000 to $322,000	N/A	$349.40
Above $161,000 to $193,000	Above $322,000 to $386,000	N/A	$454.20
Above $193,000 and less than $500,000	Above $386,000 and less than $750,000	Above $103,000 and less than $397,000	$559.00
$500,000 or above	$750,000 and above	$397,000 and above	$594.00

Impact on ACERA Retirees

ACERA retirees enrolled in Kaiser Senior Advantage have their entire insurance premium covered by the Monthly Medical Allowance (MMA) if they have 20 years of service. The majority of these retirees will not pay out of pocket for Medicare premiums in 2024. Most retirees have the 40 quarters required for fully subsidized Part A. If continued in 2024, ACERA's Medicare Part B Reimbursement Plan reimburses Part B premiums up to the standard amount, which covers the entire Part B premium for most retirees. A smaller proportion of retirees are required to pay the IRMAA.

The following table summarizes out of pocket costs to retirees based on income, using ACERA retirement income as Individual Taxable Income.

2022 File Individual Tax Return	Retirees Over Age 65	% of Retirees	2024 Monthly Premium	Cost to Retiree*
$103,000 or less	7,201	85%	$174.70	$0.00
Above $103,000 to $129,000	595	7%	$244.60	$69.90
Above $129,000 to $161,000	370	4%	$349.40	$174.70
Above $161,000 to $193,000	151	2%	$454.20	$279.50
Above $193,000 and less than $500,000	162	2%	$559.00	$384.30
$500,000 or above	0	0%	$594.00	$419.30

**The cost to the retiree is the IRMAA, which is the difference between the Part B premium and ACERA's reimbursement of the standard premium amount of $174.70 per month.*

Under the Medicare Part B Reimbursement Plan, the majority of ACERA's Medicare retirees will be able to avoid paying out of pocket to cover premiums in 2024 by enrolling in Kaiser Senior Advantage if they have 20 years of service.

By comparison, ACERA's Non-Medicare retirees enrolling in Kaiser will have a single retiree premium of $1,037.76 of which $635.37 is covered by the MMA, resulting in an out-of-pocket cost of $402.39 per month.

Please feel free to call or email us with any questions or concerns you may have.

Sincerely,

Richard Ward FSA, FCA, MAAA
Senior Vice President
West Region Market Director, Public Sector

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

Segal

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: December 6, 2023

TO: Members of the Retirees Committee

FROM: Carlos Barrios, Assistant Chief Executive Officer

SUBJECT: **Revision of Resolution No. 07-29, Appendix A**

In February 2007, the ACERA Board of Retirement (Board) passed Resolution No. 07-29 - 401(h) (Resolution). That Resolution set forth the legal requirements and procedural operations of the 401(h) accounts managed by ACERA. The Resolution consists of a detailed recitation of the requirements under the Internal Revenue Code that ACERA and its Participating Employers must satisfy to properly operate the 401(h) accounts.

Attached to Resolution No. 07-29 is Appendix A, which sets forth the cost and eligibility requirements for the Retiree Health Benefits (RHBs) paid to ACERA retirees through the 401(h) accounts. Those benefits include:

1. Monthly Medical Allowance
2. Medicare Part B Premium Reimbursement
3. Dental Care Contribution
4. Vision Care Contribution

Throughout the course of calendar year 2023, as is done each year, the Retirees Committee (Committee) and the Board have evaluated and approved changes to the Monthly Medical Allowance (MMA) and the contribution amounts associated with the RHBs for Plan Year 2024. The Board approved increasing the MMA for Group Plans and Individual Plans through the Health Exchange for early (non-Medicare) retirees living outside the HMO service area from its 2023 maximum amount of $616.12 to $635.37. The Board also approved increasing the MMA for Individual Plans through the Medicare Exchange from its 2023 maximum amount of $471.99 to $486.74. The pro-rated MMA distributions were also increased accordingly. The Board approved setting the cost of the Delta Dental Care DPO plan at $51.05 (a 0.4% decrease from the 2023 rate), and the cost of the Delta Dental DMO plan at $22.18 (the same amount as 2023). The Board approved a $4.63 premium (the same amount as 2023) for the Vision Service Plan. Lastly, we anticipate the Board will approve the Medicare Part B Reimbursement Plan (MBRP) benefit of $174.70 (the lowest standard monthly Medicare Part B premium rate) for 2024 (an increase in the premium rate) at the December 21, 2023 Board meeting.

Accordingly, in order for Resolution No. 07-29 to remain current for the upcoming 2024 Plan Year, Appendix A must be amended to reflect the decision regarding the MMA, Medicare Part B premium reimbursement, and dental and vision premium amounts as adopted by the Board for 2024. Staff has revised Appendix A and requests that the Board adopt the suggested changes.

Attached to this memorandum for your review is a revised version of Resolution 07-29, Appendix A, that reflects the changes described above to the MMA and RHB premiums for Plan Year 2024.

Annually, Staff will request that the Committee and the Board approve modification of Appendix A so that the 401(h) Resolution accurately reflects the eligibility requirements and contributions for the upcoming Plan Year.

Recommendation

Staff recommends that the Retirees Committee recommend to the Board of Retirement (Board) to adopt the revised and updated Appendix A to Resolution No. 07-29, which reflects the changes approved by the Board to the Monthly Medical Allowance amounts for Group and Individual Plans as well as the Retiree Health Benefit contribution amounts for Plan Year 2024.

Attachment

ALAMEDA COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

RESOLUTION # 07-29

401(h) ACCOUNT

APPENDIX A - AMOUNT OF BENEFITS FROM 401(h) ACCOUNT

FOR PLAN YEAR 2024

1. Monthly Medical Allowance

- Group Plans

The Monthly Medical Allowance ("MMA") is a subsidy amount covering all or a portion of the eligible retiree's health plan premiums when enrolled in an ACERA-sponsored health plan. Premium costs for an enrolled surviving spouse and dependents are not paid by ACERA and are deducted from the retiree's monthly retirement allowance. Premium costs that exceed the MMA are paid by the retiree and are deducted from the retiree's monthly retirement allowance. If premium costs for any retiree are less than the maximum MMA, no additional cash or other benefit shall be paid to the retiree.

- Individual Plans – Early (non-Medicare) Retirees Living Outside the HMO Service Area

The MMA is provided as a reimbursement for premiums, co-pays and deductibles for Individual Plans for retirees enrolled in a plan through the Health Exchange. The reimbursement amount will not exceed the total annual MMA amount.

- Individual Plans – Medicare Eligible Retirees

The MMA is provided as a reimbursement for premiums, co-pays and deductibles for Individual Plans for retirees enrolled in a Medicare plan through the Medicare Exchange. The reimbursement amount will not exceed the total annual MMA amount.

For the health Plan Year beginning February 1, 2024 for Group Plans and January 1, 2024 for Individual Plans and for all later years (unless and until amended by the Board of Retirement), the maximum MMA for Group Plans and Individual Plans provided through the Health Exchange for early (non-Medicare) retirees living outside the HMO service area is $635.37 per month. The maximum MMA for Individual Plans for Medicare eligible retirees provided through the Medicare Exchange is $486.74 per month. The MMA amounts that are paid to retirees based on years of service are set out below:

YEARS OF SERVICE	**AMOUNT OF MONTHLY MEDICAL ALLOWANCE BENEFIT**		
	Group Plans	***Individual Plans – Out-of-Service Area Early Retirees***	***Individual Plans – Medicare Eligible Retirees***
20 or more years or retired on service connected disability	$635.37	$635.37	$486.74
15 through 19	$476.53	$476.53	$365.06
10 through 14	$317.69	$317.69	$243.37
Under 10	$0	$0	$0

As a result of the Affordable Care Act, in 2014 ACERA's plans are required to be "retiree only plans" in order to provide reimbursement through a Health Reimbursement Account (HRA). In order to comply with this federal law, retirees who return to work for an ACERA Participating Employer for any amount of time on or after January 1, 2014, will not be eligible for medical plan and prescription drug plan reimbursements through a HRA during the time period they are working. This is because retirees who return to work (including retired annuitants) are considered "active employees" as defined by the Affordable Care Act, and therefore cause ACERA's plans to not meet the "retiree only" plan qualifications for benefits.

2. Medicare Part B Premium

The Medicare Part B premium that will be reimbursed for the calendar year beginning on January 1, 2024 is $174.70 per month. ACERA shall reimburse only the lowest standard monthly Medicare Part B premium, and will not make any reimbursement of the income-related monthly adjustment amount of the Medicare Part B premium. No premium will be reimbursed to a retiree unless he or she provides proof to ACERA of enrollment in Medicare Part B. Premiums will only be reimbursed for retirees and not for spouse, dependents or survivors.

No Medicare Part D premiums will be reimbursed to retirees enrolled in Group Plans.

3. Dental Care

The dental care contribution is payment of the eligible retiree's Delta Dental premium when enrolled in the Delta Dental plan. Premium costs for an enrolled spouse and dependents are not paid by ACERA and are deducted from the retiree's monthly retirement allowance.

For the health Plan Year beginning February 1, 2024 and for all later years (unless and until amended by the Board), the monthly Delta Dental premiums paid by ACERA are as follows: for retirees enrolled in the Delta Dental DPO Plan, $51.05; and for retirees enrolled in the Delta Dental DMO Plan, $22.18.

4. Vision Care

The vision care contribution is payment of the eligible retiree's Vision Service Plan (VSP) premium when enrolled in the VSP plan. Premium costs for an enrolled spouse and dependents are not paid by ACERA and are deducted from the retiree's monthly retirement allowance.

For the health Plan Year beginning February 1, 2024 and for all later years (unless and until amended by the Board), the monthly VSP premium paid by ACERA is $4.63.

5. Spouse, Dependents and Surviving Beneficiaries

ACERA shall not provide payment for any health or medical or other retiree health benefits to any spouse, dependent, or surviving beneficiary of a retired member. However, to the extent available from the applicable health plan or carrier, ACERA will allow the retired member to purchase for his or her spouse and dependents the same coverage as the member has through ACERA by paying the full premium cost of such coverage. A surviving beneficiary may purchase coverage available from the applicable health plan or carrier by paying the full premium cost of such coverage.

Office of the Chief Counsel

To: Retirees Committee

From: Jeff Rieger, Chief Counsel

Meeting: December 6, 2023

Subject: **Potential Policy To Help Members Maximize Death Benefits**

In October 2022, when the Committee was considering whether to reauthorize the Active Death Equity Benefit "ADEB," the Committee directed staff to investigate alternative ways to help members maximize the benefits owed to their beneficiaries in a similar fashion as the ADEB. At the August 2, 2023 meeting, staff presented an alternative method that the Contra Costa County Employees' Retirement Association (CCCERA) has employed for years. At that meeting, staff was directed to prepare a draft policy for the Committee's consideration at a future meeting.

Attached as Exhibit 1 is a draft policy for the Committee's consideration. Attached as Exhibit 2 is input from the Board's Medical Advisor, MMRO, which is referenced in the draft policy. Attached as Exhibit 3 are the documents that were provided to the Committee for the August 2, 2023 meeting.

A few notes on the draft policy:

1. The draft policy presumes that all members with a fatal injury or illness will be permanently incapacitated for duty for some amount of time before they die and therefore eligible for a disability retirement for that amount of time. The policy does not incorporate the "real and measurable" concept used at CCCERA, but instead allows an employer to challenge a disability application. An employer may raise whatever arguments the employer deems appropriate and the Board will have the opportunity to consider those arguments based on the facts of the individual case.

2. The draft policy is designed to ensure that members' most likely wishes are carried out by establishing rules for what will happen if certain events occur (e.g., marriage, divorce, children born/adopted, death of beneficiaries, changes to other beneficiary designations) after the member files the Pre-Filed Application.

3. The draft policy allows beneficiaries to pursue service-connected death benefits, if doing so would result in greater benefits.

Whether to adopt the draft policy is entirely up to the Board. Staff makes no recommendation. While there is no guarantee that the courts would uphold the draft policy if were challenged, I believe the draft policy is sound and most likely would survive a judicial challenge based on *Gorman v. Cranston* (1966) 64 Cal.2d 441, the input the Board has received from Reed Smith regarding CCCERA's longstanding practices (in Exhibit 3), the input the Board has received from MMRO (Exhibit 2) and the Board's thoughtful consideration of this issue in public meetings.

Exhibit 1

ALAMEDA COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

Death Benefit Equity Policy

I. Purpose:

This Policy establishes administrative procedures to allow ACERA members to pre-file a disability retirement application and Optional Settlement election so that their beneficiaries may be eligible to receive the maximum benefits allowable under the County Employees' Retirement Law of 1937 ("CERL") if the members become entitled to a disability retirement before dying.

II. Board Findings

A. Before the first payment of a retirement allowance, members may elect Optional Settlement 2 (Gov't Code § 31762) or Optional Settlement 4 (Gov't Code § 31764). Each provides lifetime monthly allowances to a member's designated beneficiary (Optional Settlement 2) or multiple designated beneficiaries (Optional Settlement 4) upon the member's death, with a reduced lifetime allowance paid to the member. The total benefits paid under Optional Settlements are actuarially equivalent to the member's unmodified retirement allowance alone.

B. Members with terminal injuries or illnesses that render them permanently incapacitated for duty before they die may apply for a disability retirement and elect Optional Settlement 2 or Optional Settlement 4.

C. Some members with terminal injuries or illnesses die before they apply for a disability retirement and elect Optional Settlement 2 or Optional Settlement 4. This can result in lower benefits for their beneficiaries compared to beneficiaries of members who apply for a disability retirement and elect Optional Settlement 2 or Optional Settlement 4. The Board finds that different outcomes for beneficiaries, based on whether a member was able to apply for a disability retirement, are arbitrary, inequitable and should be avoided whenever possible.

D. In *Gorman v. Cranston* (1966) 64 Cal.2d 441, an active member of a retirement system had surgery planned and wanted to ensure that his beneficiaries would receive the maximum available benefits under law if he became permanently incapacitated and was unable to apply for a disability retirement before dying. The member filled out a disability application and requested that "if he were to become disabled and unable to post the letter, his son should mail copies to" the appropriate parties. After the member's death, his son mailed the application to the appropriate parties. The California Supreme Court held that the retirement system was required

to process the disability retirement application. The Board finds that the principles in *Gorman v. Cranston* should apply equally to all ACERA members without regard to their individual circumstances (e.g., whether they have surgery planned).

E. Based on input from its Medical Advisor, the Board finds it is reasonable to conclude that every member with a terminal injury or illness while eligible to apply for a disability retirement would be able to establish permanent incapacity for some amount of time between the time of injury or illness and death. Further, all members should be able to maximize the benefits available to their beneficiaries irrespective of how quickly they die after suffering a fatal injury or illness.

F. This Policy does not expand members' eligibility to retire for disability retirement and it does not expand the benefits available to members who retire for disability.

III. Death Benefit Equity Procedures

A. **Pre-Filed Disability Retirement Applications**. ACERA will make available to members the form attached hereto as Exhibit A ("Pre-Filed Application"). If a fully executed Pre-Filed Application is on file with ACERA, it shall serve as the member's application for a non-service-connected disability retirement and selection of Optional Settlement 2 or Optional Settlement 4 (as indicated by the member), if the member later becomes eligible for a disability retirement but dies before applying for a disability retirement, unless the member has revoked the Pre-Filed Application, per Section III(B), or Invalidation Event has occurred before the member's death, per Section III(C).

B. **Revocation**. A member may revoke their Pre-Filed Application by filing with ACERA the fully executed revocation form attached hereto as Exhibit B ("Revocation Form").

C. **Invalidation Events.** If any of the following events occur after the member files a Pre-Filed Application and before the member's death, the Pre-Filed Application shall be wholly or partially invalidated as described below:

1. **Dissolution Of Marriage Or Termination Of Domestic Partnership After Pre-Filed Application**:

   a. If a member names a spouse or domestic partner as an Optional Settlement 2 beneficiary in a Pre-Filed Application and the marriage or domestic partnership later dissolves or terminates, the Pre-Filed Application shall be wholly invalidated.

b. If a member names a spouse or domestic partner as one of multiple Optional Settlement 4 beneficiaries in a Pre-Filed Application and the marriage or domestic partnership later dissolves or terminates, the designation of the spouse or domestic partner shall be invalidated. The remaining beneficiaries in the Pre-Filed Application shall receive the percentage designated to the spouse or domestic partner based on their proportional designations. For example, if the spouse was a 50% beneficiary and there was a 30% beneficiary and a 20% beneficiary, the 30% beneficiary will become a 60% beneficiary and the 20% beneficiary will become a 40% beneficiary.

2. **Marriage And Domestic Partnership After Pre-Filed Application:** If a member marries or enters into a domestic partnership after filing a Pre-Filed Application and the member's Pre-Filed Application would result in lower payments to that spouse or domestic partner than would otherwise be available under governing law, the Pre-Filed Application shall be wholly invalidated.

3. **Children Born Or Adopted After Pre-Filed Application:** If a member's child is born or adopted by the member after the member files a Pre-Filed Application and the Pre-Filed Application would result in lower payments to that child than would otherwise be available under governing law, the Pre-Filed Application shall be wholly invalidated.

4. **Newly Filed Pre-Filed Application**: When a member files a Pre-Filed Application with ACERA, the filing wholly invalidates any prior Pre-Filed Application the member filed.

5. **Death Of Beneficiary After Pre-Filed Application**:

a. If an Optional Settlement 2 beneficiary in a Pre-Filed Application predeceases the member, the Pre-Filed Application shall be wholly invalidated.

b. If an Optional Settlement 4 beneficiary in a Pre-Filed Application predeceases the member, the remaining beneficiaries on the Pre-Filed Application shall receive the percentage designated to the deceased beneficiary based on their proportional designations. For example, if the deceased beneficiary was a 50% beneficiary and there was a 30% beneficiary and a 20% beneficiary, the 30% beneficiary will become a 60% beneficiary and the 20% beneficiary will become

a 40% beneficiary. If all Optional Settlement 4 beneficiaries are deceased, the Pre-Filed Application is wholly invalidated.

6. **Different Beneficiary Designation After Pre-Filed Application:** If after filing a Pre-Filed Application a member files with ACERA any other type of beneficiary designation form that differs from the Pre-Filed Application—either in which beneficiaries are designated or in the percentages assigned to the same beneficiaries—then the Pre-Filed Application is wholly invalidated. Provided, however, that if the difference can be explained by another Invalidating Event (marriage, divorce, birth, adoption, death), then the Pre-Filed Application shall remain valid to the extent it would remain valid under those other Invalidating Events as described above. ACERA staff shall implement forms and procedures to reasonably inform members about the need to update any Pre-Filed Application any time they file another type of new beneficiary designation form.

D. **Service Connected Disability Claims**. If a service-connected disability would result in greater benefits or tax advantages for the beneficiaries designated in the Pre-Filed Application, one or more of the designated beneficiaries may pursue a claim for a service-connected disability for the deceased member. If the member was eligible for a non-service-connected disability (i.e., five years of ACERA or combined reciprocal service), benefits shall be paid to the beneficiaries in the Pre-Filed Application based on a non-service-connected disability while the claim for a service-connected disability is pending. If the Board grants a claim for a service-connected disability, the additional benefits and/or tax advantages shall be paid to all designated beneficiaries, regardless of whether they all participated in the pursuit of the claim for service-connection. If a surviving spouse or domestic partner would receive greater benefits for a service-connected death than under a service-connected disability with Optional Settlement 2 election, the surviving spouse or domestic partner shall receive those greater benefits.

