

Accrual Funding for Military Retirement Health Care

Final Report

PR008R1

January 2001

Melvin R. Etheridge, Jr.
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The views, opinions, and findings contained in this report are those of LMI and should not be construed as an official agency position, policy, or decision, unless so designated by other official documentation.

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Executive Summary

The National Defense Authorization Act for Fiscal Year 2001 expanded DoD health care benefits for Medicare-eligible military retirees and their dependents and survivors. The Act also established the Medicare-Eligible Retiree Health Care Fund (MERHCF), which will start October 1, 2002.

Specifically, the Act removed the exclusion of Medicare-eligible beneficiaries from the Tricare program; made Tricare responsible for payment of Medicare deductibles and co-payments; and extended eligibility for the National Mail Order Pharmacy (NMOP) to Medicare-eligible beneficiaries nationwide.

This report presents Logistics Management Institute's findings, conclusions, and recommendations on major financial issues regarding the concepts, establishment, management, operation, and oversight of the MERHCF. One of LMI's guiding precepts was that agencies and commands that expend funds for Medicare-eligible health care should be paid for their actual costs of delivering the benefit. Therefore, we recommend that the fund reimburse military treatment facilities for their operating costs and the Service accounts for military personnel, procurement, and military construction costs.

The MERHCF will pay for the retiree health care benefit just as the Military Retirement Fund (MRF) pays the military pension. The MRF has been running smoothly since 1985. Therefore, we recommend that the MERHCF use the same organizational structure and relationships as that for the MRF. We also recommend that DoD propose legislation to shift the DoD deposits into the MERHCF from the Defense Health Program to the military personnel accounts, which is where the MRF deposits are found. This change will better align the cost of the retirement health care benefit with the true cost of military labor.

Because the MERHCF is simply a different method for DoD to fund the benefit there is no reason for a large infrastructure to develop and process individual bills for each episode of covered health care. Instead, the Defense Health Program should collect and retain sufficient documentation to justify a consolidated request for a withdrawal of funds.

The method used to calculate withdrawals from the fund to pay for health care is critical to all other operations. We recognize that the changes in DoD health care benefits for Medicare-eligible beneficiaries make initial estimates of the costs of their care uncertain. During the first years of fund operation, we recommend these calculations be based on a proportion of actual operating costs determined by the level of effort devoted to Medicare-eligible beneficiaries. This approach will overcome the uncertainty in forecasting costs and help to ensure that fixed costs can be met.

After this initial transition period, we recommend that withdrawal calculations use variations of current third-party collection rates that are now used to charge other agencies and civilian health insurers for beneficiaries' care. Current third-party collection rates are based on averages over broad categories that are not Service-specific. More specific rate schedules will be necessary for each Service.

As the Act is written currently, MERHCF funds benefit only Medicare-eligible beneficiaries. We believe there are compelling arguments to extend coverage to all military retirees and their dependents and survivors. This extension would make funding for retirement benefits consistent across all categories of retirees. It would provide the same stable funding and institutionalization of the benefit to non-Medicare-eligible beneficiaries that Medicare-eligible beneficiaries enjoy. It would also lead to more accurate representation of military labor costs and hence better manpower decision-making.

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Chapter 1

Introduction

The Department of Defense Office of the Actuary (OOA) requested that Logistics Management Institute (LMI) provide an independent analysis of accrual funding for the military retirement health care benefit. During the course of the task, Congress passed the National Defense Authorization Act for Fiscal Year 2001 (H.R. 5408), which expanded the DoD health care benefit for Medicare-eligible military retirees and established a trust fund—the Medicare-Eligible Retiree Health Care Fund (MERHCF, or “the fund”)—to finance the expanded coverage for these beneficiaries on an accrual basis.

Because the scope of the task changed, LMI’s focus changed to how to implement and operate accrual funding for Medicare-eligible military retirees and their dependents and survivors. We also addressed the desirability and feasibility of extending the trust fund coverage to all military retirees.

In this report, we present our findings, conclusions, and recommendations on major financial issues concerning the concepts, establishment, management, operation, and oversight of the MERHCF. Because DoD has yet to identify the total scope and parameters for the newly expanded benefit for Medicare-eligible military retirees, we do not address those issues. An example of an unresolved issue is whether the fund will pay only for health care delivered under Medicare, or if it also will pay for care delivered in military medical treatment facilities (MTFs).

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2001

Before passage of the National Defense Authorization Act for FY2001, military service members and retirees apparently perceived an erosion in the availability of health care for Medicare-eligible beneficiaries in MTFs when they were not eligible to participate in the Tricare program. The Act expanded DoD health care benefits for Medicare-eligible military retirees and their dependents and survivors. The Act provides the following changes:

- ◆ Removes the exclusion of Medicare-eligible beneficiaries from the Tricare program;
- ◆ Makes Tricare responsible for payment of Medicare deductibles and co-payments; and

- ◆ Extends eligibility for the National Mail Order Pharmacy (NMOP) to Medicare-eligible beneficiaries nationwide.

The Act also established the MERHCF to fund the expanded benefit on an accrual basis, ensuring the availability of funds to pay for the expanded benefit. The Act directs that the MERHCF is established on sound actuarial techniques and functions under the guidance of the DoD Medicare-Eligible Retiree Health Care Board of Actuaries.¹ Congress directed that the Department of the Treasury administer the fund. We anticipate that the Bureau of the Public Debt (BPD) will carry out these responsibilities.

Federal appropriations and interest on the fund's investments will finance the MERHCF—either to amortize the accrued liability or to pay for benefits as they are earned by current service members. Although the fund's assets are held in trust to fund military retiree health care, these funds are assets of the federal government and do not belong to the beneficiaries themselves.

REPORT ORGANIZATION

We have organized our report into nine chapters and five appendixes. Chapter 2 discusses the issues surrounding the implementation of accrual funding and establishing the MERHCF. Chapter 3 presents different options for calculating MERHCF withdrawals. Chapter 4 presents options for disbursing the withdrawals to different recipients. Chapter 5 contains the methodology for calculating MERHCF deposits. Chapter 6 explains the budget building process under accrual funding. Chapter 7 describes considerations for managing and operating the MERHCF. Chapter 8 presents the rationale for extending the coverage of the MERHCF to all military retirees. In Chapter 9, we summarize our findings and recommendations.

Appendix A contains a detailed description of federal trust funds and their operations. Appendix B contains examples of third party collection payment and maximum allowable payment calculations under Tricare and Medicare and a discussion of Medicare payments for care delivered in MTFs. Appendix C documents the Medicare program experience with fee-for-service and capitation payments. Appendix D contains the text of Section 713 of the National Defense Authorization Act for Fiscal Year 2001. This is the section that expands the benefit and establishes the MERHCF. Appendix E contains the definitions of the abbreviations we used in this report.

¹ DoD has three actuary boards. The DoD Retirement Board of Actuaries guides how the military pension, which is funded by the Military Retirement Fund, is calculated. The DoD Education Board of Actuaries guides administration of the DoD Education Fund (VA benefits). The DoD Medicare-Eligible Retiree Health Care Board of Actuaries guides how the cost of retirement health care (the subject of this report) is calculated. In this report, references to the "Board of Actuaries" pertain to the Medicare-Eligible Retiree Health Care Board of Actuaries unless noted otherwise.

ACCRUAL FUNDING OPERATION OVERVIEW

Federal accrual accounting requirements were released recently as working drafts.² The MERHCF should follow all accounting practices in the final version of these requirements.

Under accrual funding, money is deposited by DoD into the MERHCF as military service members earn their retirement benefits. Money will be withdrawn from the MERHCF to pay DoD's cost for health care as the benefit is delivered to Medicare-eligible military retirees. As with many financial processes in the federal government accrual funding is continuous, with past experience used to plan future budgets.

Funds withdrawn from the MERHCF will be disbursed to appropriate DoD agencies to pay or reimburse them for the care they deliver. These agencies will use these costs to build their budgets for the succeeding budget year. Simultaneously, the actuaries of the OOA will use the withdrawals to calculate deposits required for the coming year, which will become part of the budgets for DoD and the Treasury Department. As the budget is executed, deposits are invested by fund managers in U.S. Treasury securities. Securities are redeemed to generate funds to be disbursed to DoD.

ASSUMPTIONS AND PRECEPTS

Following are the assumptions we make in this report:

- ◆ The reader generally is familiar with the military retirement health care benefit and how it is earned, as well as with the concepts of accrual funding.
- ◆ The MERHCF will pay DoD's cost for care delivered by civilian providers as well as care provided through military MTFs; however, our recommendations accommodate a decision to only pay for care in the civilian sector.
- ◆ Current legislative language that requires the fund to pay for retirement health care for non-DoD uniformed retirees (Coast Guard, National Oceanographic and Atmospheric Administration, Uniformed Public Health Service) will be repealed, so that the fund is responsible for DoD military retirees only. If this repeal does not occur, the operating procedures we discuss remain applicable, although additional actuarial data will be required for those populations.

² Standard General Ledger and Policy Branch, Fiscal Standards and Reporting Division, Department of the Treasury, *Trust Fund Accounting Guide* (draft), 1 June 2000.

Following are the precepts we apply in this report:

- ◆ A strong case can be made to extend accrual funding to the entire military retiree community. We make that case in Chapter 8. Thus, any decisions made now with regard to the Medicare-eligible segment of this community should allow for this eventuality.
- ◆ The MERHCF solely and completely will pay the DoD-funded portion of the retirement health care benefit for Medicare-eligible military retirees and their dependents and survivors.
- ◆ Under accrual financing, the Defense Health Program (DHP) will have the dual objectives of increasing the availability of health care to Medicare-eligible beneficiaries and controlling health care costs.
- ◆ The MERHCF should pay the actual costs of care spent by agencies and commands to provide health care to Medicare-eligible beneficiaries. The fund should not pay when actual money is not spent (e.g., depreciation, unfunded retirement benefits).

Chapter 2

Implementing Accrual Funding for Military Retirement Health Care

This chapter discusses how DoD and other agencies can implement accrual funding for military retirement health care within the constraints and requirements of the language of the National Defense Authorization Act for Fiscal Year 2001, which established the MERHCF. Implementation will entail several processes.

The first process will develop the organization for accrual funding. This process will identify agencies within DoD, the Department of the Treasury, and elsewhere that have a role in accrual funding. As this process progresses, it will identify these agencies' accrual funding roles and responsibilities and interagency relationships.

The second process develops the operational procedures and functions of accrual funding. This process first identifies operational issues that must be resolved before accrual funding can start, then proceeds to develop the body of documentation that provides the framework for MERHCF operations. This documentation includes interagency memoranda of agreement, regulations, instructions, and system definitions.

Subsequent chapters discuss the operational issues of the first phase of the second process. This chapter concentrates on the first process. As background, we first discuss some of the requirements placed on federal trust funds.

FISCAL REGULATIONS AND OVERSIGHT REQUIRED OF FEDERAL TRUST FUNDS

This section specifically explains the types of stewardship activities that are required to safeguard special funding, including trust fund activity.

Congressional Statutory Requirements for Fund Management and Fiscal Responsibility

Over the past 20 years, Congressional legislation has increasingly redefined and enhanced the fiscal responsibilities of all federal missions and federal program

managers. Major statutory requirements in fiscal stewardship and responsibility include the following:

- ◆ *The Inspector General Act* (P.L. 95-452, as amended) provides for independent performance reviews, financial audits, and compliance audits of agency mission-oriented programs, financial operations, and special funds (trust funds, industrial funds, etc.).
- ◆ *The Federal Managers' Financial Integrity Act of 1982* (P.L. 97-255, as amended) establishes specific requirements for fiscal responsibility in the management of major programs, appropriations, and special funds (e.g., trust funds, industrial funds, business activities, credit management and insurance funds), including management controls and internal control systems and reviews.
- ◆ *The Chief Financial Officers Act of 1990* (P.L. 101-576)—codified in Title 31 of the United States Code (U.S.C.), section 901(b), 3515—requires the preparation and auditing of financial statements. This statute includes a requirement for an auditor's report (by the inspector general [IG] or by an independent certified public accounting firm under the oversight of the IG) on internal controls and compliance with the laws and regulations under which a trust fund was established.
- ◆ *The Government Performance and Results Act* (P.L. 103-62) calls for federal agencies to develop plans for major missions/funds that are integrated into the budget process, the operational management of their programs, and accountability reporting to the public on performance results. As stated in the Act, this reporting is to include "the integrity, efficiency, and effectiveness with which they are achieved."

After federal trust funds are established by Congress, they assume fiscal and stewardship responsibility for an asset that belongs to other parties or assets that—though owned by the federal government—are "set aside" for the benefit of a specific group identified by the fund's enabling legislation. As such, fiscal stewardship responsibility for the management of trust funds is to be exercised in the most effective manner possible.

These statutes are codified into the United States Codes (U.S.C.); where appropriate, the legislation and the U.S.C. citation are presented in this report.

Executive Branch Requirements for Program and Fund Management Fiscal Responsibility

In the executive branch, these statutes have been implemented through Office of Management and Budget (OMB) and Department of the Treasury regulations. Trustees who oversee the management and maintenance of the trust usually employ all of the management control regulations and financial security practices

prescribed by fiscal regulatory functions such as OMB, the Joint Financial Management Improvement Program, the Department of the Treasury, and the Office of Personnel Management (OPM).

The MERHCF should have a board of trustees that is responsible for the stewardship of the fund; this board should be separate from the organizations that provide services to it. These organizations include BPD, the Department of the Treasury, the Defense Finance and Accounting Service (DFAS), and DHP. Placement of this independent board within the Office of the Secretary of Defense (OSD) is an important requirement to ensure the fund's independence and objectivity.

Other DoD funds, such as the MRF, do not have boards of trustees. Other funds within the Federal government do have such boards, however. The difference between the MERHCF and the MRF is that the military pension benefit is much better defined, and the benefit is paid directly to the recipient. By contrast, the definition of the retirement medical benefit will change with time, and the withdrawals will be paid back to DoD. Without implying malfeasance on the part of DoD, we believe that it is important to ensure that there is not even the perception of an opportunity for DoD to take advantage of the trust fund. Ensuring this level of trust will be the role of the Board of Trustees.

The following major management and control regulations implement the aforementioned legislation and prescribe financial practices:

- ◆ Management and internal control reviews and resource management requirements:
 - OMB Circular A-123: *Internal Control Systems*
 - OMB Circular A-127: *Financial Management System*
 - OMB Circular A-130: *Management of Federal Information Resources*
- ◆ Independent financial and compliance audit requirements
- ◆ Treasury Department and Federal Accounting Standards Advisory Board (FASAB) accounting regulations and compliance guidance
- ◆ Program and mission compliance reviews.

We discuss these regulations in detail in Chapter 7 of this report.

ACCRUAL FUNDING ORGANIZATION

Federal agencies that have a role in the accrual funding of military retirement health care include the following:

- ◆ DoD
- ◆ Department of the Treasury
- ◆ OMB
- ◆ Congress
- ◆ General Accounting Office (GAO).

Legislative Direction

The National Defense Authorization Act for Fiscal Year 2001 established the MERHCF to fund the health care that DoD provides to Medicare-eligible military retirees and their dependents and survivors. The Act contains specific direction regarding specific agencies:

- ◆ Secretary of the Treasury/Department of the Treasury:
 - Administer the MERHCF.
 - At the beginning of the fiscal year, pay into the fund from the General Fund of the Treasury the amortization of the
 - original unfunded liability, and
 - cumulative unfunded liability resulting from changes in benefits and/or actuarial gains or losses.
 - Invest any portion of the fund that is not required for current withdrawals in public debt securities.
- ◆ Secretary of Defense:
 - Annually determine the total amount of DoD contributions to be made to the fund during the fiscal year.
 - Not less than every 4 years, carry out an actuarial valuation of the fund.
 - Keep records necessary for determining the actuarial status of the fund.

- Pay into the fund monthly the DoD contribution to the fund, representing the present value of benefits earned by current service members during that month (the *normal cost*).
- Determine and certify the amortization payment for the Secretary of the Treasury.
- ◆ DoD Medicare-Eligible Retiree Health Care Board of Actuaries:
 - Report to the Secretary of Defense annually on the actuarial status of the fund.
 - Report not less than once every 4 years to the President and Congress on the status of the fund.
 - Determine the original unfunded liability of the fund and a schedule to amortize it.
 - Set the methods and assumptions (including assumptions about interest rates and medical inflation) used to determine the Treasury's and DoD's contributions to the fund.

Relationship to the Military Retirement Fund

The MRF is a trust fund that pays the pensions of retired military service members. The purpose of the MRF is very similar to that of the MERHCF. The MRF has been operating since 1985; the operation appears to be smooth, with stable organizational responsibilities and relationships.

For the MRF, the OOA, acting under the recommendations and guidance of the DoD Retirement Board of Actuaries (not to be confused with the DoD Medicare-Eligible Retiree Health Care Board of Actuaries for the MERHCF), develops annual funding estimates for the MRF and publishes supporting documentation. The Department of the Treasury makes amortization payments for the unfunded liability and actuarial gains and losses. The Services make monthly normal cost payments to DFAS, which selects securities for investment and transfers the funds to BPD. BPD receives the payments and invests them as directed by DFAS. Concurrently, DFAS determines the funding required to make monthly pension payments and selects securities for disinvestment. BPD disinvests the securities as directed by DFAS and transfers the funds generated to DFAS. DFAS then disburses the money to military retirees.

We must acknowledge that the cost of the MRF benefit (i.e., the military pension) is much more stable than the cost of health care for Medicare-eligible beneficiaries. An individual military retiree's pension is determined at the time he or she retires. The only variables are future cost-of-living increases and how long the pension will be paid.

The cost of health care for Medicare-eligible beneficiaries is volatile in comparison. Aside from the variables of longevity and inflation, health care costs are driven by availability of MTF space, demand for different categories of DoD health care, and the cost growth of health care in relation to the general inflation rate.

We recommend that, absent a compelling rationale otherwise, the procedures and organizational relationships and responsibilities that apply to the MRF should be adopted for the MERHCF.

Organizational Roles, Responsibilities, and Relationships

In general, we find no reason that the MERHCF should function any differently than the MRF. We have the following recommendations:

- ◆ The OOA, under the guidance of the DoD Medicare-Eligible Retiree Health Care Board of Actuaries, should provide actuarial estimates and valuations.
- ◆ DFAS should provide all financial and accounting services and manage the MERHCF by
 - transferring funds to BPD for normal cost deposits,
 - collecting requests for funds transfer and other data from the DHP claimants and consolidating them into a single funding request to BPD,
 - disbursing funds received from BPD to the DHP and others claimants, and
 - selecting securities for investment and disinvestment.
- ◆ BPD should administer investment and disinvestment, receiving payments and transferring funds generated.

MERHCF operations will differ from those of the MRF because of the role of the DHP agencies and commands. Specifically, these agencies and commands will collect, maintain, and retain data necessary to accurately estimate the current cost of health care delivered by DoD to Medicare-eligible beneficiaries. These data will be furnished to the OOA for its calculations. DHP components also will receive and further disburse, as necessary, funds received from the MERHCF.

The DoD IG and the GAO will be responsible for reviewing and auditing the fund and its operation. A completely independent board of trustees, including the Secretaries of Defense and Treasury as well as other members that may be appointed by the President, should review and oversee the management and operation of the

MERHCF. (We detail the reporting and internal control requirement of all participants in Chapter 7.)

