DEPARTMENT OF DEFENSE
MEDICARE-ELIGIBLE RETIREE HEALTH CARE BOARD OF ACTUARIES
4800 MARK CENTER DRIVE, SUITE 03E25
ALEXANDRIA, VA 22350

September 17, 2020

MEMORANDUM FOR THE RECORD

SUBJECT: Minutes of the July 24, 2020, Meeting of the DoD Medicare-Eligible Retiree Health Care Board of Actuaries

These are the minutes of the July 24, 2020, meeting of the DoD Medicare-Eligible Retiree Health Care Board of Actuaries (Board). The Board advises on the actuarial valuation of the Medicare-Eligible Retiree Health Care Fund.

List of Attachments:

1 – Meeting agenda
2 – List of attendees
3 – DoD Office of the Actuary handout
4 – Meeting transcript

We have reviewed and agree with the meeting minutes. Responsibility for the accuracy of each attachment resides with the organization creating it.

Lynette L. Trygstad, Chairperson
DoD Medicare-Eligible Retiree
Health Care Board of Actuaries

Inger M. Pettygrove
Designated Federal Officer

MEDICARE-ELIGIBLE RETIREE HEALTH CARE BOARD OF ACTUARIES
MEETING MINUTES

July 24, 2020
10:00 a.m.
Virtual Meeting

HIGHLIGHTS/KEY BOARD DECISIONS

Introduction:

- Transcript Page 6-10: Pete Zouras, DoD Chief Actuary, announced that this will be the last meeting for the Chairperson, Lynette Trygstad. On behalf of Mr. Booth, DHRA Director, Jeff Register acknowledged Ms. Trygstad's service for 15 years on the Board with the Office of the Secretary of Defense Medal for Exceptional Public Service.
- Transcript Page 10-12: Ms. Trygstad announced the Chairperson beginning next year will be Dave Osterndorf.

Agenda Item 2: September 30, 2018, Actuarial Valuation Results

- Transcript Pages 13-14: The DoD Office of the Actuary (OACT) presented the Medicare-Eligible Retiree Health Care Fund's (MERHCF) valuation history and gains/losses to the Fund.

- Transcript Page 13: MERHCF per capita normal costs for FY 2021 are $4,911 and $1,952 for active duty and reserve, respectively. The actuarial liability as of September 30, 2018, was $436.3 billion and the unfunded liability was $170.6 billion. The Treasury payment for October 1, 2019, was $6.6 billion.

- Transcript Page 14: There was an experience gain of $4.4 billion and an assumption loss of $17.6 billion, leading to an aggregate valuation loss of $13.2 billion.

Agenda Item 3: September 30, 2019, Actuarial Valuation Proposals

- Transcript Pages 15-16: Active employee and retired beneficiary counts for FYs 18-19 were presented as shown on pages 3-4 of OACT's handout (Attachment 3).

- Transcript Pages 17: Medical cost/trend experience was discussed as shown on page 5 of OACT's handout. MERHCF total incurred outlays increased by 4.0% from FY18 to FY19. Per capita costs had an increase of 2.8%.

- Transcript Page 34: OACT proposed a 25 basis point decrease in both the discount rate and ultimate trend assumptions to 4.75%. The proposed rates reflect consideration of assumptions from Blue Chip Financial Forecasts and the DoD Board of Actuaries as well as MERHCF's historical experience.

- Transcript Pages 34-35: OACT proposed select medical trend assumptions as shown on page 7 of OACT's handout. Revised in-patient (IP) and out-patient (OP) medical trend rates were proposed after considering information from CMS actuaries, including issues raised in their alternative scenario analysis as well as MERHCF's recent experience and short-term expectations due to COVID-19. For prescription drug trends, OACT analyzed DoD's experience, industry reports, and the effects of federal pricing rules.

- Transcript Page 36: OACT proposed assumptions related to administrative cost loads, decrement rates, and retail pharmacy rebates as shown on page 8 of OACT's handout. Except for IP and OP, proposed admin loads were slightly increased from the prior year. The IP and OP admin load decreased from 2.15% to 2.10%. Modifications were proposed to mortality, active duty disability retirement rates, and reserve rates/factors. The same methodology as prior years was proposed to develop the pharmacy rebate assumption.

- Transcript Page 42: OACT proposed medical cost assumptions as described and highlighted on page 9 of OACT's handout. Average claims level was updated for FY2019 experience, and no changes were proposed for the valuation claims costs age grading.

Agenda Item 4: Decisions

- Transcript Page 49: The MERHCF Board approved OACT's proposed methods and assumptions for calculating the FY 2022 per capita normal costs, the September 30, 2019, unfunded liability (UFL), and the October 1, 2020, Treasury UFL amortization and normal cost payments.

ATTACHMENT 1

MEDICARE-ELIGIBLE RETIREE HEALTH CARE BOARD OF ACTUARIES
MEETING AGENDA

July 24, 2020
10:00 a.m.
Virtual Meeting (CVR/MS Teams)

CVR/MS Teams Link: ***Join Microsoft Teams Meeting***

Call-In (for audio only): Dial: 571-388-3904 Conference ID: 519 188 212#

***

(1) Please ensure your audio is muted when not speaking or actively participating.
(2) Please identify yourself before asking a question.

***

1. **Meeting objective** (Board)

   Review actuarial assumptions and methods needed for calculating:

   a. FY 2022 per capita full-time and part-time normal costs
   b. September 30, 2019, unfunded liability (UFL)
   c. October 1, 2020, Treasury UFL amortization and normal cost payments

2. **September 30, 2018, Actuarial Valuation Results**
   (Chelsea Chu, DoD Office of the Actuary)

3. **September 30, 2019, Actuarial Valuation Proposals**
   (Chelsea Chu, Nick Garcia)

4. **Decisions** (Board)

   Actuarial assumptions and methods needed for calculating:

   a. FY 2022 per-capita full-time and part-time normal costs
   b. September 30, 2019, UFL
   c. October 1, 2020, Treasury UFL amortization and normal cost payments

ATTACHMENT 2

MEDICARE-ELIGIBLE RETIREE HEALTH CARE BOARD OF ACTUARIES
MEETING ATTENDEE LIST

July 24, 2020

	NAME	POSITION or OFFICE
1	Lynette Trygstad	Chairperson
2	Dave Osterndorf	Board Member
3	Stuart Alden	Board Member
4	Pete Zouras	DoD Chief Actuary
5	Chelsea Chu	DoD OACT
6	Pete Rossi	DoD Deputy Chief Actuary
7	Richard Allen	DoD OACT
8	Inger Pettygrove	DoD OACT
9	Nick Garcia	DoD OACT
10	Hyung Ju Ham	DoD OACT
11	Paul Bley	General Counsel
12	Chris Borcik	CCA
13	Gerald Davenport	DFAS
14	James Fasano	OUSD (C)
15	Jeff Goldstein	OMB
16	Lori Haines	DFAS
17	Shristi Humagai	OMB
18	Coralita L. Jones	DFAS
19	Daniel Lee	OUSD (C)
20	Patty Lewis	USFHP
21	Bob Moss	Advisor
22	Matt Schmit	CBO
23	Edith Smith	Advocate
24	Rick Virgile	USCG
25	Tim Wilder	Milliman