E. **Processing A Pre-Filed Application Upon Member's Death**

1. After the member's death, the ACERA Chief Executive Officer (or designee) will place the member's disability application on the Board's Consent Calendar (or regular calendar at the discretion of the Chief Executive Officer) with at least 60-day notice to the member's employer. The Board will receive supporting documentation to show the member's cause of death and the fact that the member satisfied all requirements for a non-service-connected disability before death in its confidential agenda backup. The Chief Executive Officer may, but not need, include input from

the Board's Medical Advisor. The notice to the employer must include copies of the documents provided to the Board and the employer will be advised of its right to object to the granting of the disability application.

a. If the employer does not object and the Board grants the application on its Consent Calendar, the member's Optional Settlement 2 or Optional Settlement 4 election will be implemented.

b. If the employer objects, the disability application will be removed from the Consent Calendar and will proceed through ACERA's Disability Retirement Procedures to determine whether the member was entitled to a disability retirement before death.

1) If the Board finds the member was entitled to a disability retirement before death, the member's disability retirement will be granted and the member's Optional Settlement 2 or Optional Settlement 4 election will be implemented.

2) If the Board does not find that the member was entitled to a disability retirement before death, the member's Pre-Filed Application shall be null and void and the member's death benefits shall be determined as if the Pre-Filed Application never existed.

IV. Policy Modifications

This Policy will be reviewed by the Retirees Committee at least every three years. The Committee will make recommendations to the Board concerning any improvements or modifications it deems necessary.

V. Policy History

A. The Board adopted this Policy on _____, 2023.

Exhibit A

Pre-Filed Disability Retirement Application

475 14th Street, Suite 1000, Oakland, CA 94612-1916 • QIC 22901
510-628-3000 • 1-800-838-1932 • Fax: 510-268-9574
info@acera.org • www.acera.org

SECTION 1

Purpose of This Form

This form authorizes ACERA to file an application for non-service-connected disability on your behalf, in the event you suffer a terminal injury or illness that entitles you to a disability retirement and leads to your death. This form allows you to select an Optional Settlement pursuant to Government Code Sections 31762 (Optional Settlement 2) or Government Code Section 31764 (Optional Settlement 4), which provide your designated beneficiary(ies) greater benefits than they would receive if you were to die without retiring for disability and electing an Optional Settlement 2 or Optional Settlement 4.

For more information on death benefits, please visit: www.acera.org/death

SECTION 2

Information About You

Your Name (First Name, Middle Initial, Last Name)	Full Social Security Number

SECTION 3

Your Option Allowance Election

Please consult ACERA staff if you have questions about how death benefits are calculated, how non-service-connected disability allowances are calculated and/or how the election of Optional Settlement 2 and Optional Settlement 4 impact a retirement allowance.

Designating a younger beneficiary for a higher portion of the benefit under Optional Settlement 4 will reduce the total available monthly benefit more than designating an older beneficiary for a higher proportion of the total monthly benefit, because these are lifetime benefits and a younger beneficiary is expected to receive the benefit for longer.

Choose One:

☐ I elect Optional Settlement 2 and designate the following beneficiary to receive a lifetime monthly allowance upon my death:

_____

☐ I elect Optional Settlement 4 and designate the following beneficiaries to receive lifetime allowances in the following percentages of the total available monthly allowance upon my death:

_____ _____%

_____ _____%

_____ _____%

_____ _____%

_____ _____%

_____ _____%

Your Name (First Name, Middle Initial, Last Name) | Date (dd/mm/yyyy)

SECTION 4

Authorization and Signature

I understand that by signing this completed form, I elect a monthly allowance for my beneficiary(ies) in lieu of any other death benefits that might be available from ACERA at the time of my death.

I understand that if, after my death, my employer successfully objects to my application for a disability retirement such that the Board of Retirement denies that application, then this form will be null and void and benefits will be paid to my beneficiaries as if this form never existed.

I understand that the following Invalidating Events will wholly or partially invalidate this form as described below.

Dissolution of Marriage or Termination of Domestic Partnership After Filing This Form:

- If I name a spouse or domestic partner as an Optional Settlement 2 beneficiary in this form and the marriage or domestic partnership later dissolves or terminates, this form shall be wholly invalidated.

- If I name a spouse or domestic partner as one of multiple Optional Settlement 4 beneficiaries in this form and the marriage or domestic partnership later dissolves or terminates, the designation of the spouse or domestic partner shall be invalidated. The remaining beneficiaries in this form shall receive the percentage designated to the spouse or domestic partner based on their proportional designations. For example, if the spouse was a 50% beneficiary and there was a 30% beneficiary and a 20% beneficiary, the 30% beneficiary will become a 60% beneficiary and the 20% beneficiary will become a 40% beneficiary.

Marriage and Domestic Partnership After Filing This Form**:** If I marry or enter into a domestic partnership after filing this form and implementation of this form would result in lower payments to that spouse or domestic partner than would otherwise be available under governing law, this form shall be wholly invalidated.

Children Born or Adopted After Filing This Form**:** If my child(ren) is/are born or adopted by me after I file this form and implementation of this form would result in lower payments to a child or children than would otherwise be available under governing law, this form shall be wholly invalidated.

Death of Beneficiary After Filing This Form:

- If an Optional Settlement 2 beneficiary in this form predeceases me, this form shall be wholly invalidated.

- If an Optional Settlement 4 beneficiary in this form predecease me, the remaining beneficiaries on this form shall receive the percentage designated to the deceased beneficiary based on their proportional designations. For example, if the deceased beneficiary was a 50% beneficiary and there was a 30% beneficiary and a 20% beneficiary, the 30% beneficiary will become a 60% beneficiary and the 20% beneficiary will become a 40% beneficiary. If all Optional Settlement 4 beneficiaries are deceased, this form will be wholly invalidated.

Different Beneficiary Designation(s) After Filing This Form**:** If after filing this form, I file with ACERA any other type of beneficiary designation that differs from this form—either in which beneficiaries are designated or in the percentages assigned to the same beneficiaries—then this form is wholly invalidated. Provided, however, that if the difference can be explained by another Invalidating Event (e.g., marriage, divorce, birth, adoption, death), then this form shall remain valid to the extent it would remain valid under those other Invalidating Events as described above.

I understand that if the designation of person as my beneficiary would be invalidated by any of the Invalidating Events describe above I can still designate that person as my beneficiary, but I must file a new Pre-Filed Disability Retirement Application after the Invalidating Event (e.g., marriage, dissolution of marriage, birth or adoption of a child).

I understand that I may revoke this election at any time before I die by filing a Revocation of Pre-filed Disability Retirement Application with ACERA.

By filing this Pre-Filed Disability Retirement Application I am revoking any previously filed Pre-Filed Disability Retirement Application that may be on file with ACERA.

I hereby authorize ACERA to file an application for a non-service connected disability retirement on my behalf if I am permanently incapacitated by reason of injury or illness that leads to my death. I understand that that my beneficiaries may also present a claim to the Board of Retirement for a service-connected disability retirement.

I hereby elect an Optional Settlement as indicated in Section 3 above.

Member Signature	Date (dd/mm/yyyy)

Exhibit B

Revocation of Pre-Filed Disability Retirement Application

475 14th Street, Suite 1000, Oakland, CA 94612-1916 • QIC 22901
510-628-3000 • 1-800-838-1932 • Fax: 510-268-9574
info@acera.org • www.acera.org

I, _____, hereby revoke any Pre-Filed Disability Retirement Application that I have on file with the Alameda County Employees' Retirement Association (ACERA). Such revocation is effective as of the date I file this completed Revocation of Pre-Filed Disability Retirement Application form with ACERA.

Dated: _____ Signed: _____

Exhibit 2

Memorandum

TO: Jeff Rieger, Chief Counsel, Alameda County Employees' Retirement Association
FROM: Managed Medical Review Organization, Inc.
DATE: September 20, 2023
RE: Determining Permanent Incapacity in an "Active Death" Claim

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In our discussion on August 16, 2023, you shared an outline of ACERA's consideration in moving toward a "preauthorization approach" for disability retirement benefits in cases where there is an "active death" of a member. In this regard, you have asked MMRO to provide thoughts on the following three (3) points:

1. Does the phrase "real and measurable"[1] have any medical significance that might be relevant to the kind of program ACERA is considering?

2. Is there any medical support for the concept that nobody "dies" instantly? In other words, everyone is incapacitated but medically alive for at least some amount of time (perhaps a very short time in some cases) before they are declared medically dead.

3. What role would MMRO play in the type of program ACERA is considering?

In providing this Memorandum, these issues were reviewed with Jennifer Mongeau, R.N., MMRO's Vice President of Clinical Programs, MMRO's Associate Medical Director, Michele Brezinski, M.D., and Doug Minke, MMRO's Vice President/General Counsel. We are providing general information in this regard, in the hopes that it will aid your design and policy drafting for the Board's consideration. We recognize that you may have additional questions and/or may want a sharpened analysis, as you have considered this issue further. Our team is happy to attend a call to discuss these issues in detail, or to provide any further information, if you feel appropriate.

General Discussion on Determining "Death"

We will start with a hypothetical: when one sustains a gunshot wound (GSW) to the head, it appears that "death" is instantaneous. In reality, it is not that simple. Barring direct trauma to the brainstem, it is not the GSW itself that kills the individual, but rather the rapid blood loss and the swelling of the brain over the ensuing 3-5 minutes. It is these things that lead to cardiopulmonary failure and the layperson's perception of death (not breathing, no heartbeat/pulse, etc.). However, even this state of cardiopulmonary

[1] You have shared materials which shows that the Contra Costa County Employees' Retirement Association ("CCCERA") has adopted a similar program, and utilizes the language "real and measurable" as a time interval that a member must have been alive and permanently incapacitated prior to death in order for a preauthorized Disability Retirement Application to become effective.

failure is not immediately considered "death" in medicine as the cells in the body can survive for at least four minutes without blood supply before the process of cell death and irreversible organ damage begins.

Basic and advanced cardiac life support algorithms exist to aid first responders in detecting and attempting to reverse cardiopulmonary arrest. With improving medications and technology, they can be successful in doing so, even in severe trauma. It is only when these measures fail (or are deemed futile) that the individual is officially pronounced "deceased", and the time of death is recorded.

The following medical literature articles illustrate some of the complexity of assigning the label of "death" in modern medicine. We believe the first article (*The debate about death: an imperishable discussion?*: https://pubmed.ncbi.nlm.nih.gov/18575685/) to be the most useful in illustrating why there are reasonable and clinically supported grounds upon which to support a "preauthorization" approach for disability retirement benefits in the case of a member's active death.

We do note that the difficulty with medical literature surrounding death is that much of it is entangled in the organ donation/determination of brain death controversies and about the issues with the laws that have been passed throughout the country over the last 50 years defining "death." The remainder of the articles also serve, in some form, to discuss the various definitions of death and how modern medicine impacts them, while also touching on how incredibly much we still do not know.

Medical Literature References

Bacigalupo F, Huerta D, Montefusco-Siegmund R. *The debate about death: an imperishable discussion?* Biol Res. 2007;40(4):523-34. Epub 2008 May 28. PMID: 18575685.

Gligorov N. *Is Death Irreversible?* J Med Philos. 2023 Sep 14;48(5):492-503. doi: 10.1093/jmp/jhad027. PMID: 37329567. <https://pubmed.ncbi.nlm.nih.gov/37329567/>

Baker A, Shemie SD. *Biophilosophical basis for identifying the death of a person.* J Crit Care. 2014 Aug;29(4):687-9. doi: 10.1016/j.jcrc.2014.04.013. Epub 2014 Apr 29. PMID: 24930370.

Moschella M. *Complexity of defining death: organismal death does not mean the cessation of all biological life.* J Med Ethics. 2017 Nov;43(11):754-755. doi: 10.1136/medethics-2017-104363. Epub 2017 Aug 26. PMID: 28844057.

Shemie SD. *Life, death, and the bridges in-between.* Ann N Y Acad Sci. 2014 Nov;1330(1):101-4. doi: 10.1111/nyas.12564. Epub 2014 Oct 28. PMID: 25351389; PMCID: PMC4285944.

Molina-Pérez A, Bernat JL, Dalle Ave A. *Inconsistency between the Circulatory and the Brain Criteria of Death in the Uniform Determination of Death Act.* J Med Philos. 2023 Sep 14;48(5):422-433. doi: 10.1093/jmp/jhad029. PMID: 37364165; PMCID: PMC10501178.

Responses to Questions Posed

1. ***Does the phrase "real and measurable" have any medical significance that might be relevant to the kind of program ACERA is considering?***

Our clinical team recognizes the phrase "real and measurable" from the guidance provided in relation to the CERL standard for service-connection. While this does provide a somewhat vague time interval, we do not believe ACERA would necessarily need to utilize this exact language, as it does not have meaningful clinical consequence. We do believe that, in many active death instances, ACERA would likely have clinically-supported grounds for the concept of considering a "preauthorized" disability retirement application having been "filed" during this small window of time between when the member has sustained a fatal wound and when they are truly evidenced to be irreversibly "dead." During this small window of time, we find it likely that any physician reviewer would consider the member to be "incapacitated" for the performance of their usual duties and, based on the severity of the injury sustained, the incapacity should be considered permanent.

The greater challenge will be in identifying the exact criteria/standard for this requisite period of time and then subsequently crafting questions which aid a physician reviewer in providing the necessary analysis in these unique cases.

2. ***Is there any medical support for the concept that nobody "dies" instantly? In other words, everyone is incapacitated but medically alive for at least some amount of time (perhaps a very short time in some cases) before they are declared medically dead.***

As stated in the attached reference article, "[o]ne extensively accepted definition of death is the 'permanent cessation of the critical functions of the organism as a whole." While this definition does beg further questions, it is also noted that:

> In sum, there are two sets of tests that can be used to ascertain death: neurological and/or cardio-pulmonary; which test is used depends on whether or not the patient is on mechanical ventilation. In non-artificially ventilated patients, physicians evaluate the irreversible absence of heartbeat and breathing to declare death, but in patients who are mechanically ventilated, validated neurological tests are used to assure irreversible absence of brain (brainstem) function. (*Bacigalupo et al., 2007*)

Likewise, Gilgorov states in her article "Is Death Irreversible?":

> There are currently two legally established criteria for death: the irreversible cessation of circulation and respiration and the irreversible cessation of neurologic function. (*N. Gligarov, 2023*)

Gilgorov goes on to argue that recent technological advancements make this determination of "irreversibility" an important part of the definition of when someone is considered "dead," as current possibilities for the reversal of biological processes at play must be evaluated before a death determination is made. *Ibid*.

In this regard, perhaps a relevant standard can be built around the period of time between when a fatal wound is incurred and when a medical professional has determined that the member has suffered a permanent, irreversible cessation of neurological and/or cardio/pulmonary function?

3. ***What role would MMRO play in the type of program ACERA is considering?***

MMRO believes that the claim review process in these "preauthorized" active death claims would likely be materially streamlined when compared to the normal disability retirement claim review. Speaking to the clinical portion of the review, there will be substantially less clinical analysis required for the aspects of service connection and permanency compared with a typical disability retirement claim review. Based on the information ACERA has provided surrounding the circumstances required for initiation of these active death claims, these determinations are anticipated to be straightforward in the majority of cases reviewed. We would view our main role as opining to whether there is clinical support within the claim file that the member was incapacitated for at least a defined period of time prior to death (whether that be a "real and measurable" analysis or some other medically supported interval, as noted above). While each claim would be clinically unique based on its circumstances, we do believe in most instances, this analysis could be undertaken and completed.

On the administrative processing side of such a claim, we would defer to ACERA as to whether the usual "Disability Packet Review and Comment" process would apply in these claims, and the answer to that question would, of course, impact the overall claim processing timeline. If the commenting process would still be required, we do believe this can be expedited to ensure efficiency in arriving at the claim recommendation.

Biological Research
Print version ISSN 0716-9760

Biol. Res. vol.40 no.4 Santiago 2007

http://dx.doi.org/10.4067/S0716-97602007000500014

Biol Res 40: 523-534, 2007

ARTICLE

The debate about death: an imperishable discussion?

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Dirección para Correspondencia

ABSTRACT

In this concise review we discuss some of the complex edges of the concept of death that arose after the notorious advances in science and medicine over the last 50 years, in which the classical cardio-pulmonary criteria have led to the neurological criteria of death. New complicated questions like the definition of death and the operational criteria for diagnosing it have arisen and we think that they are far from being adequately and satisfactorily solved. A number of important issues -like the reliability and differences

between cardio-pulmonary versus brain based criteria of death, if death is an event or a process, the meaning of integration and irreversibility- have not yet received sufficient attention. Here we have approached the death problem from two (biological) complex system perspectives: the organism level and the cellular-molecular level. We also discuss issues from a third systemic approach, that is, the entire society, thus involving legal, religious, bioethical and political aspects of death. Our aim is to integrate new perspectives in order to promote further discussion on these critical yet frequently neglected issues.

"Dimmed your eyes!
Silent your heart!
Not a breath's
gentle wafting!
Must she now in misery
stand before you,
she who joyously, to marry you,
bravely crossed the sea?
Too late!
Spiteful man!"

Tristan und Isolde. Richard Wagner
Act III, Scene II.

INTRODUCTION

Imagine this desperate scene of Wagner's Opera "Tristan und Isolde" changed by the current advances of science and medicine; maybe Isolde could include some of the brain death criteria, like coma and the absence of brainstem reflexes, to assert the death of her beloved Tristan. It could be

argued that this is art, and that science and the criteria of death have nothing to do with it. We would say that, on the contrary, it is important to consider the influence that the advances of science in general and medicine in particular have on other disciplines and in everyday life, especially in such dramatic circumstances. For us, children of a materialistic age characterized by an amazing development of sophisticated technology, in which the intensive care techniques are seen as one of its highest achievements, it might be argued without doubt that brain death *is death.* It is a fact around us, influencing our daily life, thoughts and decisions; it could be understood as a contemporary dogma. The fast life style of our times generally does not allow us to stop and question the grounds from which our truths have been built and in consequence, we are blind to the many controversies and criticisms about brain death, from its philosophical definition to the medical diagnostic tests that confirm it. Yet there is still a great discussion about some fundamental aspects regarding the concept of death. One extensively accepted definition of death is the "permanent cessation of the critical functions of the organism as a whole" (Bernat, 2005). Bernat and colleagues (1981) have distinguished three levels of discussion: the definition or concept of death (a philosophical matter); the anatomical criteria of death (a philosophical/medical matter); and the practical testing which, by way of clinical or complementary examinations, can determine that death has occurred (a medical matter) (Bernat et al., 1981).

Here we will discuss about death, a phenomenon that people in general do not want to talk about, but inevitably will someday confront. We will approach the death problem from two biological complex system perspectives with special attention on the interactions and regulatory processes involved: the organism and cellular-molecular levels. But we will also refer to a third system: the entire society, therefore involving historical, legal, religious, bioethical and political aspects.

THE PROBLEM OF DEATH BEFORE THE INTRODUCTION OF INTENSIVE MEDICAL CARE

Since the beginning of humankind the most natural sign of life has been movement; with spontaneous respiration being probably the paradigmatic example. The concept of movement as sign of life is called *quickening,* an old term related to the latin *vivus* and the greek *bios* (Dagi and Kaufman, 2001). In old biblical translations, the divine ability to instill life into corpses is described as the ability to quick the dead. According to this concept, the presence of the divine soul or the conjunction of atoms that originated human life was detected through the existence of some minimal movement or spontaneous activity. The idea of quickening was extended to the activity of the heart and lungs and for this reason, cessation of

heartbeat and respiration were considered the first "standard" criteria of death (i.e. classical cardio-respiratory criteria of death) (Dagi and Kaufman, 2001). From ancient times to the first half of the 20th century there were no doubts that death was confirmed by the absence of pulse and breathing. Nevertheless, from the seventeenth century onwards scientists, physicians, theologians and the lay public had become preoccupied with premature burial (Ducachet, 1822; Snart, 1824). At the beginning of the eighteenth century, the Resuscitation Movement strove to promulgate and popularize the skills of resuscitation and artificial respiration that had to begin at the moment of loss of spontaneous pulse or respiration (Dagi and Kaufman, 2001). At this "point of resuscitation", it could be considered that the person was either truly or just apparently dead. The difference between real death and apparent death depended whether death was "tested", based on the response to resuscitation: outside the immediate reach of medical care, apparent death equated to death; within the reach of medical care, response to resuscitation meant life and failure of resuscitation categorically meant death (Dagi and Kaufman, 2001).

