Report to the President and Congress
On the Department of Defense
Medicare-Eligible Retiree Health Care Fund

Submitted by the Department of Defense
Medicare-Eligible Retiree Health Care Board of Actuaries

December 2021

DEPARTMENT OF DEFENSE
MEDICARE-ELIGIBLE RETIREE HEALTH CARE
BOARD OF ACTUARIES
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December 2021

President Joseph R. Biden, Jr.

The Honorable Nancy P. Pelosi
Speaker of the House of Representatives

The Honorable Patrick J. Leahy
President Pro Tempore of the Senate

Dear Sirs/Madam:

We have the honor of transmitting to you the 2021 Report of the Department of Defense Medicare-Eligible Retiree Health Care Fund (MERHCF). The report, prepared by the DoD MERHCF Board of Actuaries, includes a report on the status of the MERHCF and recommendations for changes that in the Board's judgment are necessary to protect the public interest and maintain the Fund on a sound actuarial basis, in compliance with Section 1114 of Title 10, United States Code.

Respectfully Submitted,

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A. SUMMARY

Background

The Medicare-Eligible Retiree Health Care Board of Actuaries (Board) was established by law in October 2000, with its three members appointed by the Secretary of Defense to staggered 15-year terms (10 USC §1114). The Board is required to report at least once every four years to the President and Congress on the status of the Medicare-Eligible Retiree Health Care Fund (MERHCF, or Fund). This "quadrennial" report is to include any recommendations the Board believes appropriate and necessary to protect the public interest and to maintain the MERHCF on a sound actuarial basis.

With oversight from the Board, the Department of Defense (DoD) Office of the Actuary (OACT), is required to (1) develop a methodology to fund the cost of those health care benefits that are promised to military retirees and their dependents after they become eligible for Medicare under the TRICARE for Life (TFL) program, (2) develop estimates of the present value of the long-range costs of those benefits, and (3) determine the annual amount required to fund those benefits earned during the current and next fiscal years. Since current service personnel may live to age 110 or older, the projection period approaches 100 years, a timeframe in which nearly every financial aspect of health care may change. Further, the increasing nature of per-capita health care costs, which have for decades increased more rapidly than the country's gross domestic product, causes the long-range future costs to have as much impact on the funding calculations as current outlays (in contrast to the diminishing effect of present values of fixed cash benefits promised decades into the future). In addition, these projections must be made from an uncertain base, since the program is still affected by data insufficiencies. One source of questionable data is DoD's health care operations ("direct care"). Direct care information systems were developed to track the number of services provided and not for financial analysis. This data is not entirely appropriate for actuarial analyses and therefore results in a degree of uncertainty as to the direct care portion of the actuarial liability (currently estimated at 22%).

OACT, under the oversight of the Board, has carefully assessed the available data and adopted a methodology that provides a reasonable assessment of these long-range costs. Any projection over such a long time span cannot be more than a rough estimate of the future. Consequently, substantial adjustments must be anticipated as more reliable and complete data become available and as the future unfolds.

Prior to the legislation that established the Fund[1], DoD paid all costs resulting from providing health care to retired service personnel and their dependents on a pay-as-you-go or cash basis, without any pre-funding of the obligations. The costs of these retiree health benefits had been rising rapidly for several decades. Under P.L. 106-398, the budgeting for retiree health benefits incurred while the beneficiary is Medicare-eligible was changed to an actuarial basis that accounts for the benefits while the personnel are active. Since the number of retired, Medicare-eligible beneficiaries at that time was larger than implied by current force levels (relating to the much larger armed forces during the cold war, especially before the advent of the

[1] Public Law 106-398, the National Defense Authorization Act for 2001.

all-volunteer force), it was believed that legacy costs accrued at the time of the legislation imposed an unfair burden on the current military budget. Thus, the goal became for annual DoD appropriations to cover only the Fund costs associated with the benefits being promised during the current fiscal year, rather than the costs of promises made in past years. This was accomplished by charging the DoD budget for the cost (referred to as "normal cost"[2]) of medical benefits provided to future Medicare-eligible retirees that are earned during the current fiscal year. The normal costs are accumulated in a trust fund maintained by the Treasury, along with payments to amortize the unfunded liability arising due to experience, assumption, and benefit changes, plus the initial liability (for past promises) when the fund was created in 2002[3].

This actuarial budgeting system also promotes economic efficiency by relating the current cost to the burden imposed on U.S. taxpayers by the promises being made today. Congress and policymakers can accurately weigh alternative strategies to pay and motivate our military only if the full cost (present and future) of these promises is funded *currently*, a basic requirement for economic efficiency. The system parallels the budget accounting method followed for the Military Retirement System, and is generally required in the private sector by the Financial Accounting Standards Board for retiree medical benefit accounting in the United States[4] and for states and local governments by the Governmental Accounting Standards Board.[5]

Under the 2005 National Defense Authorization Act, however, neither the normal cost nor the actual costs of benefits being provided to current retirees are actually paid by DoD. Rather, these costs are paid directly from the Treasury. Under the 2006 President's Budget, these costs are still effectively reflected in the DoD budget; however, this was accomplished through a complicated series of budgetary maneuvers that are not guaranteed to occur in the future. If such costs are removed from the DoD budget, health benefits for Medicare-eligible retired military personnel would be treated as if they have no cost to DoD. The MERHCF Board notes that under this budget accounting system, policymakers facing limited budgets have strong incentives to substitute future medical benefits for other forms of compensation. Such decision making could ultimately cost taxpayers more if medical inflation continues at a higher rate than the growth in other forms of compensation.