ATTACHMENT 3

MEDICARE-ELIGIBLE RETIREE HEALTH CARE BOARD OF ACTUARIES
DOD OFFICE OF THE ACTUARY HANDOUT

July 24, 2020

Medicare-Eligible Retiree Health Care Fund
Board of Actuaries Meeting

Department of Defense
Office of the Actuary
July 24, 2020

Medicare-Eligible Retiree Health Care Fund (MERHCF) Valuation History

Board Meeting	Per-Capita Normal Costs for	Full-time	Part-time	Liability ($B) as of	AL	Fund	UFL	UFL Payment ($B) on	amount
Summer 2015	FY17	**$4,252**	**$1,723**	9/30/14	**$381.6**	**$226.5**	**$155.1**	10/1/15	**$3.3**
Summer 2016	FY17R	**$4,213**	**$1,704**						
Summer 2016	FY18	**$4,890**	**$1,955**	9/30/15	**$427.3**	**$232.8**	**$194.4**	10/1/16	**$5.7**
Summer 2017	FY19	**$4,632**	**$1,844**	9/30/16	**$409.4**	**$239.3**	**$170.1**	10/1/17	**$6.6**
Summer 2018	FY19R	**$4,471**	**$1,760**						
Summer 2018	FY20	**$4,621**	**$1,847**	9/30/17	**$406.4**	**$250.2**	**$156.2**	10/1/18	**$5.7**
Summer 2019	FY21	**$4,911**	**$1,952**	9/30/18	**$436.3**	**$265.7**	**$170.6**	10/1/19	**$6.6**
Summer 2020	**FY22**	**?**	**?**	**9/30/19**	**?**	**?**	**?**	**10/1/20**	**?**

Valuation (Gains)/Losses ($B)

Val Date	Experience asset*	other	total	Assumptions trend	admin	other	total	Benefits	TOTAL
9/30/15	$7.4	$22.0	$29.4	$9.3	($2.5)	$2.7	$9.5	($3.9)	$35.0
9/30/16	$7.3	($11.2)	($3.8)	($41.8)	($2.6)	$16.7	($27.7)	$0.0	($31.5)
9/30/17	$4.7	($6.8)	($2.2)	$0.9	($0.5)	($1.0)	($0.6)	($14.1)	($16.9)
9/30/18	$1.4	($5.9)	($4.4)	($4.5)	($0.2)	$22.3	$17.6	$0.0	$13.2
9/30/19	$4.4								

* Includes yield as well as budget lead time effect.

Effective Yield During the Fiscal Year

Medicare-Eligible Retiree Health Care Fund

($ in billions)

Fiscal Year	Fund Balance, Beginning of Year	Contributions Received: From Uniformed Services, for Normal Costs	Contributions Received: From Treasury, for Unfunded Accrued Liability	Investment Income	Benefit Payments: DC	Benefit Payments: PC	Benefit Payments: Total	Fund Balance End of Year	Effective Annual Yield
2015	$227.5	$7.2	$4.0	$4.7	$1.9	$8.1	$10.0	$233.5	**2.0%**
2016	$233.5	$6.8	$3.3	$6.1	$2.0	$7.8	$9.8	$240.0	**2.5%**
2017	$240.0	$7.2	$5.7	$7.9	$2.1	$7.8	$9.9	$250.8	**3.2%**
2018	$250.8	$8.4	$6.6	$10.7	$2.2	$7.9	$10.1	$266.4	**4.1%**
2019	$266.4	$7.8	$5.7	$9.1	$2.3	$8.1	$10.5	$278.5	**3.3%**

NOTES: Fund balances are book values.
Benefit payments are on a paid (not incurred) basis.

Active Employees

	9/30/18	9/30/19	% Change from End of FY18 to FY19
DoD			
Active duty	1,382,518	1,409,079	1.9%
Reserve	716,997	716,643	0.0%
Coast Guard			
Active duty	40,990	40,266	-1.8%
Reserve	6,038	6,229	3.2%
PHS Active duty	6,343	6,159	-2.9%
NOAA Active duty	322	323	0.3%
TOTAL			
Active duty	1,430,173	1,455,827	1.8%
Reserve	723,035	722,872	0.0%

Note: These are end of FY counts

Retired Beneficiaries

	9/30/18	9/30/19	% Change from End of FY18 to FY19
Retirees			
Sponsors			
Non-Medicare-eligible	1,041,669	1,035,068	-0.6%
Medicare-eligible	1,176,601	1,190,075	1.1%
Total	2,218,270	2,225,143	0.3%
Spouses			
Non-Medicare-eligible	940,117	929,767	-1.1%
Medicare-eligible	721,004	733,379	1.7%
Total	1,661,122	1,663,146	0.1%
Others			
Non-Medicare-eligible	862,174	833,947	-3.3%
Medicare-eligible	13,790	13,498	-2.1%
Total	875,964	847,445	-3.3%
Survivors			
Spouses			
Non-Medicare-eligible	79,738	78,161	-2.0%
Medicare-eligible	509,127	516,588	1.5%
Total	588,864	594,749	1.0%
Others			
Non-Medicare-eligible	31,124	30,843	-0.9%
Medicare-eligible	7,926	8,015	1.1%
Total	39,050	38,858	-0.5%
Retirees and Survivors			
Non-Medicare-eligible	2,954,822	2,907,786	-1.6%
Medicare-eligible	2,428,448	2,461,555	1.4%
Total	5,383,270	5,369,341	-0.3%

Note: Medicare-eligible includes all uniformed services. Non-Medicare-eligible includes DoD only.

MERHCF Incurred Outlays

Aggregate ($ in millions)	FY 2018	FY 2019	% Change from FY18 to FY19
Purchased Care			
IP	$893	$886	-0.8%
OP	$2,829	$2,984	5.5%
Rx	$3,256	$3,305	1.5%
Other	$132	$141	6.3%
TOTAL	$7,110	$7,316	2.9%
Direct Care			
IP	$627	$640	2.1%
OP	$760	$775	2.0%
Rx	$841	$979	16.3%
TOTAL	$2,228	$2,394	7.4%
US Family Health Plan			
Capitation Rates	$704	$733	4.1%
Other	$3	$4	35.0%
TOTAL	$706	$736	4.2%
Grand Total	$10,044	$10,446	4.0%

Per Capita	FY 2018	FY 2019	% Change from FY18 to FY19
Purchased Care	$2,998	$3,053	1.8%
Direct Care	$940	$997	6.0%
TOTAL	$3,938	$4,050	2.8%
US Family Health Plan	$14,636	$15,418	5.3%

Notes:

1. PC Retail Rx incurred amounts are net of incurred Rx rebates.
   Incurred Rx rebates in FY 2018 / FY 2019 were $463m / $455m.
2. Medicare is primary payer in most cases with PC IP and PC OP.
3. TRICARE is primary payer in most cases with PC mail order Rx, DC (IP, OP, Rx) and USFHP.
4. Purchased care "other" includes:
   admin costs and certain claim adjustments or payments not already included in claims; some admin costs are included in the claims line.
5. Average USFHP capitation rate is influenced by various factors, including changes in plan enrollment (among six plans), demographic mix (age / gender), and utilization experience.

MERHCF Valuation Key Economic Assumptions
Discount Rate and Ultimate Medical Trend

	September 30, 2018 Val	September 30, 2019 Val (Proposed)
Discount Rate	5.00%	4.75%
Ultimate Medical Trend	5.00%	4.75%
MERHCF Ultimate Medical Trend		
real per capita gdp	1.50%	1.50%
inflation	2.75%	2.75%
margin or excess medical cost growth	**0.75%**	**0.50%**
Total	5.00%	4.75%
MERHCF Discount Rate		
real yield/real interest	**2.25%**	**2.00%**
cpi	2.75%	2.75%
Total	5.00%	4.75%