THE PROBLEM OF DEATH AFTER THE INTRODUCTION OF INTENSIVE MEDICAL CARE

In the 1950s the poliomyelitis epidemic took place in the United States, with hundreds of people dying from its most dangerous clinical syndrome (the paralytic form) in which patients suffered paralysis of the muscles responsible for ventilation. In this context, the use of the "iron lung", a device that sustained artificial ventilation until the full recovery of the patients, became widespread. A great proportion of these patients maintained consciousness and did not exhibit cognitive impairment, thus being considered in a "critical near-death but conscious" state. In those days, such medical intervention was considered a "resuscitation" technique and the notorious results obtained thereby motivated the extensive use of artificial ventilators in patients with diseases other than poliomyelitis that involved coma or unconsciousness. It was assumed that, as in the cases of poliomyelitis, the body would recover to self-sufficiency after mechanic ventilation. However, some of them did not recover and the event that resulted in cardiopulmonary arrest also resulted in irreversible brain damage. These patients never regained consciousness or the ability to breathe spontaneously, with the consequent dissociation never seen before between "body and brain" functioning. This state was initially described as *coma depassé* (Mollaret and Goulon, 1959). One factor identified with the irreversibility of brain damage was liquefaction of the cerebral tissue after prolonged mechanical ventilation. This condition is known as "respirator brain", and was considered incompatible with recovery of spontaneous respiration and consciousness.

It is at this point in time that the disintegration of the consensus about death emerges because, as we have described, it became possible to observe the dissociation between the function of the brain and the heart and lungs. The moment of death-until then a reliable and secure fact-was irrevocably questioned. The second half of the 20th century witnessed the surge of the practical uncertainty about death. In this new scenario new questions and problems emerged: for example, ventilatory support did not reliably restore patients to self-sufficiency or to consciousness; the demand for intensive care unit beds outstripped the supply so that there were more patients needing ventilatory support than the health system could afford; finally, heart transplantation had just begun, requiring a precise criterion to declare that the donor was dead, while also avoiding the loss of adequate myocardial function. As these practical problems arose, due mainly to the advances of science and medicine, such disciplines became relevant for the discussion about the definition of death, as had never happened before. An example of this is the allocution of the Pope Pius XII (1957) entitled "The Prolongation of Life", which established that the pronouncement of death was not the province of the church but responsibility of the physician: "It remains for the doctor [...] to give a clear and precise definition of death and the moment of death of a patient who passes away in a state of unconsciousness" (XII, 1977).

After all of these new advances and controversies, in 1968 the Harvard Ad Hoc Committee was conformed, defining the criteria for brain death (1968) . The suggestion that brain-based criteria might lead to a new, generally accepted definition, independent of cardio-pulmonary function, led to a general reappraisal of the meaning of death. We agree with Youngner and Arnold that a number of important issues about death have not received sufficient attention, i.e. the meaning of integration, the reliability and differences between cardio-pulmonary versus brain based criteria of death, if death is an event or a process and irreversibility (Youngner and Arnold, 2001). In the following section we turn to these matters with the aim to integrate new perspectives in order to promote further discussion of these critical issues.

THE PROBLEM OF INTEGRATION AND THE CRITERIA OF DEATH

An important concept related with death is the consideration of the organism as a whole, which refers to its unity and functional integrity, not to the simple sum of its parts, thus encompassing the concept of an organism critical system (Korein and Machado, 2004). In this line, Shewmon (1999) proposes that living

organisms have an integrative unity, that is, they have at least one emergent holistic-level property. Emergent means that it derives from the mutual interaction of all of the parts, and holistic means that the property is originated only from the whole composite. (Shewmon, 1999). Critical functions are those that are necessary for the organism to work as a whole: control of respiration and circulation, neuroendocrine and homeostatic regulation and consciousness. Some authors propose that these functions are ultimately carried out by the brain (Laureys, 2005). However, the persistence of hypothalamic neuroendocrine functions in "whole brain-dead" patients has been advocated against this formulation (Machado, 1999). For Shewmon, the integrative unity of a complex organism involves the cooperative interaction of all of its components, therefore it could not be realized as just the simple coordination imposed by one part upon the others, nor can it be anatomically localized in just one organ (Shewmon, 1999). This author suggests that most of the integrative functions of the brain are not somatic; in fact, most of the integrative functions of the body are not mediated by the brain (e.g. homeostasis, energy balance, maintenance of body temperature). Brain function would be more modulatory than constitutive, increasing the quality and the survival potential of the living organism (Shewmon, 2001).

Death of the whole organism: cardio-pulmonary versus brain-based criteria of death

Prior to medical intensive care, there was only one criterion of death: cessation of respiration and circulation, conforming to the cardio-pulmonary criteria. However, as discussed previously, after important scientific advances, alternative criteria based on the ceasing of brain functioning were proposed. In 1968 the criteria of death of the Harvard Committee was published stating that irreversible coma was equal to death (1968). Nowadays, death can be diagnosed in two ways, by cardio-respiratory or neurological criteria. Authors like Laureys (2005) suggest that brain death means human death determined by neurological criteria. Within the "neurological" criteria there are three main sub-criteria: the whole brain, the brainstem and the neo-cortical criteria of death (Laureys, 2005). The whole brain formulation requires bedside demonstration of irreversible cessation of all clinical functions of the brain, and is the most widely accepted. For Bernat (2005), there is a rigorous conceptual basis for regarding whole-brain death as human death based on the biophilosophical concept of the loss of the organism as a whole (Bernat, 2005). The brainstem formulation regards irreversible cessation of clinical functions of the brainstem as not only necessary but also sufficient for the determination of death. In this way, Pallis (1995) argues that the brainstem is the through-station for almost all hemispheric input and output, the centre that generates arousal (which is essential for consciousness), and the centre of respiration (Pallis, 1995). Both criteria suppose that the brain (with its cortical and subcortical structures including the brainstem) has a fundamental role in the integration of the organism. The clinical set of tests for whole brain and brainstem death are identical.

In sum, there are two sets of tests that can be used to ascertain death: neurological and/or cardio-pulmonary; which test is used depends on whether or not the patient is on mechanical ventilation. In non-artificially ventilated patients, physicians evaluate the irreversible absence of heart beat and breathing to declare death, but in patients who are mechanically ventilated, validated neurological tests are used to assure irreversible absence of brain (brainstem) function. As mentioned above, the criteria for brain death is based principally in findings from the clinical examination (coma, apnoea, absence of brainstem reflexes and motor responses); the confirmatory laboratory tests are only required when specific components of the clinical tests cannot be reliably evaluated (The Quality Standards Subcommittee of the American Academy of Neurology, 1995). Such ancillary diagnostic studies include cerebral angiography and transcranial doppler sonography which can be used with a very high sensitivity and specificity to document the absence of cerebral blood flow in brain death (Ducrocq et al., 1998a, Ducrocq et al., 1998b). In this line, radionuclide cerebral imaging like single photon emission computed tomography (SPECT) and positron emission tomography (PET) can show the hollow-skull sign, confirming the absence of brain function (Conrad and Sinha, 2003, Laureys et al., 2004). The electroencephalogram (EEG) in patients with brain death shows the absence of electrocortical activity with a sensitivity and specificity of 90% (Buchner and Schuchardt, 1990) and, because of its availability, it has become the preferred confirmatory test for brain death and has been implemented in many countries' guidelines (Wijdicks, 2002, Laureys, 2005). Somatosensory evoked potentials show arrest of conduction at the cervicomedullary level in brain death (Facco and Machado, 2004). Anatomopathology in patients with brain death who are receiving maximal artificial means of support will inevitably end up showing the "respirator brain": surface vasocongestion, subarachnoid haemorrhage, and cortical congestion and haemorrhage (Leestmaetal., 1984).

Cortical death

Brierley et al (1971), Veatch and others suggest that death can be defined by the permanent cessation of those higher functions of the nervous system that demarcate man from the lower primates and other animals. This neocortical or higher brain death definition has its conceptual basis on the premise that consciousness, cognition and social interaction, not the bodily physiological integrity, are the essential

characteristics of human life (Brierley et al., 1971, Veatch, 2005). In this line, the neocortical death criterion includes only the permanent loss of neocortical function, not of the whole brain or of the brainstem. As Laureys suggests, clinical and confirmatory tests for neocortical death have never been validated as such (Laureys, 2005). In contrast to brain death (whole brain and brainstem) for which the neuroanatomy and neurophysiology are both well established, anatomopathology, neuroimaging and electrophysiology techniques cannot, at present, determine the presence or absence of human consciousness. Therefore, no accurate anatomical criteria can be defined for a higher brain formulation of death. Moreover, in clinical practice, tests would require the provision of bedside behavioural evidence showing that consciousness has been irreversibly lost. This however implies a strong methodological and philosophical limitation, because consciousness is a subjective first-person experience and clinical evaluation is limited to evaluating patients' responsiveness to the environment (Laureys, 2005). Unlike patients with brain death, patients in a vegetative state can move, breath and open their eyes spontaneously, showing how extremely difficult it is to clinically differentiate between automatic and willed movements (Prochazka et al., 2000). Furthermore, complementary tests for neocortical death would require the confirmation of irreversible loss of *all* cortical functions; but patients in a vegetative state may show preserved islands of functional pallium or cortex. Recent functional neuroimaging studies have shown limited, but undeniable, neocortical activation in patients in a vegetative state, disproving the idea of complete neocortical death in these patients (Rudolf et al., 1999, Beuthien-Baumann et al.,2005).

Finally, based on the neocortical definition of death, patients in a vegetative state following an acute injury or chronic degenerative disease like Alzheimer's disease, and anencephalic infants, are considered dead. As Serani (1999) suggests, for the "living human" the personal, intellectual, volitive, free and moral life conform the higher and most proper level of ontological manifestation, a level for which the mere organic life represents the lesser and poorer degree of realization. Nevertheless, in an inverse hierarchic view, organic life appears as the primary, radical and unchangeable condition of any ontologically superior manifestation. In this line, Serani proposes that organic life is the nursemaid, the throne, the home for all the others superior manifestations of human life. It is the first to arise and the last to disappear. Human life is expressed organically before the conformation of the tools of superior life and persists beyond their disappearance. The human being is much more than a living organism but it is nothing less than one either (Serani, 1999).

Death as event versus death as process

A second rather critical issue in the discussion about death, and which is related to the above considerations, is if death is a clear cut event or a progressive, temporally extended, process. According to the "dead donor rule" for organ transplantation, we cannot take a critical organ from a living person in order to save another, because it means that in the process we are killing somebody. It is clear that considering death as event or death as process is critical to this question. If we consider that death is an event, maybe we will focus in those signs that accurately confirm that a person is dead, and maybe we will use the cardio-pulmonary criteria, in which we will diagnose the death of a person through the absence of respiration or heart beating. One extreme position in this line is to wait for the expression of "positive" signs of death like cooling of the body (algor mortis), rigidity (rigor mortis), lividness (livor mortis) and dehydration (Echeverría et al., 2004). On the other hand, we could also consider death as an event if we assume, guided by brain death criteria, that the dead body is artificially maintained by technology. Lizza (2005) proposes that by artificially sustaining brain-dead human bodies or, hypothetically, decapitated human bodies, we intervene in the life history of the organism in such a radical way that we create new kinds of beings, and that we should recognize that the human being or "person" has died. In fact, artificially sustaining a "brain dead" body falls outside the natural or normal course of events; it is more a technological artifact (Lizza, 2005). As Laureys (2005) suggests, brain death would signify death not because it is invariably imminently followed by asystole, but because it is accompanied by irreversible loss of critical cerebral functions and thus it would represent the disintegration of the organism as a whole (Laureys, 2005).

On the other hand, if we assume that death is a process we could consider that the brain death criteria give us a practical tool to determine that the "death cascade" has begun and will inevitably end in death according to cardio-pulmonary criteria. From a thermodynamical perspective, the "point of non-return" occurs if the tendency to the active self-sustainment of the body is irreversibly lost so that entropy will increase as for inanimate objects. In the opinion of Shewmon (2001), the loss of integrative unity involves anatomically a critical level of damage at molecular scales in the complete body; we can see death like a progressive process of energy disorganization. From this point of view, life is the state of an organized system that has a dynamic balance of energy exchange with the environment, and the loss of such balance (point of non-return) would imply the disorganization of the system, inevitably ending in the total disintegration of the organism (Shewmon, 2001).

Until now we have referred to death in an organism level, but we think that we could provide new insights into this issue if we look at the cellular-molecular level. In this line, the death of a cell can be defined as an irreversible loss of plasma membrane integrity. Historically, three types of cell death have been distinguished in mammalian cells by morphological criteria. Type I cell death, better known as apoptosis, is defined by characteristic changes in nuclear morphology, minor changes in cytoplasmic organdíes, overall cell shrinkage, blebbing of the plasma membrane and formation of apoptotic bodies that contain nuclear or cytoplasmic material. All of these changes occur before plasma membrane integrity is lost. Type II cell death is characterized by a massive accumulation of two-membrane autophagic vacuoles in the cytoplasm. Type III cell death, better known as necrosis, is often defined in a negative manner as death lacking the characteristics of the type I and type II processes. (Golstein and Kroemer, 2007). Apoptotic cell death is characterized by controlled autodigestion of the cell. Cells appear to initiate their own apoptotic death through the activation of endogenous proteases named caspases, which are classified into 'initiator caspases' (caspases 2, 8, 9 and 10) and 'effector caspases' (caspases 3, 6 and 7). It has been proposed that in the apoptotic model the threshold for cell death is dynamically regulated and determined by the combined effects of external and internal survival factors (Thompson, 1995). On the other hand, another kind of cell death, necrosis, can be both fully unregulated and 'programmed'. Necrosis might be programmed in terms of both its course and its occurrence, and this is supported by numerous results. Golstein and Kroemer suggest that the same upstream signal can produce different types of cell death as a function of, in particular, the activation or inhibition of catabolic enzymes in the cell (Golstein and Kroemer, 2007). As we can see, at the cellular level, death is realized as a process.

About irreversibility

If we consider death as a process, we are confronted with a rather complex issue, that is, to define or pinpoint the moment of irreversibility of death. This is obviously not a trivial issue because we have to be able to predict, with extremely high reliability, that death according to one criterion, say brain death, will be inevitably followed by death diagnosed by cardio-pulmonary criteria. In the context of death as a process, it could be argued that a person with brain death has begun an irreversible process of disintegration that could be delayed by artificial means like mechanic ventilation. In this line, one prospective study (1977) supporting the neurocentric criteria of death found that cerebral unresponsiveness, apnoea and an isoelectric electroencephalogram were predictors of death based on cardio-pulmonary criteria within 3 months, despite continued ventilatory and cardiac support. However, Shewmon (1998) in a meta-analysis, found 175 cases of patients diagnosed with brain death surviving 1 week or more, with enough information of factors affecting survival capacity on 56 cases. Of these cases, one-half (28/56) survived more than 1 month, nearly one-third (17/56) more than 2 months, seven (13%) more than 6 months, and four (7%) more than 1 year, the record being 14 years. For Shewmon, the tendency to asystole in brain death can be transient and is attributable more to systemic factors than to the absence of brain function per se (Shewmon, 1998).

Evidently, an important aspect is the role and availability of technological advance plays in the determination of irreversibility. For Lizza (2005), we should consider realistic impediments for holding that a patient's condition is irreversible. As the author suggests, to clarify this sense of "irreversibility" it may be helpful to distinguish three factors that can affect the reversibility of either the cessation of cardio-respiratory functions or the cessation of all brain functions: the physical state of the person, factors external to the person, and individual and social decisions. The physical state of the person with respect to "irreversibility" refers to whether a person's physical state is sufficient to prevent the reversibility of cardio-respiratory functions or all brain functions. Factors external to the person refer to whether medical interventions are available to the patient at the time of cardio-respiratory arrest or cessation of all brain functions. Individual and social decisional factors refer to whether decisions have been made by the patient, family, health care providers, or society to obstruct any medical intervention to reverse the cessation of cardio-respiratory functions or brain functions. For example, in a patient with a "do not resuscitate" order, the cessation of cardio-respiratory functions can be said to be irreversible and the patient is beyond the point of spontaneous auto-resuscitation. This, even though features of the patient's physical state alone are insufficient to determine irreversibility and the medical technology to resuscitate is available. In this example of Lizza (2005), external factors in the form of a deliberate decision lead to practical restrictions on what can be done to the patient, although there are no technological or physical arguments to consider this situation irreversible (Lizza, 2005).

As Laureys (2005) proposes, the prolonged absence of intracranial blood flow is considered to prove irreversibility based on brain death criteria. On the contrary, the reduced -but not absent-cortical metabolism observed in the vegetative state cannot be regarded as evidence for irreversibility according to cortical death criteria, (Schiff et al., 2002, Bernat, 2004). Indeed, fully reversible causes of altered consciousness, such as deep sleep and general anaesthesia, have shown similar decreases in brain function, and the rare patients who have recovered from a vegetative state have been shown to resume

near-normal activity in previously dysfunctional associative neocortex (Alkire et al., 1999, Laureys et al., 1999).

At a cellular level one might assume that in apoptosis, caspase activation is the 'point of no return' for a cell to die. However, as Kaufmann and Hengartner (2001) discuss, recent studies cast doubt on this assumption. Two studies in *C. elegans* have demonstrated that mutations in genes required to remove 'dead cells' can actually lead to increased cell survival. These studies found that cells expressing maimed CED-3 sometimes started to undergo programmed cell death and then reverted to a normal phenotype when they were not engulfed (Hoeppner et al., 2001, Reddien et al., 2001). This reversibility of cell death has also been reported in growth-factor-deprived neurons when caspase activation is inhibited (Martinou et al., 1999, Kaufmann and Hengartner, 2001). In sum, there is contradictory evidence about the irreversibility of the death process, both at global and cellular levels.

LEGAL, RELIGIOUS AND BIOETHICAL PERSPECTIVES

Legal issues

Nowadays, the brain death criterion of death is widely accepted throughout the world. However, there are some differences between countries. For example, the brainstem criterion is accepted in the United Kingdom, while in the United States the whole brain criterion is considered. Wijdicks (2002) explored the international practices for diagnosing brain death, obtaining original brain death documents of 80 countries. Legal standards on organ

transplantation were present in 55 of 80 countries (69%) and practice guidelines for brain death for adults were present in 70 of 80 countries (88%). More than one physician was required to declare brain death in half of the practice guidelines. Countries with guidelines specified exclusion of confounders, irreversible coma, absent motor response, and absent brainstem reflexes. Apnoea testing using a $PC0_2$ target was recommended in 59% of the surveyed countries. Differences were also found in the time of observation and in the required expertise of examining physicians. Confirmatory laboratory testing was mandatory in 28 out of 70 practice guidelines (40%). Wijdicks concluded that there is uniform agreement on the neurologic examination with exception of the apnoea test. Nevertheless, other major differences in procedures for diagnosing brain death in adults were also found in this survey (Wijdicks, 2002).

In 1996 the law N° 19.451 was promulgated in Chile, establishing the norms for organ transplantation and donation. For Flores et al (2004) this law is a relevant contribution because it defines death by neurological criteria (brain death), incorporating appropriate diagnostic protocols that clearly establish the conditions for diagnosing death. It also permits to establish the person's choice on organ donation during her/his life. However, the authors note that this law also has deficiencies because according to it, brain death criteria are only applicable to those who *will be* organ donors (Flores et al., 2004). Consequently, according to this law, those who will be donors could be diagnosed dead by brain death criteria, while those who will not, lack the corresponding criteria.