Details regarding these roles, responsibilities, and relationships require decisions regarding withdrawal calculation methods and payment procedures. We discuss these issues in subsequent chapters of this report. Once final decisions have been made, the roles, responsibilities, and relationships should be formalized with appropriate letters or memoranda of agreement.

IMPACT ON OTHER FEDERAL AGENCIES AND HEALTH CARE PROGRAMS

We do not believe that establishing the MERHCF, by itself, will have an impact on any other federal agency in terms of health care programs or budget. The MERHCF, after all, is simply an alternative method of funding the benefit. DoD pays for the benefit now and will do so in the future.

What will affect other agencies and programs is the increase in the benefit—specifically, making Tricare a secondary payer to Medicare. This arrangement makes the Medicare benefit free to military retirees except for their Medicare Part B enrollment fee. As such, this arrangement logically will increase demand for Medicare-paid health care. If this increase occurs, it will increase costs to the Medicare Trust Fund and the general revenues that fund the benefit. It might decrease the costs to DoD if sufficient numbers of patients who currently receive care in MTFs (100 percent of which is paid by DoD) migrate to Medicare (where only 20 percent of the cost will be paid by DoD).

USING THE MERHCF TO PROVIDE ECONOMIC INCENTIVES TO DHP

Recent legislation establishing the MERHCF and expanding the military retirement health care benefit is the latest major initiative to improve health care for the military retiree population that is eligible for Medicare. This new entitlement comes at a time when DHP is undertaking significant initiatives to improve health care for all of its beneficiaries.

The primary implication that establishment of the MERHCF has for DHP and for current and future Medicare-eligible beneficiaries is the assurance of stable funding that a trust fund provides and the elevation of military retirement health care to the status of an entitlement. Of much greater import is the expansion of the retirement health care benefit to make Tricare a secondary payer to Medicare for civilian health care and the extension of Tricare eligibility to Medicare-eligible beneficiaries. At this point, nobody knows how these developments will affect the demand by this group for care from direct and purchased care systems.

DHP operates several teaching hospitals. These major medical centers provide graduate medical education (GME) to health care professionals. This GME is vital to maintain an experienced, stable cadre of military medical professionals. This community is a critical component not only of health care delivery but also military readiness. To provide this GME, a sufficient supply of patients is necessary. Because older people need more medical care than younger ones (particularly active military personnel), DHP has a requirement for some number of Medicare-eligible patients. In fact, MTFs have always treated Medicare-eligible beneficiaries on a space-available basis.

One of the concerns of DHP managers is that Medicare-eligible beneficiaries will migrate from MTFs, particularly GME hospitals, to more convenient civilian care that is paid primarily by Medicare (because it will be virtually free). Without enough patients, the GME function will suffer—in turn degrading the personnel management of the military medical community. Conversely, there also is a concern that Medicare-eligible beneficiaries will demand care at smaller MTFs that do not have the capacity or facilities to provide it.

The MERHCF provides the opportunity to use economic incentives to elicit behavior on the part of MTF managers to achieve a desired systemwide outcome.

Current Initiatives

There are several current initiatives to improve the delivery of health care within DHP. One is the Military Healthcare System (MHS) Optimization Plan.¹ This plan aims, among other things, to “optimize the health of MHS beneficiaries by providing the best value health services using best clinical and business practices.”² A related initiative is the emphasis by senior leadership in the Tricare Management Activity (TMA) on optimization to increase beneficiaries’ access to care in MTFs.³

The MHS Optimization Plan is reengineering components of the MHS to improve force health and protection and population health. In that regard, one goal is to fully optimize clinical outcomes across the MHS. Improved demand management that stresses prevention and wellness programs, increased productivity of support providers, and greater availability of providers and staff can result in increased capacity, increased enrollment, and decreased costs.⁴ Tricare leadership regards optimization as the bedrock of Tricare success.⁵ One of the five imperatives for

¹ Military Healthcare System Optimization Plan Update, Tricare Conference 2000, January 31–February 3, 2000.

² Ibid.

³ H. James T. Sears, “Plain Talk about TRICARE: ‘Optimization—What’s it all about?’” November 1, 2000. Available at <<http://www.tricare.osd.mil/tricare/beneficiary/plaintalk1000.htm>>.

⁴ Military Healthcare System Optimization Plan Update.

⁵ H. James T. Sears, “TRICARE Grand Rounds: ‘Optimization—The bedrock of our success,’” November 1, 2000. Available at <<http://www.tricare.osd.mil/tricare/beneficiary/grandrounds1000.htm>>.

Tricare is to optimize MTF capacity and recapture care. According to James Sears, Tricare Executive Director,

We have to make full use of the capacity in our military treatment facilities. This means offering a broad spectrum of services and the highest quality care...we must provide managed care instead of episodic care, and efficiently manage our health care resources.⁶

Some Economic Incentives for MTF Managers

Establishment of the MERHCF and expansion of the military retirement health care benefit offer opportunities and challenges for achieving optimization goals set by DHP and Tricare leadership. Clearly, realization of those goals will depend on efficient and effective management of delivered health care at the facility level—particularly to keep, if not expand, the Medicare-eligible patient load.

We considered two systemwide goals that economic incentives could help to achieve: to control the costs of health care and to increase the amount of health care delivered to Medicare-eligible beneficiaries. The following discussion covers economic incentives that may help achieve these goals.

Using reimbursements to MTFs for the care they deliver to Medicare-eligible patients provides a vehicle to encourage a variety of outcomes. Varying the reimbursement rate can encourage or discourage provision of care to Medicare-eligible beneficiaries. The rate-setting methodology we present in Chapter 3 is revenue-neutral and based on average performance. If the reimbursement is set below the variable costs of providing the care, for example, MTFs would be encouraged *not* to provide the care. Rates can be varied between different categories of MTFs to encourage GME MTFs to bring in the older patients they need to support the teaching function.

TMA should set rates with the approval of the Assistant Secretary of Defense (ASD) (Health Affairs) to encourage MTF behavior that is consistent with systemwide goals. This mechanism is flexible in that TMA can vary the rate structure to adjust to changes over time to systemwide goals.

MTFs ALLOWED TO RETAIN EXCESS PAYMENTS

If MTFs are paid for the care they deliver on the basis of a rate schedule, they should be allowed to retain any difference between the revenues they receive and the cost of the care they deliver. This arrangement gives MTFs an incentive to control costs, thereby increasing their profit margin. It also provides an incentive to increase access to Medicare-eligible beneficiaries if care delivered to non-Medicare-eligible beneficiaries comes from a fixed budget. Because the

⁶ "TRICARE Director's 'Imperatives' Provide Strategies for Success," March 29, 1999, No. 99-9/P6. Available at <<http://www.tricare.osd.mil>> (search on "Imperatives").

MERHCF payment is the only variable source of profit, MTF management will be encouraged to increase access to Medicare-eligible beneficiaries as long as there is a positive net difference between fees and costs.

ADJUSTED RATES

The underlying premise of health maintenance organizations (HMOs) is that preventive medicine is cheaper than diagnostic medicine—that is, a flu shot is cheaper than treating a case of the flu. Thus, one approach to controlling costs would be to encourage MTF managers to aggressively pursue a program of preventive medicine. One way would be to increase the profit margin for preventive procedures. This strategy also recognizes that the MTF is making money by delivering care; without adjusting rates in favor of preventive medicine, there is an incentive for MTF managers to concentrate on diagnostic medicine because that is where the money is.

At this writing, some uncertainty exists among DHP managers regarding the exact nature of health care that is covered by Tricare as a secondary payer to Medicare portion of the expanded retirement health care benefit. Specifically, there are preventive and wellness measures available in the MTF that are not covered under Medicare. If a goal is to increase the care delivered to Medicare-eligible beneficiaries, emphasizing the expanded benefits available at an MTF might provide an incentive for beneficiaries to use direct care instead of purchased care.

This approach would reward MTF managers for operating effective outreach programs to underserved members over 65, some of whom may be beyond the 40-mile catchment area of an MTF. Such programs could increase enrollment of Tricare beneficiaries who would partake of programs that promote population health. For example, the Medical Outreach Program of Tricare Region 6 sent medical transport teams to underserved medical clinics and hospitals via operational support aircraft. Between December 1994 and April 1996, the total costs avoided from this program exceeded \$377,850.⁷

TRANSITIONING TO ACCRUAL FUNDING

The change in the DoD health care benefit for Medicare-eligible beneficiaries increases the uncertainty of resource requirement predictions within DHP. This uncertainty will be felt most keenly within the direct care system. Errors in forecasts for Medicare-eligible care in the purchased care system will only affect the way contract overhead and administrative costs are distributed across the claims. In the direct care system, if forecasts significantly underestimate the demand for care there might not be sufficient capacity to meet the demand. Conversely, if the new benefit results in a major migration of caseload to the civilian sector, MTFs may not have the resources to meet their fixed costs—particularly if the MERHCF is

⁷ “Moving Region 6 toward a successful transition to the 21st Century is a top priority,” TRICARE Southwest Online. Available at <<http://www.tricaresw.af.mil/brochure.html>>.

billed only for the cost of the care actually delivered to Medicare-eligible beneficiaries.

One proposal to alleviate this dilemma is to provide a guaranteed level of funding for the first few years of trust fund operations, until trends in the demand for care become apparent. This strategy poses the problem of reconciling the payment from the MERHCF with the actual cost of care delivered. If the cost of care was greater than the withdrawal, the fund would owe the appropriated accounts the difference. Presumably this amount could be repaid at the beginning of the next fiscal year, although there may be some question regarding which commands would get the reimbursement. More important, if the actual cost of care was significantly less than the payment, the implication would be that the MERHCF paid for care delivered to non-Medicare-eligible beneficiaries, whose care is supposed to be funded by appropriations.

A better approach would be to determine the withdrawals from the trust fund on the basis of the proportion of actual operating costs as determined by the level of effort allocated to Medicare-eligible beneficiaries. If there is a significant decrease in care delivered to this segment, a greater proportion of direct care fixed costs would have to be borne by appropriations. If necessary, this approach would justify a request for supplemental appropriations to make up the shortfall.

Chapter 3

Calculating Trust Fund Withdrawals

As we note in Chapter 1, the accrual funding process is circular: Withdrawals from the MERHCF are used to fund the delivery of health care, and the cost of the health care delivered is used to calculate future years' withdrawals. To describe the entire process, we pick a point on the circle from which to start calculating trust fund withdrawals.

Trust fund withdrawals will be used to pay for retirement health care. There are several different ways the MERHCF could do this. The options that we present and our recommendations are based on the following principles:

- ◆ The fund will pay only for the actual costs of health care benefits of Medicare-eligible retirees, their dependents, and their eligible survivors. Payment from the fund will not be used for any other purpose.
- ◆ The fund will fully pay for covered health care benefits.

DHP uses two methods to provide health care: directly, through the system of MTFs, and by purchasing care in the civilian market. Because these two methods are funded in very different ways, the withdrawal calculations for each method are different and independent. This independence has the advantage that calculations for purchased care do not rely on those for direct care; thus, if DoD decides not to fund direct care for Medicare-eligible beneficiaries from the MERHCF, the Department can still use our methodology to calculate withdrawals for purchased care.

CALCULATING FUND WITHDRAWALS FOR PURCHASED CARE

DHP purchased care consists of the following programs:

- ◆ *Tricare Prime, Tricare Extra, and Tricare Standard.* This program of care is delivered by civilian providers and managed by regional contractors. It provides inpatient, ambulatory, and pharmacy benefits. Tricare Prime is an HMO operation that uses networks of providers set up by the regional contractors. Tricare Extra operates like a preferred provider organization (PPO), using the contractors' provider networks. Tricare Standard is a fee-for-service (FFS) option. At this writing, Medicare-eligible beneficiaries cannot participate in any of the Tricare options. The National Defense

Authorization Act for Fiscal Year 2001 extended eligibility for Tricare to all Medicare-eligible beneficiaries, effective October 1, 2001.

- ◆ *National Mail Order Pharmacy.* Under this program, eligible beneficiaries can have their prescriptions filled by mail. At this writing, only a limited number of Medicare-eligible beneficiaries can participate in the program. The National Defense Authorization Act for Fiscal Year 2001 extended eligibility for the NMOP to all Medicare-eligible beneficiaries, effective April 1, 2001.
- ◆ *Uniformed Services Family Health Program (USFHP).* The USFHP is an HMO operation that is run by not-for-profit contractors in former U.S. Public Health Service (PHS) hospitals in select areas of the continental United States (CONUS). This program is open to Medicare-eligible beneficiaries.
- ◆ *Tricare as a secondary payer to Medicare.* The National Defense Authorization Act for Fiscal Year 2001 made Tricare a secondary payer to Medicare, effective October 1, 2001. This arrangement is a new program under Tricare. The DHP interprets this benefit as paying up to the Tricare maximum allowable, less what Medicare pays. A provider will bill Medicare first, and Tricare will pay whatever remains. The beneficiary will pay only the Medicare Part B enrollment fee.

Each incident of purchased care delivery is documented in computer files maintained by DoD. Tricare health care and pharmacy costs are contained in files of Health Care Standard Records (HCSRs). DHP maintains files of prescriptions filled under the NMOP program and enrollees in the USFHP. All of these files contain data elements to identify the beneficiary (e.g., sponsor social security number, Defense Eligibility Enrollment System [DEERS] Dependent Data Suffix). They also contain data elements with the government's share of the health care cost or USFHP capitated cost.

Because Tricare will be a secondary payer to Medicare, we anticipate that claims made under this program will be documented, possibly using the HCSR that Tricare uses to document care delivered by Tricare regional contractors. DoD has not yet decided on a method to administer this program. We anticipate that the Department will contract with one or more fiscal intermediaries to pay claims. The fiscal intermediaries may be current Tricare regional contractors, who fill that role for Tricare purchased care; a single national contractor; or current Medicare fiscal intermediaries. As with current Tricare purchased care, proper administration of the program will require that claims for Medicare-eligible beneficiaries be maintained in a central location.

Determining the withdrawal from the MERHCF for purchased care is straightforward. For the purposes of this discussion, we call each record of purchased care a "claim," although this usage is not strictly accurate in cases such as the USFHP.

In addition to the direct costs of the health care delivered, some amount of indirect costs also will be covered by the fund. We recommend that the fund pay contract costs for fiscal intermediaries and other contractors; we recommend that government in-house costs be covered by appropriated funds. This arrangement is consistent with the way the federal government administers other trust funds—in particular, the MRF.

The direct costs of purchased care under a program should be appropriately “burdened” by a share of that program’s indirect costs. The proper method of allocating indirect costs can be determined on the basis of the individual contract line item and the method by which the contract bills the item. In general, these costs are a fixed amount per claim or a percentage of the direct costs of the claim. The former method is appropriate for administrative costs such as those associated with paying each claim (assuming that each claim requires approximately the same processing workload); elements such as profit or fee may be allocated more appropriately on a percentage basis. Different methods for allocating each contract line item may prove too complex, in which case a single method (fixed percentage or cost per claim) can be adopted.

Once system administrators have selected an allocation method, the amount of indirect costs to allocate to each individual claim is determined. For example, the total number of claims is divided into the total cost of fixed contract line items to determine a fixed amount per claim:

$$\text{Fixed Indirect Cost Allocation per Claim} = \frac{\sum \text{All Claims Payment Costs, etc.}}{\text{Total Number of Claims}}$$

The total of all direct health care costs is divided into the total cost of contract line items to be allocated as a percentage of claims costs:

$$\text{Indirect Cost Percentage} = \frac{\sum \text{All Contractor Overhead, Profit}}{\sum \text{All Claims Direct Costs}}.$$

This calculation then forms a relationship to determine the amount of indirect cost to allocate to an individual claim:

$$T = (1 + I)C + F,$$

where

T is the total cost (direct + indirect) for each claim,

I is the indirect cost percentage,

C is the claim direct cost, and

F is the fixed indirect cost allocation per claim.

This relationship is then programmed into the claims processing software and applied to each claim. The fund withdrawal is the sum of the total costs for claims under each purchased care program for Medicare-eligible beneficiaries.

CALCULATING FUND WITHDRAWALS FOR DIRECT CARE

The first decision in calculating MERCHF withdrawals to pay for direct care is which cost basis to use in computing the cost of the care delivered. Once the cost basis has been chosen, the method of allocating direct care costs between Medicare-eligible and non-Medicare-eligible beneficiaries can be chosen.

Direct Care Cost Bases

DHP tracks costs in the direct care sector using systems:

- ◆ *Budgets.* Budgets for MTFs and higher levels of DHP are used not only to plan future expenditures but also to track past actual spending. These data are subject to external audits and internal controls and hence are very reliable. Unfortunately, MTFs also engage in a wide variety of activities that do not involve delivering health care. These activities include military readiness, veterinary care, occupational safety, and environmental compliance support for host installations, among many others. Separating the costs of health care-related activities from those that do not support health care delivery often is very difficult with budget data.
- ◆ *Medical Expense and Performance Reporting System (MEPRS).* MEPRS is an MTF workcenter-based management information system. It tracks costs by seven major categories:
 - Inpatient care
 - Ambulatory care
 - Dental care
 - Ancillary services
 - Support services
 - Special programs
 - Medical (military) readiness.

The advantage of MEPRS is that it clearly displays health care and non-health care costs. Reconciling MEPRS with budget data is difficult, although the TMA is making improvements in this area through the MEPRS Improvement Group. In addition, because MEPRS is intended to support MTF management, it does not include certain cost elements, such as military construction and central headquarters support (medical commands, automatic data processing, and so forth).

Because MEPRS clearly displays health care costs broken down into inpatient and ambulatory care, we believe it is the best choice as a cost base for MTF operating and maintenance (O&M), locally managed equipment procurement and minor construction, and military personnel (MilPers) costs. Actual expenditures are more accurate for centrally managed equipment procurement and military construction (MilCon) costs.

Direct Care Cost Allocation Methods

There are several ways to calculate fund withdrawals to pay the costs of direct care provided to Medicare-eligible beneficiaries. The method ultimately chosen by DoD is critical because it will determine the costs that the Department pays—and thus drive deposit calculations. Changing the methodology after the fund is established will have significant repercussions not only on the annual normal cost but also on the size of the unfunded accrued liability. Changes in the latter could amount to tens of billions of dollars. Thus, the selection should receive due deliberation.

Another consideration in choosing a payment option for direct care is the way in which that care is funded by Congress and DoD. Individual MTFs pay only a portion of their total operating costs. The MTF budget covers consumables, building maintenance, government civilian employees and contractors, and minor capital expenses. Major construction and equipment purchases and military personnel costs are centrally funded by other agencies. As a result, withdrawals will be split to pay for MTF operating costs, major equipment procurement and construction costs, and military personnel costs.

PRICE-BASED DIRECT CARE WITHDRAWAL CALCULATIONS

The precepts listed in Chapter 1 preclude a price-based method (one that uses the price charged in the market place for the services delivered) for calculating withdrawals because market prices do not reflect the actual costs of care. Therefore, DHP cannot charge the fund on the basis of rate schedules such as those used by Medicare or Tricare regional contractors. If the rates charged did not cover total costs, either annual appropriated funds would make up the difference or the care delivered to Medicare-eligible beneficiaries would suffer. Conversely, if the rates overpaid the cost of care, the profit would go to purposes other than care delivered to eligible beneficiaries.