Although outside the current scope of this Board, we are concerned that health benefits for retired military personnel not yet eligible for Medicare are also provided but there is no advance funding of these costs. Consideration should be given to funding the future benefits for retired beneficiaries who are not yet Medicare-eligible in the same fashion as for Medicare-eligible; there is no logical rationale for differing treatment.

The Board believes that one of the implied elements of the Board's mission is to provide recommendations on other issues directly related to the provision of retiree health care benefits

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[2] Normal cost, an actuarial concept used in pension and other postretirement benefit funding, is the discounted "present value" of the cost to pay benefits in the future that were deemed earned in the current year. If the normal costs for specific beneficiaries are accumulated during all years of service in which benefits are earned, and all actuarial assumptions are met, the sum accumulated will just pay for the benefits as they come due.

[3] Since in the context of the Unified Budget payments to the Fund by DoD and the Treasury will be matched by borrowing by the Treasury, no real funding is actually taking place (just as is the case with the Social Security and Medicare trust funds).

[4] At the time, the Financial Accounting Standards Board (FASB) Statement of Accounting No. 106. This standard has since been re-codified as Accounting Standards Codification 715-60 (ASC 715-60).

[5] Governmental Accounting Standards Board (GASB) Statement No. 45.

for military personnel. Thus, there are several recommendations made in this report that reflect policy suggestions, including operational recommendations that will help OACT better perform their duties in support of policymaking and program operation, as well as improved operational effectiveness of the Board itself.

Report Overview

Section B provides a brief historical overview of the MERHCF and its function. It also notes that this report does not include a comprehensive listing of the various actuarial costs determined each year and directs the reader to OACT for such information.

Financial Operations

Section C provides an overview of the financial operation of the MERHCF. Each year prior to FY 2006, DoD[6] paid the system's normal cost for benefits being earned currently, and the Treasury paid an additional amount to amortize the system's unfunded liabilities. Beginning with FY 2006, the Treasury has paid all amounts—both normal costs and unfunded liability amounts, and the DoD reflects the normal cost payments in its annual budget appropriations. Contributions are paid into the Fund each October 1, and benefit costs for eligible retired beneficiaries are paid from the Fund. We believe that the Fund is in sound financial condition, but we recommend several changes as noted later.

Recommendations

Section D discusses the MERHCF Board's recommendations for the MERHCF and the Military Health System, namely:

Policy Recommendations:

1. Extend the Fund to cover benefits for retirees who are not yet Medicare-eligible.
2. Eliminate the TRICARE Plus program unless modifications can be made to enable the program to bill for services in a manner allowing the Medicare program to become the primary payer of benefits.
3. Convert the USFHP program for Medicare-eligible retirees to a Medicare Advantage plan to allow for similar Medicare funding of all MERHCF plans.
4. Consider expansion of the available investments for the Fund, similar to the Military Retirement Fund, creating opportunities for enhanced returns while also targeting an effective matching of assets and liabilities of the program.

[6] Even though the Fund's statutory title is the *Department of Defense* Medicare-Eligible Retiree Health Care Fund, it now also includes the three non-DoD Uniformed Services, i.e., Coast Guard, Public Health Service, and National Oceanic & Atmospheric Administration. In this report, unless stated otherwise, the use of "DoD" or "Department of Defense" in reference to the Fund's liabilities, costs, or operations should be assumed to also include the three non-DoD Uniformed Services.

Operational Recommendations:

1. Institute an annual benefits enrollment for all Medicare-eligible military retirees.
2. Require the Defense Health Agency (DHA) to provide improved claims reporting for determining claim liabilities for the MERHCF, particularly with respect to prescription drug expenditures
3. Require that future TRICARE vendor contracts stipulate reporting of collected enrollment fees.
4. Coordinate with OACT when making data system changes in response to TRICARE program benefit changes.

Role of the Board Recommendations:

1. Provide a supplemental report, if appropriate, with ongoing recommendations and program suggestions reflecting information gained during the annual MERHCF valuation process.
2. Reduce the term length and amend qualification requirements for Board members.
3. Exempt the Board from the type of administrative reviews of the status and membership of the Board that were performed in the 2021 zero-based review process.

B. INTRODUCTION

In October 2000, Public Law 106-398 changed the accounting basis for financing a portion of retiree[7] health care benefits provided under the Military Health System (MHS)—specifically, benefits incurred while the beneficiary is Medicare-eligible.[8] The accounting change took effect on October 1, 2002, and the DoD began charging the costs of Medicare-eligible military retiree health care benefits on an actuarial basis as benefits are earned by years of service rather than on a cash basis as benefits are paid. The Medicare-Eligible Retiree Health Care Fund (MERHCF, or Fund) was established to receive the actuarial contributions and to pay the benefits.[9]

As part of this change, the Secretary of Defense appointed a three-member MERHCF Board of Actuaries in 2001 to provide technical advice and perform other functions related to the financial operation of the MERHCF (see Appendix). Among those functions is the requirement to report at least every four years to the President and Congress on the status of the Fund, including recommendations for such changes as are necessary in the Board's judgment to protect the public interest and maintain the Fund on a sound actuarial basis.