Religious aspects

As we mentioned previously, the Catholic Church through Pope Pius XII declared that the diagnosis of death was a strictly medical matter. Later, Pope John Paul II recognized the neurological criteria of death and declared that if rigorously applied, they do not seem to conflict with the essential elements of a sound anthropology. In other major religions there are similar positions. The Jewish law recognizes the ethical value of organ donation and the Islamic code of medical ethics approved the organ donation as a benefit to society (Flores et al., 2004). Thus, several major religions agree with the neurological criteria of death and organ transplantation.

Bioethics

Bioethical principles are at the basis of the conception of death and are intrinsically related with organ donation and transplantation. They involve aspects like not using human beings with instrumental purposes. For Tomlinson (1993), the meaning of irreversibility in the definition of death is an ethical one: for him "irreversibility" means that "the possibility of reversal is not ethically significant". According to this author, because there are good ethical reasons for honouring the wishes of the donor, "those medical means for reversing his cardio-respiratory arrest are no longer ethically significant possibilities" (Tomlinson, 1993). In this line, in relation to cases involving "do not resuscitate" orders, despite that from a strictly technological point of view the dying patient's physical condition could be reverted, practical restrictions to perform resuscitation on the patient make it extraordinarily improbable that the cessation of cardio-respiratory functions will be reversed. Even though it may be physically possible to resuscitate some

"do not resuscitate" patients, they are correctly declared dead soon after cardiac arrest, because their cardio-respiratory functions have irreversibly ceased, that is, it is highly unlikely that their functions will resume, given their physical state and recognition of the patient's wish not to be resuscitated (Tomlinson, 1993, Lizza, 2005). On this issue, the Pontifical Academy for Life stated that the approach to the gravely ill and the dying must be inspired by the respect for the life and dignity of the person. It should pursue the aim of making proportionate treatment available but without engaging in any form of "overzealous treatment". One should accept the patient's wishes when it is a matter of extraordinary or risky therapy which he is not morally obliged to accept. One must always provide ordinary care (including artificial nutrition and hydration), palliative treatment, especially the proper therapy for pain, while always keeping the patient informed. At the approach of death, which appears inevitable, "it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life" accepting the natural conclusion of life (Vial Correa and Sgreccia, 2000).

In relation to the principles of bioethics, the principle of autonomy must be reflected in the informed consent and the statement of the will for donation of patients and "do not resuscitate" orders. The principle of beneficence relates to human solidarity and compassion in the decision of donation and the non-maleficence principle could be reflected in the security of procedures (Flores et al., 2004). It is important to take into account the deep meaning of the organ donation that deserves the higher respect to the dead body of the person who decided in life to donate himself.

CONCLUSION

In this concise review we have discussed some of the complex edges of the concept of death. Of course, these issues are intimately related with the notorious advances in science and medicine over the last 50 years. New complicated questions therefore are posed, from the definition of death to the operational criteria for diagnosing it, and answering them requires from philosophy to physiology. We can see that some of these problems are far from being adequately and satisfactorily solved, and there is an important debate around them. We have tried to approach the death problem from two biological complex systems perspectives in which interactions and regulatory processes are paradigmatically involved: the organism level and the cellular-molecular one. Of course, we could realize that there is a third systemic approach: the entire society, involving the legal, religious, bioethical and political aspects.

Historically, the classical cardio-pulmonary criteria have led to the neurological criteria of death. It could be argued that the circulation-respiration proposal signals in a more accurate way the death phenomenon if we dimension it as a clear-cut event, but if we look at death as a process of disintegration, then brain death can be viewed as the beginning of this irreversible chain. However, there is a great discussion about the real irreversibility of this process whether at a human dimension or at a cellular one. If we attend to aspects like the practical testing of death it could be realized the difficulty of demonstrating the theoretical concept of circulation-respiration death; nowadays it is almost unaffordable to prove the ceasing of circulation at the cellular level or the end of respiration at the mitochondrial level. Instead of it, cardio-pulmonary and neurological criteria of death can be clinically tested in patients.

On other hand, we have to take into account that despite the fact that technological advances allow us to maintain life artificially and that the notion of irreversibility may therefore change depending on available technological support, the goal of medical care must be to preserve human dignity at any moment, including the moment of death. In this line, it is fundamental to respect the will of the patient and family concerning conducts such as orders of no resuscitation and to avoid therapeutic cruelty that goes against human dignity. In this context, we believe that there are more important things than mere technical advances or the biological possibility of recovery to declare some situation reversible or not.

From a practical point of view, the scientific improvement of medicine has led to important questions, related to organ transplantation and artificial life-sustaining, in intensive care units that constitute "everyday situations" for physicians and the patient's family, requiring clear and adequate answers. As we have seen, only brainstem and whole-brain criteria have good anatomical and clinical support, and are accepted in most countries. In contrast, the cortical death criterion does not have scientific support, besides the ethical problems that it raises. It could be suggested that the neurocentric concept of brain death is no more than utilitarian criteria for defining death. However, we must also consider that scientific progress has opened the way to medical "miracles" like organ donation and transplantation that without this concept would be difficult to afford. In order to define the limits of intensive care unit treatment and organ donor transplantation policies, it is necessary to have accurate and dependable criteria of death; nobody should interrupt a life in order to save another.

Finally, we have to consider that death is a natural and inevitable event and although patients, their families and physicians have the right to fight against disease, some day the moment of the disintegration

will arrive. Independently of every human being's beliefs, it is important to be conscious that death is no defeat, but a defining part of the nature of life.

ACKNOWLEDGEMENTS

This work was financed by a MECESUP doctoral full scholarship awarded to FB and a CONICYT doctoral full scholarship awarded to DH.

We would like to thank Diego Cosmelli and Francisco Aboitiz for revisions and comments on previous versions of this manuscript. We would like also to thank Adrián Palacios and Diego Cosmelli, chairs of the workshop "Networks in Cognitive Systems / Trends and Challenge in Biomedicine: From Cerebral Process to Mathematical Tools Design" at the Instituto de Sistemas Complejos de Valparaíso (ISCV).

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Exhibit 3

ACERA

Office of the Chief Counsel

To: Retirees Committee

From: Jeff Rieger, Chief Counsel

Meeting: August 2, 2023

Subject: **Preauthorization of Disability Application and Optional Settlement**

In October 2022, when the Committee was considering whether to reauthorize the Active Death Equity Benefit "ADEB," the Committee directed staff to investigate alternative ways to help "active"[1] members maximize the benefits owed to their beneficiaries in a similar fashion as the ADEB. At this meeting, staff is presenting an alternative method that has been employed by the Contra Costa County Employees' Retirement Association (CCCERA) for years. Attached hereto are (1) a memorandum from outside counsel Maytak Chin (Reed Smith LLP) describing the CCCERA program and the legal bases for the program, (2) a cost study by Segal that estimates the annual costs if ACERA were to implement a similar program, and (3) a copy of *Gorman v. Cranston* (1966) 64 Cal.2d 441.

Please read Maytak Chin's attached memorandum before continuing. This memorandum will be hard to follow if you have not read that memorandum.

I am providing this separate memorandum for the following reasons:

First, I agree with Reed Smith that the CCCERA program is authorized under California law—in particular, the California Supreme Court case *Gorman v. Cranston* (1966) 64 Cal.2d 441. While there are some differences between the individual circumstance addressed in *Gorman* and CCCERA's system-wide program,[2] I agree with Reed Smith that the principles of *Gorman* are broad enough to authorize the CCCERA program.

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[1] The program would be offered to those who qualify for the Section 31781 "death benefit" under Section 31780: "… death before retirement of a member while in service or while physically or mentally incapacitated for the performance of his duty, if such incapacity has been continuous from discontinuance of service, or within one month after discontinuance of service …" Most such members are in active status at the time of death, but some may be in deferred status.

[2] There are statements on page 445-46 of *Gorman* that may suggest the specific facts of that case (the member knew he was going into surgery) were important to the Court and the Court may have ruled differently on a system-wide program that allowed all members to fill out preauthorization forms. While that language poses some risk to the CCCERA program if it were challenged, I do not believe the language is fatal to the program. In *Gorman*, the Court was stating that Gorman's election was not a system-wide program in response to arguments about the implications of a system-wide program. The Court was not stating that a system-wide program was necessarily problematic. A system-wide program was not before the Court, so we cannot know whether the Court would have analyzed such a program differently. I do not believe the Court would have rejected a system-wide program like CCCERA's, because a retirement system should not be

Second, if the Board implements a program like CCCERA's, I recommend that the Board adopt a written policy that outlines how the program would work at ACERA and explains the legal bases for the program. I expect such a policy will include some terms that are not included in the CCCERA program. For example, I recommend that such a policy would explain what will happen when there is a relevant marriage, divorce, death or beneficiary change after the member submits active death form.[3]

Third, I want to highlight that the CCCERA program may result in less benefits for some beneficiaries if members die quickly after an injury or disease. Like the ADEB, the CCCERA program grew out of the arbitrarily different outcomes that turned on whether the member lived long enough to apply for disability and elect an optional settlement. The CCCERA program eliminates that difference for most "active" member deaths, but still allows for a different outcome for members who live for a "real and measurable" amount of time after the injury or disease that resulted in death and those who do not. If the Board adopted the CCCERA program, there may come a time when ACERA will have to deny benefits because a member died "too quickly." For example, if a member is hit by a car and, based on the medical records, the member died "immediately on impact," ACERA may have to deny benefits that would have been payable if the member had lived another minute after being hit (if a minute is a "real and measurable" period of time of the member being medically alive). If the Board would like benefits to be available to those members who might not be covered under the CCCERA program, we can analyze the Board's options in collaboration with MMRO[4] and/or prepare a proposed hybrid program similar to CCCERA's, but with a scaled-back version of the ADEB to cover just those members.

Based on the above, there are three choices before the Committee: (1) continue the status quo; (2) implement a plan like CCCERA's with some minor changes; or (3) implement a plan like CCCERA's, with some minor changes, but set up in a way that covers those members who die "too quickly" to qualify under the CCCERA plan.

If the Committee wishes to proceed with a change to the status quo, I recommend that the Committee direct staff as to the kind of program the Committee prefers and then staff can come back to the next feasible Retirees Committee meeting with a proposed policy.

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put in the position determining whether a member's fear of disability followed by death is "specific enough" to allow the member to file a preauthorization. I believe members either have a right to file a preauthorization or they do not and *Gorman* held that they have that right. Would the Court have ruled differently if Gorman had a history of heart attacks and feared the next one might disable and kill him? What if he just had a family history of heart attacks? What if he was about to climb a mountain and feared an incapacitating injury followed by death? How can CCCERA (or ACERA) possible draw a line to determine which members would and would not be entitled to make a preauthorization based on whether a member has a specific situation in mind when filing the form?

[3] The form should be automatically invalidated if: (1) the member marries after submitting the form and did not designate the spouse as the beneficiary; (2) a member names a spouse as the beneficiary and later divorces that spouse; (3) a named beneficiary dies after the member files the form; or (4) after filing the form, the member files another beneficiary designation that is inconsistent with the form.

[4] For example, ACERA might obtain input from MMRO to support the proposition that nobody dies instantaneously and therefore everyone is incapacitated for duty for some amount of time in every case (if that proposition is medically supportable).

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MEMORANDUM

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To: Retiree Committee of the Board of Retirement
Alameda County Employees Retirement Association ("ACERA")

Date: August 2, 2023

Subject: **Preauthorization Approach for Benefits in Death of Active Members**

At its October 5, 2022 meeting, this Retiree Committee considered recommending to the Board the reauthorization of ACERA's prior Active Death Equity Benefit ("ADEB") approach, which the Board terminated in 2012. At that meeting, the Committee directed staff to explore other options to address the benefits available in the instance of a death of an active member.

This memorandum provides information regarding an alternative approach that another county retirement system uses. In this memorandum, you will find: (1) a summary of survivor benefits under the County Employees' Retirement Law of 1937 ("CERL"), and (2) a summary of the pre-authorization approach for death of active members that Contra Costa County Employees' Retirement Association ("CCCERA") uses.

1. CERL Provisions for Survivor Benefits

The CERL provides for three statutorily defined survivor benefits, which are mutually exclusive:

A. Member Election of Optional Settlement Allowances Before Retirement (Option A). Under CERL §§ 31760 and 31762, a member may elect one of a series of "optional settlement allowances" by filing a written election with the retirement board before the first retirement check is received. In essence, these options actuarially value the expected total benefits payable to the member and their survivors over their covered lives and apportion the total benefit between the member's and survivor's lives in different ways. The various choices must be "actuarially equivalent" in value to the present value of the "unmodified benefit" to which the member would be entitled if no other election is made.

   It is important to note that, in order for a surviving beneficiary to receive an Optional Settlement allowance, the active member must have on file their Optional Settlement election and retirement application at the time of death.

B. Default Death Benefits Payable After a Member's Death, Before or After Retirement (Option B). In the absence of an elected Optional Settlement on file at the time of a member's death, the CERL provides a statutorily defined death benefit. For the beneficiary to receive this statutorily defined death benefit, the member must have died "before retirement and while in active service, or while physically or mentally incapacitated for the performance of their duty, if such incapacity has been

continuous from discontinuance of service, or within one month after discontinuance of service," and the member's accumulated contributions must still be on deposit with the Plan. CERL § 31780. In general, the death benefit paid to the surviving beneficiary consists of the member's accumulated contributions plus a lump-sum payment based on years of service, up to 50% of annual compensation. *Id.* § 31781. This option only applies if there is no Optional Settlement election on file (Option A above) at the time of death.

C. Spousal Election in Lieu of Death Benefits (Option C). The CERL provides an alternative to the default death benefit for a surviving spouse or domestic partner (or minor children if there is no spouse or domestic partner). If the active member "would have been entitled to retirement in the event of a non-service-connected disability, but dies as the result of an injury or illness prior to retirement," then "the surviving spouse [or minor children] of the member shall have the right to elect, by written notice filed with the board, to receive and be paid in lieu of the [default] death benefit" the alternative death benefit provided under CERL § 31781.1. That alternative death benefit available to a surviving spouse or domestic partner (or minor children) grants a "monthly payment equal to 60 percent of the monthly retirement allowance to which the deceased member would have been entitled if he or she had retired by reason of non-service-connected disability as of the date of his or her death." *Id.* This option is available only if there is no Optional Settlement election on file (Option A above).

It appears from this statutory structure that the Legislature intended for the member to have the ability to make an election among various actuarially equivalent streams of payment for the retirement allowance they and their survivors would receive. This allows consideration of marital, parental, health and economic conditions up to the time of retirement, whether the retirement is for service or by reason of disability. Where *no* Optional Settlement election is made for a surviving spouse and/or minor children (the "unmodified allowance"), the Legislature provided that a surviving spouse or minor children could supersede that default option (i.e. Option C above), which otherwise would provide nothing more than the statutory death benefit to survivors (i.e. Option B above).

2. The Active Death Circumstance and CCCERA's Preauthorization Approach

The CERL provides members a choice of several options for receiving their retirement allowances and splitting the benefit stream among the member and their surviving beneficiaries, as discussed above. Members are required to elect their option prior to retirement (whether service retirement or disability retirement) or death.

In rare circumstances, however, an active member will be incapacitated for service only moments or hours before death, without time to file for a disability retirement allowance or to make their choice of Optional Settlement payments to be split between the member and their surviving beneficiaries. Failing the ability to file before death, the member's survivors are left to receive only the limited death benefits provided under the CERL, which could be substantially less than one or more of the Optional Settlement allowances that might have been chosen had a timely filing been made. This results in an inequity between the

survivors of the few members who die before being able to make the filings, and the survivors of other members who had time to file the necessary applications and declarations before death.

To ameliorate this inequity, one CERL system (CCCERA) has created a policy that allows survivors of "active death" members to receive the maximum benefit payments that would otherwise be due to them had the member been physically able to apply for a disability retirement and make the requisite Optional Settlement election before death. The intent of this policy is not to let the relative shortness of time between incapacity and death create arbitrary differences in benefits payable to similarly situated members.

A. Key Components of CCCERA's Preauthorization Approach

- Paperwork for Pre-Authorized Filing: The active member files a written authorization with the Plan during service that: (1) authorizes the Plan to file an application for a non-service connected disability retirement on the member's behalf in the event that the member is permanently incapacitated by reason of injury or other disability leading to death while the member is an active member of the Plan, and (2) allows the member to pre-elect an Optional Settlement 2 (CERL § 31762) or an Optional Settlement 4 (CERL § 31764) prior to retirement.[1] The application and election "spring" into being the instant the member is incapacitated before death. Thus, with this springing authorization, a member can conditionally pre-file their non-service connected disability application and Optional Settlement election. In essence, the pre-authorization approach is like an advanced directive for public pension benefits for circumstances involving the death of an active member.

  A copy of CCCERA's Form 104 (Member Election Form for Optional Allowance in the Event of Death During Active Membership) is attached to this memorandum as Exhibit A.

- Beneficiary Designation: Under this pre-authorization approach, an active member can name any individual with an "insurable interest" in the member's life for an Optional Settlement 2 or Optional Settlement 4 election.[2]

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[1] Optional Settlement 2 under CERL § 31762 reduces the member's monthly retirement benefit, but after the member's death, requires the Plan to pay the same reduced benefit to the named beneficiary for the rest of their lifetime. Under Optional Settlement 2, the amount of the member's monthly benefit that is reduced depends on the member's age at retirement, the age of the beneficiary at the member's retirement date, and the life expectancy of both parties.

Optional Settlement 4 under CERL § 31764 is similar to Optional Settlement 2, but allows more than one beneficiary. The benefits paid under Optional Settlement 4 must not place any additional burden upon the retirement system and requires consultation with the Plan's actuary.

Both Optional Settlement 2 and 4 are irrevocable once the member retires, and do not allow the member to re-designate a new beneficiary if the named beneficiary predeceases the member.

[2] CCCERA's Form 104 does not address what to do in the case where the member designates a surviving spouse/domestic partner in the pre-authorized election but later divorces the surviving spouse/domestic partner and then dies. It may be wise to

- Timing of Filing: The pre-filed non-service connected disability retirement application and Optional Settlement election can be filed at any time while the member is in service, within four months after discontinuing service, or from discontinuance of service to the date of the application if continuously incapacitated during that time. CERL § 31722. The pre-filed application and election "spring" into effect when there is reason to believe that the member is permanently incapacitated for the performance of their duties. Once the application is deemed filed, the Board has the responsibility of "determin[ing] the existence of the disability." CERL §§ 31723, 31725.

- Who Can File for the Member: The member, an employer, retirement board/staff, or anyone else can file a non-service connected disability retirement application with the Board (CERL § 31721), and a member may elect one of the Optional Settlements at any time "until the first payment of the retirement allowance is made" (CERL § 31760). Therefore, the retirement board and staff can be "deputized" by the active member to file a non-service connected disability retirement application on their behalf if the member becomes incapacitated and is physically unable to file the application after the event causing their incapacity.

- Board Determination: However, once the conditional authorization is triggered by the active member's incapacity and the Plan files the non-service connected disability application, the member is not granted an automatic right to a disability retirement benefit. Rather, the Board must adjudicate and determine whether the member was indeed incapacitated for the performance of duty prior to death at the time the disability retirement application was filed based on competent medical evidence. This determination based on competent medical evidence must be made before any disability retirement benefit entitlement is granted, just as it would with any disability retirement application. CERL §§ 31723, 31725. In making this determination, the Board considers the following:

    - *First*, whether the member prepared the pre-filed paperwork with a set purpose and provided clear instructions for executing the non-service connected disability application and Optional Settlement election in the instance where the member becomes permanent incapacitated for performance of the member's duties;

    - *Second*, whether there was a time interval that was "real and measurable" where the member was alive and incapacitated prior to death as determined by the Board's medical advisor and supported by medical records, or whether there was a sudden and instantaneous death with no room for a period of disability for determination; and

    - *Third*, whether the finding of disability is supported by competent medical evidence.