Another problem with externally generated rates would be deciding how the rate would be allocated between the agencies that actually pay the costs, since military personnel and major capital expenses are not funded by the MTF. Such an allocation is feasible using rates generated from within DHP but would be difficult with externally generated prices.

PROSPECTIVE OR RETROSPECTIVE WITHDRAWAL CALCULATIONS

The amount to be withdrawn from the fund to pay for benefits in a given period can be calculated before the period starts (prospectively) or after the period is over (retrospectively).

Prospective Withdrawal Calculations

Under a prospective scheme, the amount to be withdrawn would be estimated and the funds withdrawn and disbursed appropriately. The difficulty with this approach is that the cost of the health care delivered might not (and probably would not) equal the withdrawal. (This problem is analogous to that of price-based calculations.) DHP would then find itself either underfunded or overfunded. In the former case, DHP might be unable to deliver health care to eligible beneficiaries. In the latter case, it would have to reimburse the fund for the overpayment.

Either of these situations is unacceptable. The purpose of establishing the fund is to provide a stable funding source for health care benefits. A payment method that would impede the delivery of these benefits is contrary to that purpose. Likewise, overpayment would put the DHP in the position of having to find funds to repay the fund—possibly eroding health care for other, non-Medicare DHP beneficiaries.

Retrospective Withdrawal Calculations

In view of these problems, we recommend a retrospective approach to paying for retiree health care. In this case, the fund would reimburse DoD at the end of the period for the health care that DHP delivers to covered beneficiaries. DHP would record the health care it delivers to covered beneficiaries and then present a bill for reimbursement at the end of the period. A difficulty with this approach is that obligational authority must be available at the commands spending the money before payments can be made.

Using reimbursable obligational authority or a small working capital fund would provide a solution to this difficulty. A working capital fund would require an initial start-up payment from the trust fund that would be sufficient to cover all expected costs during the payment period, plus a generous safety factor. At the end of the period, the trust fund would replenish the working capital fund for the costs of health care actually delivered to covered beneficiaries. A better approach would be to use reimbursable obligational authority to provide bridge funding required to cover the period between expenditures and receipt of reimbursement

from the fund. This approach requires an estimate of the proportion of the total budget that will be required for Medicare-eligible health care.

WITHDRAWAL CALCULATION METHODS FOR MTF OPERATING COSTS

There are several different methods to calculate MERHCF withdrawals to cover MTF operating costs. We have rejected a price-based approach, for the reasons discussed above. Other methods include the following:

- ◆ *Capitation.* This approach pays a fixed fee for each beneficiary served by an MTF. These individuals typically are identified in one of several ways. The Tricare Prime program enrolls beneficiaries and assigns them to an MTF. Other beneficiaries are deemed to be within an MTF's *catchment area* if they live within 40 miles of the MTF. This somewhat arbitrary determination is the result of the requirement for such beneficiaries to obtain a statement on nonavailability from the MTF before receiving inpatient purchased care.

DoD is discussing plans to enroll all beneficiaries. Systemwide enrollment would not alleviate the problems of capitated funding. Utilization of MTFs would still vary between different beneficiary groups; hence, capitated rates would have to vary between MTFs, based on demographics and geographic distribution of beneficiaries. Nor would a systemwide enrollment plan address problems of paying for care that beneficiaries receive from MTFs other than their "home" MTF.

An alternative capitation approach would be to allocate total costs according to proportions of beneficiaries. This general approach could be further broken down. One subcategory would use the proportion of beneficiaries in the catchment area. The other subcategory would use the proportion of patients actually served by the MTF.

- ◆ *Level of effort.* This approach allocates MTF costs to Medicare-eligible and non-Medicare-eligible beneficiaries according to the relative amount of workload devoted to the two groups. MTFs use several different measures to track their workloads. Inpatient workloads are measured in inpatient relative weighted products (RWPs). These RWPs are derived from the primary diagnosis and the length of the patient's stay in the hospital. Ambulatory care is measured with two units. The older metric is the ambulatory workload unit (AWU), which varies according to the outpatient clinic (e.g., pediatrics, orthopedics). The newer unit is the ambulatory procedure grouping (APG), which varies according to the procedures performed and can accommodate up to five procedures per visit. We believe that the APG is a better measure of resources expended on a particular outpatient visit, although it is more complex to calculate. Outpatient prescriptions are assigned a *fillcost* value, which is the cost the government paid for the medication dispensed.

These workload units have no quantitative relationship to each other: An RWP does not correspond to a certain number of AWUs or APGs. This characteristic is critical with respect to using workload units for withdrawal calculations because it means that MTF costs must be divided into categories of care before workloads can be applied. This division can be done with MEPRS costs. Alternatively, budget costs can be allocated according to MEPRS proportions.

Each inpatient admission, ambulatory clinic visit, and outpatient prescription filled is assigned the appropriate workload. For RWPs and APGs, records are maintained centrally. Clinic visits and outpatient prescription data are kept by each MTF. DHP can be reimbursed by the fund on the basis of the proportion of total workload assigned to care delivered to Medicare-eligible beneficiaries.

- ◆ *Fee for service.* DHP charges non-DoD agencies and third-party insurers for care delivered to their members. These charges are derived from the procedures performed for inpatient care and the clinic visited for ambulatory care. This arrangement is analogous to the RWP and AWU workload measures. These fees have components that represent MTF operating and maintenance costs and pay for military personnel.

We discuss these methods in the following subsections.

Capitation

The advantage of capitation is its simplicity: The withdrawal is simply the number of Medicare-eligible beneficiaries multiplied by the cost per person. The primary disadvantage is that because capitation uses preset rates it is, in reality, a prospective payment method. The per capita cost is determined in advance, and DHP—and, ultimately, the MTF—receives money from the fund regardless of the amount of care that DHP delivers to these beneficiaries. This arrangement easily leads to the over- or underfunding situation of prospective payments. Other difficulties associated with capitation involve accurate rate-setting, determining the population actually served by an MTF, and reimbursing MTFs for care delivered to beneficiaries that are not in their catchment area. We recommend against using a capitation method to calculate trust fund withdrawals.

If DoD were to adopt a capitation method to calculate trust fund withdrawals to pay MTF operating costs, the Department could implement the method in several different ways. All of the methods would determine capitation rates on the basis of the number of Medicare-eligible beneficiaries who received care in a previous period as a proportion of the total number of beneficiaries in that period. The measurement period need not correspond to the period covered by the withdrawal. For example, the measurement period could be annual and the withdrawal period monthly. The more recent the measurement period, the more accurate the rates and the lower the risk of significant over- or underfunding.

Rates could be set at each MTF, regionally, by military Service (Army, Navy, Air Force), or for the entire DHP. The cost base would be the corresponding budget for MTF O&M, procurement (OP), and MilCon costs and the number of full-time equivalent (FTE) military personnel multiplied by the corresponding composite pay rates for MilPers costs. The simplest approach would be to set rates for the entire DHP and charge the fund accordingly. Service resource managers would have the responsibility to equitably disburse the funds withdrawn. Resource managers could adjust disbursements to allow for shifts in population and patient loads.

Capitation that uses the population served by an MTF has the problem of identifying the population actually served by an MTF. Unfortunately, the 40-mile limit may be too large for some patient categories and not large enough for other categories in identifying the population an MTF actually serves. A fully retired beneficiary (probably eligible for Medicare) might be more likely to take the time to drive a greater distance than a younger individual who is still employed and has to take time off from work to obtain medical care.

Capitation that is based on the relative proportion of beneficiaries actually served avoids this problem. This capitation approach probably is best. Like all capitation methodologies, however, it overlooks intensity of care in the name of simplicity. The per capita cost is the same regardless of how much care the individual actually receives. One can reasonably assume that older, Medicare-eligible beneficiaries would need more health care than younger, non-Medicare-eligible beneficiaries. As such, patients who need less care in effect subsidize the more expensive patients. In this case, the result would be that the trust fund would not pay the entire cost of Medicare-eligible health care because care for younger beneficiaries would be paid from appropriated funds.

Level of Effort

Using the level of effort delivered to Medicare-eligible beneficiaries to determine MERHCF withdrawals is the most flexible approach for determining MERHCF withdrawals. Reimbursement requests (bills) can be generated at any level, from the individual MTF up to DHP. The amount of the reimbursement/withdrawal is proportionate to the workload associated with the health care actually delivered to Medicare-eligible beneficiaries.

There are several potential cost bases for the reimbursement. One approach would be simply to reimburse on the actual expenditures. To reimburse MTFs for their O&M spending, total expenditures on inpatient care would be multiplied by the fraction of RWPs for Medicare-eligible beneficiaries to determine the reimbursement for inpatient care. Similarly, total ambulatory cost would be multiplied by the fraction of AWUs or APGs and total outpatient pharmacy cost by the fraction of fillcosts for eligible beneficiaries. The inpatient, ambulatory, and outpatient pharmacy reimbursements are then summed to determine the total O&M reimbursement.

Fee for Service

The advantages of using an FFS methodology to determine MERHCF withdrawals are that the methodology for making the calculations is already established and a billing infrastructure—albeit small—is in place at MTFs. There actually are three rate schedules, depending on who the patient is:

- ◆ *Third-party collection.* This rate schedule is used to bill third-party health insurance companies when a patient at an MTF is covered by insurance. This rate is fully burdened with all costs, including some intangibles. These intangibles include unfunded civilian pensions and capital depreciation.
- ◆ *Interagency.* This rate schedule is used to bill other government agencies for health care delivered in MTFs to their personnel—for example, the Department of Transportation for Coast Guard personnel. It includes all expenditures but excludes intangible costs.
- ◆ *International.* This schedule is used for foreign military personnel on duty in this country, usually for training. This rate is the Interagency rate less military personnel costs.

The TMA's Uniform Business Office (UBO) generates these rates for the coming year by building up from current MEPRS expenditures. The UBO adds civilian and military pay raises to those components, an asset use charge (depreciation), and inflation onto non-pay O&M and local procurement. There is a single DHP rate for ambulatory care. Outpatient pharmacy costs are not treated separately; they are embedded in the ambulatory care rates.

Inpatient rates are generated differently, using adjusted standardized amounts (ASAs). This methodology is comparable to that used by the Health Care Financing Administration (HCFA) for the Medicare program. The UBO places each MTF in one of three categories:

- ◆ Continental United States in large urban areas
- ◆ Continental United States in other urban or rural areas
- ◆ Overseas.

Many MTFs have GME programs for health care personnel. As a result, their operating costs are higher than those of nonteaching facilities. Additional costs associated with GME are deducted from each MTF's inpatient operating costs. A factor for regional differences in labor costs also is applied. The remaining operating costs and total RWPs for each MTF are then used to calculate an average cost per RWP in each of the three categories. This figure is then applied to the RWPs associated with each procedure to generate the ASAs. The regional labor factor is applied and GME costs are then added to the ASA to generate a rate

schedule for a particular MTF. The rates are based on the primary diagnosis, with allowance for unusual lengths of stay in the hospital for that diagnosis.

These rates can be used to determine the MERHCF withdrawal. The international rate schedule represents local MTF O&M and procurement expenditures.

Military Personnel Costs

MilPers costs are paid by agencies outside DHP: The Services' Military Personnel Commands. Moreover, by law the military pay appropriation must be fully funded in the budget submitted to Congress. MilPers represents a significant portion of the cost of direct care in DHP: 55 percent in FY98. This cost element cannot be ignored in computing the cost of the care for Medicare-eligible beneficiaries and hence MERHCF withdrawals.

When an MTF bills third-party insurers, the MTF is permitted to retain the entire amount collected—including the MilPers component—even though MTFs do not pay the costs of their military personnel. Because third-party collections represent a small portion of most MTFs' budgets, allowing them to retain the MilPers component is a reasonable way to provide an incentive for them to pursue collections aggressively. We believe that Medicare-eligible beneficiaries represent a greater portion of many MTFs' caseloads. Therefore, allowing MTFs to retain the MilPers component of the trust fund withdrawal is inappropriate, inasmuch as Congress will have appropriated funds to the Service's military personnel commands to pay these costs.

We are faced first with the methodology of calculating the magnitude of the MERHCF withdrawal for MilPers costs and second with the payment method. We discuss the former here and the latter in a subsequent section.

One approach would be to fund MilPers by using the level-of-effort ratios available from the most recent fiscal year when the budget is built. These ratios would be applied to the MilPers costs of the Future Years Defense Plan (FYDP) Program Eight, Medical commands for the coming year.¹ For simplicity, we recommend using the composite MilPers rates found elsewhere in the budget including accrual amounts for military retirement pay and retirement health care.²

¹ The FYDP is broken into major sections—called *programs*—by the type of force. For example, Program Two covers general purpose forces. Program Eight covers support forces, including medical forces. There are medical units in other Programs that support the forces in those programs; an example is the Medical Department aboard an aircraft carrier. We believe that the cost of these medical units is a part of the cost of the parent command and hence a sunk cost of that command's contribution to readiness. The trust fund should not reimburse readiness costs; hence, it should not fund the costs of these medical activities.

² The Services' military personnel commands budget and pay all military personnel costs. Therefore, MilPers costs displayed in the FYDP for individual commands such as MTFs are calculated amounts because the commands do not actually pay their MilPers costs. These calculated amounts use average, or composite, rates by pay grade that do not reflect the specialty pays, bonuses, housing allowances, and so forth of personnel actually assigned to the command. Because these costs are available and are widely used, we recommend their use for MERHCF withdrawals.

This approach presents the same risk as other prospective payment methods of over- or underfunding actual MilPers costs. It does, however, address the requirement for the budget to fully fund MilPers costs.

Another approach is to bill the trust fund at the end of the following year, using the MilPers component of the third-party collection rates including accrual amounts for military retirement pay and retirement health care, and apply the withdrawal against the coming year's MilPers costs. For example, the fund would be billed at the end of FY03 for labor care delivered in FY02, and funds withdrawn would be used to offset MilPers costs in FY04. The funds could be applied to the MilPers costs of Program Eight, Medical commands or simply added to the Services' MilPers accounts. The funds in the MERHCF have no appropriation year associated with them, so there is no problem with applying them in any particular year. The 1-year lag enables DoD to submit the budget to Congress to reflect just how much will be withdrawn and thus fully fund MilPers.

There are minor issues regarding inflation (i.e., paying for FY02 labor with FY04 dollars). One solution to this problem is simply to use FY04 rates to calculate the withdrawal. Another solution—if the later rates are not available when the budget is built—would be to apply military pay raises, which are known, for the interval involved. Although the later rates will be higher because of inflation, the funds that eventually will be withdrawn earn interest during the extra time they are in the trust fund, offsetting the higher rates.

A variation on the latter approach would be to apply the relative level of effort to MilPers costs in the Program Eight, Medical account instead of using the third-party collection rates. Again, there would be a lag in the withdrawal to allow for the amount to be used in the budget-building process.

We recommend that the delayed billing approach be used for MilPers costs and that the withdrawal should be calculated by using rates developed as the difference between interagency and international third-party collection rates.

Capital Investments

Capital investment includes major equipment items, buildings, and land. Major equipment purchases are funded by the OP appropriation category; building construction and, if needed, land acquisition are funded by MilCon funds. Small projects and single purchases to replace and modernize equipment at existing facilities are managed and paid for locally by the MTF. Major construction projects are managed centrally by the military Services.

The costs of capital investment, along with those for labor and consumables, are part of the total cost of health care for Medicare-eligible beneficiaries. If the MERHCF is to pay for the total cost of this health care, it must pay a share of DHP's capital investment costs. The first problem is determining the appropriate size of the share; the second problem is settling on a method to pay the share.

There are two possible ways for the MERHCF to reimburse capital expenditures. One way would be a *pay-as-you-go* approach in which the fund reimburses a portion of costs of each construction and procurement project as project funds are expended. As project managers pay invoices, a portion of the payment would be funded by the MERHCF. A second approach would be for the MERHCF to reimburse the MilCon and OP accounts after the fact in the same way we recommend that the fund reimburse military personnel costs. A *capital use fee* would be included in the rates charged for health care. A similar fee by the same name already is part of the third-party collection rates.³

Paying for Capital Projects as Funds are Expended

The fund will have to generate funds as capital payments are made. Therefore, payments will have to be based on some forecast utilization by Medicare-eligible beneficiaries or on recent past actual utilization rates.

Presumably, basing MERHCF withdrawals for capital expenses on forecast utilization would more accurately reflect actual future utilization by retirees. In this case, as a major project is proposed planners would conduct credible analysis to indicate the future utilization ratio of Medicare-eligible beneficiaries to non-Medicare-eligible beneficiaries. This analysis would become part of the project documentation. As each project is executed, contractor invoices would be paid in the same ratio of trust fund and appropriated funding that was determined by the original analysis. The disadvantage of this approach is that each procurement would have a unique ratio, making invoice payments more complex. Besides the advantage of accuracy, however, an additional benefit is that the trust fund and appropriated fund mix is fixed and known during the budget-building process.

An alternative for MERHCF capital payments would be to determine a DHP-wide ratio, based on recent utilization statistics. These statistics could be relative level of effort or numbers of beneficiaries who actually use MTFs. We believe that relative effort would be a truer representation of the resources spent and thus required.

This approach has the advantage of simplicity. The same ratio is applied to all projects. As each invoice is received, the same proportion of appropriated and trust funds is used for payment. The disadvantage is that the most recent utilization statistics available during the budget-building process (the previous fiscal year) will be 3 years old when that budget is executed.⁴ This approach does not allow for changes in the utilization mix. Conceivably, a procurement project

³ The third-party collection capital use fee covers capital depreciation and unfunded civilian and military retirement costs. We do not believe that these costs are appropriate charges for the MERHCF because funds are not expended to pay for these costs. We believe that actual capital expenses (i.e., MilCon and OP) should make up the MERHCF capital use fee.

⁴ For example, the FY02 budget is built during the summer of calendar year 2000. At that time, the most recent statistics will be for FY99. The budget will be submitted to Congress in early calendar year 2001. Congress will appropriate the funds in summer 2001, and FY02 will start October 1, 2001.

would be initiated with the intention of changing an MTF's caseload and hence should be paid in a different ratio than the current caseload.

We do not believe that treating the largest procurements on a case basis would be disproportionately burdensome. Therefore, if DoD adopts this approach we recommend that centrally managed procurements totaling \$20 million or greater combined MilCon and OP be billed on the basis of project analysis of projected caseload. Procurements of less than that amount should use the caseload ratio of the most recently completed fiscal year at the time the budget was built for that year. Procurements funded out of the individual MTF's budget should be billed with whatever methodology is selected to pay the facility's O&M costs.

Capital Use Fee

We believe that a better approach would be to charge a capital use fee as part of the rates charged for health care delivered by the direct care system, as suggested by the Office of the Secretary of Defense Program Analysis and Evaluation Directorate. DFAS would then withdraw the total of these charges from the fund at the beginning of the second fiscal year following the year in which the care was delivered. The funds generated would be paid into the Service MilCon and OP accounts as an offset. As with MilPers, the actual total of these charges for the year will be known just as the Services build the budget for the second following year. These budgets would then be sent to Congress with a combination of appropriated funding and reimbursement from the MERHCF.