In this report, the Board reviews the financial status of the Fund and recommends changes to certain aspects of the Fund and the MHS. The Board asks that the Administration and Congress consider these recommendations to protect the public interest and maintain the Fund on a sound actuarial basis.

The text of this report does not necessarily reflect the views of any staff members or officials of the Department of Defense or the Administration.

This report does not contain a comprehensive listing of the various actuarial costs determined since 2002, nor of the technical bases underlying these calculations. Such information is available from the OACT.

[7] "Retiree" in this context refers to costs incurred by all retiree-related beneficiaries, i.e., retirees themselves, their dependents, and survivors.

[8] The basis for determining whether benefits are paid from the Medicare-Eligible Retiree Health Care Fund (MERHCF, or Fund) is Medicare Part A eligibility. In order to be eligible for the TFL "purchased care" benefits also enacted under P.L. 106-398, the beneficiary must be enrolled in Medicare Part B. However, costs incurred by Medicare-eligible retirees who do not enroll in Medicare Part B also will be charged to the MERHCF if the medical services and supplies are received at a medical treatment facility or from the US Family Health Plan (USFHP, or the Designated Provider program enacted in the 1997 National Defense Authorization Act).

[9] The MERHCF also pays administrative costs associated with providing the benefits, such as claims-processing fees.

C. FINANCIAL OPERATIONS

This section presents an overview of the financial operations of the MERHCF for the last eight valuation periods. Previous quadrennial reports showed data since the inception of the Fund.

Nature of the Fund and Financing Procedures

Since October 1, 2002, the Medicare-eligible retiree portion[10] of the MHS has operated under a financing procedure by which the MERHCF is paid contributions equal to the system's "normal cost" plus annual installments to amortize its "unfunded accrued liability."[11] The Fund is invested in Treasury debt securities that generate interest income to the Fund. Payments for benefit costs (claims, capitated payments, administration, and distributions to military treatment facilities) are disbursed from the Fund. Based upon methods and assumptions approved by the Board, OACT performs all of the detailed studies and calculations used in the financing procedure.

While the nation has not actually set aside money to pay the benefits of those who have served in uniform, the MERHCF can be viewed as earmarking future tax receipts for the benefit of military retirees.

There are two misconceptions about the MERHCF:

- The MERHCF represents government tax receipts that have been accumulated in the past. Due to the "unified budget" accounting, however, additions to the Fund are matched by additional U.S. borrowing, so that the Fund actually represents a measure of future tax receipts that will be required to pay principal and interest on government securities being held by the Fund.

- The actuarial soundness of the MERHCF can be measured by prospective short-term (or medium-term) cash flows alone. Rather, the entire present value of the liabilities must also be compared to the current Fund value plus future contributions. A year-by-year cash flow projection is also needed to measure the Fund's ability to pay benefits every year.

[10] The non Medicare-eligible retiree portion of the MHS continues to operate on a "pay-as-you-go", or cash basis whereby benefit costs are recognized as they are paid.

[11] The **normal cost** is the amount that would be necessary to finance the benefits earned by active and reserve military personnel in the current year, assuming it is paid into a fund during each year of service of such group and the fund is invested in interest-bearing securities. In the case of the MERHCF, an active duty normal cost and a reserve normal cost are determined as per-person amounts that are level for every active duty and reserve duty member of the group in a given year; each per-person amount is multiplied by the total number of active duty and reserve duty, respectively, members to compute the total normal cost contribution. The **accrued liability** is the theoretical amount that would be in the fund at any given time for a group of participants if normal costs had been paid throughout all past years of service and all assumptions had been realized. Because no advance funding was done before October 1, 2002, the accrued liability on that date is called the initial unfunded accrued liability.

The current financing procedure, although carried out by allocating no more tax dollars than needed to pay benefits to military retirees as they come due, has nonetheless contributed to a more accurate allocation of costs within the defense budget and to formal recognition of the government's obligation to pay future Medicare-eligible retiree health care benefits to retired military members and their dependents and survivors.

In contrast, however, the MERHCF does not address the retiree health care benefits of military retirees not eligible for Medicare. Since a military retiree could be eligible for military retiree health care benefits for many years before becoming eligible for Medicare and the Fund does not include the cost of the most expensive services (those that are not partially paid by Medicare), the total retiree health liabilities for military personnel are much higher than those accounted for by the normal cost and the MERHCF.

Progress of the Fund: Payments by DoD and Treasury

The progress of the Fund in recent years is summarized in Table 1.