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consider and include language on any pre-authorization paperwork to provide clear directions to the Plan on what to do in this circumstance.

Note, however, that CCCERA's second requirement stated above for medical evidence of a "real and measurable" period of life between injury and death is a best practice and not a legal requirement. The "real and measurable" requirement comes from proof of service-connection in disability retirement cases, and CERL § 31724 allows the Board to grant a disability retirement upon satisfactory proof that the member is permanently incapacitated (physically or mentally) for the performance of their duties in service (i.e. it does not require medical proof). The reason why CCCERA requires medical proof of a "real and measurable" period between disability and death is because the member must be considered medically alive for a period of time prior to death to qualify for a disability benefit. Without sufficient proof that the member was medically alive between the period of injury and death, CCCERA instead would grant qualified surviving beneficiaries the default death benefits statutorily provided under the CERL.

- Effective Date and Benefits Granted: The Board's determination of permanent incapacity for the performance of duty, and therefore the entitlement to a non-service connected disability retirement benefit, is effective as of the date the application is filed, but not earlier than the date following the last day of regular compensation. CERL § 31724. The benefit granted based on this determination provides a disability allowance with an elected 100% continuance to the surviving beneficiary.

- Funding: CCCERA pays out benefits that are granted through this pre-authorization approach from its general Retiree Reserve, not a supplemental reserve funded only by excess earnings, because these benefits are not deemed supplemental non-vested benefits, but rather vested benefits under the CERL. As a result, the cost of non-service connected disability retirement benefits and the Optional Settlements provided through the pre-authorization approach are paid for by employer and employee contributions as well as investment earnings of the system, similar to all other retirement benefits.

B. Legal Authority for Pre-Authorization Approach

This "pre-authorization" approach that CCCERA uses is supported by *Gorman v. Cranston* (1966) 64 Cal. 2d 441. In *Gorman v. Cranston* (1966) 64 Cal.2d 441, the California Supreme Court approved a member's pre-authorization and advanced consent for the filing of a disability retirement application. There, the Court analyzed whether, under Government Code § 75060 (the disability retirement provision in the Judges Retirement Law administered by CalPERS), an active judge could execute an advance consent form for retirement and other post-employment benefits based on disability. *Id.* at 442. The member in *Gorman* signed a standard form for a disability retirement prior to undergoing surgery but left it undated, and showed this document to his son. *Id.* The member requested that if he suffered complications with surgery that prevented him from filing his disability retirement application himself, that his son file it for him on his behalf. *Id.* After surgery, the member suddenly lapsed into a coma and then died. *Id.* The member's request for disability retirement was submitted thereafter. *Id.*

The Court held in *Gorman* that the member's pre-authorized filing of his disability retirement application was valid and enforceable. *Id.* at 446. The Court reasoned that the fact that the member "was not

conscious during his last hours while he was disabled after giving explicit instructions, which, if carried out, would have qualified [his spouse] for benefits, should not itself operate to deprive [his spouse] of such benefits." *Id.* at 447. Because the member pre-authorized the filing of his retirement application to allow him to retire if he became unable to do so himself after surgery, and because the member provided explicit instructions to elect a disability benefit if that event occurred, he provided the needed irrevocable consent to apply for disability retirement if he became incapacitated.

In sum, the *Gorman* Court unanimously held the pre-authorized election was valid, the election sprang into being when the member became incapactiated, and the member's surviving spouse should receive benefits based on the member's disability retirement. *Id.* at 445–47.

***

We would be pleased to address any questions you may have on this pre-authorization approach.

EXHIBIT A

DEATH DURING ACTIVE MEMBERSHIP

MEMBER ELECTION FORM
FOR OPTIONAL ALLOWANCE IN THE EVENT OF
DEATH DURING ACTIVE MEMBERSHIP

FORM 104
(Rev. 2020)

Purpose of the form: This form authorizes CCCERA to file an application for non-service connected disability on your behalf, in the event that you are permanently incapacitated by reason of injury or other disability leading to death while you are an active member of CCCERA. This form allows you to preselect an Optional Settlement, pursuant to CERL Section 31762 or 31764 or the successor section.

NOTE: The original document must be submitted. Fax/copies are not accepted.

Section 1: MEMBER INFORMATION		
Full Name	**Employee #**	**Social Security #**

STOP

STOP – Your choice must match the beneficiaries chosen in your *Beneficiary Designation Form (Form 102)* and a SIGNATURE(s) and adult witness is required below in order for this form to be valid.

Section 2: ELECTION OF OPTIONAL SETTLEMENT

To the Board of Retirement:

☐ I choose Optional Settlement 2 (up to 100% continuance to one beneficiary) I only have 1 primary beneficiary listed on Form 102 – Beneficiary Designation Form.

☐ I choose Optional Settlement 4 (up to 100% continuance divided among more than one beneficiary) I have 2 or more primary beneficiaries listed on Form 102 – Beneficiary Designation Form.

Section 3: AUTHORIZATION TO FILE NON-SERVICE CONNECTED DISABILITY RETIREMENT APPLICATION

I understand that the beneficiary(ies) of the allowance that continues after my death is (are) the beneficiary(ies), having an insurable interest in my life, on file at CCCERA at the time of my death as were designated by me on a *Beneficiary Designation Form (Form 102)*, a separate form.

I understand that by signing this form I elect a monthly allowance for my beneficiary(ies) in lieu of any other death benefit including the return of accumulated contributions under CERL Section 31781.

I understand that this election is binding on me unless I withdraw this election before the first payment of any retirement allowance is made to me, and that at retirement I may make another election of an Optional Settlement, or choose to receive the unmodified allowance, under CERL.

In accordance with the provisions of CERL, I hereby authorize CCCERA to file an application for a non-service connected disability retirement on my behalf in the event that I am permanently incapacitated by reason of injury or other disability leading to death while I am an active member of CCCERA. I understand that, if granted, this will entitle my survivor(s) to receive a non-service connected disability retirement survivor continuance under Optional Settlement 2 or 4.

In accordance with the provisions of the County Employees Retirement Law of 1937 (CERL), and the by-laws and regulations governing the Contra Costa County Employees' Retirement Association (CCCERA), I hereby elect an Optional Settlement, pursuant to CERL Section 31762 or 31764 or successor section.

Member Signature *(Required)*	**Date (mm/dd/yyyy)**
Adult Witness Signature *(Required)*	**Date (mm/dd/yyyy)**
Adult Witness Name *(Print)*	

Contra Costa County Employees' Retirement Association
1200 Concord Avenue, Suite 300, Concord, CA 94520
Phone 925-521-3960 • Fax 925-521-3969 • cccera.org

CCCERA

DEATH DURING ACTIVE MEMBERSHIP

MEMBER ELECTION FORM
FOR OPTIONAL ALLOWANCE IN THE EVENT OF
DEATH DURING ACTIVE MEMBERSHIP

FORM 104
(Rev. 2020)

Survivor Benefits: Active Member Death (Pre-Retirement)

Death and continuing benefits depend on several factors. If a member dies prior to retirement, death benefits are determined based on:

- Member status (active or deferred)
- Category of death (service-connected or non-service connected)
- Retirement Service Credit
- Relationship of recipient to member (eligible survivor or named beneficiary)

To qualify as an eligible survivor in cases involving the death of an active member, a spouse or domestic partner must have been married to or in a duly registered California domestic partnership with the member prior to the member's death. No minimum length of marriage or domestic partnership requirement applies.

Type of Death	Basic Death Benefit	Optional Death Allowance
Service-Connected	Lump-sum payment of member's accumulated contributions Salary Death Benefit: one month of member's compensation earnable for each full year of Service Credit (not to exceed six months of compensation)	Full amount (100%) of disability retirement allowance deceased member would have received had he or she been retired on an Service-connected Disability at the time of death
Non-Service Connected	Lump-sum payment of member's accumulated contributions Salary Death Benefit: one month of member's compensation earnable for each full year of Service Credit (not to exceed six months of compensation)	60% of disability retirement allowance deceased member would have received had he or she been retired on an Non-service Connected Disability* at the time of death
Deferred Member	Lump-sum payment of member's accumulated contributions	
**In order for the survivor to be eligible for the Optional Death Allowance following a non-service connected death, the member must have been eligible for a retirement in the event of a non-service connected disability.*		

NON-SERVICE CONNECTED DISABILITY
A non-service connected disability means a member's permanent illness or injury did not arise from his or her employment. Members who qualify for a non-service connected disability retirement will receive the service retirement allowance to which the member is entitled, or one-third of your annual Final Average Salary, whichever is greater.

Segal

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July 19, 2023

Mr. Dave Nelsen
Chief Executive Officer
Alameda County Employees' Retirement Association
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Re: Pre-retirement Death Optional Settlement 2 Election

Dear Dave:

As requested by ACERA, we have provided in this letter the cost impact of allowing active members[1] to elect an Optional Settlement 2 allowance that leaves a 100% continuance to a beneficiary upon the member's pre-retirement death.[2] Under current practice, vested active members who die while in active employment would only be allowed to leave a 60% automatic continuance (unless the death is service connected, in which case a 100% automatic continuance would be paid without any service requirement).

Background

We are aware of one other California public retirement system that allows active members to file an election form for optional allowance in the event of death during active employment. At that retirement system, a member may elect during employment an Optional Settlement 2 to provide a 100% continuance (with actuarial adjustment) to their spouse (including domestic partner) or beneficiary having an insurable interest in their life. In the event the member dies while in active employment under non-service connected death, this election would allow the beneficiary of the member to receive a 100% continuance under Optional Settlement 2.

Currently, if a member has 5 or more years of service and has a spouse at the time of the member's death during active employment, the spouse would be entitled to the 60% automatic continuance of the allowance the member would have received if the member had retired for non-service connected disability on the date of death. If the member has no surviving spouse but has a minor child(ren), the child(ren) will collectively be entitled to the 60% automatic continuance of the member's non-service connected disability retirement benefit until they reach age 18 (or age 22 if a full-time student). If the member has no eligible spouse or child(ren), the member's estate may receive the lump sum death benefits that include a return of employee

[1] We have assumed as part of this study that deferred vested members will not be eligible to make this election.
[2] See discussion starting on page 2 regarding pre-retirement death election of Optional Settlement 4 (in lieu of Optional Settlement 2).

contributions with interest and one month of salary for each year of service up to a maximum of 6 months of salary.

If the member is allowed to make an Optional Settlement 2 election during active employment, the member's spouse or beneficiaries would be eligible for an allowance of up to 100%[3] of the member's non-service connected disability benefit payable for their lifetime. Even after we apply the current actuarial assumptions in determining the 100% continuance benefit, the amount of benefit for the beneficiary would generally be greater than what they would have received without this election. For example, for a member with a spouse who dies while in active employment, the spouse would have received 60% of the member's non-service connected disability benefit without this election and that amount would generally be less than the actuarially reduced Optional Settlement 2 continuance. For a member with a minor child(ren), the 60% automatic continuance would only be paid for a period of time without this election. For a member without a spouse or minor child(ren), the member's estate would only have been entitled to a refund of the member's contributions and a lump sum of up to 6 months of pay without this election.

Alternative Election of Optional Settlement 4

If the pre-retirement death election of an optional settlement is adopted by the Board, we understand members may alternatively make an Optional Settlement 4 election (in lieu of Optional Settlement 2) during active employment, such that the member's spouse or beneficiaries would be eligible for an allowance of no greater than 100% of the member's non-service connected disability benefit payable for their lifetime.[3] With that said, the costs prepared herein only include assumed Optional Settlement 2 elections, although the results in this cost study would still be applicable if some members should actually elect Optional Settlement 4 (assuming they choose the maximum 100% continuance) in lieu of Optional Settlement 2.

Methodology and Assumptions

We assumed this election would only apply to future active deaths and there would be no change to the existing benefits for any current beneficiaries. The additional liability is determined based on the active population and actuarial assumptions used in the December 31, 2022 valuation. Moreover, we made additional election assumptions for members who are expected to die during active employment.

ACERA provided us a file with the relationship information for the beneficiaries of about 70 members who died while in active employment from calendar year 2018 to calendar year 2021 (including some death in calendar year 2022). Out of the 70 members, 31 members (somewhat less than 50%) were reported to have a spouse eligible to receive a lump sum or continuance

[3] The maximum continuance percentage for a non-spouse beneficiary could be limited based on § 1.401(a)(9)–6 of the Internal Revenue Code and would be less than 100% if the adjusted age difference between the member and the beneficiary is 10 years or more.

benefit. Our current assumptions in the valuation are that 70% of all male members and 50% of all female members would be expected to be married at retirement or active death. For the purposes of this study, we have applied the same assumptions to anticipate the proportion of vested members who would be married and expected to elect an Optional Settlement 2 to cover their spouses at pre-retirement death.

For the remaining 39 members provided, 19 (about 50%) had listed a child, 10 (about 25%) had listed a sibling, and 10 had listed a parent/ex-spouse/other (about 25%) to receive primarily a lump sum death benefit. For the purposes of this study, we have grouped and treated an ex-spouse/other as if they were a parent of the deceased member. We have applied the above percentages to approximate the proportion of vested single active members who would be expected to elect an Optional Settlement 2 to cover their child, sibling and parent. Furthermore, we assumed that on the average, a child is 30 years younger than the member, a sibling is at the same age of the member and a parent is 30 years older than the member.

In summary, we have assumed that 70% of male members and 50% of female members have a spouse at pre-retirement death, and male members are assumed to have a female spouse who is 3 years younger than the member and female members are assumed to have a male spouse who is 2 years older than the member. The assumptions for the remaining beneficiaries covered under the Optional Settlement 2 elections are as follows:

Beneficiary type*	Percentage	Age Difference with Active Member
Child	50%	30 years younger
Sibling	25%	Same age
Parent	25%	30 years older

* We made the simplifying assumption that the beneficiary is of the opposite sex of the member.

Results

The increase in Actuarial Accrued Liability for the pre-retirement death Optional Settlement 2 election is $12,134,000 for the total Plan. The increase in average employer contribution rates is summarized below:

	Employer Contribution Rate Impact (as % of Payroll)		
	General	Safety	Total
Normal Cost	0.07%	0.09%	0.07%
UAAL	0.06%	0.07%	0.06%
Total	0.13%	0.16%	0.13%
Projected Payroll	$1,052,930,000	$205,096,000	$1,258,026,000
$ Annual Contribution	$1,369,000	$328,000	$1,697,000

There will also be an increase in the average member normal cost rates of 0.03% for General members and 0.03% for Safety members. For PEPRA tier members, the increase is due to 50/50 sharing of the increase in normal cost rate for their respective tier. For the legacy members, there is no change in the member's basic contribution rate. However, the member's COLA contribution rate is increased due to the increase in the normal cost for the COLA benefits which is shared 50/50 by the legacy members.

Other Considerations

Effective Date of Implementing Employer and Member Contribution Rates in this Study

If the change to elect Optional Settlement 2 is implemented, we would need guidance from ACERA regarding the timing of implementation of the revised contribution rates to the employers and members. According to the Board's Actuarial Funding Policy, any change in contribution rate requirements that results from a plan amendment is generally implemented as of the effective date of the plan amendment or as soon as administratively feasible. As a result, we understand that ACERA has generally implemented new employer and member contribution rates upon the effective date of a benefit enhancement. However, in the case of this change, implementing the higher rate for the employers would have the impact of changing the contribution rates that had already been approved by the Board in the December 31, 2022 valuation for FY 23-24. We would be available to provide the more detailed employer and employee contribution rates resulting from this change.

Rather than changing the contribution rates starting in FY 23-24, the Board could consider putting off revising the contribution rates until after the next actuarial valuation (i.e., as of December 31, 2023). However, under that scenario, there would be some actuarial losses for the Plan as the higher employer and member contribution rates would not be paid immediately.

All results shown in this letter are based on the data and actuarial assumptions used in the December 31, 2022 actuarial valuation, except for the additional assumptions as detailed above. That valuation and these calculations were completed under the supervision of Eva

Yum, FSA, MAAA, Enrolled Actuary. We are members of the American Academy of Actuaries and we meet the Qualification Standards of the American Academy of actuaries to render the actuarial opinion herein.

Please let us know if you need any additional information and we look forward to discussing this letter with you.

Sincerely,

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

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

EZY/bbf

cc: Carlos Barrios
Lisa Johnson
Jeff Rieger

Segal

Gorman v. Cranston

Supreme Court of California

April 21, 1966

Sac. No. 7693

Reporter
64 Cal. 2d 441 *; 413 P.2d 133 **; 50 Cal. Rptr. 533 ***; 1966 Cal. LEXIS 271 ****

GENEVIEVE C. GORMAN, Petitioner, v. ALAN CRANSTON, as State Controller, etc., Respondent

Prior History: [****1] PROCEEDING in mandamus to compel the Controller of the State of California to approve an application for benefits to the widow of a retired judge.

Disposition: Writ granted.

Counsel: Beardsley, Hufstedler & Kemble, Charles E. Beardsley, Seth M. Hufstedler, John Sobieski and Harry L. Hupp for Petitioner.

Thomas C. Lynch, Attorney General, and William J. Power, Deputy Attorney General, for Respondent.

Judges: In Bank. Peek, J. Mosk, Acting C. J., McComb, J., Peters, J., Tobriner, J., White, J., * and Roth, J. pro tem., ** concurred.

Opinion by: PEEK

Opinion

[*442] [**134] [***534] Petitioner, the widow of the late Judge Joseph G. Gorman, former Judge of the Superior Court in and for the County of Los Angeles, seeks to compel the respondent Controller of the State of California to approve her application for benefits as the widow of a retired judge pursuant to the provisions of the Judges' Retirement Law. (Gov. Code, §§ 75000-75108.) The Controller opposes the application, at least in part, in reliance on an opinion [****2] of the Attorney General (45 Ops.Cal.Atty.Gen. 85) that prior to his death Judge Gorman had not executed a consent to retirement within the meaning of the statute (Gov. Code, § 75060), so as to qualify petitioner for the benefits she seeks.

The facts are not in dispute. On or before November 7, 1964, Judge Gorman, planning to undergo surgery, signed a standard form letter of request for a disability retirement, addressed to the Governor and the Chief Justice, the latter as Chairman of the Judicial Council. The judge showed this letter, at that time undated and with a blank space for the name of a [**135] [***535] doctor who would attest to any disability, to his son. He requested that if he were to become disabled and unable to post the letter, his son should mail copies to the Governor and Chief Justice. Following surgery, Judge Gorman appeared to be making satisfactory progress when suddenly he lapsed into a coma resulting from a cerebral hemorrhage, and expired early on November 10 without having regained consciousness.

Thereafter a letter of request for disability retirement, signed by Judge Gorman and dated November 10, 1964, was received by the Governor. The name [****3] of a doctor was in the proper place, attesting to the judge's disability. Since there was some doubt as to whether the letter constituted a valid request and consent to disability retirement, the opinion of the Attorney General was requested. It was his view that the consent was not executed as required by section 75060, and that the judge had not made a proper application for retirement for reasons of disability. (45 Ops.Cal.Atty.Gen. 85.)

The Governor and the Chief Justice certified to the Secretary [*443] of State the facts as stated above and withheld approval of the application solely on the determination of the Attorney General that Judge Gorman had not validly consented to retirement. Their certificate further states: "We agree with the Attorney General that this issue of law should be determined by a court of competent jurisdiction. If there is a final

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* Retired Associate Justice of the Supreme Court sitting under assignment by the Chairman of the Judicial Council.