The difficulty here is determining an accurate fee. There are two approaches. One way would be to determine a rate before the beginning of the fiscal year and then apply that rate as care is delivered. With this approach, the first question is the cost basis. Capital outlays vary significantly from year to year. One potential cost base would be the average cost for a period of time, such as the previous 10 years. Another cost base could be the medical MilCon and OP budgets. Both of these bases are known when the budgets are built. Whichever base is used could then be allocated to inpatient and outpatient care in the same relative proportion as the previous year's MEPRS costs. The allocated costs could then be divided by the inpatient and outpatient workload totals from the previous year to derive a cost per workload unit. This unit cost would then be figured into the calculations of the FFS rates. This rate would be a global systemwide rate; it would not be specific to an MTF or Service.

A second approach to calculating the withdrawal would be to make the calculation after the fact. At the end of the year, medical capital expenditures would be totaled. This total could then be apportioned between appropriated and MERHCF funding, using the same proportions as the total MTF O&M plus medical MilPers expenditures for the year. In other words, if 15 percent of the other costs of the direct care system were paid by the fund, 15 percent of the capital costs also would be paid by the fund. We recommend this approach.

Chapter 4

Disbursing MERHCF Withdrawals

Once a methodology for calculating MERHCF withdrawals has been chosen, that methodology must be applied to determine how much to withdraw. In addition, a system must be in place to make this determination, request the funding from the trust fund, and distribute the funding generated. In Chapter 3, we discuss options for the methodology by which to calculate the withdrawals. In this chapter, we discuss the application of whichever methodology is used.

One of the guiding precepts for this task has been that the agency or command that spends the money should receive the payment. The process of paying for the health care delivered is simple. A request for payment (bill) is generated and provided to DFAS trust fund managers on a periodic (monthly) basis. DFAS consolidates all bills for the month and submits one request for funds to the BPD. The BPD cashes in MERHCF securities to generate the funds requested and transfers them to DFAS. DFAS then disburses the funds. Issues that require resolution are as follows:

- ◆ Who generates bills to DFAS?
- ◆ Who ultimately gets the money?

This chapter addresses these issues. Because purchased care is the simplest case, we discuss it first.

DISBURSING FUNDS TO PAY FOR PURCHASED CARE

The MERHCF will have to pay for care delivered by current purchased care programs (Tricare, NMOP, USFHP) now that they will be available to Medicare-eligible beneficiaries, as well as the portion of civilian care that Medicare does not cover up to the limit of the Tricare benefit. The answers to the two questions raised above are straightforward for purchased care: The contract office managing the purchased care contract will generate a single, consolidated request for payment on the basis of contractor invoices and receive the trust funding to pay these invoices.

Existing contract management organizations within the TMA will generate payment requests for contracts under their purview. We expect that DHP will use one or more contract fiscal intermediaries to pay purchased care claims. DHP has not made a decision in this regard at this time.

The process of calculating the payment request is common to all programs. The purchased care contractor will invoice its contract officer for the care it delivers or, in the case of the USFHP, enrollment costs. The invoice includes care records that justify the invoice. Each care record includes the DoD share of the cost of care. For Tricare as a secondary payer to Medicare, this share would be the difference between the Tricare allowable and the total of all other payments (Medicare and third-party insurers).

The contract officer applies the formula that burdens the direct cost with contract administrative costs (see Chapter 3) for that contract to the sum of the DoD cost share for Medicare-eligible beneficiaries. The result is the amount to request from the trust fund. Upon receiving transferred trust funding from DFAS, the contract officer pays the invoice with a combination of appropriated and trust funding.

DISBURSING FUNDS TO PAY FOR DIRECT CARE

The answers to the questions raised at the beginning of this chapter are more complex for direct care. The options that are available do not have equal costs.

The overhead cost of the trust fund's disbursement process (determined by the processes under which invoices and claims are established, examined, and paid or by the methods in which funds may be transferred into other appropriation accounts) may vary greatly according to the method chosen for reimbursement. The more complex the requirements under which the MERHCF makes payments for Medicare-eligible medical care, the more complex and administratively expensive the fund's disbursement process will be.

Payment accounting regulations and reimbursement transaction volumes are much less complex (and less expensive to administer) if the trust fund reimburses at the appropriations level or the MTF's O&M funds level. Partially offsetting this advantage, however, may be increased costs of the information systems to support centralized billing.

Conversely, a reimbursement process that is based on establishing, examining, and paying individual (fee-for-service) claims may be much more costly to administer for the billing organization and the reimbursing organization (MERHCF and DFAS). More complex MERHCF disbursement regulations also may require MTFs to maintain more complex information systems than they do now.

The MTFs' third-party collection infrastructure could be expanded, however, to provide FFS billing to the fund on a one-invoice-per-month basis without a significant increase in administrative cost.

We have developed three broad options for the direct care reimbursement process. Although variations may exist, these options illustrate the issues involved. In summary, these options are as follows:

- ◆ Reimbursing DoD appropriations that pay direct care costs. The TMA would present a single request for funds, and DFAS would turn over the funds generated to the DoD Comptroller to repay the general accounts in these appropriation categories or to the TMA to repay the Program 8, Medical accounts.
- ◆ Reimbursing the commands and agencies that actually pay for Medicare-eligible health care. The TMA would generate a consolidated request for payment, based on the data of individual MTFs. Reimbursement payments could be made to the TMA for further reallocation to the MTFs or directly to the MTFs
- ◆ Reimbursing the MTFs directly, whereby each incident of health care generates a request for funds. This option would be analogous to the way civilian providers operate: Each incident of care generates a bill.

We provide a detailed discussion of each of these options in the following subsections.

Reimbursing Appropriations Accounts

Under this option, the MERHCF would directly reimburse the appropriate DoD health care O&M, OP, MilCon, and MilPers appropriations. The payment could be applied at the DoD level or the DHP level.

The TMA would generate a single request for funds to DFAS for each appropriation category, using whatever methodology has been selected from those we discuss in Chapter 3. DFAS would turn over the funding received from the BPD to the DoD Comptroller—who would reimburse the general DoD accounts in those appropriation categories. This next-lower level would be the TMA for Program 8, Medical O&M accounts, the appropriate Service agencies managing centrally funded major construction and procurement, and the Service military personnel commands for their MilPers accounts. Under this option, agencies receiving the funding would determine how best to allocate that funding.

Each year, as part of the budget review process or trust fund reconciliation process, an accurate percentage estimate could be reapplied to each of the major appropriations that support health care. The accuracy of these amounts would be a part of the DoD's health care financial A-123 Internal Control Review, which is required in support of the DoD chief financial officer's (CFO) annual report.

PROS

This method would be the least administratively costly reimbursement process to develop, implement, and maintain. It could be the fastest and most efficient method of reimbursing appropriations for expenditures on behalf of covered retirees. Yet if it were established after adequate financial and patient care system

and process reviews, it could provide a fair reimbursement for retiree medical services rendered by the direct care system and represent a fair cost for medical services received by retirees. Moreover, this process would be the least costly option for DoD, DHP, and the fund to administer.

CONS

Although this option would be the least expensive methodology to establish and maintain, commands and agencies that actually deliver health care would not necessarily see any changes arising from the provision of that care (i.e., return on their investment). There would be little incentive to provide care, and DHP would lack economic mechanisms to effect changes in MTF behavior.

To avoid errors, a diligent (but labor-intensive) A-123 management and internal control process should be established with this option to help ensure accurate costing analysis and estimates.

Reimbursing Commands and Agencies That Pay for Retirement Health Care on the Basis of Consolidated Invoices

Under this option, each MTF would be reimbursed for its costs for treating Medicare-eligible beneficiaries. Similarly, as in the first option, central Service agencies that manage major procurement and construction projects and Service military personnel commands would receive reimbursement for the share of their outlays that is attributable to the delivery of health care to Medicare-eligible beneficiaries.

TMA could present DFAS fund managers with one monthly invoice, or each command or agency that provides Medicare-eligible health care could submit its own bill.¹ If DHP submitted a single request for funds, that request would be based on information provided by the MTFs and Service procurement agencies. Upon receipt of funding from the BPD, DFAS would then either

- ◆ reimburse TMA—which, in turn, would allocate funds appropriately—or
- ◆ reimburse the individual MTFs and Service procurement agencies directly.

In either case, DFAS would reimburse the DoD Comptroller or the Service military personnel accounts directly for MilPers costs.

This approach would require accurate (auditable) patient treatment information systems, as well as patient and managerial cost accounting capabilities within the

¹ MilPers costs are incurred at the MTFs, which have the data to determine these costs—whether they are calculated using a level-of-effort or FFS methodology. Therefore, the MTF bills, whether consolidated or submitted individually, would contain a MilPers amount that is distinct from the MTF O&M. The MTF would receive the O&M reimbursement, and the MilPers reimbursement would go to the Service MilPers accounts.

financial systems at each MTF. If TMA submitted a consolidated request for funds, that request would be based on supporting data from the MTFs and central procurement agencies. Regardless of whether the bill was submitted by TMA or individual MTFs, only a certification of the total amount due would be submitted to DFAS as a proper invoice for payment. Detailed billing/patient service data would be retained at the organization, as prescribed by appropriate instructions.

As with all reimbursement methods, DFAS would consolidate all requests for payment and submit a single request monthly to the BPD. The BPD would make a single fund transfer to DFAS, which would then disburse the funds to claimants.

PROS

This method would reimburse and reward organizations that provide service to Medicare-eligible beneficiaries for the least administrative burden. The local MTF O&M fund and separate support appropriations would be quickly reimbursed for retiree treatment expenses.

This method also provides a mechanism for establishing incentives to drive MTF behavior (e.g., to increase or decrease resources devoted to Medicare-eligibles), if desired—now or at a later time. Finally, the more rigorous recordkeeping required for this option would support better management decision making in other areas of health care delivery.

CONS

This method would be more costly than reimbursing central accounts because it entails a greater administrative load. This cost would be borne by DHP, which would drive up DHP costs without any increase in service. We believe that with current DHP data systems, this additional cost would not be significant.

Reimbursing Commands and Agencies That Pay for Retirement Health Care on the Basis of Individual Treatment Invoices

Under this option, MERHCF managers at DFAS would reimburse MTFs directly for each patient treatment episode. DoD could establish universal (non-MTF-specific) treatment rates, based on an average cost for all MTFs; alternatively, MTF-specific rates could be developed locally or by the TMA. The MTF would bill on a case-by-case basis. This capability would require detailed and accurate (auditable) patient treatment information systems, as well as patient and managerial cost accounting capabilities within the financial systems at each MTF. This option would put MTF financing on a comparable footing to that of civilian institutions. It also would represent a major change in the way MTFs operate. There would be major expenses for new accounting systems and personnel to operate them.

This approach does not account for centrally managed equipment procurement and MilCon costs. These costs would have to be reimbursed under a different approach. The individual MTF bills, however, would contain a MilPers component that would be paid to the DoD Comptroller or the Service military personnel accounts.

PROS

This method would allow costs to be assessed for each medical treatment code category, and it would process local individual bills for retiree treatment expenses. This option probably would result in the quickest reimbursement to individual MTFs. This method would put MTFs on more of an enterprise operating basis and could lead to increased cost-consciousness by MTF managers.

CONS

This approach would require a very large infrastructure—and attendant cost—with no increase in service. It would require the MTFs to generate thousands of invoices and, correspondingly, would require the fund's disbursement organization to process those thousands of invoices for payment each month. In fact, because of the impact these cost increases could have on the DHP operating budget, service levels could decline. Fund management also would be much more expensive.

This approach also would represent a major shift in the current culture of the military medical corps. The team could not find any financial or management advantage to this option, compared with the second option.

Recommendations

Our research indicates that planned improvements to DHP information systems, with minor changes, will support centralized billing by DHP that is based on individual MTF operations (the second option). We believe that providers of health care to Medicare-eligible beneficiaries should be rewarded for their efforts. Furthermore, the second option provides the means to encourage desirable behaviors on the part of MTFs—such as increased cost-consciousness (if they are allowed to retain any difference between the reimbursement rate and their cost of providing care). The types of encouragement also would depend on the withdrawal calculation methodology.

Chapter 5

Calculating MERHCF Deposits

The MERHCF will receive deposits from the following sources:

- ◆ A monthly deposit by DoD that represents the present value of benefits paid by the fund that are earned by service members during that month. This amount is the *normal cost*. The MERHCF will have separate normal costs for the active and Reserve components, as does the MRF for military pensions.
- ◆ An annual deposit by the Department of the Treasury that will amortize
 - the unfunded accrued liability (UAL) as of the start of the fund (1 October 2002) for future benefits of retirees and service members earned with previous service,
 - any change to the accrued liability arising from changes in the benefit,
 - any change to the accrued liability arising from changes in the underlying actuarial assumptions, and
 - any change to the accrued liability resulting from actuarial experience in operating the fund
- ◆ Any return on investment of the assets of the fund
- ◆ Any other amount that Congress might appropriate.

With the exception of investment return and supplemental Congressional appropriations, all of these amounts are calculated actuarially. The process (overly simplified) takes current per capita spending on the benefit in various demographic categories and applies a projected cost growth to obtain per capita costs in each future year. Similarly, a typical cohort of new entrants to the military is projected into the future through their careers into retirement until they and all of their dependents and survivors have died. The products of the resulting projected beneficiary population and annual per capita costs over all demographic categories represent a stream of projected annual benefits for the new entrant cohort. This stream is then discounted to produce a present value of benefits. When this figure is divided by the projected (and discounted) number of the cohort's months of military service (whether they retire or not), the result is a cost per service member per month. This amount is multiplied by the service population for a month to produce the normal cost for that month.

Detailing the data collection and processing and the actuarial calculations that generate the normal cost and UAL estimates is beyond the scope of this report. The key factor is that they are based on recent experience with the cost and delivery of a benefit. Therefore, they rely on sufficiently accurate and precise cost and utilization data. Such data are currently available; they are used in military retirement health care liability calculations for the annual DoD financial statements. We recommend that the same methodology that is used in the liability calculations be used to calculate the MERHCF deposit calculations. The only difference would be that different cost bases should be used. The liability calculations include intangible costs such as depreciation in the cost base. The fund is intended to pay actual costs. Therefore, the fund should include capital expenditures instead of depreciation in its calculations.

DATA COLLECTION AND PROCESSING OVERVIEW

LMI has supported the calculation of the military retirement health care liability since 1990. A more detailed discussion appears in *Estimating the Military Retirement Health Care Liability*.¹ The purpose of data collection and processing is to determine exposed population counts and per capita benefit costs by age and demographic category.

Two basic data sets are used in deposit calculations:

- ◆ *Population data.* These data are used to determine exposed population counts and provide demographic data for beneficiaries who receive health care. Data elements include demographic information for beneficiaries and their military sponsors, as well as identification information that allows correlation with the health care delivery data.²
- ◆ *Health care delivery data.* These data include health care costs and records of health care delivery. Additional data enable workloads to be attributed to incidents of care.

Population Data

The Defense Manpower Data Center (DMDC) maintains DEERS, which contains detailed information on all individuals who are eligible for DoD health care benefits and their sponsors. The population categories are defined by sponsor demographic information (e.g., age, pay grade, retired/deceased). Files of beneficiaries and sponsors are provided by DMDC. These files are merged into a single file

¹ Logistics Management Institute, *Estimating the Military Retirement Health Care Liability*, Report PR003T1, Melvin R. Etheridge, January 2001.

² The term *sponsor* refers to the military service member—who may be active, retired, or deceased—whose service entitles the beneficiary to the benefit. Beneficiaries can be the sponsor or the sponsor's spouse, dependent children, and, for certain benefits, dependent parents.

with a record for each beneficiary and data fields for all demographic information, health care workloads, and attributed costs for that beneficiary.

Health Care Delivery Data

Health care data are provided by various elements of the DHP. The health care delivery data files cover direct and purchased care and categorize care into inpatient, ambulatory, and outpatient pharmacy categories.

DIRECT CARE DATA

These data include MTF inpatient care, MTF outpatient clinic visits, MTF ambulatory procedures, and MTF outpatient prescriptions filled. Each file has one record for each episode of care in that category.

The problem with the direct care system is that it does not have a patient-level accounting system, so the costs of individual episodes of care are not available. Instead, workloads are attributed to each episode of care. The sum of the workloads in each category is divided into the total cost of care in that category to obtain a cost per workload unit. This unit cost is then multiplied by the workloads attributed to each individual to yield a cost allocation for that individual's care.

PURCHASED CARE DATA

The advantage with data from the purchased care sector is that it includes the cost to the government of the care delivered. As a result, totaling the direct costs for each beneficiary is easy.

The largest segment of the purchased care sector is Tricare, which has the Prime (HMO), Extra (PPO), and Standard (FFS) plans. As with direct care data, the claims costs for each plan are further broken into inpatient, ambulatory, and outpatient pharmacy categories in each plan. Tricare will become available to Medicare-eligible beneficiaries on October 1, 2001.

The USFHP is an HMO that is operated by contractors at former PHS hospitals in selected areas in CONUS. DoD pays a capitated enrollment charge for each person who enrolls in the program. The USFHP is available to Medicare-eligible beneficiaries. The data files include the government's enrollment cost for enrollees.

The NMOP allows beneficiaries to receive prescription medication through the mail, with a \$8.00 copayment. Medicare-eligible beneficiaries who live in areas where an MTF was closed during the base realignment and closure process are eligible to use the NMOP. The NMOP will become available to all Medicare-eligible beneficiaries on April 1, 2001. The data files include the government's cost for each prescription the NMOP fills.

Data files that contain the DoD cost share of Tricare as secondary payer to the Medicare benefit must be available to the MERHCF actuaries. We do not anticipate a problem in this area. The records undoubtedly will be a requirement of any contract with a Fiscal Intermediary (FI) to justify reimbursing the FI for the payments it makes on claims.

Health Care Cost Data

Chapter 3 contains a detailed discussion of options for the cost base to support MERHCF calculations. The crucial point is that the cost base used to calculate withdrawals must be the same as the cost base used to calculate deposits.

As with current Military Retirement Health Care Liability (MRHL) calculations, we anticipate that the fund's cost of purchased care claims paid will be available in one or more database files containing individual claims, their costs, and beneficiary identification data. With these files, merging fund claims costs with demographic data will be a simple procedure.

The degree of difficulty associated with merging direct care costs with demographic data will be driven by the method DoD selects to calculate direct care withdrawals. If DoD uses an FFS rate schedule like that currently used in third-party collections, there will be a cost associated with each individual episode of health care delivery. Associating those costs with the patients' demographic data will be straightforward, as with purchased care. If a level-of-effort approach is selected, however, the MERHCF calculations will require an allocation of total cost on the basis of workloads. This approach is used in the calculation of DoD's liability for military retirement health care in the Department's annual financial statements. In either case, MERHCF actuaries will require access to direct care files that substantiate the withdrawals to predict future costs. If the level-of-effort approach is selected for withdrawal calculations, the actuaries also will require access to the total cost bases used to calculate the withdrawals.