MERHCF Valuation Key Economic Assumptions - Medical Trends

September 30, 2018 Val

		DC			PC			USFHP
From FY:	To FY:	IP	OP	Rx	IP	OP	Rx	
2018	2019	2.50%	4.00%	5.68%	1.00%	4.00%	5.67%	2.52%
2019	2020	3.00%	4.50%	4.00%	1.94%	4.00%	3.87%	3.48%
2020	2021	3.74%	5.50%	3.98%	2.79%	5.50%	3.87%	4.62%
2021	2022	4.08%	5.63%	4.02%	3.05%	5.63%	3.92%	4.49%
2022	2023	4.24%	5.60%	4.07%	3.16%	5.60%	3.97%	4.50%
2023	2024	4.30%	5.62%	4.11%	3.21%	5.62%	4.02%	4.55%
2024	2025	4.20%	6.11%	4.15%	3.14%	6.11%	4.07%	4.79%
2025	2026	4.16%	5.81%	4.20%	3.11%	5.81%	4.12%	4.65%
2026	2027	4.48%	5.70%	4.24%	3.35%	5.70%	4.17%	4.69%
2027	2028	4.40%	6.49%	4.29%	3.29%	6.49%	4.22%	5.12%
2028	2029	4.44%	5.80%	4.33%	3.40%	5.80%	4.26%	4.80%
2029	2030	4.48%	5.75%	4.38%	3.50%	5.75%	4.31%	4.83%
2030	2031	4.51%	5.70%	4.42%	3.61%	5.70%	4.36%	4.85%
2031	2032	4.55%	5.64%	4.47%	3.72%	5.64%	4.41%	4.87%
2032	2033	4.59%	5.59%	4.51%	3.82%	5.59%	4.46%	4.88%
2033	2034	4.63%	5.54%	4.55%	3.93%	5.54%	4.51%	4.90%
2034	2035	4.66%	5.48%	4.60%	4.04%	5.48%	4.56%	4.92%
2035	2036	4.70%	5.43%	4.64%	4.14%	5.43%	4.61%	4.93%
2036	2037	4.74%	5.38%	4.69%	4.25%	5.38%	4.66%	4.94%
2037	2038	4.78%	5.32%	4.73%	4.36%	5.32%	4.71%	4.95%
2038	2039	4.81%	5.27%	4.78%	4.47%	5.27%	4.75%	4.96%
2039	2040	4.85%	5.21%	4.82%	4.57%	5.21%	4.80%	4.97%
2040	2041	4.89%	5.16%	4.87%	4.68%	5.16%	4.85%	4.98%
2041	2042	4.93%	5.11%	4.91%	4.79%	5.11%	4.90%	4.99%
2042	2043	4.96%	5.05%	4.96%	4.89%	5.05%	4.95%	4.99%
Ultimate		5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%

September 30, 2019 Val (Proposed)

		DC			PC			USFHP
From FY:	To FY:	IP	OP	Rx	IP	OP	Rx	
2019	2020	1.19%	1.42%	4.75%	0.20%	0.93%	4.84%	1.15%
2020	2021	5.22%	8.04%	4.58%	4.31%	8.04%	3.89%	6.13%
2021	2022	4.13%	6.12%	4.59%	3.27%	6.12%	3.93%	4.81%
2022	2023	3.43%	5.13%	4.59%	2.57%	5.13%	3.96%	4.07%
2023	2024	3.33%	5.23%	4.60%	2.48%	5.23%	4.00%	4.10%
2024	2025	3.48%	5.71%	4.61%	2.60%	5.71%	4.03%	4.42%
2025	2026	3.33%	5.52%	4.62%	2.49%	5.52%	4.07%	4.30%
2026	2027	3.52%	5.46%	4.62%	2.63%	5.46%	4.11%	4.34%
2027	2028	3.61%	5.54%	4.63%	2.70%	5.54%	4.14%	4.43%
2028	2029	3.68%	5.50%	4.64%	2.75%	5.50%	4.18%	4.44%
2029	2030	3.75%	5.45%	4.64%	2.88%	5.45%	4.21%	4.47%
2030	2031	3.82%	5.40%	4.65%	3.00%	5.40%	4.25%	4.50%
2031	2032	3.88%	5.36%	4.66%	3.13%	5.36%	4.29%	4.53%
2032	2033	3.95%	5.31%	4.66%	3.25%	5.31%	4.32%	4.55%
2033	2034	4.02%	5.26%	4.67%	3.38%	5.26%	4.36%	4.58%
2034	2035	4.08%	5.22%	4.68%	3.50%	5.22%	4.39%	4.60%
2035	2036	4.15%	5.17%	4.69%	3.63%	5.17%	4.43%	4.62%
2036	2037	4.22%	5.12%	4.69%	3.75%	5.12%	4.46%	4.63%
2037	2038	4.28%	5.08%	4.70%	3.88%	5.08%	4.50%	4.66%
2038	2039	4.35%	5.03%	4.71%	4.00%	5.03%	4.54%	4.67%
2039	2040	4.42%	4.98%	4.71%	4.13%	4.98%	4.57%	4.68%
2040	2041	4.48%	4.94%	4.72%	4.25%	4.94%	4.61%	4.70%
2041	2042	4.55%	4.89%	4.73%	4.38%	4.89%	4.64%	4.71%
2042	2043	4.62%	4.84%	4.74%	4.50%	4.84%	4.68%	4.72%
2043	2044	4.68%	4.80%	4.74%	4.63%	4.80%	4.71%	4.74%
Ultimate		4.75%	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%

MERHCF Valuation Assumptions - Other

	September 30, 2018 Val	September 30, 2019 Val (Proposed)
Admin Load		
IP & OP	2.15%	2.10%
Rx	1.63%	1.70%
USFHP	0.36%	0.40%

Decrements	Consistent w/prior year's Val, except: (1) one more year of mortality improvement (MI), (2) update spouses per sponsor rates	Consistent w/Sept-18 Val, except: (1) One More Year of MI (2) Update MI Scale (based on MIL MI) (3) Update Active Duty Disability Retirement Rates (4) Update Reserve Rates/Factors

New Total Disabled from Active (AC) and Reserves (RC)			
FY	AC	RC	Total
2010	6,975	1,730	8,705
2011	7,799	1,672	9,471
2012	9,773	1,970	11,743
2013	16,214	3,099	19,313
2014	14,672	4,078	18,750
2015	15,880	3,694	19,574
2016	14,786	2,133	16,919
2017	13,615	1,170	14,785
2018	15,751	2,317	18,068
2019	12,085	2,016	14,101

NOTES:

i. The current rates contain an adjustment where 1/2 of estimated combat-related disability retirements are removed. The proposed rates do not include an adjustment. The new disability retirements (shown above) are the actual number during each FY (without an adjustment).

ii. Comparing FY 2020 projections using current and proposed rates, total new disabled retirements increase by about 55%.

MERHCF Valuation Assumptions - Average Claim Costs Development

	September 30, 2018 Val	September 30, 2019 Val (Proposed)
Average Claims Level	FY 2018 experience	FY 2019 experience
Valuation Claims Costs Age Grading		
Direct Care	Blend of FY 2015 - 2017 experience	Blend of FY 2015 - 2017 experience
Purchased Care	Blend of FY 2015 - 2017 experience (2017 for Rx)	Blend of FY 2015 - 2017 experience (2017 for Rx)
USFHP	Blend of FY 2015 - 2017 rates by gender	Blend of FY 2015 - 2017 rates by gender

ATTACHMENT 4

MEDICARE-ELIGIBLE RETIREE HEALTH CARE BOARD OF ACTUARIES MEETING TRANSCRIPT

July 24, 2020

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HUMAN RESOURCE ACTIVITY

BOARD OF ACTUARIES

VIRTUAL MEETING (MS TEAMS)

MEDICARE-ELIGIBLE RETIREE HEALTH CARE

Washington, D.C.

Friday, July 24, 2020

PARTICIPANTS:
LYNETTE TRYGSTAD
Chairperson

STU ALDEN
Board Member

RICHARD ALLEN
Actuary

PAUL BLEY
General Council

CHRIS BORCIK
CCRC

CHELSEA CHU
Actuary

GERALD DAVENPORT
DFAS

JAMES FASANO
OSD(C)

NICK GARCIA
Actuary

JEFF GOLDSTEIN
OMB

LORI HAINES
DFAS

SHRISTI HUMAGAI
OMB

HAM HYUNG
Actuary

CORALITA L. JONES
DFAS

PARTICIPANTS (CONT'D):
DANIEL LEE

OUSD(C)

PATTY LEWIS
USFHP

BOB MOSS
Advisor

DAVE OSTERNDORF
Board Member

INGER PETTYGROVE
Actuary

PETE ROSSI
Deputy Chief Actuary

MATT SCHMIT
CBO

EDITH SMITH
Title Not Specified

RICK VIRGILE
USCG

TIM WILDER
Milliman

PETE ZOURAS
Chief Actuary

* * * * *

P R O C E E D I N G S

(10:00 a.m.)