** Assigned by the Chairman of the Judicial Council.

judgment of a court of competent jurisdiction that such application and consent of Judge Gorman is legally sufficient, we approve his retirement. . . ."

Petitioner alleges that she has filed a formal claim for benefits with the Controller and, on information and belief, that the Controller has not acted on her application [****4] because he desires to have a court pass upon the validity of the application before he acts. She argues that her late husband's consent was validly executed subject to a condition subsequent, namely, his disability; that this condition subsequently occurred, thus completely effectuating his request for retirement.

Government Code section 75060 authorizes in subdivision (a) that a judge may retire for reasons of disability if he has met three requirements: (1) the judge must be, in fact, disabled; (2) the judge must consent to his retirement; and (3) the Governor and the Chief Justice must approve the retirement. There is no provision for determining whether the judge is or is not disabled save, perhaps, for the requirement that the Governor and the Chief Justice approve the retirement. In the instant case, of course, there is little question that Judge Gorman was disabled, and the Governor and the Chief Justice so certified. The more difficult question is whether Judge Gorman "consented" to his retirement within the meaning of the statute.

Subdivision (b) of section 75060 states: "Any judge who dies after executing an application evidencing his consent and before the approval [****5] of both of the designated officers has been obtained shall be deemed to have retired on the date of his death if the designated officers prior to the filling of the vacancy created by such judge's death, file with the Secretary of State their certificate of approval."

Subdivision (b) was added to section 75060 in 1962 following the deaths of disabled judges before the necessary approval was obtained. It authorizes a judge to be placed on a retired status and his spouse to receive benefits accordingly even though he may die before the Governor and the Chief Justice actually execute the requisite certificate. Concurrently with the enactment of subdivision (b) the Legislature adopted [*444] an urgency clause in the following language: "In many instances, a judge is stricken with a serious illness on a weekend or a holiday when it is not possible to secure the written approval of the Governor and the Chief Justice of the Supreme Court to the application of the judge for disability retirement. If such approval is obtained before the judge dies, the benefits [**136] [***536] provided by law for his spouse are preserved; if the approval is not obtained prior to his death, [****6] all such benefits are lost. In order to cure this inequity and thus avoid the recurrence of a situation which has arisen twice within the last 60 days, it is necessary that this act take effect immediately." (Stats. 1963, First Ex. Sess. 1962, ch. 61, p. 353, § 2.)

(1) It has long been settled in this state that pension legislation is to be liberally construed. In *Jorgenson* v. *Cranston*, 211 Cal.App.2d 292, 296 [27 Cal.Rptr. 297], the rule is stated thus: "'. . . [Pension] legislation must be liberally construed and applied to the end that the beneficent results of such legislation may be achieved. Pension provisions in our law are founded upon sound public policy and with the objects of protecting, in a proper case, the pensioner and his dependents against economic insecurity. In order to confer the benefits intended, such legislation should be applied fairly and broadly.'"

Section 75104.4 of the Government Code relating to judges retirement supports the foregoing view: "The Legislature hereby finds and declares that the payment of allowances to the surviving spouse of a judge pursuant to this section, as amended at the 1959 Regular Session of the Legislature, serves [****7] a public purpose in that it promotes the public welfare by encouraging experienced jurists to continue their service in the expectation that the Legislature will fairly provide for their surviving spouses under changing circumstances, as the Legislature is now doing for spouses of judges who have heretofore died. Continued service by, and increased efficiency of, judges secure in this knowledge will more than compensate the State for any increased expense for allowances to surviving spouses provided by the amendment enacted at the 1959 session of the Legislature."

(2) The Controller raises the question whether the preparation of a letter of retirement in advance of a disability does not, in fact, delegate the power of retiring a judge who has prepared such a letter to the Chief Justice and the Governor. There is, however, no real question of delegation of authority presented herein. The consent given by the judge was *his* consent, [*445] expressed over his signature. The fact that it was to take effect on the happening of an objective condition to which the Governor and Chief Justice were to certify does not make it any the less *his*. To argue, as the Controller does, [****8] that the Chief Justice and the Governor may retire any judge who has

executed such a consent "if they feel he is incapacitated" appears to imply that such action might be taken at whim or bias on the part of those officials. We cannot presume that they would act in flagrant disregard of their statutory duty in such cases. Disability is an objective condition, and while its limits are perhaps subject to disagreement it is nevertheless sufficiently certain to condition the happening of an operative event.

(3) It is also contended by the Controller that a judge who wishes to retire for disability must evidence his intention to so retire *after* the onset of the disability. In this connection it is argued that even though it be conceded that Judge Gorman intended to retire if he became disabled, and in fact formalized this intention by signing a letter of resignation to take effect upon his becoming disabled, still the equities of the situation are no greater than had Judge Gorman regained consciousness for a few moments and directed that the request to retire be forwarded to the Governor and then lapsed into unconsciousness and expired. In such a situation, the Controller contends, [****9] the Legislature, in enacting subdivision (b) of section 75060, intended to exact still a further formality, that is, the execution of a consent. But subdivision (a) requires only that a judge "consent" to his retirement, and in subdivision (b) it is stated only that his death occur "after executing an application evidencing his consent." There is no language in section 75060 which requires the consent to be executed before or after the operative fact which brings an anticipated disability [**137] [***537] into being. Nor is there anything in the language or in the authorities to which we are referred which precludes a conditional consent. (See *People* v. *Porter*, 6 Cal. 26.)

(4) It is further argued that to construe section 75060 in the manner urged by petitioner would be to authorize a disability benefit in almost every instance, since by the mere signing of an advance consent a judge will have been deemed to have retired for disability at such time as he becomes disabled, even if minutes before death. But the Controller overlooks the full commitment which Judge Gorman made in the instant case. The situation is not one in which an all purpose consent [*446] was [****10] signed and made ready for any eventuality. It appears that the judge, with a specific situation in mind, irrevocably committed himself to a position based on eventualities over which he had no further control. The consent was not only executed by him, but he had authorized and directed that it be completed and forwarded, if certain conditions were fulfilled. When these conditions developed the letter was completed and forwarded as he had directed. Since these acts were done pursuant to his direction and in the manner which he had directed, it must follow that he consented thereto.

We distinguish this case from that in which a judge does not, by his own act, irrevocably place himself in a position where he must be retired upon the occurrence of a condition or conditions without reliance on the exercise of a subsequent and intervening act of discretion to effectuate his consent to such retirement. In the instant case only the administrative acts of completing and forwarding the letter pursuant to instructions, were left to be done. The fact that the person charged with this responsibility failed to carry it out until after the judge's death should not detract from what otherwise [****11] appears to be his firm commitment to retirement upon first becoming disabled. (See *Watenpaugh* v. *State Teachers' Retirement System*, 51 Cal.2d 675 [336 P.2d 165].)

We are thus persuaded to the conclusion that Judge Gorman's consent committed him to a retired status while he survived although he may thereafter have made a complete recovery. The fact that his death occurred before rather than after necessary administrative action preliminary to presenting the consent to the Chief Justice and Governor for their approval does not alter our conclusion that he was in a retired status immediately upon the happening of the event which conditioned his consent, for purposes of subdivision (b) of section 75060.

Arguments which go to discrepancies in benefits which surviving spouses of judges may receive, depending upon whether particular judges had retired for disability prior to death and their lengths of service, do not meet the instant issues. Such matters are for the Legislature and our concern is with compliance with the statutes as now provided. In construing those enactments we are mindful that the Legislature has attempted to provide for a better qualified and more efficient [****12] judiciary. It has made clear that it intends to secure, equally with the purpose of encouraging retirement of those judges who are not able to perform their duties, the further purpose of providing an incentive to qualified members of the bar to accept judicial [*447] responsibilities by ensuring that the families of those judges who become incapacitated are not left in financial need. Section 75060 is intended to provide for the surviving spouse of any judge who retires due to disability. Petitioner herein fairly comes within this class, and the fact that her late husband was not conscious during his last hours while he was disabled after giving explicit instructions which, if

carried out, would have qualified her for benefits, should not in itself operate to deprive her of such benefits.

Let a peremptory writ of mandate issue directing the Controller to act upon petitioner's application in consideration of the [**138] [***538] valid consent to a disability retirement on the part of Judge Gorman.

End of Document

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: December 6, 2023

TO: Members of the Retirees Committee

FROM: Jessica Huffman, Retirement Benefits Manager

SUBJECT: **Retired Member Lump Sum Death Benefits Paid in 2023**

In July 1992, the Board of Retirement adopted Government Code Section 31789.12 to provide a one-time Retired Member (lump sum) Death Benefit payment of $1,000 to beneficiaries of retirees. For reciprocal members who did not render their last active service with an ACERA employer before retiring, ACERA will consider the death benefit payable by the reciprocal agency. If that agency pays less than $1,000, ACERA will supplement that amount up to $1,000. This is considered a vested benefit, per Government Code Section 31789.12, as long as there are funds available in the Supplemental Retiree Benefit Reserve (SRBR). This Code Section states:

> *Notwithstanding Section 31789.1, the board may increase the sum payable pursuant to Section 31789.1 to one thousand dollars ($1,000).*
>
> *Upon adoption by any county providing benefits pursuant to this section, of Article 5.5 (commencing with Section 31610) of this chapter, the board of retirement shall, instead, pay those benefits from the Supplemental Retiree Benefits Reserve established pursuant to Section 31618.*

Over the twelve-month period December 1, 2022 through November 30, 2023, there were 303 retired member deaths with a total of 216 retired member lump sum death benefits paid. Out of this total, there were ten retirees with reciprocity who did not render their last active service with an ACERA employer before retiring. The total amount of retired member lump sum death benefits paid from the SRBR was $180,100.25. The reciprocal agencies paid a total of $18,400.00 for the ten retirees with reciprocity. The attached tables show the breakdown of the total number of death benefits paid and the amounts paid by month for this reporting period as well as a five-year comparison of death benefits paid in previous years.

Attachment

Total Death Benefits Paid
for Period December 1, 2022 through November 30, 2023

MONTH	TOTAL LUMP SUM BENEFITS PAID	TOTAL LUMP SUM BENEFITS PAID WITH RECIPROCITY	ACERA PAID DEATH BENEFIT	RECIPROCAL AGENCY PAID DEATH BENEFIT
December - 2022	19	3	**$14,500.00**	**$4,500.00**
January - 2023	19	1	**$15,916.34**	**$500.00**
February - 2023	10	2	**$9,166.67**	**$6,900.00**
March - 2023	12	-	**$8,233.33**	**$0.00**
April -2023	22	-	**$19,366.66**	**$0.00**
May -2023	20	2	**$16,700.00**	**$4,000.00**
June -2023	30	1	**$24,866.66**	**$500.00**
July-2023	20	-	**$18,250.00**	**$0.00**
August - 2023	19	-	**$16,400.00**	**$0.00**
September - 2023	7	1	**$6,500.00**	**$2,000.00**
October - 2023	27	-	**$20,783.33**	**$0.00**
November - 2023	11	-	**$9,417.26**	**$0.00**
GRAND TOTAL	216	10	**$180,100.25**	**$18,400.00**

Five-Year Comparison - Total Death Benefits Paid

YEAR	TOTAL LUMP SUM BENEFITS PAID	TOTAL LUMP SUM BENEFITS PAID WITH RECIPROCITY	ACERA PAID DEATH BENEFIT	RECIPROCAL AGENCY PAID DEATH BENEFIT	TOTAL RETIREE DEATHS
2019 - Dec 2018 to Nov 2019	283	3	**$198,266.50**	**$2,500.00**	310
2020 - Dec 2019 to Nov 2020	213	2	**$187,311.30**	**$7,000.00**	347
2021 - Dec 2020 to Nov 2021	207	12	**$201,990.33**	**$44,000.00**	386
2022 - Dec 2021 to Nov 2022	230	7	**$186,038.33**	**$25,000.00**	312
2023 - Dec 2022 to Nov 2023	216	10	**$180,100.25**	**$18,400.00**	303

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: December 6, 2023

TO: Members of the Retirees Committee

FROM: Carlos Barrios, Assistant Chief Executive Officer

SUBJECT: **Medicare Part B Income-Related Monthly Adjustment Amounts through Health Reimbursement Arrangement**

The Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees and administers Medicare, requires individuals over certain income thresholds to pay an additional premium for Medicare Part B. The additional premium is called the Income-Related Monthly Adjustment Amount (IRMAA). Via Benefits provides individual plans through a Medicare Exchange and allows members to seek reimbursement for medical premiums through a Health Reimbursement Arrangement (HRA), up to the Monthly Medical Allowance (MMA), which is set to $486.74 per month for 2024. Up to now, all portions of the Medicare Part B premium have been excluded from reimbursement through the HRA. This memo explores the changes that would be involved in permitting members enrolled in an individual plan through the Medicare Exchange to submit claims for reimbursement of the IRMAA portion.

Medicare Part Premium

To determine the Medicare Part B premium for each participant, CMS uses a retiree's latest available income based on their individual or joint tax return. Income taxes for 2022 are filed in 2023 and are used as the basis to determine the 2024 IRMAA. Segal, ACERA's consultants, provided the 2024 cost for the Medicare Part B premium and identified the IRMAA portion for ACERA retirees based on retiree data.

Medicare Part B Premium for 2024

Individual Tax Return for 2022	Medicare Eligible	Percentage of Retirees	2024 Part B Premium	2024 IRMAA Portion
Up to $103K	7,201	85%	$174.70	$0
$129K	595	7%	$244.60	$ 69.90
$161K	370	4%	$349.40	$174.70
$193K	151	2%	$454.20	$279.50
$500K	162	2%	$559.00	$384.30
Above $500K	0	0%	$594.00	$419.30

This chart does not identify income from another source or if a retiree filed joint taxes with another person whose earnings lifted them into an IRMAA bracket or a higher bracket.

Health Reimbursement Arrangement Account Balances for 2022

For 2022, the aggregate MMA available to retirees through the HRA was $8,731,943.48. Of that, the aggregate claims reimbursed for 2022 for all Medicare eligible retirees was $4,464,904.27 and

$1,129,075.49 for early (pre-65) retirees, for a total of $5,593,979.76 of claims reimbursed. The unused HRA balance was $3,137,963.72. The average monthly reimbursement to a Medicare eligible retiree was $266.72 per month.

Reimbursement of the IRMAA portion would be limited to the available balance in the member's HRA account. The data provided at the June 7, 2023, Retirees Committee Meeting identifies the available balance for 2022 and the percentage of retirees subject to the IRMAA portion in each category, which were used to estimate the cost associated with reimbursing the IRMAA portion.

2022 Health Reimbursement Arrangement Account Balances for Medicare Eligible Retirees as of May 4, 2023

20 + Years of Service **$5,485.56 Annual MMA**		15 through 19 Years of Service **$4,114.20 Annual MMA**		10 through 14 Years of Service **$2,742.84 Annual MMA**	
Number of Retirees	Balance	Number of Retirees	Balance	Number of Retirees	Balance
122	$ 0	70	$ 0	117	$ 0
107	Under $500	26	Under $500	18	Under $500
96	$500 - $1,000	34	$500 - $1,000	19	$500 - $1,000
144	$1,000 - $1,500	23	$1,000 - $1,500	10	$1,000 - $1,500
137	$1,500 - $2,000	13	$1,500 - $2,000	6	$1,500 - $2,000
100	$2,000 - $2,500	5	$2,000 - $2,500	29	$2,000 +
53	$2,500 - $3,000	5	$2,500 - $3,000		
72	$3,000 - $4,000	19	$3,000 - $4,000		
60	$4,000 - $5,000	14	$4,000 +		
96	$5,000 +				
987 Total Number of Retirees		***209 Total Number of Retirees***		***199 Total Number of Retirees***	

ACERA reimburses the base Medicare Part B premium through the Medicare Part B Reimbursement Plan (MBRP) and, thus, the base Medicare Part B would be excluded from reimbursement. For 2024, the MMA will be $486.74, and the IRMAA portion would only be reimbursable to those who have not exhausted their HRA balance. This is not an increase to the MMA, and the same MMA amount would be available for each retiree for all their healthcare costs.

Cost Associated with Including IRMAA Portion Reimbursements

Using the remaining 2022 HRA account balances in each category for the Medicare eligible retirees, the cost to include the IRMAA portion of the Medicare Part B premium would add $223,582 in reimbursements, a 5% increase. Again, this does not include a retiree's income from another source or if the retiree files joint taxes with another person whose earning lifts them into an IRMAA bracket or a higher bracket, but reimbursements are limited to those who have not exhausted their HRA balance.

Via Benefits provides reimbursement for the entire cost of Medicare Part B for other clients but they would manually process ACERA retiree claims to prevent erroneously paying the basic

Medicare Part B premium already paid through the MBRP. The set-up cost is minimal; a one-time set-up fee of $2,000.

Health Reimbursement Arrangement (HRA)
The Individual Plan administered by Via Benefits is designed for Medicare eligible participants, and early (non-Medicare) members who live outside the service area and who cannot take advantage of the group plan benefits. An MMA is provided to eligible retired members to reimburse medical plan costs when they enroll in an Individual Plan through the Exchange. The reimbursement is paid to the eligible retired member by the Exchange through the HRA. The HRA Plan document authorizes the reimbursement of premiums, co-pays, deductibles, and health care expenses as defined under IRS Code Section 213(d)(1), which would permit the IRMAA reimbursement.

Revisions Required to the Supplemental Retiree Benefit Reserve Policy
The SRBR Policy would need to be amended to include a separate category for the IRMAA such that it is distinguishable from the Medicare Part B Reimbursement Plan (MBRP). The MBRP excludes Medicare Part B reimbursements above the "lowest standard Medicare Part B amount." The eligibility for the IRMAA would include retirees enrolled in the Individual Plan through the Medicare Exchange and the reimbursement would be limited to the MMA.

Revisions Required to Resolution No. 07-29 - 401(h) Account
Similar to the SRBR Policy, Resolution No. 07-29 describes the amount of benefits to be used from the 401(h) account each plan year. Those benefits currently include:

1. Monthly Medical Allowance
2. Medicare Part B Premium Reimbursement
3. Dental Care Contribution
4. Vision Care Contribution

The resolution would need to be amended to include that the IRMAA portion would make use of the MMA, and would be another premium reimbursable through the HRA but that it be distinguishable from the MBRP.

Communication Materials
Our communication materials indicate that only the lowest standard premium amount is reimbursed through the MBRP. We would change our communication materials and website to inform individual plan members that the IRMAA portion of Medicare Part B premium can be reimbursed through their HRA account.

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: December 6, 2023

TO: Members of the Retirees Committee

FROM: Carlos Barrios, Assistant Chief Executive Officer

SUBJECT: **Information on Hearing Aid Benefit Utilization and Reimbursement Options**

At the September 6, 2023, Retirees Committee meeting, your Board opted to keep the current Group Kaiser Permanente Senior Advantage (KPSA) Hearing Aid benefit of $1,000 per ear every three years for 2024, but directed staff to investigate whether to use the Via Benefits (Individual Plan) as an additional reimbursement program in lieu of increasing it to $2,000 per ear every three years. This question can be viewed in two ways. First, should a separate $1,000 be available through Via Benefits to complement the KPSA $1,000 benefit? Second, should the entire $2,000 benefit be made available through Via Benefits alone? This memo compares increases to the Hearing Aid benefit through Kaiser Permanente versus Via Benefits.

Hearing Aids Through the Group Kaiser Permanente Senior Advantage Plan

As of May 2023, there were 4,259 members in the Group KPSA plan. The current Hearing Aid benefit of $1,000 costs $9.31 per member per month (PMPM) for 2024. The annual cost for the entire population is $475,815. The increase to the Kaiser Hearing Aid benefit from $1,000 to $2,000 would cost an additional $18.65 PMPM and would add a cost of $953,164, annually. The total cost to increase to a $2,000 benefit is $1,428,979. This cost would be paid through the Supplemental Retiree Benefit Reserve. Kaiser provided the following utilization data for Hearing Aids purchased in the most recent years.