TABLE 1

Medicare Eligible Retiree Health Care Fund Flow of Plan Assets

(In Billions of Dollars)

		Income Sources				
Fiscal Year	Fund Balance, Beginning of Year	From Uniformed Services, for Normal Costs	From Treasury, for Unfunded Accrued Liability	Investment Income	Benefit Outlays	Fund Balance, End of Year
2014	$216.2	$7.7	$4.3	$7.7	$9.4	$226.5
2015	$226.5	$7.2	$4.0	$4.7	$9.6	$232.8
2016	$232.8	$6.8	$3.3	$6.1	$9.7	$239.3
2017	$239.3	$7.2	$5.7	$7.9	$9.9	$250.2
2018	$250.2	$8.4	$6.6	$10.7	$10.1	$265.7
2019	$265.7	$7.8	$5.7	$9.1	$10.5	$277.8
2020	$277.8	$8.1	$6.6	$7.7	$10.5	$289.7
2021	$289.7	$8.6	$7.0	$17.4	$11.0	$311.8

Notes: Rows may not add due to rounding. Fund balances and benefit outlays are adjusted to reflect accounts payable and estimates of incurred but not reported liabilities originally reported on the Fund's financial statements.

Each year's normal cost is determined by applying per capita normal cost (NC) amounts to the expected average strength counts for full-time and part-time personnel. (Full-time personnel include active duty members as well as full-time reserves; part-time personnel include part-time reserves.) The annual per capita NCs from the eight most recent valuations are presented in Table 2.

TABLE 2

Medicare-Eligible Retiree Health Care Fund
Per Capita Normal Costs

Fiscal Year	Full-time	Part-time
2016	$4,231	$1,748
2016 - restated	$3,954	$1,608
2017	$4,252	$1,723
2017- restated	$4,213	$1,704
2018	$4,890	$1,955
2019	$4,632	$1,844
2019 - restated	$4,471	$1,760
2020	$4,621	$1,847
2021	$4,911	$1,952
2022	$5,506	$2,138
2023	$5,795	$2,279

If assumptions are not changed, the per capita NCs are generally expected to increase each year at a rate approximately equal to the "ultimate" medical trend assumption[12]. However, each year the MERHCF Board reviews actuarial assumptions and methods to consider possible revisions. The effective date of a resulting change in contribution rates is scheduled to accommodate DoD's budget cycle. Contribution rates are also changed to reflect any benefit changes enacted. Actuarial methods and assumptions are changed periodically to refine the projections. At times, a restatement is also necessary if a benefit change impacting the valuation period is not known at the time the valuation was performed.

Per capita costs during the last four years have changed (in addition to expected increases) as new mortality assumptions, claims and other experience, as well as revisions to other actuarial assumptions, were incorporated. Given the long-term nature of these benefit projections, a small change to an assumption can have a noticeable impact on the normal costs.

[12] Medical trend assumptions are discussed later in the report.

Payments to amortize the Fund's unfunded accrued liability have changed for several reasons. First, these payments are set to increase at the rate assumed by the Military Retirement Fund's Board for basic pay increases. Second, amortization payments are adjusted each year to reflect, on a gradual basis, the impact of changes in actuarial assumptions, changes in benefits, and various "gains and losses," i.e., deviations of actual from assumed experience. The amortization period for the initial unfunded liability was set at 50 years at the outset, but shortened on two occasions (at the time of the FY 2013 and FY 2018 amortization payments). Going forward, the shorter amortization period ensures that the payment will at least cover the interest accrual. In addition, the Board shortened the amortization period for gains and losses due to experience, assumption, and benefit changes from 30 to 20 years at the time of the FY 2018 amortization payment, and all such gains and losses will be combined and amortized on an aggregate basis[13].

The Board approves assumptions with respect to a number of factors, including investment (e.g., future Fund interest earnings), medical (average claims levels, administrative costs, increases in per capita costs, etc.), and demographic factors (separations from service, mortality and disability rates, etc.). Deviations of actual from expected experience are sure to occur due to these multiple factors.

[13] Prior to this change, each component of the gain or loss was separately amortized.

Funding of the Accrued Liability

OACT performs annual actuarial valuations of the accrued liability under Section 1115 of Title 10, U.S.C., in accordance with methods and assumptions approved by the Board. Each valuation determines per capita NC amounts, accrued liability estimates, unfunded accrued liability amounts, and amortization payments on the unfunded accrued liability. As of September 30, 2020, the Fund held assets of approximately $290 billion. The accrued liability as of that date was $472 billion, leaving an unfunded accrued liability of $183 billion. Favorable experience and benefit changes since the Fund's inception have offset a potential $576 billion unfunded accrued liability balance (as of September 30, 2020) by $393 billion, leaving the current $183 billion balance.

The MERHCF unfunded accrued liability in the last eight years is summarized in Table 3. The Fund's assets and the percentage of the accrued liability they cover (percent funded) are shown in the table. The assets in the Fund now cover about 61% of the accrued liability. The change in the unfunded accrued liability is influenced by several factors. One is that the amortization payments are scheduled to increase at the rate assumed by the Military Retirement Fund's Board for basic pay increases. As a result, although projected to remain relatively level as a percent of payroll, the payments increase each year as a dollar amount. Under the Board's current amortization schedule, the unfunded accrued liability is projected to be extinguished in 2039.