MR. ZOURAS: Welcome, everyone, to the 2020 Annual Medicare-Eligible Retiree Health Care Board of Actuaries Meeting. This is our first meeting done totally virtual and this is the last meeting for our Chairperson, Lynette Trygstad.

Before we get started, I'd like to hand the floor over to the Deputy Director of the Defense Human Resources Activity, Mr. Jeff Register, who has a few words to say.

MR. REGISTER: Thanks, Pete, and good morning, everybody. I have the privilege of sitting in here today for Mr. Booth, who is both my and Pete's boss. And he wanted to pop in, but he's on vacation and Mrs. Booth currently controls the schedule for them. So this is their last day at the beach and they're trying to cram in a lot of activities before they head home tomorrow.

I wanted to take a quick second to acknowledge Ms. Trygstad's service here for the 15 years on the Board. If Mr. Booth were here, he would certainly acknowledge the importance of the work that both our actuary team, in terms of scope

of impact to the department and importance to the welfare of our service members and their families and that, certainly, sentiment extends to the Board members. So thank you all for your work, but, specifically, Ms. Trygstad, on behalf of Mr. Donovan, Mr. Booth, just a big thank you. Thank you for your 15 years of leadership, of wisdom, of your steadfast support for the independence of the Board. Most importantly, your commitment to the welfare of our service members and their families is very much appreciated. And on a personal note, thank you for challenging our actuary team to be, and excuse my language, "the best damn actuaries Federal dollars can buy." So that is one of their tag lines that I fully support.

So with that, I wanted to take -- here we would typically bring you to the front of the room and have everybody stand up, but given all the circumstances of virtual, we'll forego that formality, but this is the formal part. I'd like to present you with an award. So here we go.

And it reads citation to accompany the award of the Office of the Secretary of Defense Medal for exceptional public service to Lynette T.

Trygstad. Ms. Lynette Trygstad is recognized for exceptional public service for her 15 years of outstanding contributions to the DOD Medicare-Eligible Retiree Health Care Board of Actuaries. Ms. Trygstad played an invaluable role in maintaining the actuarial soundness of the Medicare-Eligible Retiree Health Care Fund for U.S. Uniformed service members and their families. She consistently offered keen insights into industry best practices and the relevance to DOD and military retired benefit systems.

Ms. Trygstad brought her unique actuarial perspective of health plans and their pricing to bear on the setting of key actuarial assumptions, improving the overall quality of work done by the DOD Office of the Actuary. Her efforts contributed to the auditability of the Medicare- Eligible Retiree Health Care fund's financial statements, a significant milestone in the department's financial improvement, and our readiness efforts.

Ms. Trygstad faithfully discharged her duty to protect the public interests while demonstrating genuine concern for the welfare of service members and their families. The distinctive

accomplishments of Ms. Trygstad reflect great credit upon herself, the Office of the Under Secretary of Defense for Personnel Readiness, and the Department of Defense.

And, Ms. Trygstad, I'm sure your version will say signed, Matthew P. Donovan, Under Secretary of Defense for Personnel and Readiness. And that is where we would all clap.

(Applause).

MS. PETTYGROVE: I think we can off on mute and applaud for that. Thank you, Mr. Register.

MS. TRYGSTAD: Thank you very much.

MR. REGISTER: And, Ms. Trygstad, any words to the group as it relates to your service?

MS. TRYGSTAD: I work with some great people. I certainly didn't expect this recognition, but I thank you. It's sort of like retiring all over again, so.

MR. REGISTER: Great. Well, congratulations, again. Thank you so much for your service. It is very much appreciated. And, Mr. Zouras, I will turn it back over to you and I will go on about my day and video call my direct reports and make sure they're dressed up like I am.

MR. ZOURAS: Okay.

MR. REGISTER: Everybody have a great day and a great weekend.

MR. ZOURAS: You, too.

MS. TRYGSTAD: Did you have anything else you wanted to say, Pete?

MR. ZOURAS: No. With that, I will hand it over to you. Thank you.

MS. TRYGSTAD: All right. Thank you. Okay, so, I'm going to introduce the Board members and then I have a bunch of housekeeping kind of items. I don't know if every screen looks the same, but on my left of my screen is Dave Osterndorf, who will be taking the Chair position next year. And then on the right is Stuart Alden, who has been key in the five years that I've worked with him and it's nice to meet you through this mechanism.

So, we are going to have this virtual meeting recorded just as if it was an in-person meeting. So there's a few things, I think, to sort of help this work a little better on a virtual format. First of all, if you're not speaking, I think you should have your microphones muted. It'll just help with feedback issues. And then, also, because we

don't get a lot of questions usually, but we do get a few and I want to make sure people get heard, so we're going to specifically call for questions at the end of each exhibit that is illustrated and then you can have an easier time to jump in and try to get your question asked.

Also, unlike other years, the defense presentation was given to us at a separate meeting before this, just in the interest of keeping the virtual difficulties to a minimum and we were able to ask and have our questions answered at that time. The handout is part of the email that went out last night with other handouts. So if you have questions on that, I'm sure you could ask Coralita also.

Let me see. Oh, and when you ask a question, would you please identify yourself, your name, and your office, before you ask the question so that it can get recorded. And, also, in the interest of attendance, Inger has been trying to get everybody's name as they dial in. So we ask that everyone send an email to Kathleen Ludwig, who sent out the agenda last night, to say I attended and make sure we get that list correct.

And then I think the last administrative

thing is if you have difficulties with connection issues, I guess try to call or email or chat with the OS staff and, you know, hopefully that can be resolved. I know some of you are only in by audio, but that should work okay also.

Okay. So with that we're ready to get started. The objective of today's meeting is listed in agenda item one and we're going to review the Office of the Actuary proposed methods and assumptions to calculate the fiscal year 2022 per capita full-time and part-time normal costs, the September 30, 2019 unfunded liability, and the October 1, 2020 treasury unfunded liability amortization and normal cost payments.

So the first presentation will be done by Chelsea Chu, from the DOD Office of the Actuary, presenting the results of the September 30, 2018 actuarial valuation. Chelsea?

MS. CHU: Okay. Hi. Good morning. Let me -- first, let me share the handout with you. If you are calling in, please go to handout with the cover page titled Medicare- Eligible Retiree Health Care Fund Board of Actuaries Meeting. If you are logging to MSPs, you should see the handout on the

screen. So, any question on these?

MS. PETTYGROVE: Hey, Chelsea. I just wanted you to know it's looking good. We can see it. You might want to shrink it down just a tad if other pages have a little more content on them. Yeah, I think that's a little better.

MS. CHU: Okay. Yeah. Anything else?

MS. PETTYGROVE: Looking good.

MS. CHU: Okay. So, let's start from the page one. This page shows history of variation result. If you go to line Summer 2019, last year MERHCF Board approved assumption to calculate the September 30, 2018 variation. Here shows the result. FY21 per capita, normal cost is $4,911 for active duty and $1,952 for reserve. As of September 30, 2018 the actuarial liability is $436.3 billion. Unfunded liability is $170.6 billion. And the treasury payment of October 1, 2019 was $6.6 billion.

The question marks in this yellow line, I thought we will promulgate it after the Board Member approved the assumptions of the September 30, 2019. Down below, we show the variation gains/losses by treasury experience, assumptions, and the benefit. As of September 30, 2019 -- 2018, sorry -- we have

a total experience gain $4.4 billion, assumption loss $17.6 billion, and then the total variation loss is $13.2 billion. Next page.

This page shows the contribution MERHCF received, investment income, benefit payment, and the effective annual yield. For 2019, MERHCF received contribution of total $13.5 billion, investment income $9.1 billion, and then the total benefit payment is $10.5 billion. The annual effective yield is 3.3 percent. And the fund balance at the end of FY2019 is $278.5 billion, which is the book value not the market value here. So any questions before we move to agenda item three?