DEPOSIT CALCULATION TIMELINE

Deposit calculations must be available for inclusion in the budget when DoD turns it over to OMB for consolidation and review. This consolidation typically takes place in late November, approximately 10 months before the start of the new fiscal year. Thus, review of the underlying actuarial calculations must be complete by that time. These calculations require 4 months to complete. Allowing a month for the review process, the data collection and processing must be completed by the end of June. Data processing typically takes 3 months, so data collection must be complete by the end of March.

Because the calculations will be made on data from the most recent fiscal year, the data that support the deposits will be more than 2 years old.³

DEPOSITING FUNDS INTO THE MERHCF

The schedule for deposits is clear in the language of the Defense Authorization Act for Fiscal Year 2001. DoD will deposit monthly normal costs at the end of each month, based on the end-strengths of the active and Ready Reserve components for that month. The Treasury Department will deposit the amortization payment at the beginning of each fiscal year. The BPD, which will manage the fund for the Treasury Department, will invest these funds in U.S. government securities upon receipt.

³ For example, FY2005 starts on October 1, 2004. The deposit calculations would be complete in November 2003. Data collection would be complete in March 2003, using data from the fiscal year ending September 30, 2002—which is FY02.

Chapter 6

Building the Budget Under Accrual Funding

Establishment of an accrual-based trust fund facilitates planning, programming, budgeting, and funding of agency missions for which that trust fund is established. Historically throughout the federal government, once Congress has established a trust fund, the missions and activities for which that trust fund is to provide have become institutionalized. Once a trust fund has been established, Congress and the agencies involved invariably have viewed the missions the fund supports as an ongoing commitment. Thus, planning, programming, and budgeting for these activities are viewed as a long-term financial management activity. The Highway Trust Fund, Medicare, and Social Security are examples of missions and funding whose long-term existence is assumed by Congress, the agencies, and the taxpaying public.

Accrual funding will require budgeting for MERHCF deposits and withdrawals.

BUDGETING FOR MERHCF DEPOSITS

MERHCF deposits will appear in the budgets for the Treasury Department and DoD. The Treasury deposit represents the amortization payment of the unfunded accrued liability. The National Defense Authorization Act for Fiscal Year 2001 requires that the Treasury Department make this deposit annually, based on information furnished by DoD. The OOA will determine the size of this payment, and furnish the information to the Treasury Department in sufficient time to be included in the Treasury budget.

DoD will have to budget for the monthly normal cost payments, which will be based on per capita normal costs. The National Defense Authorization Act for Fiscal Year 2001 requires different rates for active-duty (including full-time National Guard and Reserve personnel) and Reserve personnel. The Act specifies that this normal cost appear in the DHP budget. We believe, however, that the retirement health care benefits that these deposits will fund are a cost of military labor in the same way the military pension is a labor cost. The MRF normal cost deposits appear in the MilPers accounts, and the MERHCF normal cost deposits also should be in the MilPers accounts.

A significant advantage of including the normal cost deposit in the MilPers accounts is that the cost of military labor will be presented more accurately, which will provide better information to military personnel decision makers and, presumably, lead to better military personnel decision making. We recommend that DoD propose legislation to move normal cost deposits from DHP to MilPers.

BUDGETING FOR MERHCF WITHDRAWALS

The estimated funding that the MERHCF will provide to DHP, MilPers, OP, and MilCon accounts also will appear in those budgets.

Military Personnel, Procurement, and Military Construction Budgeting

We recommend that the fund reimburse all the accounts other than DHP at the Service level or higher, 2 years following the year in which the costs are incurred.¹ If DoD adopts these recommendations, comptrollers will know how much offsetting funds will be withdrawn from the fund to reimburse these accounts when they are building their budgets. We do not envision a significant change in budget procedures. Comptrollers will request appropriations to cover the difference between the total and the offset.

DHP Budgeting

Because DHP will be reimbursed during the year in which costs are incurred, DHP comptrollers will have to include estimates of the required reimbursement in their budgets. As with calculations of MERHCF withdrawals, the method for building budget requests for the purchased care sector will be somewhat different than that for the direct care sector.

BUILDING PURCHASED CARE BUDGET REQUESTS

The primary change to current methods for building budget requests for purchased care will be the requirement to estimate how much care will be delivered to Medicare-eligible beneficiaries and how much will be delivered to non-Medicare-eligible beneficiaries during the budget year. The budget request will then be broken into two parts. One part will contain health care and contract costs covered by the MERHCF for care delivered to Medicare-eligible beneficiaries. The other part will contain health care and contract costs covered by appropriated funds. The consolidated budget request will be subject to the review process that currently is in place.

Costs for Medicare-eligible beneficiaries will be difficult to estimate for the first few years after the benefit takes effect on October 1, 2001; there is not much experience with this group because of their limited eligibility for purchased care before this date.

¹ For example, the MilPers costs of the direct care system for FY05 will be calculated on the basis of the amount of care the system delivers to Medicare-eligible patients. At the end of FY05 (30 September 2005), these costs will be known and can be included as an offset in the FY07 budget, which at that time will be in final stages of being built.

Using the methodology in Chapter 3 for calculating withdrawals, purchased care budget analysts will allocate the appropriate share of contract and other overhead costs to be borne by the fund. The remainder of these costs will be funded by appropriations.

BUILDING DIRECT CARE BUDGET REQUESTS

MTF comptrollers build budget requests within DHP by using the current budget as a base and applying known or anticipated changes, pay raises, and so forth in accordance with published guidance. Budget requests are passed up the chain of command for consolidation, review, and, if necessary, modification. As we discuss in Chapter 3, MTF budgets include only O&M costs (including civilian personnel costs) and minor construction and procurement. Major construction and large equipment procurement are centrally funded by the Services. MilPers costs are budgeted by the Service military personnel commands. At the MTF level, the budget request covers fixed costs and estimates of variable costs, based on recent experience. Lacking the concept of revenue, budgets generally are not directly tied to the amount of care that the MTF expects to deliver.

The extent of change to this process that will take place under accrual funding depends on DoD's decisions with regard to the method it will use to calculate MERHCF withdrawals and the level at which payment from the fund occurs.

Comptrollers below the level of reimbursement for O&M probably will see little change in the way they build their budgets. If the O&M account is reimbursed at the Service level, local MTF comptrollers will continue to build their budget requests as they always have. When the O&M budget request reaches the Service headquarters, medical resource managers will allocate the consolidated O&M budget request between appropriated and trust funds. We anticipate that resource managers will use forecast proportions of level of effort to make this allocation, regardless of the method used to calculate trust fund withdrawals. This approach should be sufficiently accurate because the same workload metrics that are used to measure level of effort also are used to compute fee-for-service rate schedules.

If the trust fund will reimburse individual MTFs—regardless of whether the MTFs bill the fund directly or through a consolidated invoice—the MTF comptrollers will need to forecast the proportion of their workload in the budget year associated with delivering health care to Medicare-eligible beneficiaries. Presumably, like the budget request itself, this forecast will be based on the amount of care delivered in the previous year. This proportion will be applied to the MTF budget request and be carried forward as the request makes its way up the chain of command.

Chapter 7

Managing and Operating the MERHCF

In this chapter we discuss the management and operation of the MERHCF, including payment processes, investment of receipts, reporting requirements, auditing, and other related issues.

ACCRUAL ACCOUNTING AND OTHER TRUST FUND FINANCIAL MANAGEMENT ISSUES

Accrual accounting is a requirement for federal accounting systems recording and reporting on appropriation supported funds. This requirement includes DoD's budget execution systems for all appropriations that fund and support the MTFs, as well as accounting for the MERHCF (when it starts operating). Most trust funds operate in a manner in which a minimum of time exists between the receipt of funds and their deposit (investment, disbursement, or other use); they experience little time lag between establishment of a payable and disbursement of funds. As a result, the accrual accounting process itself does not significantly affect the financial management and operation of a trust fund or the way in which its monies are used. The accrual nature of financing is far more important than accrual accounting and reporting requirements.

The rules and processes mandated by statutes and regulations by which managers make payments from a trust fund have the largest impact on how the trust fund must operate. The method selected to reimburse the direct and purchased health care systems will be the most significant determinant of how the MERHCF must operate. The language of the National Defense Authorization Act for Fiscal Year 2001 is very general with regard to payments from the fund. Section 1113, Payments from the Fund, subsection (a), states:

There shall be paid from the fund amounts payable for Department of Defense retiree health care programs for Medicare-eligible beneficiaries.

This language provides latitude for DoD to implement the most efficient method for reimbursement. A trust fund that is used to finance DoD health programs will carry an additional operational administrative burden, however, over the current "pay-as-you-go," direct appropriation funding method.

DEPOSIT OF FUNDS INTO THE MERHCF

Because of the MERHCF's high visibility to military service members, retirees, and Congress and an initial degree of uncertainty regarding future fiscal demands

on the trust fund, we anticipate that the fund will be subject to the OMB apportionment process. If the trust fund as a whole is subject to apportionment by OMB, that apportionment will be recorded in Standard General Ledger (SGL) 4510, Apportionments, in accordance with the SGL logic published in the Treasury Department's *Trust Fund Accounting Guide* (draft), Scenario I. If the MERHCF is not subject to OMB apportionment, however, it will use SGL 4620, Unobligated Funds Transactions, for all related transactions.

Funds from any source will have to be recorded in the MERHCF's receipt account(s) as they are received. The MERHCF's enabling statute make these funds available for immediate investment in eligible Treasury debt securities.

From an investment management standpoint, federal trust funds are managed by the federal program agency or by the BPD. In either case, investment decisions for the fund are made by its managing agency. No matter who *manages* the fund, the Department of the Treasury is responsible for *administering* the investment programs for trust funds such as the MERHCF that are directed by statute to invest its funds in interest-bearing obligations of the U.S. government.

Administration of Trust Fund Investment

As investment administrator, the Department of the Treasury performs the following functions:

- ◆ It acts as executor for any investment decisions made by the federal agency that manages the trust fund.
- ◆ It performs the function of managing trustee, whereby the fund's investment decisions are made and implemented by the Department of the Treasury.

In either case, the BPD administers the process. The process of managing and reporting on investments varies greatly, however, depending on whether the program agency or the Department of the Treasury manages the trust fund.

Trust Funds Managed by the Program Agency

When the program agency is the manager of the trust fund, that agency must

- ◆ determine all amounts to be invested,
- ◆ identify terms of investment,
- ◆ place investment/redemption orders with the BPD, and

- ◆ report investment activity through the following processes:
 - SF-224, Statement of Transactions
 - FACTS I and FACTS II
 - SF-133 Report on Budget Execution
 - FMS-2108 Year-End Closing Statement
 - CFO agency annual financial statement.

Trust Funds Managed by the Department of the Treasury

When the BPD manages a trust fund, the BPD must

- ◆ determine all amounts to be invested,
- ◆ identify terms of investment,
- ◆ execute investments/redemptions, and
- ◆ report investment activity through the SF-224, Statement of Transactions and FACTS II processes.

The BPD will provide the program agency with the same financial information, however, so that it may report this information through FACTS I; the SF-133, Report on Budget Execution; FMS-2108, Year-End Closing Statement; and the agency CFO's annual financial statement.

Receipts may be invested for a short period of time or allowed by statute to be obligated immediately, depending on the requirements of the program supported by the trust fund.

GENERAL ACCOUNTING REQUIREMENTS FOR TREASURY-MANAGED TRUST FUNDS

Section V of the *Trust Fund Accounting Guide* highlights some of the unique accounting and reporting requirements to which Treasury-managed trust funds are subject. Treasury-managed trust funds are a unique group of accounts in that the law has designated the Secretary of the Treasury to act as a managing trustee for a named group of trust funds. As a result, most of these funds were established as two separate but corresponding Treasury Appropriation Fund Symbols (TAFS): the portion managed by the BPD, referred to as the "corpus account" (e.g., 20X8000), and the portion run by the program agency, referred to as the "agency account" (e.g., 75-20X8000).

For FACT II reporting (SF-133, FMS-2108, P&F), each TAFS submits its portion of the activity. The Department of the Treasury and OMB then consolidate the

data into one report. For Form and Content reporting, the agency consolidates the data and reports the trust fund as a whole.

Although the basic flow of activity within a Treasury-managed trust fund is similar in many respects to that in an agency-managed trust fund, there are a few differences. Receipts of a Treasury-managed trust fund are recorded in the corpus account; they are invested on the basis of terms stipulated in legislation.

As funds are needed by the agency account for disbursement, the program agency contacts the BPD for a transfer of funds, using SF-1151, Nonexpenditure Transfer Authorization. The BPD then disinvests funds so the transfer can occur. This transfer between the corpus account and the agency account requires different accounting and reporting treatment than that for other federal and non-Treasury-managed trust fund nonexpenditure transfers.

To maintain sound cash management principles, funds are to remain invested until needed for disbursement, to maximize the amount of interest earned.

Because the investment function is performed by the BPD and the obligation and disbursement function is performed by the agency, a budgetary mechanism may be needed for transferring authority prior to actually transferring funds. Furthermore, in support of Treasury and OMB reporting requirements, this transfer of budget authority prior to the transfer of funds is reported differently for single-entry trust funds.

OTHER DIFFERENCES BETWEEN TREASURY- AND AGENCY-MANAGED TRUST FUNDS

There are significant differences in accounting (general ledger) treatment between Treasury-managed and program-agency managed trust funds with regard to the way funds are recorded. More significant however, is the process that must be followed before funds may be obligated. There are sufficient Treasury regulations and procedures, however, to provide guidance for either method.

Receipts Not Available for Obligation

Trust fund receipts may not be available for immediate obligation and disbursement. In fact, trust funds that are established to provide benefits and are funded on an accrual basis often have all fund receipts deposited into accounts for investment as soon as they are received. Funds that are used to pay debts for which the fund is intended then must use a monthly withdrawal schedule for monies to obligate or disburse monies. The establishing language in the National Defense Authorization Act for Fiscal Year 2001 structures the MERHCF in this manner.

The *Trust Fund Accounting Guide*, Section III—Trust Fund Receipts Available for Investment But Not Obligation, provides the following guidance:

One example may be where the receipts collected in year one are not available for obligation until the following year. Another example is where the receipts are only available for obligation subject to an annual appropriation act.

Both of the foregoing conditions allow for these receipts to be immediately available for investment in eligible Treasury debt securities. As such, these receipts must be reported during the year-end closing process on the FMS-2108, Year-End Closing Statement. In OMB Circular A-34, appropriated receipts are separated into several categories—one of which is “receipts not appropriated, thus not available for obligation.” Current guidance from the Department of the Treasury to trust fund managers is that they should not report these receipts on the SF-133, Report on Budget Execution.

In theory, the normal cost deposited by DoD is a payment for the cost of *future* benefits that have been earned by the current military population. The unfunded accrued liability (amortized by the Department of the Treasury) represents the cost of benefits earned by past service, including the service of retirees. Hence, in a strict theoretical approach, the normal cost deposits by DoD would not be available for obligation because they are for future benefits.

In practice, funds deposited into the MRF are immediately available for obligation. DFAS deposits into or withdraws from the MRF the difference between the monthly pension payroll and DoD’s normal cost payment. We see no reason for the MERHCF to operate differently; therefore, we recommend that deposits be available for immediate obligation.

PAYMENTS PROCESSES

The key element affecting the fund’s implementation of reimbursement/payment procedures is the policy that DoD and/or Congress chooses for reimbursement of DHP for health care for Medicare-eligible beneficiaries. (We discuss reimbursement options in Chapter 3.) We recommend that the purchased care system and MTF operating funds be reimbursed monthly for invoices received that month. Each invoice would have to be certified by the issuing MTF or purchased care program business office to the DFAS MERHCF business office as an approved invoice. The business office would consolidate the invoices received and then present the fund with a single monthly invoice. Detail billing information would be provided by DHP claimants to the DFAS MERHCF business office but not to the fund.

Methods for extracting funds for payment from a trust fund vary greatly, depending on whether the trust fund is managed by the BPD or the program agency (i.e.,

DoD). There are sufficient Treasury regulations and procedures to provide guidance for either method.

If the MERHCF is managed by DoD, responsibility for the fund's compliance with OMB and Treasury requirements will lie with the program agency fund management function (i.e., DFAS).

Recent meetings between DoD health program managers, DFAS, and the BPD resulted in a tentative agreement that the MERHCF should be managed by the same organizational relationship that exists between the Department of the Treasury and DoD in the management of the MRF. In this process, DoD pays into the fund each month the correct amount as determined by the OOA. Concurrently, DFAS has the BPD divest and make available for payment the amounts needed to meet the fund's disbursement demands for that month. The MERHCF would operate under the same process for extracting assets from the fund and making the required monthly disbursements. DFAS will then distribute the funds received to the appropriate claimants (see Chapter 4).

FUND MANAGEMENT AND INTERNAL CONTROL REVIEWS

DHP has established business practices that bill and receive reimbursement from other organizations with accrual-based accounting, budgeting, and funding practices. DHP billing and support practices are under audit oversight by the DoD IG and the GAO. The fact that these two functions will now be billing a federal trust fund should not add any additional financial management requirements and responsibility to these organizations. Because payment from an independent federal trust fund usually brings more fiscal scrutiny, however, audits by the DoD IG, the GAO, and the fund's own auditors may become more intense.

Two major OMB regulatory circulars form the basis of management processes and data processing internal controls required to facilitate safeguarding of assets from waste, fraud, and abuse. The following subsections summarize these circulars and describe their relationship to efficient trust fund management.

Management Accounting and Control Requirements for Trust Funds

OMB Circular A-123, Internal Control Systems, establishes management accountability and control and requires federal civilian and military managers to be accountable for the assets that they manage. The circular provides direction to senior federal managers on improving the accountability and effectiveness of federal programs and operations by establishing, assessing, correcting, and reporting on management controls.

OMB Circular A-123, Part II, contains the following requirements for management and control over program funds, trust funds, and other special or industrial funds:

Agency managers shall incorporate basic management controls in the strategies, plans, guidance, and procedures that govern their programs and operations. Controls shall be consistent with the following standards, which are drawn in large part from the "Standards for Internal Control in the Federal Government" issued by the General Accounting Office (GAO).

These management standards—which are to be followed in establishing, managing, and operating the MERHCF—include the following A-123 Part II standards:

Compliance With Law. All program operations, obligations and costs must comply with applicable law and regulation. Resources should be efficiently and effectively allocated for duly authorized purposes.

Reasonable Assurance and Safeguards. Management controls must provide reasonable assurance that assets are safeguarded against waste, loss, unauthorized use, and misappropriation. Management controls developed for agency programs should be logical, applicable, reasonably complete, and effective and efficient in accomplishing management objectives.

The internal control review is the primary method for ensuring and documenting to the Secretary of Defense, OMB, and Congress that these standards are in place and that the fund has a continual management control process. This review should be documented annually, but the key elements of the review should be part of an ongoing operational funds financial management process.

Title 31 U.S.C. 3512(d)(2) mandates that the head of each agency (e.g., the Secretary of Defense) submit to the President and the Congress:

A statement on whether there is reasonable assurance that the agency's controls are achieving their intended objectives; and (ii) a report on material weakness in the agency's controls.

To meet the foregoing legal requirements and to provide this "Statement of Assurance," all departments—including DoD—have established a program of management internal control reviews and reporting on each major program/fund.