TABLE 3

Unfunded Accrued Liability
(In Billions of Dollars)

As of September 30	Accrued Liability	Assets	Unfunded Accrued Liability	Percent Funded
2013	$383.9	$216.2	$167.7	56%
2014	$381.6	$226.5	$155.1	59%
2015	$427.3	$232.8	$194.4	54%
2016	$409.4	$239.3	$170.1	58%
2017	$406.4	$250.2	$156.2	62%
2018	$436.3	$265.7	$170.6	61%
2019	$452.8	$277.8	$175.0	61%
2020	$472.4	$289.7	$182.7	61%

Notes: Rows may not add due to rounding. Assets are adjusted to reflect accounts payable and estimates of incurred but not reported liabilities originally reported on the Fund's financial statements.

Actuarial Assumptions

The normal costs and accrued liability are heavily influenced by the underlying actuarial assumptions, especially those used for future interest and increases in per capita health care costs (i.e., medical "trends"). The Board's current interest assumption is 4.50%, and the current medical trend assumptions are shown in Table 4.

TABLE 4

Medical Trend Assumptions
September 30, 2020, Valuation

		Non-USFHP						
		DC			PC			
From FY:	To FY:	IP	OP	RX	IP	OP	RX	USFHP
2020	2021	6.08%	9.55%	-2.10%[14]	6.08%	9.55%	2.93%	7.55%
2021	2022	12.20%	9.03%	4.13%	12.20%	9.03%	3.38%	9.59%
2022	2023	4.55%	4.04%	3.18%	4.55%	4.04%	2.96%	4.13%
2023	2024	3.00%	3.97%	3.25%	3.00%	3.97%	3.04%	3.51%
2024	2025	3.48%	5.71%	3.31%	2.60%	5.71%	3.12%	4.27%
2025	2026	3.33%	5.52%	3.38%	2.49%	5.52%	3.19%	4.16%
2026	2027	3.52%	5.46%	3.45%	2.63%	5.46%	3.27%	4.21%
2027	2028	3.61%	5.54%	3.52%	2.70%	5.54%	3.35%	4.30%
2028	2029	3.68%	5.50%	3.59%	2.75%	5.50%	3.43%	4.32%
2029	2030	3.75%	6.46%	3.66%	2.80%	6.46%	3.50%	4.89%
2030	2031	3.81%	6.35%	3.72%	2.92%	6.35%	3.58%	4.91%
2031	2032	3.87%	6.24%	3.79%	3.04%	6.24%	3.66%	4.92%
2032	2033	3.94%	6.14%	3.86%	3.17%	6.14%	3.74%	4.93%
2033	2034	4.00%	6.03%	3.93%	3.29%	6.03%	3.82%	4.93%
2034	2035	4.06%	5.92%	4.00%	3.41%	5.92%	3.89%	4.93%
2035	2036	4.12%	5.82%	4.07%	3.53%	5.82%	3.97%	4.93%
2036	2037	4.19%	5.71%	4.13%	3.65%	5.71%	4.05%	4.92%
2037	2038	4.25%	5.60%	4.20%	3.78%	5.60%	4.13%	4.91%
2038	2039	4.31%	5.50%	4.27%	3.90%	5.50%	4.21%	4.90%
2039	2040	4.37%	5.39%	4.34%	4.02%	5.39%	4.28%	4.88%
2040	2041	4.44%	5.28%	4.41%	4.14%	5.28%	4.36%	4.86%
2041	2042	4.50%	5.18%	4.48%	4.26%	5.18%	4.44%	4.84%
2042	2043	4.56%	5.07%	4.54%	4.38%	5.07%	4.52%	4.82%
2043	2044	4.62%	4.96%	4.61%	4.51%	4.96%	4.59%	4.80%
2044	2045	4.69%	4.86%	4.68%	4.63%	4.86%	4.67%	4.78%
Ultimate		4.75%	4.75%	4.75%	4.75%	4.75%	4.75%	4.75%

[14] This negative trend rate reflects the impact of the COVID-19 pandemic, resulting in much lower use of MTFs for the dispensing of prescription drugs as members choose other channels to fill their prescriptions.

DC	Direct Care; care received at Military Treatment Facilities
PC	Purchased Care; care received from non-military providers
IP	Inpatient (facility charges when there is an overnight stay)
OP	Outpatient
Rx	Pharmacy
Non-USFHP	Plans other than USFHP
USFHP	US Family Health Plan (a managed care plan)

As shown in Table 4, the medical trend assumptions vary by projection year[15] and benefit type. The Board reflected the impacts of COVID-19 in the trend assumptions by (1) adjusting a period of higher-than-normal utilization after that caused by a catchup effect of the deferred medical procedures and (2) shifting prescription drug fills from direct care to retail. Because the medical trends represent the rate at which per capita health care costs are assumed to increase and the interest assumption represents the rate at which future projected costs are discounted to the present, the normal cost and accrued liability calculated in the valuation are sensitive to the relative levels of the two assumptions. For example, increasing all trend assumptions by one percent without changing the interest assumption would increase the full-time and part-time per capita NCs by 61% and 59%, respectively, and the accrued liability by 26%.