MS. TRYGSTAD: Okay. If there's no questions, we're going to move to item three, which is the valuation proposal assumptions that will be presented by both Chelsea Chu and Nick Garcia.

MS. CHU: Nick?

MR. GARCIA: Sorry, I was on mute there for a second. So, yeah, yes, like Chelsea said, I'm Nick Garcia. I've been working -- for the past several years, my main role on health care has been the population projections and health care data in general. On the next two slides, we'll be showing

a summary of some of that population data.

First, on the page that you're looking at, on page 3, we show active employees for fiscal years 2018 and 2019. If you look at the totals at the bottom rows of this table, you'll see that there is a slight increase in the active duty population and the reserve component remained virtually unchanged. I'd also note that the DOD active and reserve populations at the top of this page are the same for retirement and health, and those numbers are obtained from DMDC personnel files.

MERCHB also pays benefits to non-DOD uniformed services, which include the Coast Guard, public health service, NOAA, and we provide those population numbers in the middle of the table. There was a -- some changes to those components, but if you look at the relative numbers, those are really small in size and they have a low impact on the fund in general.

So if we can go to page 5, thanks. On this slide, we show a summary of MERCHB beneficiaries and, for illustration, we also show the non-Medicare eligible population. Again, starting at the bottom rows, you'll see that there was a slight increase of

1.4 percent in the Medicare-eligible population. Also, note that as -- within this table, as the retiree dies, the dependents within that population -- so the retiree population has a subgroup of spouse and others. Those members would transition over to the survivor TIC counts which are shown in the middle of the table.

The largest change in this table that I'll point out is the retirees, others, non-Medicare-eligible group, where there is a decrease of 3.3 percent. And that was largely due to a change in how we identified Tricare young adult population. And, again, like I stated at the beginning, the non-Medicare-eligible population is shown just for illustration and so this percentage change -- this reduction in number, did not have an impact on the Health Care Fund.

Are there any questions on these data pages? Okay. If not, then I'll just hand it back over to Chelsea.

MS. CHU: Hi. Let's please go to page 5 if you are calling in. This page shows two years incurred outlays and the change of aggregate base and the per capita base. Under each, they are purchased

care, direct care, USFHP, and the grand total. As you can see, the grand total increase above 4 percent. The 4 percent of increase includes 2.9 percent increase from purchased care, 7.4 percent increase from direct care, and 4.2 percent increase from USFHP.

You probably have noticed that direct care drug increased about 16.3 percent from FY2018 to FY2019. At this point, I would like to invite Bob Moss, from DHA, to discuss this increase. Also, he will talk about (inaudible) issue and the status of moving data into a new system, Genesis. Bob, are you there?

MS. PETTYGROVE: He had not signed in. Pete Zouras heard that he was going to be a little late. Maybe we could come back to this topic if he's able to make it?

MS. CHU: Okay. So I think he will call in (inaudible) log in to the MSP.

MS. PETTYGROVE: As far as I know, he's not on yet.

MS. CHU: Okay. So let me to page 6 now. Here are discount rate and ultimate medical trend. We propose to lower both discount rate and the

ultimate medical trend by a quarter percent, from 5 percent to 4.75 percent. For the medical ultimate trend, the general infection and the medical specific infection are getting close, so we --

MS. PETTYGROVE: Hey, Chelsea? Chelsea?

MS. CHU: Yes.

MS. PETTYGROVE: Someone just joined. Bob, is that you? Whoever just called in, could you tell me who you are?

MR. MOSS: This is Bob Moss.

MS. PETTYGROVE: Good. We were just at where they wanted you to speak, literally, about a minute ago. So I think, Chelsea, if you would reintroduce that topic?

MS. CHU: Okay. Let's go back to last page. Bob, we were talking about the increase of the direct care, the 16.3 increase direct care drug. So we invited you to talk about the increase. Also, you will talk about the (inaudible) issue and the status of moving data into a new system, Genesis.

MR. MOSS: Okay.

MS. CHU: So, Bob Moss, from DHA. Thank you.

MR. MOSS: Okay. Good morning,

everybody. I hope everybody is staying safe and everything is going well. Now, on the issue of the pharmacy, there has been a significant increase. And I think a lot of it is due to new policies that the DHA imposed back in FY19 that had to with restricting the use of the retail pharmacies, i.e., if you got a -- you could certainly go into get product medications that you only needed for, you know, an initial script of 10 days, two weeks. Also, if you were on maintenance medications, the policy became that you could go in for your initial script, but your refills you either had to handle through TMOP, the mail order pharmacy component, or you had to go back to the MTF to get it. And people were encouraged to go to the MTF because, of course, there were no deductibles or copays.

So because of that policy, you saw a significant increase in the use of the military pharmacies. Some of the increase, I think, is probably also related to increases in the ingredient costs. And, by and large, of course, the Medicare-eligibles are using more of the complicated or expensive esoteric drugs than the folks under 65. But a lot of it, I think, really had to with the new

policy on where people could get refills for their maintenance medications.

The other thing that I talked to Chelsea about is keep in mind that when we compute the distribution to the MTFs, be it for pharmacy or for inpatient/outpatient. If you're familiar with the various Bags, the budget activity groups, we are including not just Bag 1, which is direct care, but essentially Bag 4, which is automated systems, and Bag 7, which has to do with the maintenance of the facility and, you know, minor renovation, minor repairs to the hospital that are where you're authorized to use (inaudible) dollars, et cetera.

That decision was made by senior managers in the department when the Fund first stood out that it ought to be kind of a full cost, if you will, of providing care. So, the MERHCF is paying for some of the overhead costs associated with operating the facility.

If you see a change in the proportion of, for example, with the drugs. If the overall distribution of medication changes in a way that there's an increase in the proportion or the percent of drugs prescribed or dispensed that are for the

Medicare-eligibles, then the formula is such that then the MERHCF winds up paying a little bit more of the overhead costs than they had before. So, I suspect that some of it has to do with the -- not only the increased volume, but the increase percent of overall prescriptions that are dispensed by the hospital or clinic that are associated with the Medicare-eligibles, which then drives up the overhead cost for -- or the contribution of overhead costs that the MERHCF pays into the fund.

Those, I think, are the contributing factors. Do I think that we're going to stay at that higher level? Yes. And we're starting to look at how FY20 is going. And I can tell you, because of COVID-19, we're seeing probably a decrease in the demand for inpatient and outpatient care. But we're not seeing an associated decrease in pharmacy. Because, of course, the folks still need to need to get their medications and even though they may not be pursing outpatient visits or admissions in the hospital for elective-type procedures, they are still reaching out to the medical facility for their prescriptions, their maintenance drugs. So I -- we went to that higher level and I think we'll stay at

that higher level. It's not a one-time blip that then is going to decline when we move into the outyears because of that change in policy as far as where the patients should be obtaining their scripts.

And, oh, by the way, part of the reason for that is that if you talk to the folks in the pharmacy department, they will tell you that, for the department, the cheapest place for dispensing medications is the military MTF pharmacy. It's a little -- it's cheaper than mail order. And mail order is cheaper than going to retail. So that's why senior management made the decision let's try to move more of these scripts from the retail pharmacy, even though we get the refunds from retail, moving them to the MTF.

Any questions on that?

MR. VIRGILE: Hi, Rick Virgile. Just a general one, I guess. There's an increase in MTF drug costs and a pretty small increase for the non-MTF drug costs, but it sounds like, from what you said, that the net of those two things together was intended to produce a small decrease in costs when you look at them combined?

MR. MOSS: That -- that -- if everything

remains static, yes. That would be the case. But, even though you see an increased use in the military pharmacies, and you can logically say that, okay, that is use that may otherwise have gone downtown, keep in mind, you still have new demand coming in and when it comes -- and note that what I was talking about as far as the dispensing of scripts, I'm talking about the chronic medications, like for blood pressure or other things that more likely the senior folks have that requires refills and new scripts every year with refills. We're not talking about the acute medications where you come in and you need an antibiotic for 10 days or so. That is still going downtown. So you're not necessarily going to see an associated decrease in the direct care system by the increase in the -- rather a decrease in the purchased care system when you see the increase in the direct care.