Hearing Aids Purchased	
2021	119
2022	113
2023	109 (Projected)
Average	114

However, Kaiser's experience shows utilization doubles by simply increasing the benefit from $1,000 to $2,000; therefore, they would expect 228 hearing aids on average per year because of the increased benefit. Although it would appear the cost of the Hearing Aid benefit compared to its utilization is not high, the cost also includes hearing aid examinations, fittings, checkups, and other hearing services.

Hearing Aids Administered Through Via Benefits

The administrative cost for Via Benefits to set up a Hearing Aid benefit would include a one-time set-up cost of $3,000 and there would be a PMPM fee of $4.00, which results in an administrative cost of $207,432 for the first year and $204,432 for each year thereafter. The benefit of adding

$1,000 per year (using Kaiser's prediction that increasing the benefit from $1,000 to $2,000 doubles the utilization), results in 228 hearing aids per year, and would cost $228,000 annually. Therefore, the combined administrative cost and benefits to make a $1,000 benefit available through Via Benefits would cost $435,432 for the first year and $432,432 thereafter. To make a $2,000 benefit available would cost $663,432 for the first year and $660,432 thereafter.

Comparison

The chart compares increasing the Group KPSA Hearing Aid benefit to $2,000, splitting the benefit between the Group KPSA plan and Via Benefits, and having the $2,000 benefit through Via Benefits alone.

Hearing Aid Administrator	Total Cost
Maintain Current $1,000 in Kaiser	$475,815
Increase Kaiser to $2,000	$1,428,979
Maintain $1,000 in Kaiser, Add $1,000 to Via Benefits	$908,247
All $2,000 through Via Benefits	$660,432

The cost to add a $1,000 per year Hearing Aid benefit through Via Benefits is $435,432 compared to $953,164 through Kaiser, a difference of $517,732 per year. The cost to have the entire $2,000 per year Hearing Aid benefit through Via Benefits is $660,432, compared to $1,428,979 to have it through Kaiser.

The Hearing Aid benefit for the Group KPSA members would require an additional funding source and data transmission to Via Benefits to set up ACERA's plan solely for hearing aid expenses. Via Benefits' reimbursement structure would allow all hearing aids and services on an annual basis. This is different from the current Group Kaiser method where hearing aids are available only once every three years. Via Benefits also suggests not having any enrollment requirement for this separate account to allow for either the enrollment into a hearing aid plan or to submit claims for all associated hearing aid expenses they incur.

Pros and Cons

- Members may find it more cumbersome to receive the first $1,000 of coverage under the Kaiser plan and then submit claims to Via Benefits for the next $1,000.

- Kaiser provides an allowance once per three years, whereas Via Benefits' structure provides an allowance on an annual basis. This would allow a member to combine the two to receive a $2,000 benefit the first year and $1,000 benefit the remaining two years through Via Benefits.

- It would be more cost effective to place the entire $2,000 under Via Benefits, but members would still receive all their medical services through the Group KPSA plan but would submit claims to Via Benefits for their hearing aid expenses.

- The HRA is only allowed for members and members would lose the ability to cover dependents under the HRA administered by Via Benefits. Those members would need to find another way to provide a hearing aid benefit for their dependent(s).

- Regardless of the years of service, the cost would be the same for all members through Via Benefits to receive the equivalent hearing aid benefit compared to if the benefit was through Kaiser.

- We would anticipate greater call volumes if changes were to include the additional benefits to Via Benefits. ACERA's Call Center receives more calls regarding Via Benefits because of the broader scope of plans available, and the additional work required by members to submit claims.

Health Reimbursement Arrangement (HRA)
The Individual Plan administered by Via Benefits is designed for Medicare eligible participants, and early (non-Medicare) members who live outside the service area and cannot take advantage of the group plan benefits. A Monthly Medical Allowance (MMA) is provided to eligible retired members to reimburse medical plan costs when they enroll in an Individual Plan through the Exchange. The reimbursement is paid to the eligible retired member by the Exchange through the HRA. The HRA Plan document authorizes the reimbursement of premiums, co-pays, deductibles, and health care expenses as defined under IRS Code Section 213(d)(1), which would permit the Hearing Aid benefit.

Revisions Required to the Supplemental Retiree Benefits Reserve Policy
The SRBR Policy would need to be amended to include a separate category for the Hearing Aid benefit for members enrolled in the Group KPSA plan to identify it as a separate cost from the MMA.

Revisions Required to Resolution No. 07-29 - 401(h) Account
Similar to the SRBR Policy, Resolution No. 07-29 describes the amount of benefits to be used from the 401(h) account each plan year. Those benefits currently include:

1. Monthly Medical Allowance
2. Medicare Part B Premium Reimbursement
3. Dental Care Contribution
4. Vision Care Contribution

The resolution would need to be amended to include a separate Hearing Aid benefit for members enrolled in the Group KPSA plan to identify it as a separate cost from the MMA.

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: December 6, 2023

TO: Members of the Retirees Committee

FROM: Ismael Piña, Assistant Benefits Manager

SUBJECT: **Virtual Retiree Health and Wellness Fair Results and Open Enrollment Activity**

The Annual Retiree Health and Wellness Fair was held on October 26, 2023, as a Virtual Event allowing members to go online to attend.

We are proud to announce another successful event this year for members to learn and have their questions answered via our Virtual Event. Attendees were ready to enjoy the opportunity to view live streaming presentations from Kaiser, VSP, Delta Dental, Via Benefits, and UnitedHealthcare. During the Virtual Event viewers submitted 186 questions and received their answers in live time during the presentations. Carriers provided information in areas ranging from plan enhancements, wellness programs, support services, and discount programs all of which are available for viewing by clicking on the various links. The presentations were recorded and are available for on-demand viewing on our website. All informational flyers and links will also continue to be displayed and accessible.

Final counts show 500+ registered for the Virtual Event and we averaged 290+ viewers for the live stream presentations. Our webpage continues to get visits daily by members seeking information on available coverage options. The ACERA Virtual Health and Wellness Fair 2023 Survey showed 36.7% of respondents preferred the Virtual Fair, 20.3% preferred the in-person Health Fair, 42.2% would like them both.

A report on Open Enrollment forms received, and status of processing will be provided at the February Retirees Committee meeting.

MEMORANDUM TO THE RETIREES COMMITTEE

DATE: December 6, 2023

TO: Members of the Retirees Committee

FROM: Mike Fara, Communications Manager MF

SUBJECT: **Silver&Fit Survey Results**

The Silver&Fit survey was opened for responses between September 12 and September 19, 2023. A compilation of the content of the online survey and the final results is attached to this memo. Staff will go over the presentation at the Retirees Committee meeting.

Attachment

2023 Silver&Fit Survey Results

CERA

ACERA's Silver&Fit Promotions

• Oct 2021	Announcement in Open Enrollment Guide
• Oct 2021	Flyer in Open Enrollment Packet
• Feb 2022–Now	Slide on home page linking to wellness post
• Feb 2022	3 Email blasts to subscribers
• Feb 2022	Postcard mailed to all KPSA enrollees
• Mar 2022	Email blast to subscribers
• Apr 2022	Email blast to subscribers
• Jul-Aug 2022	Silver&Fit survey emails
• Oct 2022	Announcement in Open Enrollment Guide
• Oct 2022	Flyer in Open Enrollment Packet
• Mar 2023	Email blast to all retirees
• Aug 2023	Email blast to all retirees

Purpose

To gauge ACERA Kaiser participant opinions regarding the Silver&Fit free gym membership program

Administration Method

- Conducted online using SurveyMonkey
- 2 Mailchimp email blasts to 3,294 retired Kaiser participants
- Open Sep. 12 – 19, 2023
- Previous survey was conducted Jul. 26 - Aug. 7, 2022

Response Rate

Year	Responses	Recipients	Rate
2022	911	7,784	11.7%
2023	648	3,294	19.7%

Note: The 2022 email was sent to all retiree email addresses on file. The 2023 email was only sent to Kaiser Senior Advantage and HMO participants.

Demographic Questions

- One to make sure they're a retiree, survivor, or payee
- One to make sure they're enrolled in Kaiser Senior Advantage or Kaiser HMO

Kaiser HMO members were skipped to the final question asking if they support continuing Silver&Fit

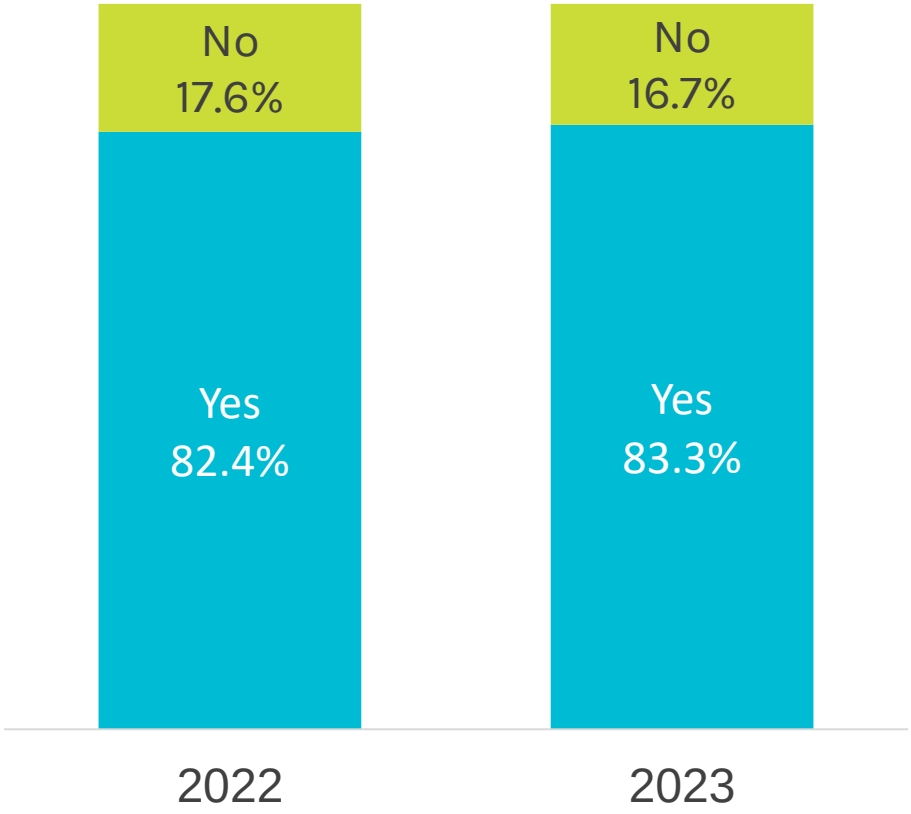
22 respondents who did not meet the criteria were disqualified (those disqualified are not included in the 648 responses for the response rate calculation)

Question

ACERA sent out a postcard and a notice in your open enrollment packet about the program last year, and sent multiple emails this year. Did you hear about the Silver&Fit program before receiving this survey?

- Yes
- No

Did you hear about Silver&Fit?

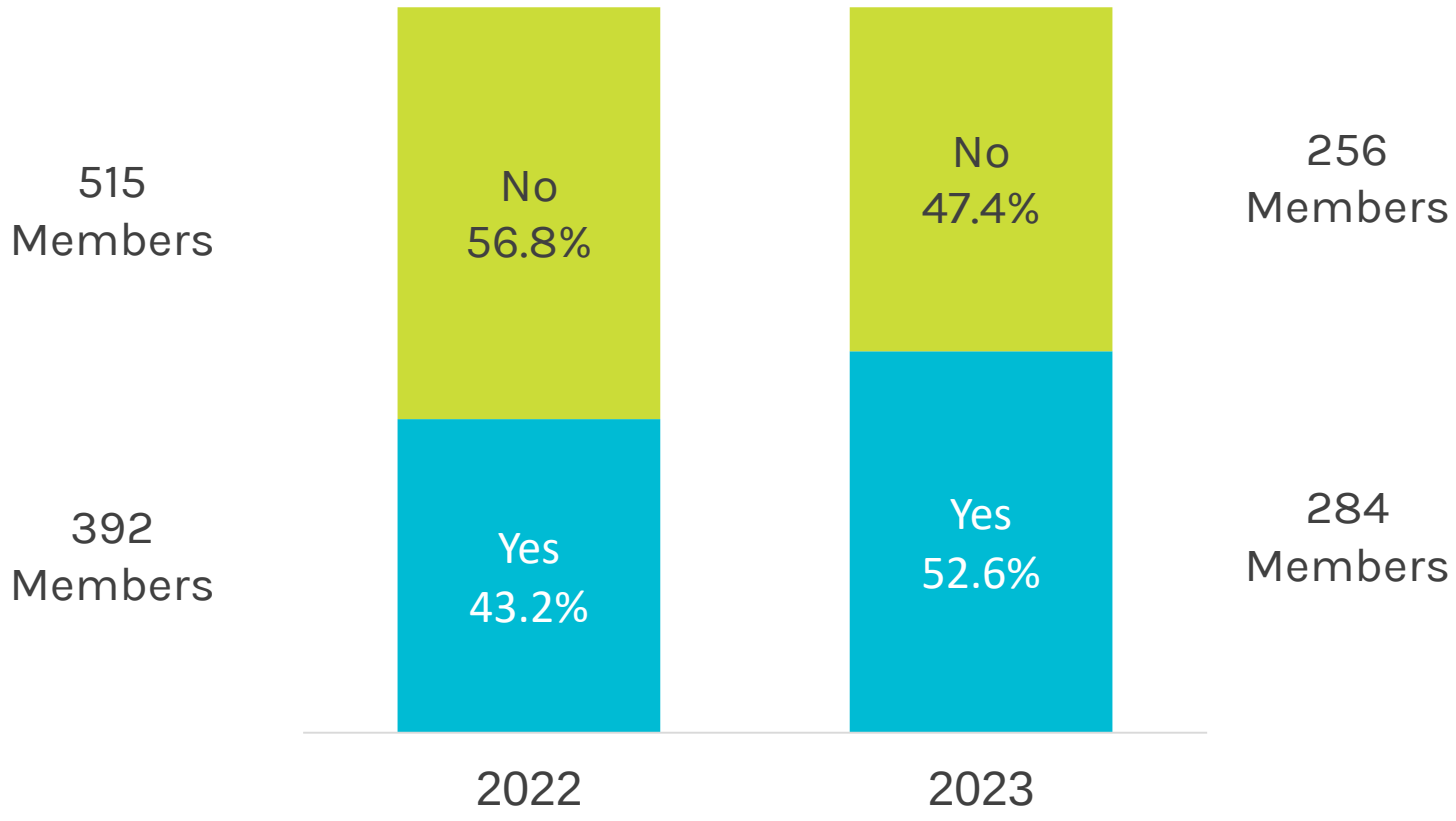


Question

Did you enroll in the Silver&Fit program?

- Yes
- No

Did you enroll in Silver&Fit?



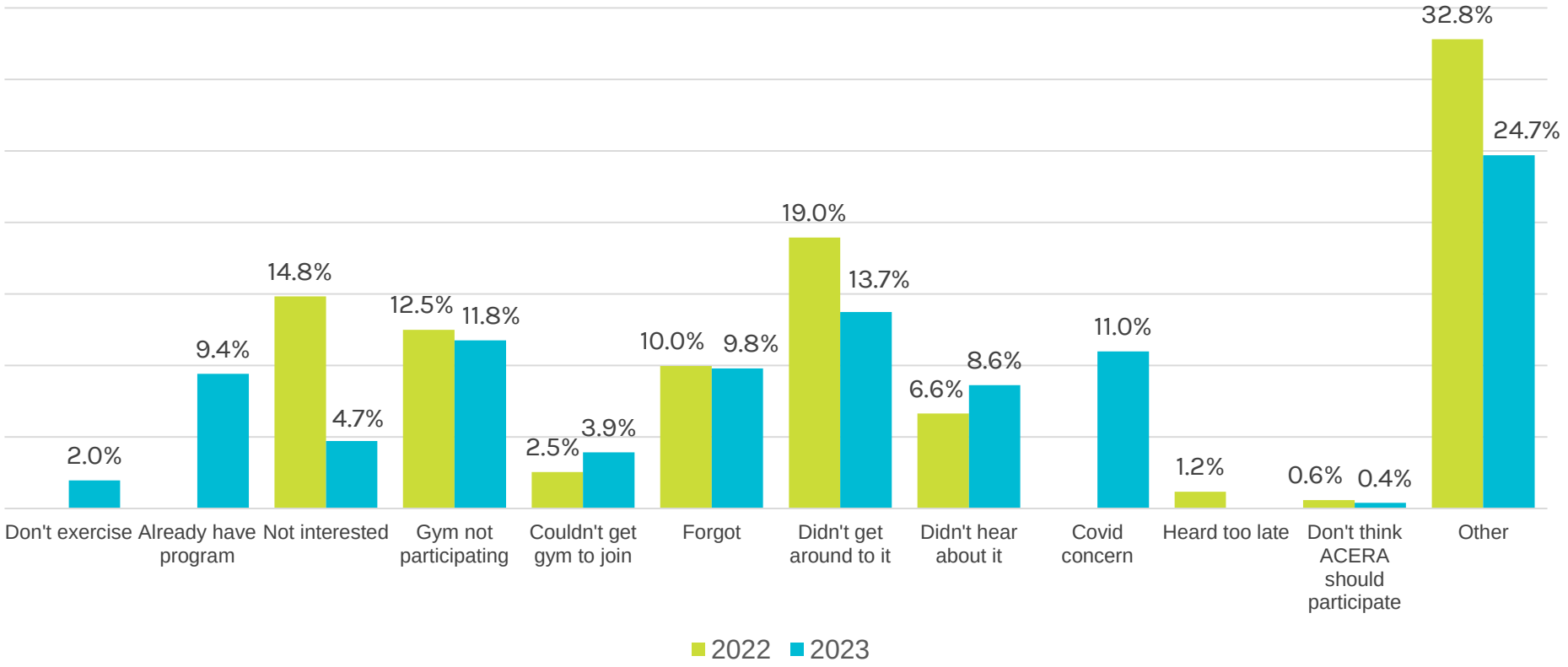
If They Did Not Enroll, They Were Skipped to This Question

If you did not enroll in Silver&Fit, why not?

- I don’t exercise
- I already have an exercise program I'm happy with
- I'm not interested in signing up for a gym or getting a home fitness kit
- My gym was not participating in the program
- I tried unsuccessfully to get my gym to participate in the program
- I forgot about it
- I didn't get around to it
- I was concerned about Covid-19
- I don't think ACERA should participate in this program with Kaiser Permanente
- Other _____

[Then skipped to question asking if they support continuing Silver&Fit]

If You Did Not Enroll, Why Not?



Note: Multiple choice options differed slightly between years. Missing bars denote unavailable options.