On the basis of the results of this review process (as required by the Federal Managers' Financial Integrity Act of 1982 and its implementing OMB Circular A-123, Internal Control Systems, Part V. Reporting on Management Controls), the Secretary of Defense issues, as part of DoD's reporting requirements under Title 31,

the following types of information regarding the status of DoD “as a whole,” as well as specific programs and funds reviewed:

- ◆ *Statement of assurance.* The statement on reasonable assurance represents the agency head’s informed judgment regarding the overall adequacy and effectiveness of management controls within the agency. The statement must take one of the following forms:
 - Statement of assurance
 - Qualified statement of assurance, considering exceptions that are noted explicitly
 - Statement of no assurance.
- ◆ *Report on material weaknesses.* The Integrity Act report must include agency plans to correct material weaknesses and process against those plans.

Thus, the DoD position of overall management responsibility for the MERHCF would be for the part of the Integrity Act/OMB A-123 process that would review and report to the Secretary on the ability of the fund to meet its fiduciary requirements under that Act.

A companion circular to A-123 for trust fund management control is OMB Circular A-127, Financial Management Systems, which provides a guide for financial systems, process regulation, and budget execution. Circular A-127 prescribes policies and standards for executive departments to follow in developing, operating, evaluating, and reporting on financial management systems and fund operating procedures and processes. Although the host accounting service organization for a trust fund will perform its own system and processes review, the trust fund management function is responsible for ensuring that the same type of review is carried out for the financial management processes under its purview. These separate A-123 and A-127 reviews should be performed on behalf of the trust fund.

Financial Management Systems and Processes Integrity (for Funds and Programs)

Financial systems also include the complete financial information operating environment. This environment includes systems and management or manual procedures, which encompass the automated system. Thus, for the purposes of management and control, the term *system* should be interpreted in its total information context (e.g., automated systems, financial processes, accounting workflow). According to OMB Circular A-127,

Financial management in the Federal government requires accountability of financial and program managers for financial results of actions taken, control over the Federal government's financial resources and protection of Federal assets. To enable these requirements to be met, financial management systems (and processes) must be in place to process and record financial events effectively and efficiently, and to provide complete, timely, reliable and consistent information for decision makers and the public.

Like Circular A-123, Circular A-127 should be considered a trust fund management responsibility. As such, it should be performed for the trust fund management function, separate and apart from studies performed by any of the trust fund's service organizations (e.g., DFAS or the BPD). This type of process review may be carried out most efficiently by an organization that specializes in financial process reviews for business-activity funds, industrial funds, or trust funds (e.g., an audit firm).

This set of processes is the responsibility of the fund's management function; this responsibility is separate from DoD's audit responsibilities. As with the audit of the trust fund, however, many trust funds obtain the services of independent audit firms to provide the fund's management with technical staff support that may be needed to supplement peak workload demands on the fund's senior staff.

Independent Audit Requirements (Financial and Compliance) for Funds

As an extension of the fund's management and internal control responsibilities, independent audit requirements are implied by the very nature of the trust fund concept. As established by the Inspector General Act of 1989, however, the DoD IG is responsible for all audits conducted within DoD, although the DoD IG may use the services of a recognized certified public accounting (CPA) firm to conduct trust fund audits.

By using the services of an experienced CPA firm, the DoD IG would maintain the Department's "arms-length" position relative to the trust fund. This arrangement facilitates the image of independent stewardship and minimizes the public perception of control over the trust fund. Overall control and responsibility for any audit remains, however, under the scope and direction of the DoD IG.

An audit of a trust fund will have at least two components. The first—and primary—function of the auditor will be to assess and certify (if appropriate) the financial position of the trust fund at the end of its fiscal year. In addition, because of the many federal accounting requirements and mandated financial reports that have evolved over the past 20 years, financial audits now address these financial requirements as well as management control issues as a part of the financial audit.

The second audit component will include an audit for compliance assessment. This type of audit initially was developed by the GAO in its "Yellow Book" to obtain the auditors' assessment of the trust fund management's compliance with the statutory intended use of trust fund investments and disbursements. Compliance components of an audit include not only the use of assets by the trust fund but also the program's compliance with laws and regulations in accomplishing its mission. In other words, is the program conducting its mission within the scope that was intended by its enabling legislation and implementing regulations?

To reduce resources costs, facilitate the use of common databases, and ensure the operational efficiency of the audit, these two components should be audited together by whatever organization conducts the audit.

Federal Accounting Standards Advisory Board Regulations and Compliance for Funds

Several FASAB Statements pertain to trust fund activities. Within the past few years, major fund managers have initiated FASAB compliance reviews to ensure that funds under their stewardship are maintained in accordance with federal accounting standards. The fund administrator's staff or a commercial firm specializing in federal audit and financial compliance services may perform FASAB compliance reviews.

The following Statements of Federal Financial Accounting Standards have relevance for trust funds. We list them here to identify their role in trust fund accounting principals, requirements, and guidelines.

- ◆ Number 1: Accounting for Selected Assets and Liabilities
- ◆ Number 4: Managerial Cost Accounting Concepts and Standards
- ◆ Number 5: Accounting for Liabilities of the Federal Government
- ◆ Number 7: Accounting for Revenue and Other Financing Sources
- ◆ Number 12: Recognition of Contingent Liabilities Arising From Litigation

DFAS systems and the MRF operate the regulations and requirements of these FASAB standards, and their managers are familiar with their application. MERHCF management and trustees should ensure that the fund is in compliance with these standards.

Department of the Treasury Trust Fund Accounting Procedures

The *Trust Fund Accounting Guide* published by the Financial Standards and Reporting Division of the Department of the Treasury incorporates trust fund accounting procedural requirements and guidelines for accurate budget execution

addressed in OMB Circulars A-11 and A-34, as well as FASAB Standard 7, Accounting for Revenue and Other Financing Services. We present the following information here so that DoD agencies outside DFAS (which already is familiar with the new trust fund accounting requirements) can obtain an appreciation for the changing complexity and detail involved in trust fund accounting.

Accounting and processing trust fund transactions are very closely controlled. Trust fund managers must establish their funds to correspond to OMB and Treasury policies and procedures. Requirements and trust fund accounting regulations are prescribed in the following areas:

- ◆ Basic trust fund accounting
- ◆ Trust funds subject to limitations
- ◆ Trust fund receipts available for investment
- ◆ Trust fund investments
- ◆ Treasury-managed trust funds
- ◆ Trust funds with contract authority
- ◆ Trust funds with limitations on administrative expenses.

There also are changes in the way some trust fund financial information is recorded. In addition, there are new and modified SGL accounts for FY 2001. These accounts are used to account for and report nonexpenditure transfers between Treasury-managed trust funds, where the transferring entity is responsible for the investment (Treasury/BPD) and the receiving entity is an allocation account. These new and modified SGL accounts are as follows:

- ◆ 1330: Receivable for transfers of currently invested balances
- ◆ 2150: Payable for transfers of currently invested balances
- ◆ 4165: Treasury-managed trust fund distributions of authority—anticipated
- ◆ 4166: Treasury-managed trust fund distributions of realized authority—to be transferred
- ◆ 4167: Treasury-managed trust fund distributions of realized authority—transferred.

Accounting SGL guidance in this area is provided in SGL account process matrices in the *Trust Fund Accounting Guide*.¹ Although these new and modified ac-

¹ *Trust Fund Accounting Guide*, 39–51.

counts do not take effect until FY 2001, they will be in effect ahead of the MERHCF effective dates.

Discussions with DFAS staff indicate that they are aware of the new procedures because they already provide accounting support for the MRF. DFAS is very experienced at providing trust fund accounting support; nevertheless, MERHCF management should ensure compliance with all of the appropriate elements of this publication as part of its management control and reviews. This assurance, which is part of the "reasonable assurance" safeguard required in the annual reporting, could be accomplished at the same time as FASAB standards compliance reviews or as part of the annual A-123/A-127 review process.

Other Methodologies to Facilitate Accurate Trust Fund Financial Management

As required by FASAB Standard 4, Managerial Cost Accounting Concepts and Standards for the Federal Government, and the need for the most accurate patient cost data by MTFs, MERHCF management and DHP should explore all processes that provide better cost accounting information in a cost-efficient manner. In addition to facilitating more accurate cost identification, this effort may help reduce any criticism from entities or agencies outside DoD that are affected by assigned health care costs (e.g., Medicare and health insurance companies).

One of the most efficient methods of developing good cost accounting processes for budget development and expenditure accounting by organization and function is activity-based cost (ABC) analysis with enhancement recommendations.

FINANCIAL TRANSACTION REPORTING

The process under which the BPD and the program agency have dual financial transaction reporting responsibility is very complex; moreover, such reporting takes place within a very short end-of-period time frame. The BPD reports monthly financial transaction through the SF-224 and FACTS II processes, but the program agency is still required to provide FACTS I and other reporting functions from information transmitted by BPD.

Whenever two accounting/reporting functions must account and report on the same information in the same accounting period, there is potential to miss accounting and reporting deadlines because of the limited time available. Thus, a specific, designated point of coordination should be established in both organizations to resolve any operational problems quickly and efficiently.

TRUST FUND FINANCIAL MANAGEMENT FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This summary of overall findings, conclusions, and recommendations about trust fund financial management requirements and responsibilities is common to all trust fund management functions. Management, internal control, and audit requirements that are part of all federal fund account stewardship are even more important when the funds have been set “in trust” for third parties to fund a benefit.

Findings

The MERHCF contains three elements that give it high visibility:

- ◆ The fund will contain a high dollar contribution level and balance, and its liabilities will be somewhat uncertain in the first years of its operation.
- ◆ The fund involves health care—a very emotional subject.
- ◆ The fund provides security benefits to a large number of military service members and retirees. The former have the advocacy of DoD’s military leadership; the latter have support from senior members of Congress.

This high visibility adds to the requirement for efficient stewardship and effective management control and integrity.

Although the MERHCF is a trust fund, the reason for its establishment and its program-support mission are limited. The fund will serve as a funding mechanism, replacing the current annual appropriations, “pay-as-you-go,” funding methodology. Thus, although the trust fund concept is critical, it is not new; it is a more effective way of maintaining the proper level of funding for health program services for military retirees.

A trust fund requires an arms-length relationship between the assets of the fund and the federal agency that manages it in both fact and perception.

Conclusions

The management and internal controls we have summarized are the same type of fiscal integrity controls required for all federal funds. Because of the stewardship nature of trust funds, however, efficient utilization of these controls is even more important. Congress, uniformed service members, and the public alike must be assured that MERHCF funds are being managed and safeguarded in a very efficient environment.

Thus, placement of the fund's stewardship/management organization within DoD should present an independent-fund image and assurance of fund autonomy to all. Furthermore, the fund's management and internal control program and activities should not only be adequately provided and supported but should present an "independently executed" image.

Recommendations

The following functions require adequate organizational placement and resources and must be conducted in an independent manner specifically for the trust fund:

- ◆ Management and internal control reviews and resource management requirements (OMB Circular A-123, Internal Control Systems; OMB Circular A-127, Financial Management System; and OMB Circular A-130, Management of Federal Information Resources)
- ◆ Independent financial and compliance audit requirements
- ◆ Department of the Treasury and FASAB accounting regulations and compliance guidance
- ◆ Program and mission compliance reviews.

These functions will not only facilitate effective management and internal control; they will assist the fund's trustees in developing annual reporting to Congress, the President, and the public.

Chapter 8

Extending Accrual Funding to All Military Retirement Health Care

There are two persuasive arguments in favor of extending MERHCF coverage to all military retirement health care benefits:

- ◆ *Consistency.* Logically, all retirement health care should have the same funding source. Furthermore, the MERHCF would provide non-Medicare-eligible retirees with the same stable benefit funding that their Medicare-eligible brethren will soon enjoy.
- ◆ *Economic military personnel decision making.* In deciding on a course of action, all relevant costs must be considered. Accrual funding of only part of the military retirement health care benefit hides a major portion of the cost of that benefit and hence total military personnel costs.

Applying accrual funding to all military retirement health care will have the effect of institutionalizing the benefit—that is, making it an entitlement. We must recognize that the eligibility of retirees and their dependents and survivors who are not eligible for Medicare already is documented and recognized by DoD and retirees. Applying accrual funding to all military retirement health care would have the primary effect of protecting the funding for this benefit. There may be some resistance to this change, but extending the same commitment to non-Medicare-eligible retirees that Congress has made to Medicare-eligibles becomes a matter of fairness. Doing so undoubtedly will have a positive effect on the morale of current service members.

The MERHCF protects the funding of the DoD health care benefit for Medicare-eligible beneficiaries. To the extent that the direct care system is operating at capacity, an increase in the amount of health care delivered to Medicare-eligibles probably would come at the expense of non-Medicare-eligible retirees. These beneficiaries probably would seek more-expensive care through the purchased care system. To the extent that there is available capacity at MTFs, an increase in care delivered to Medicare-eligible beneficiaries would not squeeze other beneficiaries out and could result in more efficient utilization of resources. Whether the marginal cost of the care delivered would be less than the cost to DoD of comparable levels of care through Medicare would depend on each individual situation.

Extension of coverage would be a matter of revising the actuarial estimates to include all military retirement health benefits in the calculation of the unfunded accrued liability and normal cost payments. The name of the fund would have to be changed, perhaps to Military Retirement Health Care Fund. DoD has been esti-

EFFECT OF ACCRUAL FINANCING FOR ALL MILITARY RETIREMENT HEALTH CARE ON THE FEDERAL GOVERNMENT AS A WHOLE

Extending the coverage will have no effect on Medicare or HCFA because, by definition, the people covered are not yet eligible for Medicare benefits.

Effects of Accrual Funding of All Military Retirement Health Care on Federal Finances

The only difference in the cost from a taxpayer's standpoint is the cost associated with administering the fund. To the extent that administrative costs might rise if accrual funding were extended to all military retirement health care benefits, there would be an increase in costs to the taxpayer.

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unfunded accrued liability. This increase in the fund balance will increase the debt, although the annual increase will be inconsequential in comparison to the size of the debt as a whole. Furthermore, extending MERHCF coverage simply formally funds a liability that is already recognized on DoD financial statements.

Costs of Accrual Funding for All Retirement Health Care to DoD as a Whole

DoD costs to administer accrual funding for all military retirement health care probably would rise. This increase would be related to expanded recordkeeping and reporting requirements to support a higher number of claims and episodes of direct care. We do not believe that this cost will be excessive as long as DFAS fund managers do not have to process individual fund requests for each episode of health care.

There is no doubt that if DFAS must process individual FFS reimbursement requests, administrative costs to DFAS and DHP will be significant. Although health care service will not increase under the trust fund concept per se, the overall cost of administering any of the trust fund options will significantly increase DoD's administrative cost of providing the current level of MTF health care services to retirees. It will not only add to the cost of administering the fund, it will increase the administrative costs to the MTFs as a result of greater demands on patient care and financial systems.

In addition, if the active uniformed services perceive this process as an erosion of their benefits, the additional cost for recruitment or retention bonuses may increase to the point of increasing, rather than decreasing, the total cost to maintain an efficient uniformed corps. This legislation should provide reassurance to the active-duty uniformed services that their health care protection has been extended by law throughout their retirement.

Other Government Entities' Financing of Retirement Health Care

Our primary method of researching this issue was a search of Internet Web sites. We also contacted local county and school districts to verify that they did not use trust funds. Governments that offer a health care component in their retirement packages provide a partial payment of premiums to health care insurance providers or health maintenance activities that are one of the accepted participants (e.g., Blue Cross, Aetna, Kaiser) in that government's health care process.

Aside from the Congressionally established Medicare and Medicaid programs—which are used to provide medical care funding for specific segments of the public—the team could not identify any other federal agency or state or local government or school district that funded retirement health care programs through a trust fund.

The private sector generally does not fund retirement health care benefits on an accrual basis because there are no tax or other incentives to do so. The Financial Accounting Standards Board (FASB)—the governing organization for accounting standards in the private sector—requires accrual accounting of retirement health care provided by employers.

STRATEGY FOR OBTAINING CONGRESSIONAL APPROVAL

Committees in the House of Representatives and the Senate have an interest in approving an accrual financing system and associated trust fund, including extending the coverage of an existing trust fund. Table 8-1 shows which committees would be a part of the legislative process.

Table 8-1. Cognizant Congressional Committees

House of Representatives	Senate
Appropriations (Defense and Military Construction Subcommittees)	Armed Services (and Subcommittee on Military Personnel Actions)
Commerce	Appropriation (Defense and Military Construction Subcommittees)
National Security	Authorization
Ways and Means	Finance

In addition to the committees listed in Table 8-1, conference committees also would be expected to convene to reconcile areas of conflict between the House and Senate versions of bills.

One strategy for obtaining favorable consideration in these committees would be presentation by DoD of evidence that links the need for the legislation and resolution of problems of recruiting and retaining qualified military personnel. DoD can make the point that extending accrual funding to all retirement health care will have a positive effect on morale and hence retention.

Another strategy would be for DoD to coordinate its position with the nonmilitary components of the uniformed services, such as the National Oceanographic Atmospheric Administration (NOAA) and the PHS, to present a consolidated perspective to the legislative committees.

A final component would be informal contact with military and retiree service and advocacy associations (such as the Fleet Reserve Association and The Retired Officers' Association). These organizations can marshal their membership to generate political support for extending MERHCF coverage.

Chapter 9

Summary of Recommendations

In the National Defense Authorization Act for Fiscal Year 2001, Congress expanded DoD health care benefits for Medicare-eligible military retirees and their dependents and survivors. The Act further established the MERHCF to fund the expansion of the benefit on an accrual basis, leaving funding of DoD health care for non-Medicare-eligible retirees to continue on a pay-as-you-go basis. The trust fund will start operation on October 1, 2002.

In this task, we researched issues relating to implementation and operation of accrual funding for the military retirement health care benefit. Although we concentrated on accrual funding of the portion of the benefit delivered to Medicare-eligible beneficiaries, we did so with the idea of future expansion of the MERHCF to fund all DoD health care for military retirees. This report presents the results of our research, as well as our recommendations for accrual funding implementation and operation.

Three primary precepts guided our research and analysis:

- ◆ The MERHCF will solely and completely pay the DoD-funded portion of the retirement health care benefit for Medicare-eligible military retirees and their dependents and survivors.
- ◆ Under accrual financing, DHP will have the dual objectives of increasing the availability of health care to Medicare-eligible beneficiaries and controlling health care costs.
- ◆ The MERHCF should pay agencies and commands that spend money to provide health care to Medicare-eligible beneficiaries for the actual costs of that care. Money that is not actually spent (e.g., depreciation, unfunded retirement benefits) should not be paid by the fund.

IMPLEMENTATION OF ACCRUAL FUNDING

We determined that the current accrual funding system for military pensions, funded by the MRF, has worked well. The organizational roles, responsibilities, and relationships for this system are well established. We find no reason for the MERHCF to do business differently. The OOA should provide actuarial support under the guidance of the DoD Medicare-Eligible Health Care Board of Actuaries.

We recommend that under accrual funding, DFAS will receive and consolidate requests for funds transfer from TMA and submit a single request for funds transfer from the BPD. DFAS will transfer funds monthly for the DoD payment and select securities for investment and disinvestment. Inter-Departmental relationships should be formalized via a letter or memorandum of understanding or agreement. Operations within DoD should be governed by appropriate DoD instructions.