But, to answer your -- but to specifically answer, I would say while you still may see an increase in purchased care, it probably isn't as big of an increase as you might otherwise have had these scripts been filled downtown versus in the military pharmacies.

MR. VIRGILE: Thank you.

MR. MOSS: My concern, guys, is, you know, there's been discussion. You've written -- you've made this recommendation in your quadrennial report, all right, every four years and that is that the trust fund, the MERHCF ought to be expanded to cover care for non-Medicare -- or, yeah, non-Medicare-eligible retirees as well. And there are a number of logical reasons why that is a good idea.

If we ever move to that, I would want to have a discussion with senior management, with the comptroller and all of that. Okay, when we go to compute what the distribution ought to be to the MTFs, should we still include those other Bags, like Bag 4 for automated systems and Bag 7, which are basically overhead costs. Should those be a component or part of the calculation in the distribution to the MTFs, or should we remove that calculation, or those Bags, and focus solely on Bag 1?

And the reason I'd want to have that discussion is that if you start to do that, one, it would, even though you would obviously have an increase in the normal cost contributions, the services have to pay into the fund versus what they're

paying in now just for the Medicare-eligibles. The increase would be a lesser amount because you'd only be including Bag 1. The other thing is you'd leave more money in the DHP for the folks in DHA, the budget folks, to use as flexibility for funding various requirements within the DHP.

You know, and as an example, when we working that issue a couple of years ago of what would be the cost or the savings with respect to putting all retirees into the fund, the effect or the impact to the DHP was going to be about an $11 billion a year reduction in the DHP budget. And I was asked, okay, how -- are there things we could do to lessen that because $11 billion out of the DHP budget won't leave them much of any flexibility at all to cover any kind of other emergencies that may occur.

So, of that $11 billion, what we were able to determine was about eight of it was for purchased care. And I said -- I told my senior management, you know, purchased care is what purchased care is going to be. But on the direct care side of that $11, about $3 billion was for direct care. And if we had gone to just calculating that savings or that reduction to the DHP based on just Bag 1 versus those other two

Bags as well, the reduction to the DHP, instead of $3 billion, would have been $2 billion. So you had about a, you know, one-third less reduction, which would have left a little more money in the DHP budget to cover, you know, various requirements that they have so. And at the same time, it lessens the increase in the normal cost contributions the services have to pay into the fund.

So, if we ever go to that route, I'd at least want to have those kinds of discussions with senior management, in DAHA, HA and the comptroller and OMB about, you know, what's the best way -- what's the overall best interest for the department. And it may -- it may, or it may not be exactly the same way we're doing it today with the MERHCF.

The other question you all had had to do with the deployment of MHS Genesis and when we deploy that, understand that one of the capabilities it's going to give us that we've never had before is the ability to truly develop itemized bills for each patient encounter -- inpatient, outpatient, pharmacy, whatever the case may be. And it will give us what the auditors say is getting down to transaction level or patient level accounting. It

would certainly help with respect to the audit of the MERHCF financial statements. I don't know for sure if right away it would get us from a qualified to a clean audit opinion, but it would certainly start to move us in that direction. And it is a great capability for many other reasons a well.

The problem that we're, or the challenge that we're facing right now is when we bought that system there was nothing in the RFP that talked about having any kind of an interface between the electronic health record and all the clinical workload data contained therein and with our cost accounting tool or cost allocation tool, E4 (phonetic). So if those MTFs that have already deployed MHS Genesis, we are not able to do any kind of cost accounting or analytic analysis of what's going on and what is it costing to do that. So folks are working between our budget folks, us in cost accounting, and the DMSM office, the programming office the deployment, to come up with some kind of an interface or a capability for us to interface. We haven't achieved it yet.

I keep foot stomping on that almost daily with senior management and that we are going to need

it if we're going to not only calculate the distribution for the MTFs from the MERHCF, not only for Chelsea to calculate the direct care portion of the MERHCF health care liability. We're going to need it for me to finish developing the charge description master and the associated charge tables that enable MHS Genesis and the billing solution called REV-X to actually produce an itemized bill based on appropriated dollars that are executed in delivering care in each of our MTFs.

So that's a challenge. We haven't resolved it yet. Every chance I get, I scream about it and say we've got to have it and we've got to have it as quickly as possible. Senior management is moving on it, but we haven't reached a final solution on that yet and, quite honestly, I can't tell you when we might. Now, we're supposed to start deploying REV-X in the, oh, probably the last quarter of next calendar year, 2021. So I would hope -- I would hope that no later than at that time we would have a solution worked out that provides us an auditable, accurate, all inclusive interface between the clinical workload generated in MHS Genesis and our E4, our cost allocation tool. But we're not there

yet. Not today.

Pending any questions, that's all I have for the group.

MR. ZOURAS: Yeah, Bob -- this is Pete Zouras. Can you tell us where you're at in the roll out of Genesis? And is it staggered by type of care?

MR. MOSS: It is -- the roll out has included -- the initial roll out was four facilities in the northwest. It was Madigan, which is a big Army Medical Center out at Fort Lewis, Washington near Seattle. Two Navy facilities, also up in the state of Washington, Bremerton and Oak Harbor, and Fairchild Air Force Base. After that -- that was a couple of years ago. Subsequent to that, they've rolled it out in about three other -- four other facilities, one of which is David Grant Medical Center at the big Air Force Base at Travis Air Force Base in Vacaville, California. And then a couple of very small facilities.

The next roll out -- and, of course, everything has been kind of pushed to the right and put on hold because of the Coronavirus, but the next facility to roll out -- they're working like Camp Pendleton in southern California and a couple other

small facilities there. But the huge facility that is next in line is Balboa, the big Naval facility in San Diego.

My concern is this, Pete. That when you start talking about you had four facilities. Then you added another four. Now it looks like we'll add Balboa. And you're saying, well, gee, of the total number of facilities, that's not a huge number. But when you take Madigan, the Army Med Center, when you take David Grant, the Air Force Medical Center, and when you take Balboa, the big Naval Medical Center in San Diego, and then those other smaller facilities, you are starting to approach, roughly speaking, about 15 to 20 percent of the total workload that goes in across the MHS. So while it may not be a huge number of facilities, because of the size of the facilities and what they do and their secondary and tertiary health care delivery capability, you are now talking about a fair amount of the total workload that goes in -- direct care workload that goes on within the MHS. That's my concern. And you get to a point after a while where you can't do any kind of analytics.

The auditors eventually -- they're aware

of the fact we can't do it at the facilities we've done so far. They're not happy about that, but they haven't raised any major concerns yet because they don't feel it's reached the level where it's material yet. My concern is once you get to Balboa, they may then look at it and say now it's material and you could see either a material weakness identified or at least a significant deficiency identified if you don't have the capability to do any analytics.

So right now, what I do in calculating the distribution is I take, for those facilities that have deployed MHS Genesis, I don't have any choice but to go back to the workload that was done in FY16 and then take that workload and the costs that were associated with that workload in FY16 and inflate those costs out to the budget execution year, whatever it is, based on the CPIU medical index inflation indexes that OMB says I can use.

So for Madigan and Balboa -- not Balboa, but Madigan, Bremerton, Oak Harbor, Fairchild, I have, for the last couple of years, have used FY16 workload data and the cost in FY16. Take those costs and inflate them out be it to FY18, 19, and 20 and out even for FY21. So I'm using some pretty old data

and I'm inflating the costs out to the approved inflation rates and making the assumption that the volume of workload -- both the volume and the intensity of that workload is staying the same. Assumptions that are probably not anywhere near 100 percent accurate.

That's my concern.