The relationship between the medical trend and interest rate assumption plays a critical role in the valuation. In this valuation, the ultimate medical trend exceeds the interest rate by 25 basis points, which is consistent with forecasts that have medical costs consuming a growing percentage of GDP. Without evidence of changes in health care delivery that would slow the growth in per capita health care spending, the Board supports this current relationship.

The Fund is invested in market-based U.S. Treasury securities, and the interest assumption reflects this constraint. While current yields are below the current interest assumption of 4.50%, it should be noted that the assumption represents an average over a long period of time.[16] The Board set this assumption by looking at historical yield rates for MERHCF and Treasury securities, as well as forecasts of future MERHCF and Treasury yields and the Military Retirement Fund Board's interest assumption.

The actuarial calculations are also impacted by the assumed level of claim costs[17] to be incurred by the eligible population. The claims data available for "purchased" care (care received from non-military providers) has improved over the last several years, and OACT continues to monitor retirees' use of medical services. This is consistent with what the Board has observed in the private sector. However, costs for "direct" care (care received at military treatment facilities) are difficult to estimate, primarily because the systems that contain the direct care data were not designed for collecting data for the purpose of determining claims costs.

[15] The term "select and ultimate" is often used for assumptions expressed in this format. The select period represents the initial period where assumptions are expressed explicitly for each projection year, and the ultimate value represents the final assumption which is assumed to be level for all years after the select period.
[16] From the perspective of the normal cost calculation, an idea of the relevant time period can be gleaned by looking at the ages of new entrants to the military, and the time period over which they and their dependents and survivors might be expected to receive Medicare-eligible retiree health care benefits.
[17] The claim cost assumptions are too numerous to list in this report.

TFL claims costs rose dramatically in the early years following establishment of the MERHCF. The key reason for this was that Medicare-eligible retirees began to reduce usage of private sector health care coverage and increase participation in the TFL benefit. This shift was further spurred by enhancement in the TFL benefit over the years. As there is no enrollment requirement or retiree contribution for TFL users, the participation rate cannot be explicitly quantified. However, analysis of observed year-over-year claim trends and key benchmark utilization levels leads OACT and the Board to conclude that TFL is approaching a steady-state status for retiree participation.

D. RECOMMENDATIONS

The Board has considered several areas where improvements could be made to the MERHCF from a policy or operational perspective. In addition, the Board believes it, as well as OACT, could provide valuable insights that may enhance the provision of military retiree medical benefits. Each of these areas is discussed below.

Policy Recommendations

1. *Extend the Fund to cover benefits for retirees who are not yet Medicare-eligible.*

As mentioned earlier in this report, a significant portion of military retiree health benefits are not covered by the Fund. Benefits for retirees who are not yet Medicare-eligible are a significant cost because of the young age at which many military members retire and because the program pays for the full cost of their health care (whereas a large portion of Medicare-eligible costs are paid by Medicare, not the DoD). Both the private sector and public sector (states and municipalities follow Government Accounting Standards Board Statements No. 43 and 45) account for both pre-Medicare and post-Medicare retiree health benefits on an advance accrual basis.

The Board recommends that the benefits for retirees not yet Medicare-eligible be included in the MERHCF. This would make DoD's budgetary accounting more comparable to private industry, reflect DoD's full costs to provide retiree health entitlements earned by military members' current service and promote a better understanding of the total program's value. If this recommendation were adopted, the estimated normal cost for fiscal year 2019 would increase from $8.0 billion for the post-Medicare population alone to $16.8 billion for pre- and post-Medicare combined.

2. *Eliminate or modify the TRICARE Plus program.*

TRICARE Plus allows retirees, who normally are only able to receive care at military hospitals and clinics on a space-available basis, to enroll at these hospitals and clinics for primary care. Medicare-covered services provided at these facilities have historically not been eligible for Medicare reimbursement. Therefore, despite retirees having paid into the Medicare system through payroll taxes, DoD pays the full cost of their care. In essence, DoD has "paid twice" for these retirees in the form of payroll taxes while active and in unreimbursed medical care as a Medicare-eligible retiree.

An alternative approach to avoiding "double payment" would be to establish a robust electronic health record (EHR) system at the military facilities, which would allow the DoD to submit claims to Medicare for reimbursement. This approach would also achieve parity with services provided in the private sector. The current initiative focused on creating such an electronic health record, which is being undertaken for a variety of purposes, should consider the potential impact on the TRICARE Plus and TFL programs. The EHR implementation should be assessed to determine if it can include the billing function discussed above, and if so, the Medicare primary reimbursement process should be effectuated as quickly as possible.

3. *Convert the USFHP program for Medicare-eligible retirees to a Medicare Advantage plan to allow for similar Medicare funding of all MERHCF plans.*

The current USFHP program is funded in a manner similar to a commercial, non-Medicare health program, without having to abide by state insurance laws. Thus, its cost is covered entirely by DoD as a plan sponsor. TFL provides benefits that are supplemental to Medicare-covered benefits. This differential in funding approach creates a large variation in the per capita costs of the USFHP and TFL programs, creating issues in comparing the effectiveness of the programs. In 2012, enrollment of Medicare-eligible retirees in USFHP was restricted, but there are still approximately 100,000 current USFHP members (pre- and post-Medicare) who have been grandfathered to remain eligible to be in USFHP while Medicare-eligible.