ACCRUAL FUNDING OPERATION

The MERHCF should reimburse DHP for care actually delivered (retrospective payment). DHP can use reimbursable obligational authority to provide funding to cover obligations before reimbursement is received.

MERHCF Withdrawal Calculations

We recommend that withdrawals from the MERHCF be calculated with a variation of the third-party collection rate schedules in use by military MTFs to collect from civilian health insurers and other government agencies. The international rate schedule reimburses MTF O&M costs. The difference between the international and interagency rates yields the MilPers cost of health care. We note that the MilPers reimbursement rate should include the full costs of military personnel, including pay and allowances and retirement benefits (pension and health care).

Because of the uncertainty of budget estimates for the cost of the new benefit, during the first few years of operation an alternative method of determining the MERHCF withdrawal for MTF operating costs can be used. This approach would allocate actual MTF operating costs according to the proportion of the MTF level-of-effort devoted to Medicare-eligible beneficiaries. This will help ensure that the MTFs can meet their fixed operating costs if the level of care for Medicare-eligible beneficiaries is lower than forecast.

Paying for Military Retirement Health Care

We recommend that MTFs submit computer records of care delivered to Medicare-eligible beneficiaries to TMA headquarters. These records would enable calculation of the reimbursement to the MTF for O&M and locally funded equipment procurement and construction. There also would be sufficient data to calculate the reimbursement for MilPers and centrally managed procurement and MilCon costs attributable to health care that the MTF delivered.

The TMA would calculate the amount due to each MTF and its associated costs in other accounts, consolidate the "bills," and submit to DFAS a single request for MTF reimbursement, as well as data for MilPers, procurement, and MilCon reimbursement. The TMA also would calculate the portion of purchased health

care costs that is attributable to Medicare-eligible beneficiaries and submit a request for those funds to DFAS.

DFAS would consolidate all funding requests, select securities, and direct the BPD to disinvest these securities to generate required funds. When funding has been transferred by the BPD, DFAS would disburse the funding to appropriate claimants.

Because MTFs do not pay MilPers costs for attached military personnel, we recommend that reimbursement for these costs be paid to the MilPers accounts at the Service level. Because MilPers costs must be fully funded in the President's budget submission to Congress, we recommend that the reimbursement be made at the beginning of the second fiscal year following the year in which the health care is delivered. This approach would allow DoD to fully fund MilPers accounts with a combination of a known MERHCF reimbursement and appropriated funding.

Similarly, Service procurement and MilCon accounts can also be reimbursed annually at the beginning of the second fiscal year following the year in which the costs are incurred. This will allow DoD to submit a fully-funded budget for these accounts.

MERHCF Deposits

The National Defense Authorization Act for Fiscal Year 2001 contains language requiring that the DoD deposits come from the DHP accounts. These deposits represent the cost of future retirement benefits earned by current service members during the period covered by the deposit. We feel that the retirement health care benefit is a cost of military labor in the same sense as the military pension. In order to accurately display that military labor cost, we recommend that the DoD deposits come from the Service military personnel accounts. DoD should propose legislation to this effect.

In addition to DoD's monthly deposits covering future benefits, the Department of the Treasury makes an annual deposit to amortize the original unfunded liability plus any actuarial gains and losses thereto. These deposits will be calculated by the OOA under the guidance of the DoD Medicare-Eligible Retiree Health Care Board of Actuaries.

The actuarial calculations that determine these deposits rely on exposed population data from DMDC and the costs of health care actually delivered. This methodology has been used since 1990 to calculate DoD's liability for military retirement health care for the Department's annual financial statements and other uses. The advantage of this methodology is that it automatically incorporates limitations of demand and availability, and changes are incorporated into the estimates as they occur.

MERHCF Operation

Legislation and regulations require the MERHCF to operate with a system of internal controls and external review and audit to ensure that the fund is used for the purpose intended by Congress in the establishing legislation and to prevent waste, fraud, and abuse. The high visibility of the MERHCF also should generate increased scrutiny from Congress and auditing agencies. OMB Circulars A123, Internal Control Systems; A-127, Financial Management Systems; and A-130, Management of Federal Information Resources provide guidance in this area. The fund must be managed to ensure compliance with applicable laws and regulations, as well as reasonable assurance and safeguards against waste, loss, unauthorized use, and misappropriation.

As with the MRF, we recommend that DFAS manage the MERHCF security portfolio and provide all accounting and financial services.

To maintain an arms-length relationship in appearance and fact, the fund should have a presidentially appointed Board of Trustees that includes the Secretaries of Defense and the Treasury.

The MERHCF should operate in accordance with guidance provided in the *Trust Fund Accounting Guide* published by the Department of the Treasury. FASAB also provides guidance in Standard 1, Accounting for Selected Assets and Liabilities; Standard 4, Managerial Cost Accounting Concepts and Standards; Standard 5, Accounting for Liabilities of the Federal Government; Standard 7, Accounting for Revenue and Other Financing Sources; and Standard 12, Recognition of Contingent Liabilities Arising From Litigation.

MERHCF managers should use ABC studies to develop good cost accounting processes for budget development and expenditure accounting.

Because the BPD and DFAS have dual financial transaction reporting responsibility, the process is very complex; it also occurs within a very short end-of-period time frame. The BPD reports monthly financial transaction through the SF-224 and FACTS II processes, but DFAS is still required to provide FACTS I and other reporting functions from information transmitted by the BPD. We recommend that both agencies designate points-of-contact to ensure expeditious resolution of any problems.

EXPANSION OF THE MERHCF TO COVER ALL MILITARY RETIREMENT HEALTH CARE

We believe that extending MERHCF coverage to all DoD health care for military retirees—not just health care for Medicare-eligible beneficiaries—is logical and desirable. This extension would result in a consistent funding method for all military retirement health care and provide all retirees with the same stable benefit

funding. It also would support better military personnel decision making because the total cost of the retirement health care benefit would be available for consideration. Extending MERHCF coverage would have the effect of making the military retirement health care benefit an entitlement, which undoubtedly would have a positive effect on the morale of current service members.

SUMMARY

Congress has established the MERHCF to provide accrual funding of the DoD military retirement health care benefit for Medicare-eligible beneficiaries. DoD will have to resolve some issues before it implements accrual funding. These fundamental decisions involve choosing among feasible alternatives. Accrual funding would provide a stable source of funding for the benefit and the potential for better health care for Medicare-eligible beneficiaries.

Appendix A

General Description of Scope and Function of Federal Trust Funds

Statutes and regulations mandate that trust fund monies are to be disbursed only to reimburse expenses incurred on behalf of the program activity associated with the specific purposes for which the trust fund has been established. For example, the National Defense Authorization Act for Fiscal Year 2001 states, "There shall be paid from the Fund amounts payable for the Department of Defense retiree health care programs for Medicare-eligible beneficiaries." The definition of what constitutes retiree health care programs, however, is determined by DoD, not the fund. This definition of health care service deliverables is a DoD health care management issue, unless otherwise directed by legislation.

A brief identification of federal trust fund parameters serves as a useful framework for understanding the MERHCF. FASAB's Statement of Federal Financial Accounting Concepts No. 2, "Entity and Display," states:

Care must be taken in determining the nature of all trust funds and their relationship to the entity responsible for them. A few trust funds are truly fiduciary in nature. Most trust funds included in the budget are not of a fiduciary nature and are used in federal financing in a way that differs from the common understanding of trust funds outside the federal government. In many ways, these trust funds can be similar to revolving or special funds in that their spending is financed by earmarked collections.

In customary usage, the term "trust fund" refers to money belonging to one party and held "in trust" by another party operating as a fiduciary. The money in a trust must be used in accordance with the trust's terms, which the trustee cannot unilaterally modify, and is maintained separately and not commingled with the trustee's own funds. This is not the case for most federal trust funds that are included in the budget—the fiduciary relationship usually does not exist. The beneficiaries do not own the funds and the terms in the law that created the trust fund can be unilaterally altered by Congress.¹

¹ Federal Accounting Standards Advisory Board, Statement of Federal Financial Accounting Concepts No. 2, "Entity and Display," June 5, 1995, paragraphs 18–19.

In normal usage—aside from the establishment of federal trust funds—a “true” trust fund contains funds that have been established on behalf of a specific individual and beneficiaries. The total trust amount for any individual will equal the balance of funds deposited into the trust fund on that individual’s behalf and associated investment interest. Many retirement funds have an employee fund balance; this balance usually is not withdrawn but is left in the fund in favor of the employee electing to receive a periodic retirement payment throughout the employee’s life. Thus, retirement trust funds are not “true” trust funds (i.e., they are not of a fiduciary nature and are used in federal financing or a retirement program). Likewise, the MERHCF will not be fiduciary in nature; it will be used in federal financing of health care for its retirees.

TRUST ASSETS, INVESTMENTS, AND ADMINISTRATION

Federal trust funds usually must be invested only in Department of the Treasury securities. Thus, the MERHCF also will be limited to investment in a mix of Treasury securities prescribed by its enabling legislation (or subsequent appropriation legislation). Like Medicare, the MERHCF was established to finance social insurance (health care) payments for individuals who are registered beneficiaries of its program. Also like Medicare, several of the payment-method options considered in this analysis are based on the concept of an FFS disbursement process.

Section 1112, Assets of the Fund, of the National Defense Authorization Act for Fiscal Year 2001 states:

There shall be deposited into the Fund the following, which shall constitute the assets of the Fund:

1. Amounts paid into the Fund under section 1116 of this title. (Note: These payments cover the liability incurred during the year by service members and amortization of the unfunded accrued liability.)
2. Any amount appropriated to the Fund.
3. Any return on investment of the assets of the fund.

There will be three primary funding sources for the MERHCF: federal contributions for the fund’s share of enrollees’ health care costs, fund interest income from investments in Treasury debt securities, and (depending on DoD and Congressional decisions concerning unfunded liabilities) special appropriations that may be required to be apportioned as deposits into the trust fund. Funds from any source are recorded in the MERHCF’s receipt account(s) as they are received into the fund. Monies deposited in these receipt accounts should be (according to the enabling statute) immediately available for investment in eligible Treasury debt securities.

MERHCF INVESTMENTS

The National Defense Authorization Act for Fiscal Year 2001, Section 1117, Investments of Assets of Fund, states:

The Secretary of the Treasury shall invest such portion of the Fund as in the judgment of the Secretary of Defense is not required to meet current withdrawals. Such investments shall be in public debt securities with maturities suitable to the needs of the Fund, as determined by the Secretary of the Treasury, taking into consideration current market yields on outstanding marketable obligations of the United States of comparable maturities. The income on such investments shall be credited to and form a part of the Fund.

GENERAL TRUST FUND ADMINISTRATIVE ISSUES

Administrative and operating costs required to establish and operate the trust fund often are provided from appropriation funding that is separate from funding for the trust fund. These costs are not considered expenses of the trust fund itself because trust fund monies, by definition, are to be expended only to reimburse health care costs on behalf of the beneficiaries.

In some cases, administrative expenses are paid by the fund itself. Several of the more notable examples are trust funds that act on the concept of collecting and distributing user fees to meet the program needs of those users (e.g., Highway Trust Fund, Airport and Airway Trust Fund).

Several social action/individual beneficiary-type trust funds (e.g., Social Security) have separate appropriated sources of funds to pay for administrative expenses.

All expenses associated with the MERHCF will be met with existing DoD appropriations or separate Treasury funds to cover administrative expenses incurred on the fund's behalf by the BPD.

In a report to Congress, the Congressional Research Service (CRS) made the following comparison:

As a result of OBRA90, the Social Security trust fund was specifically excluded from budget calculations for the unified budget. The legislation did not, however, remove the costs of administering the social security program from the budget. This is worth noting because all of the administrative expenses of the FHWA and a large portion of the FAA's operating and maintenance expenses are derived from the trust funds.²

² Congressional Research Service, "Transportation Trust Funds: Budgetary Treatment," Report to Congress (updated April 6, 1998), p. 8.

On another administrative and accounting note regarding trust funds, that same CRS report opened its Conclusions section with the following opinion:

Regardless of where trust funds reside in terms of the unified budget, they remain federal accounts with a dedicated revenue stream. As such, they must still be accounted for from an actuarial standpoint. The observation that the devil is in the details would seem to be applicable in this context.

The CRS report suggests that the most efficient way to operate the funds is to pay for any MERHCF administrative expenses from appropriated funds, rather than burdening the funds themselves. If the fund were required to pay for its own administrative and operating expenses from within the trust fund itself, those additional operating funds have to be provided from DoD contributions, and a separate fund operations accounting process would have to be implemented.

The National Defense Authorization Act for Fiscal Year 2001 does not specifically identify any direction in fund administration, other than that the fund is placed within the Department of the Treasury, with disbursements directed and utilized by DoD. Although the Department of the Treasury has the responsibility to administer the investment and some reporting responsibilities, management of the fund is within the responsibility of DoD, from the standpoint of timing and use of disbursements and DoD health care reimbursements.

REIMBURSEMENT IN GENERAL

The National Defense Authorization Act for Fiscal Year 2001, Section 1113, Payments from the Fund (in that section's direction concerning payment requirements of the fund), states:

(a) There shall be paid from the Fund amounts payable for the Department of Defense retiree health care programs for medicare-eligible beneficiaries.

(b) The assets of the Fund are hereby made available for payments under subsection (a).

Several parameters of the health care program's reimbursement process have not yet been identified. This report discusses a range of trust fund options, within potential health care delivery and reimbursement scenarios, for providing the most efficient process to reimburse DoD for retiree health care.

To date, the scope of health care provided under the MERHCF has not been defined in terms of services provided. That is, will health care be provided (to Medicare-eligible retirees) by the DoD MTFs and Tricare, or will only Tricare services be provided? The reimbursement process options we evaluated in this analysis were defined to be executed by the fund in either event.

ACCOUNTING AND AUDITING PRACTICES FOR MERHCF AND SIMILAR TRUST FUNDS

The MERHCF was established on an accrual-financing basis. The federal government bases its financial regulations, accounting, and reporting on an accrual basis for funds that are appropriated by Congress (i.e., revenues are recorded when earned, and expenses are recorded when incurred). It also uses this accrual process in accounting for funds that arise as the result of activities and programs that are funded through an appropriation process. Thus, federal trust funds use this accrual basis in accounting for funds.

The trust fund-specific federal accrual accounting requirements have just been released and provided as working drafts.³ The MERHCF should perform all accounting practices in accordance with this authority.

Because of the independent stewardship nature of the trust fund, a custodial management responsibility usually is maintained by the federal organization that is responsible for that trust fund. These funds also have separate internal control responsibilities, in addition to financial and (program and regulatory) compliance audit requirements.

Although this study is limited to the MERHCF trust funds, the MTFs' information systems also should be addressed. The more dependent the trust fund's reimbursement is on an FFS/specific patient treatment event, the more audit-worthy the MTF's patient care, treatment tracking, cost accounting, and billing systems will have to be.

For perspective on how the MERHCF would compare in complexity, the MRF—although very large and complex—does not contain as many financial variables as the MERHCF. The MRF does not require as many systems to determine the amount of payment to be made. Like the MERHCF, however, the MRF is subject to the same federal trust fund accounting and audit regulations.

Because there is a dual fund management role performed by two major departments (Treasury and DoD), to facilitate later audit and internal efforts we recommend that the Departments' Office of Inspector General meet on issues of audit responsibility and management internal control programs and responsibilities. These issues are addressed in Chapter 7 of this report.

³ "Trust Fund Accounting Guide," draft presented by Standard General Ledger & Policy Branch, Fiscal Standards and Reporting Division, Department of the Treasury, June 2000.

CONGRESSIONAL AND DEPARTMENTAL OVERSIGHT OF BUDGETARY AUTHORITY

To ensure Congressional, executive, and departmental oversight of the fund's budgetary authority, the MERHCF should be subject to an annual Congressional appropriation (within the DoD budget), OMB apportionment, and departmental allotment/suballotment (if appropriate). The need for Congressional oversight will be particularly relevant if the fund will directly reimburse appropriations that support military health care activities, as opposed to disbursement options that directly pay health care organizations for medical services provided to retired enrollees on an FFS basis (similar to the Medicare reimbursement method).

TRUSTEES

Federal trust funds have a board (or other body) of trustees who oversee their operations. Because federal trust funds are monies that are held in trust for a group of beneficiaries, the trustees have a duty to ensure proper stewardship, effective internal control, and appropriate disbursement of funds. These trustees also periodically report on the trust fund's management practices, internal control, and financial status; this report usually is certified by an independent audit function.

To maintain the level of trustee oversight in accord with other federal trust funds, we recommend that trustees of the MERHCF include the Secretary of the Treasury, the Secretary of Defense, and the Secretary of Health and Human Services. Such a board of trustees would not be inconsistent with existing guidance within the MERHCF legislation.

Appendix B

Payments Under Medicare and Tricare for Medicare-Eligible Beneficiaries

This appendix discusses payments for care of medicare-eligible beneficiaries. As a background, the following cost examples illustrate what payment might look like in two areas with large military retiree populations under each of the options discussed in this report. The numbers are from Medicare's inpatient prospective payment system (PPS) and Medicare+Choice programs.

National Standardized Amounts (NSAs) for large urban areas:

- ◆ Labor-related: \$2,809.18
- ◆ Non-labor-related: \$1,141.85
- ◆ DRG 20:
 - Medicare relative weight: 2.6125
 - CHAMPUS relative weight: 2.2244

A Medicare PPS/FFS reimbursement is calculated according to the following formula:

$$\text{Reimbursement} = [(\text{Labor-related} \times \text{Wage index}) + \text{Non-labor-related}] \times \text{Medicare Relative Weight}$$

A DoD third-party collection (TPC) reimbursement is calculated according to the following formula:

$$\text{Reimbursement} = \text{MTF Adjusted Standardized Amount} \times \text{CHAMPUS Relative Weight}$$

Examples:

- ◆ San Antonio, Texas:
 - Medicare PPS/FFS:
 - Wage index: 0.8318

- $\text{DRG 20 Reimbursement} = [(2809.18 \times .8318) + 1141.85] \times 2.6125 = \$9,087.65$. An average inpatient hospital provider in this city would receive \$9,087.65 for treating a patient coded with DRG 20.
- Medicare Capitation: Bexar County's monthly rates per enrollee are \$279.84 for hospital services and \$224.51 for nonhospital and physician services.
- DoD TPC:
 - Brooke AMC:
 - Adjusted Standardized Amount: \$8,511
 - DRG 20 Reimbursement: $\$8,511 \times 2.2244 = \$18,931.90$ According to DoD documents, the TPC for Brooke AMC for DRG 20 is \$18,931.87.
 - USAF 59th Medical Wing (Wilford Hall):
 - Adjusted Standardized Amount = \$8,640
 - DRG 20 Reimbursement: $\$8,640 \times 2.2244 = 19218.816$. According to DoD documents, the TPC for Wilford Hall for DRG 20 is \$19,218.82
- ◆ San Diego, California:
 - Medicare PPS/FFS:
 - Wage index: 1.1955
 - DRG 20 reimbursement is $[(2809.18 \times 1.1955) + 1141.85] \times 2.6125 = \$11,756.84$. An average inpatient hospital provider in this city would receive \$11,756.84 for treating a patient coded with DRG20.
 - Capitation: San Diego County's monthly rates per enrollee are \$327.89 for hospital services and \$247.15 for nonhospital and physician services.
 - DoD TPC:
 - San Diego Naval Hospital:
 - Adjusted Standardized Amount: \$9,744

- DRG 20 Reimbursement: $\$9,744 \times 2.2244 = \$21,674.553$ According to DoD documents, the TPC for San Diego Naval Hospital for DRG 20 is \$21,674.55.
- ◆ Norfolk, Virginia:
 - Medicare PPS/FFS:
 - Wage index: 0.8442
 - DRG 20 Reimbursement is $[(2809.18 \times 0.8442) + 1141.85] \times 2.6125 = 9178.6522$. An average inpatient hospital provider in this city would receive \$9,178.65 for treating a patient coded with DRG 20.
 - Capitation: Portsmouth's monthly rates per enrollee are \$271.83 for hospital services and \$204.89 for non-hospital and physician services.
 - DoD TPC:
 - Portsmouth Naval Hospital
 - Adjusted Standardized Amount: \$7,469
 - DRG 20 Reimbursement: $\$7,469 \times 2.2244 = \$16,614.043$. According to DoD documents, the TPC for Portsmouth Naval Hospital for DRG 20 is \$16,614.04.