MR. VIRGILE: I have a follow up on that. It's Rick Virgile at Coast Guard, and it may be something I misunderstood. When you are talking about the Genesis cost, you were talking about essentially the IT costs or does this somehow come back to our data collection process that we currently get everything from DHA? Is that going to be moving?

MR. MOSS: No. What I'm talking about is MHS Genesis -- what I get from MHS Genesis, I don't get any cost out of -- from MHS Genesis. Or nor from the current CHCS system. What I get from MHS Genesis is the workload -- the clinical workload, be it -- and I'm looking at the weighted workload, so I'm not looking at number of visits or number of admissions. I'm looking at DRGs for inpatient. I'm looking at RVUs for outpatient. So I get that workload information and then, of course, I get scripts and

I get, you know, things having to do with lab work and X-ray work and that kind of stuff. I then have --

MR. VIRGILE: Understood. I just want to make sure we're still not changing the process with DEERS and DHA?

MR. MOSS: No, no, no, no.

MR. VIRGILE: Thank you, Sir. So, that was my concern.

MR. MOSS: Yeah. No, we're not changing any of that.

MR. VIRGILE: Okay.

MR. MOSS: The only thing that is changing is we're moving from CHCS to MHS Genesis. But DEERS and using dimerseye (phonetic) for where providers are assigned and the other costs and everything, all of that is still coming from the various systems that we're currently using.

MR. VIRGILE: That's comforting. Thank you.

MR. MOSS: Yeah, yeah. Any other questions? Okay, Chelsea. That's all I have.

MS. CHU: Thank you, Bob. So let's go back to the discount rate and the ultimate medical trend. Let me start it. We propose to lower

discount rate and the ultimate medical trend by a quarter percent, so about 5 percent last year to 4 and 3 percent this year. And the change for the ultimate medical trend because we think the general inflation and the medical specific inflation are getting closer. So we move the margin for the component of our ultimate medical trend from.75 percent to.5 percent. Okay? So the discount rate will reduce the real yield by 2-1/4 percent to 2 percent given by investment duration is much shorter than liability duration.

So in test over impact on variation result, if the discount rate is lowered by a quarter percent, actuarial liability increases about 5 percent. And the normal costs increases about 12 percent. Reducing medical ultimate trend by a quarter percent almost offset the increase over a general liability and the normal costs due to the decrease of the discount rate.

Okay, any question on this page? Okay. Let's move to trend -- 25 years trend, plus COVID year. For this year's valuation, we are sure inpatient procedure and the outpatient basis are expected to be deferred in the first projection year,

which is 2019-2020. And we also assume no impact on the drug cost. So we propose to lower inpatient and the outpatient trend for both purchased care and direct care from 2019-2020. So compare these number with last years number, is much lower. And the fund FY20 to 22.

We think the inpatient or outpatient defer case from last year will catch up in two years. We expect most of the deferred care catch up in second projection year, which is from 2020-2021. By 2021-2022, the adjustment factors are still positive, but it's about half of the last year the adjustment factors. The interest of the adjustment factor, we recognize that outpatient basis are more optional or voluntary than inpatient procedure. Therefore, the outpatient adjustment factors are larger than inpatient adjustment factors.

Overall, we project that impact of COVID-19 has shortened (inaudible). The cost (inaudible) today as the world returns to normal when the pandemic is no longer exist. Unfortunately, the COVID-19 situation is still developing as of today. We will keep monitoring the development and the impact of COVID-19 and we will propose adjustment

accordingly.

So any questions on this page? Okay, let's move to the next page.

This page shows two proposals. The first one Admin Load. We applied the Admin Load to cash with certain claim adjustment or payment which are not included in claim. The Admin Load applied to purchased care in the USFHP only. For this year we propose the load 2.1 percent for inpatient and outpatient, 1.7 percent for drug, and other will be for USFHP, .4 percent.

Next, decrement rate. Decrement rates are applied to purchase of future member of retirees and the survivor by age in the five years. The rates are consistent with last years assumption except, one, we apply more years of mortality improvement; two, update the mortality improvement scale; three, update active duty disability retirement rates; four, update reserve rates or factors.

Now, Nick will go over details of disability retirement rates.

MR. GARCIA: Yes. Thanks, Chelsea. And, like I said before, I've mainly worked on the population projections over the years and this

decrement rate is used in the population projection. It is applied to the active duty population and transitions them from active population into a disability retirement retiree position. So the -- let me get back here -- so for illustration, in the lower right corner, you'll see that there's a table of the actual number of disability retirements for each fiscal year, 2010-2019. And, on average, this table shows that the number of new disability retirements has been increasing.

Now, note -- and Chelsea did talk about the COVID-19 pandemic. Due to the COVID-19 pandemic, the number of disability evaluations have -- the deferments has increased, so the total number of disability retirements will be affected by COVID-19 pandemic, but we expect that to be made up in future fiscal years.

So the current disability retirement rate that we're using uses data from fiscal years 2010-2014, along with one- half of estimated combat-related disability retirements removed, which was based on information that was provided by the disability evaluation system policy office. And that was a decision that was made because when without

that removal, it was a very high increase in disability retirements and there was a question of whether that was going to continue. Our proposed update uses a more recent experience period of fiscal years 2015 and 2019 and that, also, we're not going to remove the combat disabilities. We're now expecting that this number of new disability retirements will continue into the future.

This also, just to make a comparison between, because this is also applied to retirement. This update has a larger impact on the MERHCF compared to retirement and reasons include, under current law, the disability retired pay is largely offset by VA disability compensation. So those new disability -- there's a large number of new disability retirements that are not a liability to the MRF, the Military Retirement Fund. Also, a disability retiree would receive the same health benefit coverage as a regular retirement, which is not the case. The benefit is different for military retirement, just the retired pay.

So, underneath the table that's provided on the handout, we have a comparison. We compared the current and proposed rates and we projected the

fiscal year 2020 population and we saw that the current -- the updated rates lead to an increase of 55 percent in the new disabled retirements. And this overall proposal would increase the disabled per capita normal costs by roughly 5-6 percent.

And, also, just as someone who does work on the population projections and health care data analysis, Bob Moss' conversation about Genesis was very exciting from my point of view. So I'm looking forward to those changes taking place. If Bob is still on the phone, you have someone looking forward to that. Now if there are any questions on this -- yeah. Any questions related to the decrement rate? We also have Pete Zouras on the line. If you have specifics on how this rate was developed, he can answer those questions.

MR. SCHMIT: Hey, Nick.

MR. GARCIA: Yes.

MR. SCHMIT: Nick, this is Matt Schmit.

MR. GARCIA: Oh, hi. Hi, Matt. How's it going?

MR. SCHMIT: Nick, the 55 percent. So -- and that seems like a really big jump. So, how -- like what portion of your disability

retirements were combat related? I mean it's got to be like two-thirds.

MR. GARCIA: Well, they -- the number of disability -- the combat-related number is decreasing because we're not -- there's not as many that fall into that category. And the rationale for doing that in the past -- I know Pete was -- we were just discussing this before the meeting and I warned Pete that I might have him go into more detail on that and here's the opportunity, Pete.

MR. ZOURAS: Yeah, I think Matt's right. It was about two-thirds. So we took half of that. And there may have been some other adjustments, but that was a big one. And, as you can see from the trajectory, you know, when we're standing at 2014, you know, deciding on what rates to use, you know, you have quite a spread in disability retirements. So we were not sure, you know, what was going to happen in the future, so we just kind of mitigated the effect. Because if we had just taken the rates based on kind of unadjusted disability retirements, it would have had a huge impact. So we kind of cut it down a little bit. And now -- and we were projecting about 10,000 a year. And now, we're projecting about

15,000 a year.

MR. SCHMIT: And who is making the determination on what caused it to combat-related?

MR. ZOURAS: Yeah, it was the DES policy point of contact. It was an estimate, pretty rough, but that's what we had at the time. And it does seem kind of high, but it's -- these are disabilities that don't all occur in theater. Some of them are in like simulations of war.

MR. SCHMIT: All right.

MR. ZOURAS: So.