Conversion of the USFHP program for Medicare-eligible retirees to a Medicare Advantage (MA) plan would provide for direct Medicare funding for the plan, significantly decrease DoD's costs and maintain the same incentive for strong plan management of claims and participant health status as expected of all MA plans. The Board recommends that DoD study the financial impact of requiring USFHP to convert its program for Medicare-eligible retirees to an MA plan, while preserving the plan's ability to dispense prescription drugs based on Federal Ceiling Prices. Such a plan can be structured under the rules for Employer Group Waiver Programs, which could allow USFHP to make the change more easily since many plan requirements are waived.

4. *Consider alternative investments for the assets of the Fund*

The current assets of the Fund are mainly invested in Treasury Inflation-Protected Security (TIPS), with limited assets held in US Treasury Bonds. These investments are held to maturity. TIPS and US bonds are highly conservative investments, which have the advantage of not being subject to attack as government investment in the private economy. However, the return on these investments have not kept pace with the expected investment return assumed in the annual MERCHF valuation. In fact, the Fund has experienced investment losses in almost all years of its existence. Alternative investments would provide a greater probability of improved investment performance. Since the Military Retirement Fund has already been allowed to invest in a greater variety of investments, the precedent has been set as to how to structure the investment policies. The Board would encourage the investment committee to consider how well matched the liabilities and investments are in any investment scenario. However, since the Normal Cost annual contributions are projected to exceed benefit payments for a significant period, long-term changes in investment strategy would not create liquidity issues.

Operational Recommendations

1. *Institute an annual benefits enrollment for all Medicare-eligible military retirees.*

There is no formal enrollment for TFL, so it is difficult to assess the number of military retirees who intend to use the program. The MERHCF valuation includes an estimate for eligible retirees who participate in TFL. Requiring a formal enrollment would eliminate the need for such an assumption. More importantly, an enrollment process would enhance data integrity and improve benefits communication, allowing for a smoother coverage transition for retirees when their status changes from pre-Medicare to Medicare-eligible.

2. *Require the Defense Health Agency (DHA) to provide improved claims reporting for determining claim liabilities for the MERHCF.*

Claim detail reports received by OACT contain inconsistencies in reporting the date a service was incurred and when it was paid. These reports are relied upon for producing reasonable estimates of incurred claims as soon as possible for claim cost projections. An example of inconsistency is an initial report that shows $X incurred in June 2016 and paid in September 2016, but a subsequent report does not show the same figures. Subsequent reports should not have any changes in the historical data.

Another area of data challenges is with the reporting of expenditures on Prescription drugs by MERCHF members. With the increasing level of very high cost, specialty drugs and the allocation process for assigning Rx costs to the MERCHF for prescriptions filled through mail order or at the MFTs, the Board's ability to set claims costs and projected future Rx trends has been challenged by data gaps. OACT has made efforts to coordinate with components of DoD charged with the management of Rx drug spending, but has had limited success in gleaning additional data,

3. *Require that future TRICARE vendor contracts stipulate reporting of collected enrollment fees*.

Currently enrollment fees (for plans that have them) are collected by the plan vendors. Under the latest set of contracts, it is problematic to track these fees as they are kept by the vendors as a supplement to administrative fees paid per the terms of their administrative fee contract. This makes it difficult to have a true picture of the cost to administer the program when some fees are not directly reported.

4. *Coordinate with OACT when making data system changes in response to TRICARE program benefit changes.*

It would be beneficial to work with OACT whenever benefit changes are made to the TRICARE program to ensure that collected data is adequate to continue reasonable estimates of future costs. For example, the Defense Manpower Data Center should add fields to the Defense Enrollment Eligibility System (DEERS) that track USFHP members who are grandfathered under the prior eligibility rules. This will allow OACT to better estimate future enrollment in USFHP.

Role of the Board

1. *Provide a supplemental report, if appropriate, with ongoing recommendations and program suggestions reflecting information gained during the annual MERHCF valuation process.*

The Board members, by definition, are experts in the field of medical benefits and the financial considerations of those benefits. In addition, OACT spends considerable hands-on time with the detailed mechanics of the TFL program. These resources could provide more valuable input to the retiree medical system than just the realm of the MERHCF valuation. The Board recommends that it, in conjunction with OACT, consider ways to reach a targeted audience outside of OACT regarding insights and suggestions for potential improvements to the DoD's retiree medical program. This may come in the form of a supplemental report or merely a copy of this Quadrennial Report to the Assistant Secretary of Defense for Health Affairs and/or a specific DoD department.

2. *Reduce the term length and amend qualification requirements for Board members.*

Statutory language enabling the MERHCF Board set the length of time Board members serve at fifteen years. This is a very long time for qualified actuaries to balance commitments to their primary employer during their working careers and to maintain qualification standards after retirement. The long time period may reduce the pool of qualified actuaries willing to make this commitment. The Board recommends that 10 U.S.C. § 1114 be amended to reduce Board terms to nine years, including a phase-in period as the term length is shifted to this shorter time period.