"Other" Responses to Why They Did Not Enroll

Full list of responses in appendix. Some summarized themes:

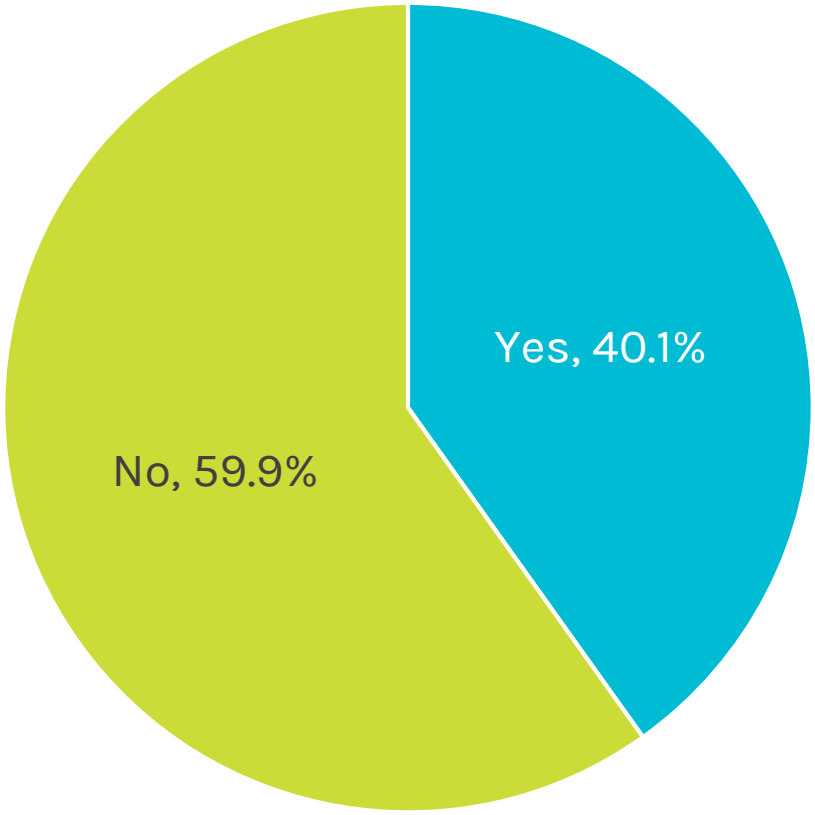
- Physical / medical limitations
- I had problems signing up
- I'm still considering signing up
- I already have an exercise program
- My retirement community has a gym
- My gym didn't want to sign up
- Participating gyms too far away
- Didn't like the gym choices
- I have my own gym equipment
- Covid concern

If They Did Enroll, They Were Skipped to This Question

Did you have a gym membership before signing up for Silver&Fit?

- Yes
- No

Prior Gym Membership?

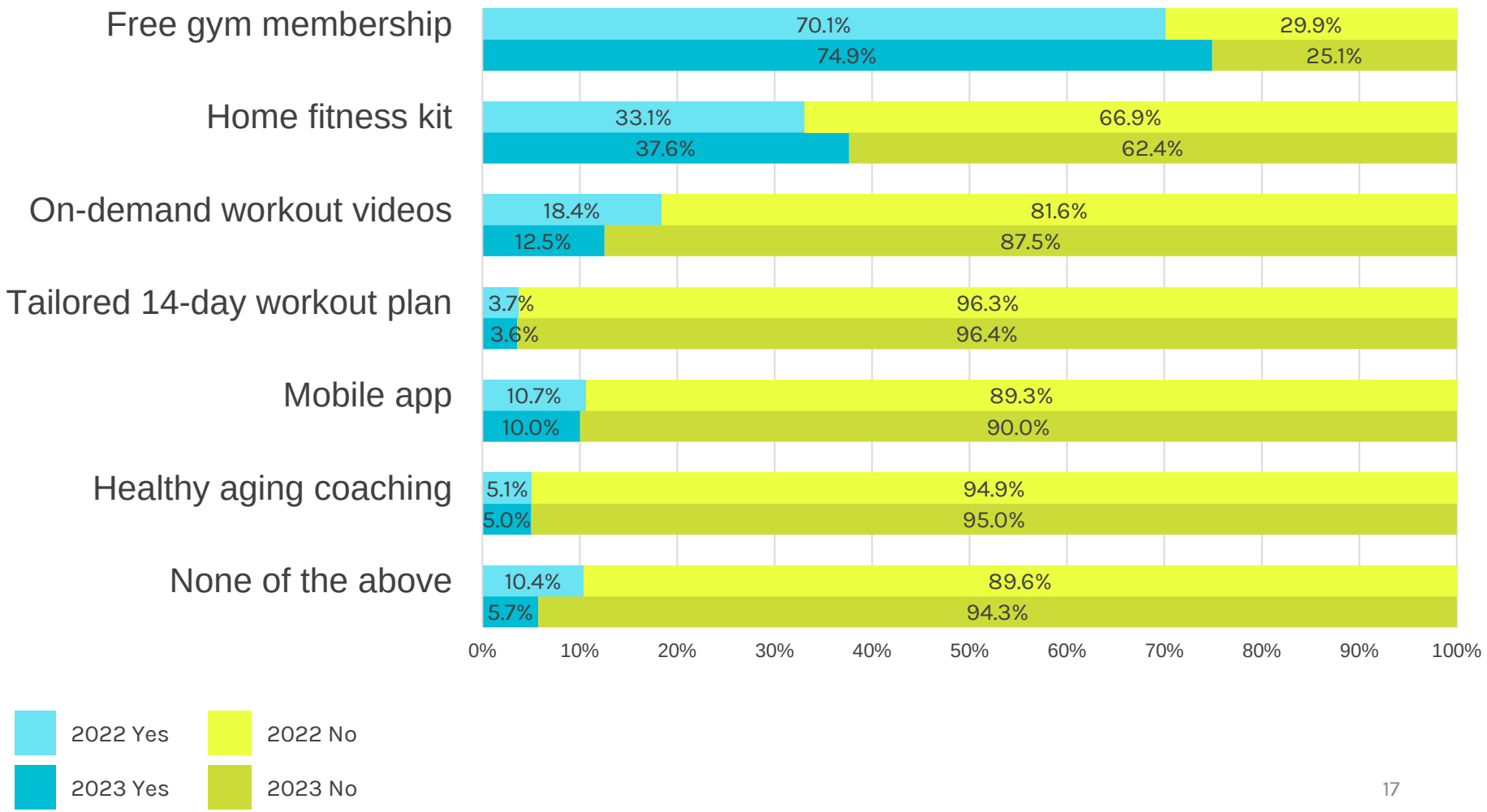


Question

Which features of the Silver&Fit program did you utilize? Check all that apply:

- ❑ Free gym membership
- ❑ Home fitness kit
- ❑ On-demand workout videos
- ❑ Tailored 14-day workout plan based on your fitness goals
- ❑ Mobile app
- ❑ Healthy aging coaching
- ❑ None of the above

Which Features Did You Utilize?



Question

How do you rate the free gym membership part of the program?

Gym Membership Rating

2022

Very Bad | Bad | Neutral | Good | Very Good

4.6 Stars

2023

Very Bad | Bad | Neutral | Good | Very Good

4.7 Stars

Question

How do you rate the home fitness kit part of the program?

Home Fitness Kit Rating

2022

Very Bad | Bad | Neutral | Good | Very Good

4.5 Stars

2023

Very Bad | Bad | Neutral | Good | Very Good

4.5 Stars

Question

What did you like about the Silver&Fit program? (Optional)

What Did You Like?

Full list of likes in appendix. Some summarized themes:

- Can't afford gym on my own
- Free gym membership!
- Free membership is strong motivation to exercise; keeps me active
- Getting in shape
- Gym choices
- Gym close to home
- Classes: Zumba, swimming, etc.
- Aquatic therapy
- Easy to enroll
- Everything!
- Free fitbit
- Ability to workout at home
- On-demand workout videos
- Home fitness kit
- Many options
- I love it!

Question

What did you not like about the Silver&Fit program? (Optional)

What Did You Not Like?

Full list of dislikes in appendix. Some summarized themes:

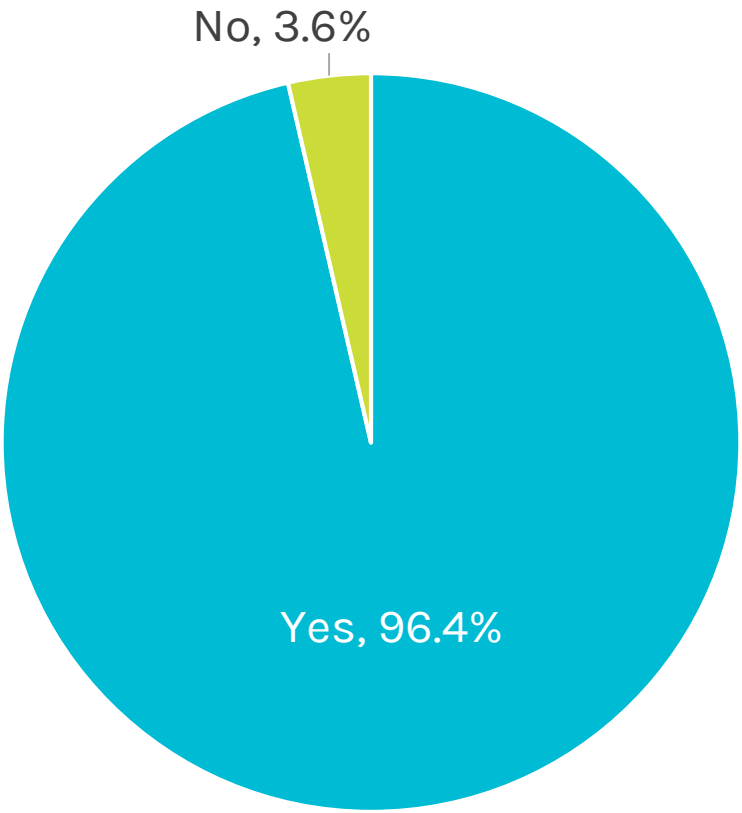
- Nothing; no dislikes; loved everything
- [Complaints about specific gym]
- Can't use the YMCA
- Nearby gyms weren't great
- Limited gym selection
- Couldn't get the gym I wanted to participate
- Crowded facilities
- Doesn't allow use of multiple locations of chain gyms
- Some chain gym locations don't join while others do

Question

Are you still enrolled in Silver&Fit?

- Yes
- No

Are You Still Enrolled?

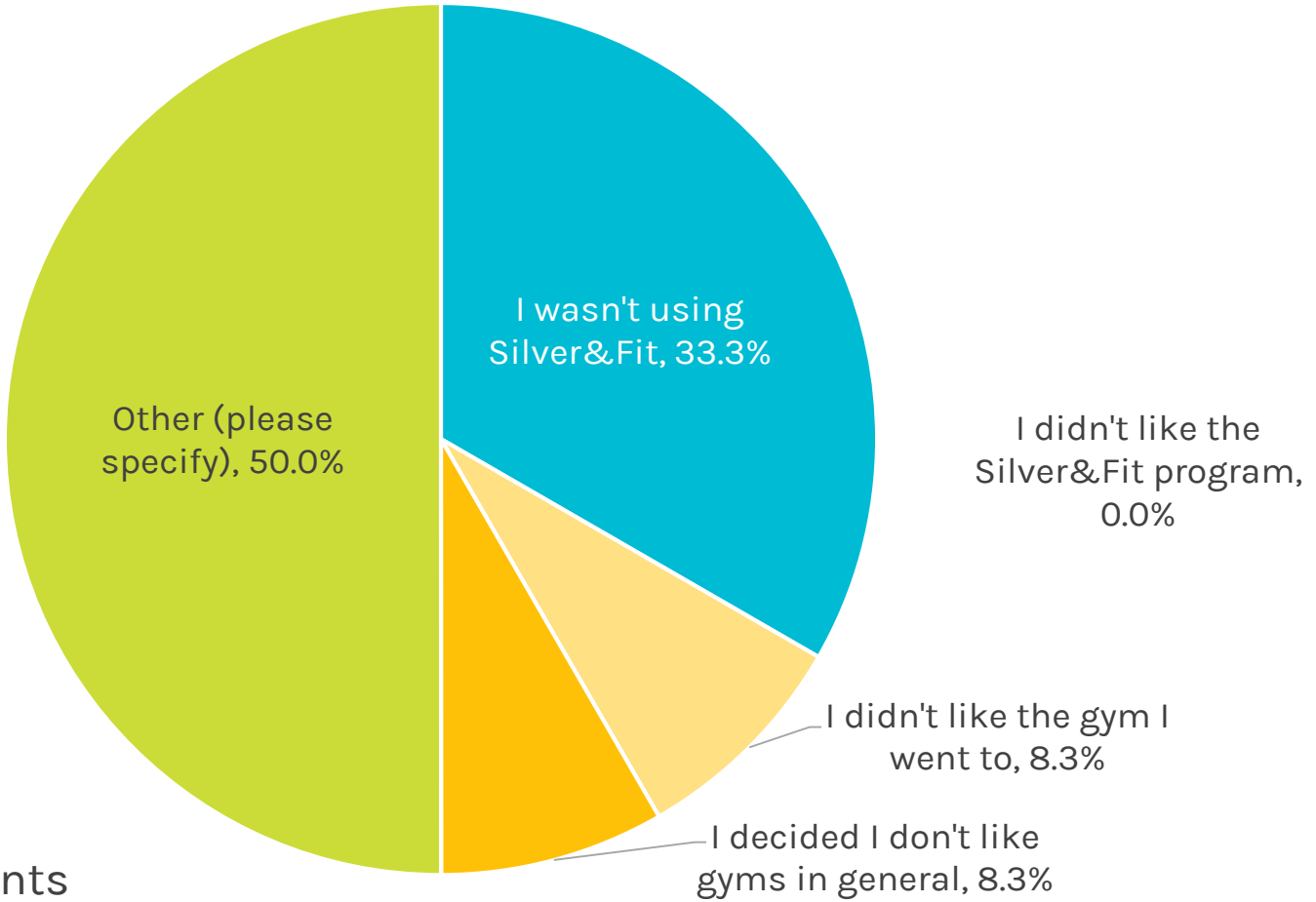


Question

[If no] Why did you unenroll from Silver&Fit?

- I wasn't using Silver&Fit
- I didn't like the gym I went to
- I decided I don't like gyms in general
- I didn't like the Silver&Fit program

If No, Why Did You Unenroll?



Note: Graph represents only 12 answers.

“Other” Responses to Why Did You Unenroll?

Full list of comments in appendix. Some summarized responses:

- My gym is not on the program
- I don’t remember
- I could not figure out how to sign up

Question Introduction

The premium charge for the Silver&Fit program is $2.80 per-member per-month, and is included in the Kaiser Permanente Senior Advantage Medicare Plan 2023 monthly premium of $316.81. If ACERA's Board of Retirement approves continuation of the Silver&Fit program for 2024, the $2.80 monthly charge would also be included in the Kaiser Permanente Senior Advantage Medicare Plan 2024 monthly premium of $354.31. If they do not approve continuation of Silver&Fit, the 2024 premium would be $351.51.

The additional premium for Silver&Fit is charged to all people enrolled in the Kaiser Permanente Senior Advantage Medicare Plan including ACERA members, spouses, and survivors, regardless of whether people participate in the Silver&Fit program or not. Based on limited usage data, our benefits consultant estimates that around 10% of enrollees are utilizing at least one Silver&Fit program feature.

Because ACERA subsidizes the cost of the Kaiser Medicare plan premium from the Supplemental Retiree Benefits Reserve, a rough estimate of the total annual cost to the reserve for the Silver&Fit program is $126,000.

For reference, the total projected medical plan subsidy for this population for 2024 is roughly $17,759,000 with Silver&Fit and $17,633,000 without Silver&Fit.

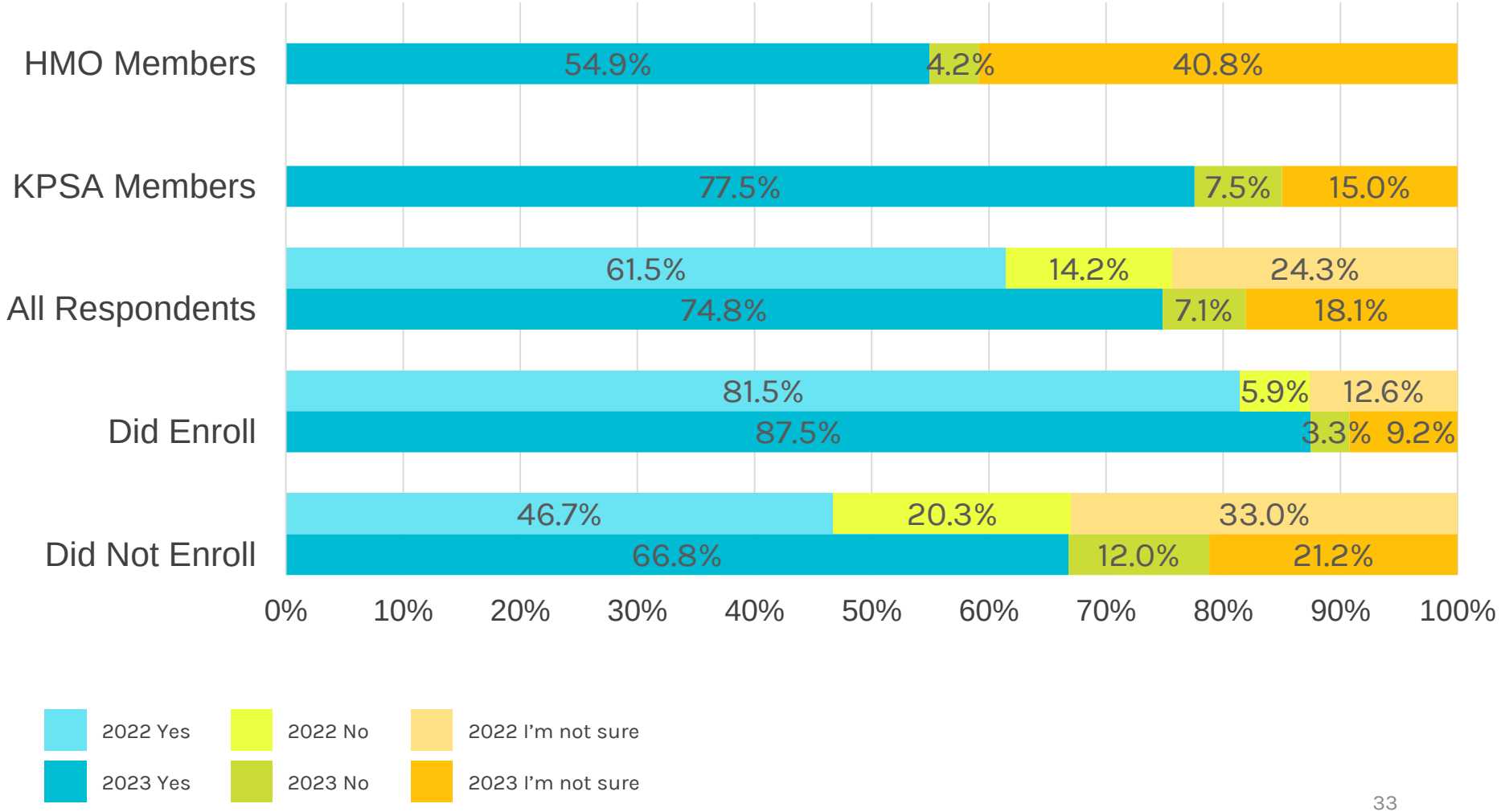
Non-Medicare-eligible members (usually under age 65) in the Kaiser Permanente HMO would qualify for the Silver&Fit program once they reach Medicare age and switch to the Kaiser Permanente Senior Advantage Plan.

Question

Do you support ACERA continuing the Silver&Fit program for the 2024 plan year?

- Yes
- No
- I’m not sure

Support for Continuing Silver&Fit



Question

Please provide any additional comments you have. (Optional)

Additional Comments

Full list of comments in appendix. Some summarized themes:

- It has helped me improve my physical and mental health
- Please expand number of gyms
- I'd rather just have a subsidy I could use at any gym
- Swimming and water aerobics are critical
- The cost to ACERA seems worth it
- I'm not participating for [reason], but I think it's valuable for senior health and should continue
- I'm concerned about the cost to ACERA / the higher premium to myself; it's too expensive; don't continue it
- Only those who use it should pay for it
- The participation rate seems too low to continue it
- Excellent program; I think it should continue
- Once I turn 65, I want to sign up