MR. SCHMIT: Thanks.

MR. GARCIA: Also, Matt, there was some additional information that I can maybe send to you if you wanted more clarification on that.

MR. SCHMIT: Yeah, it's not a huge number. It just seems like the quoted total for the full fund, it's probably not a big number. But it seemed like a really big jump, because I looked at combat-related in the past and it didn't seem -- I don't recall it being that big percent of the whole. But maybe it is. It's been a while since I looked at it.

MR. GARCIA: Okay.

MR. SCHMIT: Thanks.

MR. GARCIA: Mm-hmm.

MS. CHU: So any more questions on this page? If not, then let's move to the last page.

This page is the development of average claim costs. Each year, based on three of experience, we produce a claim cost age grading metric. The metric is per family claim cost base by retirement status, type of medical benefit, and age. Then we apply average claim (inaudible), and the other assumption, we have proposed to project the total claim costs in the future.

For this year, we propose the average claims level is equal to FY2019 experience and no change on the claim cost of grading.

Any question on this one?

MR. FASANO: (inaudible)

MS. CHU: Okay, I want to also --

MR. FASANO: Hi, Chelsea. This is James Fasano from Comptroller. I guess I don't understand why did we not change the (inaudible) shift that blend 15-17 forward to 16-18, while we're changing claims level to 19 levels?

MS. CHU: I'm sorry, who was talking? I couldn't hear at all what he said.

MR. GARCIA: Yeah, the connection is really -- it was breaking up. Whoever was asking that question, your phone call or your phone connection was really choppy. Sorry about that.

MR. FASANO: Hi, Nick. This is --

MS. CHU: Would the person, would you please just send me an email?

MS. TRYGSTAD: Wait, wait, wait. Hold on, guys. Guys, just a second. There is also a chat feature if you're -- oh, except you're calling in. Can you try to restate your name and question?

MR. FASANO: Yes, is this working? This is James Fasano (inaudible). If it's not clear, I'll just send an email or something.

MS. CHU: Would you please send me an email and I can answer your question? I couldn't really hear from you.

MS. TRYGSTAD: Chelsea, this is Lynette. I'm sorry, the connection is really bad. Maybe somebody could mute. Anyway, Chelsea, I don't know who said the question, but they were asking why you didn't update the claim vector timeframe when you updated the average claims level that you were applying it to?

MS. CHU: Okay. The claim vector, itself, is like a cost curve. So we know from year to year because we always use a three years of experiences. So from year to year, they don't change that much. But we need to level up to the first years of the projection year. We know that to have the starting point to project for the future 100 years. So that's why we do this. We don't update the curve, but we do level up to the cost (inaudible) 2019.

MR. ALDEN: Chelsea, this is Stu Alden. Let me just offer up. I think the rationale here is that the age grading does not change much as we bring a new experience. It doesn't change much. It has very little impact on the overall valuation, yet it's very arduous. It's time consuming and arduous to do. And so we found, as a practical matter, to not update that regularly. It's very important to update the average claims level but updating the age grading can be done less often and not seriously impact the valuation. That would be my opinion. Does that sound right?

MS. CHU: Yes, yes. Just like Stu said. In terms of variation result, the -- for the actuarial liability and the normal cost, it's kind of

immaterial change if we update the claim cost age grading every year. So, basically, like Stu said, new experience does not have a lot of impact.

MR. VIRGILE: Can I offer something? It's Rick again at Coast Guard. We don't do grading by age. We actually take the gross claims at every age, which means they jump up and down a lot in the pattern that you wouldn't really expect to see, but that's what happens in real life. And it sounds like you are saying you have a detailed grading process to take the age claims and smooth them out. And that's the part that you're not changing -- is how you smooth them out.

MS. CHU: Yes. We have all kind of smoothing technique like weighted average by certain age group and they -- other smoothing technique to smooth out the rough jumping down curve because we assume from age to age, they shouldn't jump because those costs are age related. So it shouldn't jump around very much from age to age, and also from year to year.

MR. ALDEN: Rick, this is Stu. Let me -- let me just make sure I understand. So you say you use unadjusted average claims cost by age as

single age buckets? You don't even group into five or ten year buckets?

MR. VIRGILE: That's correct.

MR. ALDEN: Okay. And you let that ride every year, so the curve, if you will, it's probably not very smooth, but the curve changes year to year. You could have a decrease as you move from one age to an older age even.

MR. VIRGILE: That's correct. And it looks funny when you look at it, but, you know, it's -- you know, if one age should be a little higher and another should be a little lower just to make them look smoother and I like nice lines and (inaudible).

MR. ALDEN: Yeah, yeah, yeah. Understood. Understood. Yeah, we're just using a different technique. I have a feeling we get to a similar place when we're operating with a group this size.

MR. VIRGILE: Yeah, at first it looked like a typo on the page, but then I understand it now.

MR. ALDEN: Great. Thanks.

MS. CHU: Thank you. Any more questions?

MR. BORCIK: Hi, Chelsea. This is Chris Borcik from CCA.

MS. CHU: Uh-huh.

MR. BORCIK: I had a question going back to decrements. Was there any consideration to making an adjustment similar to the way you made it in trend to account for COVID in terms of retiring mortality given that, you know, COVID is seen to have a high mortality for the older age groups? Would you consider having 2020 -- an increase in mortality in 2020 or by maybe an offset decrease in mortality in 2021? Or is there any consideration around the mortality rates with that respect?

MS. CHU: Pete, I don't think we have it. Can you answer the question?

MR. ZOURAS: Yeah, I don't -- there was, I think, a belief that the effect on mortality would occur over time and the short-term effects would be really hard to predict for the population that we're looking at.

MR. OSTENDORF: Yeah, and this is Dave Ostendorf from the Board. I mean one of the things we did look at is where our retirees reside. And they are not predominantly in some of the hot spots, so it was likely to be less of an impact relative to short-term mortality. I don't know if we have enough

data to be able to be precise on this one, so it's going to ultimately come through in gains and losses as opposed to coming through as an assumption change. But it is something that we are, I guess, keenly aware of and it will be something that we look over the next year.

MR. ZOURAS: Of course there are offsetting impacts. You know, it's not all in the, you know, higher mortality. There could be lower mortality, you know, as people, you know, are getting in fewer accidents and, you know, other things that -- like they have cleaner air or whatever, but, yeah.

MR. BORCIK: Okay, great. Thank you for that.

MS. CHU: Any more questions? If not, let's return to the agenda. Lynette?

MS. TRYGSTAD: Okay. I just want to make sure, Dave, Stu -- you don't have any questions you have for the staff?

MR. ALDEN: No.

MR. OSTENDORF: No, I'm good.

MS. TRYGSTAD: Okay. Then I think our next step is to give an opinion on the methods and

assumptions that are presented today and have them use them for the items as stated in agenda item one. And then we'll cross the liability payments and all of those things, the 2020 payment from the treasurer. So, I would like to suggest that we approve it. Anybody want to make a motion?

MR. OSTENDORF: I'll move that we accept the assumption and methodology as presented in the meeting today as the basis for the valuation.

MR. ALDEN: And I'd like to second that motion.

MS. TRYGSTAD: Thank you. Okay. All in favor? Motion to approve the assumptions pass 3 to 0.

Okay, so we have concluded our tasks for today and I guess the meeting is then adjourned. Thank you all.

MS. PETTYGROVE: Just a reminder, if you guys who are still on remember to send Kathleen Ludwig an email or anybody in the elect staff. We can get it to Kathleen.

MR. OSTENDORF: If we wanted to stick around and anyone wanted to chat or if there is any unfinished business that we can talk about.

MS. PETTYGROVE: Yeah. I think people are dropping off. Mark, it looks like you're still there. I just wanted you to know that was the end of the meeting. We're probably just going to hang out and chat for a little bit afterwards. The court reporter?

REPORTER: Okay. But end the transcript, correct?

MS. PETTYGROVE: Yeah, I believe so.

REPORTER: Thank you very much.

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