In addition, the current requirements state that a Board member must be a member of the Society of Actuaries. The Board suggests that the statutory language be further modified to allow *either* members of the Society of Actuaries or the American Academy of Actuaries. Many actuaries are members of both organizations, but some only maintain one membership – especially after retirement. Both organizations have criteria governing the requirements for qualification to practice and the pool of potential Board members would be expanded by recognizing both organizations.

3. Exempt the Board from DoD organizational reviews similar to the 2021 zero-based reviews of advisory boards within the DoD

The Board serves as a highly technical, apolitical advisory entity providing oversight intended to ensure appropriate recognition and funding for a key element of compensation provided to the retired veterans of the US Armed Forces. Its proper functioning depends on the efforts of a 3-person board that has historically been comprised of leading actuaries in the country who have performed in very senior roles in major health plans or consulting firms in the health care industry. As part-time federal employees, with limited time committed to the process, delays or impediments in performing its role in the typical annual cycle can severely challenge the Board's effectiveness. An example of this occurred in 2021 where the Board structure was reviewed for reauthorization under the zero-based review process. The reauthorization did not occur until June, leading to an extremely compressed time frame for the Board to perform its work and still meet the deadline for the public meeting required to approve methods and assumptions necessary for OACT to complete the annual valuation cycle. Worse, the delay caused the deferral of the appointment of the newest third member of the Board until December – meaning that only two Board members were tasked with the role usually performed by the full three-person Board. The compressed time frame and understaffed Board structure created a suboptimal process for review – which was further exacerbated by the global pandemic and the pandemic's direct impact on health care expenditures for the members of the MERCHF.

We respectfully recommend that the DoD avoid similar situations in the future to allow the Board to more effectively perform its designated role.

APPENDIX

Statutory References for the DoD Medicare-Eligible Retiree Health Care Board of Actuaries[18]

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10 U.S.C. § 1114. Board of Actuaries

(a)

(1) There is established in the Department of Defense a Department of Defense Medicare-Eligible Retiree Health Care Board of Actuaries (hereinafter in this chapter [10 USCS §§ 1111 et seq.] referred to as the "Board"). The Board shall consist of three members who shall be appointed by the Secretary of Defense from among qualified professional actuaries who are members of the Society of Actuaries.

(2) (A) Except as provided in subparagraph (B), the members of the Board shall serve for a term of 15 years, except that a member of the Board appointed to fill a vacancy occurring before the end of the term for which his predecessor was appointed shall only serve until the end of such term. A member may serve after the end of his term until his successor has taken office. A member of the Board may be removed by the Secretary of Defense for misconduct or failure to perform functions vested in the Board, and for no other reason.

(2) (B) Of the members of the Board who are first appointed under this paragraph, one each shall be appointed for terms ending five, ten, and 15 years, respectively, after the date of appointment, as designated by the Secretary of Defense at the time of appointment.

(3) A member of the Board who is not otherwise an employee of the United States is entitled to receive pay at the daily equivalent of the annual rate of basic pay of the highest rate of basic pay under the General Schedule of subchapter III of chapter 53 of title 5 [5 USCS §§ 5331 et seq.], for each day the member is engaged in the performance of duties vested in the Board, and is entitled to travel expenses, including a per diem allowance, in accordance with section 5703 of title 5.

(b) The Board shall report to the Secretary of Defense annually on the actuarial status of the Fund and shall furnish its advice and opinion on matters referred to it by the Secretary.

(c) The Board shall review valuations of the Fund under section 1115(c) of this title [10 USCS § 1115(c)] and shall report periodically, not less than once every four years, to the President and Congress on the status of the Fund. The Board shall include in such reports recommendations for such changes as in the Board's judgment are necessary to protect the public interest and maintain the Fund on a sound actuarial basis.

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[18] 10 U.S.C. §1114 is shown in its entirety; for the other sections in this appendix, only select subsections that reference the Board are shown.

10 U.S.C. § 1115. Determination of contributions to the Fund

(a) The Board shall determine the amount that is the present value (as of October 1, 2002) of future benefits payable from the Fund that are attributable to service in the participating uniformed services performed before October 1, 2002. That amount is the original unfunded liability of the Fund. The Board shall determine the period of time over which the original unfunded liability should be liquidated and shall determine an amortization schedule for the liquidation of such liability over that period. Contributions to the Fund for the liquidation of the original unfunded liability in accordance with such schedule shall be made as provided in section 1116 of this title [10 USCS § 1116].

(d) All determinations under this section shall be made using methods and assumptions approved by the Board of Actuaries (including assumptions of interest rates and medical inflation) and in accordance with generally accepted actuarial principles and practices.

10 U.S.C. § 1116. Payments into the Fund

(b) At the beginning of each fiscal year, the Secretary of Defense shall determine the sum of the following:

(1) The amount of the payment for that year under the amortization schedule determined by the Board of Actuaries under section 1115(a) of this title [10 USCS § 1115(a)] for the amortization of the original unfunded liability of the Fund.