WHO PAYS FOR OVER-65 RETIREES IN MTFs?

Naturally, the question arises: Who pays for retirees to receive care in MTFs? Retirees who are over age 65, of course, are eligible for Medicare. If they receive medical care outside the MTF, Medicare would pay for that care.

Medicare receives its funds through different sources for each of its two parts: Medicare Part A and Medicare Part B. (In general, Part A covers inpatient services; Part B covers outpatient and physician services.) Medicare Part A is financed primarily through the hospital insurance (HI) payroll tax levied on current workers and their employers. Part B is financed through a combination of monthly premiums levied on program beneficiaries and federal general revenues.

Ideally, Medicare would reimburse DoD for beneficiaries who receive otherwise Medicare-covered services in an MTF. Under a recent demonstration project called Medicare Subvention, the Secretaries of Defense and Health and Human Services were to reach an agreement under which Medicare would reimburse DoD for those services. Serious disputes have arisen, however, concerning the amount of money Medicare will pay for care delivered in MTFs. One basis for

those disagreements is evident in the foregoing cost examples: The costs for the MTFs are considerably higher in each case than the FFS cost for other providers in the same area.

The National Defense Authorization Act for Fiscal Year 2001 (H.R. 5408) expands and extends the Medicare Subvention demonstration project. First, it takes the project from a demonstration project to a "program." Second, it contains a budget neutrality provision that limits the amount of money paid out of the Medicare Trust Fund for Medicare services provided in an MTF to the amount that Medicare would have paid for those services in the private sector, plus a set amount for each year through 2005. The authorization act also provides for Medicare to pay for these services in "any site designated jointly by the administering Secretaries." Therefore, the two Secretaries could provide that all MTFs are covered under any agreement they ultimately reach.

CURRENT PAYMENT FOR TRICARE FOR LIFE BENEFICIARIES

MTFs currently are funded by appropriations. These facilities are operated on a day-to-day basis by O&M funding from DHP. This funding pays for civilian staffing, contractual services, supplies, rents, and equipment that costs less than \$100,000. Military costs are paid centrally by the Services. The military payroll is not part of the MTF budget. Equipment purchases for items that cost more than \$100,000 are centrally justified, approved, and funded. A similar process of central funding is in place for construction. Construction projects require Congressional approval.

This system includes funding for all categories of patients: active-duty service members, dependents of active-duty service members, retirees, dependents of retirees, and survivors.

The new trust fund would reimburse MTFs for the costs of care rendered to Medicare-eligible patients over the age of 65. This arrangement generally would include only retirees, dependents of retirees, and survivors.

The reimbursement rate for each MTF rate is based on a mix of civilian and military personnel. This mix will be MTF-specific, based on authorized personnel in that facility. To the extent that authorized military personnel are not assigned for a particular month, the reimbursement to the military pay account is reduced and reimbursement to DHP is increased. This can be averaged for the year.

ESTABLISHMENT OF DEFENSE MEDICARE-ELIGIBLE RETIREE HEALTH CARE FUND

The National Defense Authorization Act for Fiscal Year 2001 also establishes the MERHCF. This fund, to be on the books of the U.S. Treasury, will “be used for the accumulation of funds in order to finance on an actuarially sound basis liabilities of the Department of Defense under Department of Defense retiree health care programs for Medicare-eligible beneficiaries.” In other words, a fund separate from Medicare monies is being established to pay for medical services provided to Medicare-eligible military retirees within MTFs.

This fund will be accrued from monthly payments by DoD, based on current military personnel levels. Theoretically, as these funds accumulate over time, the fund will be sufficient to cover retirees’ health care costs. The law states that the fund is to finance coverage of these beneficiaries’ health care costs under “Department of Defense retiree health care programs for Medicare-eligible beneficiaries.” That phrase is defined as any entitlement to health care for a military retiree who also is eligible to receive coverage under Medicare. Therefore, DoD could use the fund to cover retirees’ health care costs for services provided elsewhere than in an MTF, such as Medicare copayments and deductibles and other services Medicare does not cover (such as prescription drugs).

The law is silent about whether this fund is to be used to pay for Medicare-covered services provided in MTFs. There is no indication that DoD would be expected to pay for services that Medicare would be covering otherwise. For example, if a retiree receives care in a civilian hospital, Medicare should continue to pay for that care. DoD is expected to use the new trust fund to help the retiree pay for copayments and deductibles resulting from services that Medicare would not otherwise cover (in essence, DoD would be using the trust fund to act as a Medi-gap policy for the retiree).

As a corollary (hypothetically), Medicare also should be expected to pay for services provided in an MTF that Medicare would have paid for anyway if they had been provided in the civilian sector. Therefore, the provisions of the Act regarding Medicare subvention would take effect in these instances. The new trust fund would be used to reimburse DoD for expenses incurred within the MTF that Medicare would not have covered in a civilian facility; the Medicare Trust Fund would be expected to pay for Medicare covered services, even if they were provided in the MTF.

It is doubtful whether Medicare would ever reimburse MTFs; thus, all care rendered to eligible beneficiaries would be reimbursed from the MERHCF.

POSSIBILITIES FOR THE MEDICAL HEALTH CARE SYSTEM

MTFs readily lend themselves to offering HMO-style packages. These facilities already have systems in place to track enrollees and the services they receive. MTFs also have a "network" of physicians in their facilities and associated clinics. The main drawback of using MTFs solely to provide care to military retirees is that these facilities do not currently have the capacity to fully provide care to everyone seeking it there. One alternative to this problem may be to add civilian physicians to the MTF network, thus expanding the "MTF HMO."

An MTF HMO could be paid from the DoD trust fund on a capitated basis for each enrollee in the geographic area. The MTF HMO could then arrange to pay civilian physicians needed to expand their reach, on a capitated basis or under a DRG-style system.

This arrangement could place MTFs in direct competition with existing Tricare contracts. Tricare already is providing health care services to military personnel and, in some cases, retirees in areas that also are served by MTFs. Of course, in areas where there are no MTFs, the problem of competition would not exist.

COVERAGE FOR RETIREES WHO ARE ELIGIBLE FOR MEDICARE

The main concern in covering retirees over the age of 65 is ensuring that they do not face excessive health care costs that are not covered by Medicare. The "Medicare for Life" initiative contained in H.R. 4205 would address this concern. The initiative puts DoD in the position of offering a Medigap policy for over-65 retirees, paying for all but a very small amount of non-Medicare-covered expenditures.

The purpose of Medigap is to help beneficiaries pay for costs and services that are not covered under basic Medicare. In the private sector, Medigap plans' basic coverage includes hospital coinsurance coverage, 365 days of full hospital coverage, the 20 percent coinsurance for non-inpatient hospital services that Medicare does not cover, and the first 3 pints of blood needed by a beneficiary in a given year. Many Medigap plans also include payment of the hospital deductible and at least limited prescription drug coverage.

Obviously, recently passed legislation does not permit DoD to limit coverage to the extent that the private sector can. Providing extra services within MTFs should not be problematic, as long as those MTFs have the capacity. DoD could build on the Medicare Subvention demonstration project (which has had limited success) to obtain reimbursement from Medicare as the primary payer for medical services. DoD would then simply absorb the cost of all other services provided.

DoD would still be required to act as a Medigap plan for beneficiaries who receive care outside the MTFs (the law contains no requirement that care be obtained in that setting). This is the point at which DoD would need to decide whether to pay for services provided to eligible retirees on an as-provided basis (also known as FFS) or contract for those services under some form of managed care.

Appendix C

Medicare Program Experience with Fee-for-Service and Capitation Payments

Accrual financing of the DoD health care system will work best if a payment method for services is implemented that lends itself to easily estimating how much money the system will need to pay out in a given year. Two approaches are most likely: creating specific payment amounts for each episode of care—known as fee-for-service—or paying each provider a capitated amount for each enrollee.

FEE-FOR-SERVICE

An FFS system pays the provider each time the enrollee receives medical services. This method has the advantage that the payment follows the enrollee, with no regard to whether the enrollee receives services from a particular provider. On the civilian side, Medicare has created an FFS system that applies particular payment amounts for each service supplied, based on the enrollee's diagnosis. This system allows providers to know, upon diagnosis, how much they will receive for treating these patients.

To implement such a system, providers must have special computer systems to allow coding and processing of diagnosis codes. Medicare has had difficulties with providers "gaming" the system by "upcoding"—whereby providers enter a particular diagnosis with a code that receives a higher payment than a more applicable code. Coding, like medicine itself, is not always a precise science. MTFs already have such computer systems.

A key point is that under an FFS system beneficiaries are most likely to have fewer concerns about whether they are receiving all of the medical care they need. Managed care, or capitated, systems offer at least the potential appearance of rationing of medical care because the provider has a financial incentive to not provide services. Under FFS, the provider receives an additional payment every time the beneficiary is seen or cared for. If anything, this system can lead to overuse of the medical system.

DIAGNOSIS-RELATED GROUPINGS UNDER MEDICARE

Since 1983, Medicare Part A has reimbursed inpatient hospital care through the PPS. Beginning in 1999, separate PPSs have been implemented to cover services such as outpatient care by hospitals and physicians, home health services, skilled nursing, and rehabilitation services.

Under the PPS, fixed payment amounts are established in advance of provision of services, based on a patient's diagnosis. Facilities that can provide services for less than the fixed PPS payment may retain the difference. Hospitals with costs that exceed the fixed PPS payment lose money. The system's fixed prices are determined in advance on a cost-per-case basis, using a classification system of approximately 500 diagnosis-related groups (DRGs).

Each Medicare case is classified according to the appropriate system, based on the patient's medical condition and treatment. DRGs are weighted in relation to each other to reflect variations in the costs of treating a particular diagnosis, including the use of physical resources and personnel. The DRG-based payment rate is designed to represent the national average cost per case for treating a patient with a particular diagnosis.

DoD already has information in its computer databases to enable it to create payment rates for hospitals, physicians, and other services provided in its MTFs. Therefore, such a system would be relatively simple to create and implement.

PPS rates are updated each year, using an update factor that is based, in part, on the expected increase in the hospital market basket index. Additional payments are added to account for facilities' unique circumstances, such as size (or lack thereof), urban or rural location, teaching status, and high level of uninsured patients. Therefore, not every hospital receives the exact same amount of money for every service, although all facilities start from the same nationally determined amount. In a particular hospital, however, all cases assigned to the same DRG are reimbursed at the same predetermined rate. The TMA uses a similar approach to calculate third-party collection rates.

CAPITATED PAYMENTS

With the advent of managed care in the general marketplace, Medicare began to explore how to utilize this form of care delivery for Medicare beneficiaries. In 1972, HMOs operating under cost or risk contracts were authorized to serve Medicare beneficiaries on a prepaid basis. Payment rates were based on actuarial estimates of the per capita cost that Medicare incurred to pay claims on an FFS basis in a beneficiary's county of residence. These county estimates were adjusted for the demographic composition of that county (age, gender, Medicaid eligibility status, working aged status, and institutional status) to produce a figure representing the costs that would be incurred by Medicare on behalf of a national average Medicare beneficiary living in that county.

An average payment rate (APR) was calculated, which was the amount an HMO expected to receive from Medicare. The APR was based on adjusted average per capita cost (AAPCC) rates and the numbers and categories (e.g., age, gender, institutional status) of enrolled beneficiaries.

The adjusted community rate (ACR) was used to help ensure the accuracy of HCFA's AAPCC rates. The ACR was calculated by HMOs; it was an estimate of what they would charge Medicare beneficiaries for Medicare-covered services if the beneficiaries were commercial enrollees. If the APR was greater than the ACR, the savings had to be returned to Medicare or program beneficiaries, usually through richer benefits. If the APR was less than the ACR, the loss had to be absorbed by the HMO.

Under this system, Medicare managed care rates were based on all local Medicare FFS spending, including payments for services as well as payments for GME and payments to hospitals that serve a disproportionate share of low-income and elderly patients. Managed care rates reflected local practice patterns, the health status of local beneficiaries, and local prices. This arrangement resulted in large variations across the country and within individual states. Managed care rates were reduced by 5 percent to reflect the assumption that managed care can be more cost-effective than FFS. Growth in managed care rates also was tied to growth in FFS spending.

AAPCC was criticized for its wide range of payment rates among geographic regions: In some cases, payment rates varied by more than 20 percent between adjacent counties. It also was criticized for its poor risk adjustment capabilities and inappropriate provision of GME funds to some Medicare risk plans. Moreover, AAPCC was criticized for setting erratic annual payment updates, which often made long-term business planning difficult for contracting health plans.

MEDICARE+CHOICE

The Balanced Budget Act (BBA) of 1997 revamped Medicare's use of managed care through implementation of the Medicare+Choice (M+C) program. This program would allow a wide range of health care plans to participate in Medicare: not just HMOs but also PPOs, medical savings accounts, and private FFS plans. The BBA's initiatives also were designed to address the foregoing criticisms of AAPCC.

The BBA established new rules for calculating payment amounts for these plans. The annual capitation rate for a payment area is set at the highest of three amounts calculated for each county: a blend of a local rate and a national rate; a minimum or floor rate per beneficiary in the county; or a rate reflecting a minimum increase from the previous year's rate (with the 1997 amount as the baseline). As with the AAPCC methodology, monthly payments are county rates, adjusted for the demographic status of each enrollee. The BBA changes are designed to correct excess payments to health plans, reduce geographic variations in payment, and align managed care organization (MCO) payments to reflect beneficiaries' health status.

It is unclear whether DoD would need to follow Medicare in this area, but HCFA also is implementing risk adjustment factors to M+C payment rates. These factors

attempt to adjust managed care plans' payments to account for "adverse selection," which occurs when most enrollees are the healthiest in a county, leaving less-healthy people to continue to utilize FFS. Under this arrangement, adverse selection would lead to plans receiving payments that are too high. Research by the Medicare Payment Assessment Commission has been revealing, however, that the risk adjustment system accounts for only a very small amount of payment rate differentiation across the nation. Therefore, there is some question about whether risk adjustment is worth the effort.

One last comment about risk adjustment: DoD does not really need to worry about adverse selection because the entire eligible population (that is, all military retirees over the age 65) is likely to enroll in the final system. Therefore, there will be no payment rate differentiation caused by enrollment patterns.

Appendix D

National Defense Authorization Act for Fiscal Year 2001, Section 713

SEC. 713. ACCRUAL FUNDING FOR HEALTH CARE FOR MEDICARE-ELIGIBLE RETIREES AND DEPENDENTS.

(a) ESTABLISHMENT OF FUND- (1) Part II of subtitle A of title 10, United States Code, is amended by inserting after chapter 55 the following new chapter:

CHAPTER 56—DEPARTMENT OF DEFENSE MEDICARE- ELIGIBLE RETIREE HEALTH CARE FUND

Sec.

1111. Establishment and purpose of Fund; definitions.

1112. Assets of Fund.

1113. Payments from the Fund.

1114. Board of Actuaries.

1115. Determination of contributions to the Fund.

1116. Payments into the Fund.

1117. Investment of assets of Fund.

Sec. 1111. Establishment and purpose of Fund; definitions

(a) There is established on the books of the Treasury a fund to be known as the Department of Defense Medicare-Eligible Retiree Health Care Fund (hereinafter in this chapter referred to as the 'Fund'), which shall be administered by the Secretary of the Treasury. The Fund shall be used for the accumulation of funds in order to finance on an actuarially sound basis liabilities of the Department of Defense under Department of Defense retiree health care programs for Medicare-eligible beneficiaries.

(b) In this chapter:

(1) The term 'Department of Defense retiree health care programs for Medicare-eligible beneficiaries' means the provisions of this title or

any other provision of law creating entitlement to health care for a Medicare-eligible member or former member of the uniformed services entitled to retired or retainer pay, or a Medicare-eligible dependent of a member or former member of the uniformed services entitled to retired or retainer pay.

(2) The term 'Medicare-eligible' means entitled to benefits under part A of Title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.).

(3) The term 'dependent' means a dependent (as such term is defined in section 1072 of this title) described in section 1076(b)(1) of this title.

Sec. 1112. Assets of Fund

There shall be deposited into the Fund the following, which shall constitute the assets of the Fund:

(1) Amounts paid into the Fund under section 1116 of this title.

(2) Any amount appropriated to the Fund.

(3) Any return on investment of the assets of the Fund.

Sec. 1113. Payments from the Fund

(a) There shall be paid from the Fund amounts payable for Department of Defense retiree health care programs for Medicare-eligible beneficiaries.

(b) The assets of the Fund are hereby made available for payments under subsection (a).

Sec. 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 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.

(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, 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 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.

Sec. 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 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(b) of this title.

(b)(1) The Secretary of Defense shall determine each year, in sufficient time for inclusion in budget requests for the following fiscal year, the total amount of Department of Defense contributions to be made to the Fund during that fiscal year under section 1116(a) of this title. That amount shall be the sum of the following:

(A) The product of—

(i) the current estimate of the value of the single level dollar amount to be determined under subsection (c)(1)(A) at the time of the next actuarial valuation under subsection (c); and

(ii) the expected average force strength during that fiscal year for members of the uniformed services on active duty (other than active duty for training) and full-time National Guard duty (other than full-time National Guard duty for training only).

(B) The product of—

(i) the current estimate of the value of the single level dollar amount to be determined under subsection (c)(1)(B) at the time of the next actuarial valuation under subsection (c); and

(ii) the expected average force strength during that fiscal year for members of the Ready Reserve of the uniformed services other than members on full-time National Guard duty other than for training) who are not otherwise described in subparagraph (A)(ii).

(2) The amount determined under paragraph (1) for any fiscal year is the amount needed to be appropriated to the Department of Defense for that fiscal year for payments to be made to the Fund during that year under section 1116(a) of this title. The President shall include not less than the full amount so determined in the budget transmitted to Congress for that fiscal year under section 1105 of title 31. The President may comment and make recommendations concerning any such amount.

(c)(1) Not less often than every four years, the Secretary of Defense shall carry out an actuarial valuation of the Fund. Each such actuarial valuation shall include—

(A) a determination (using the aggregate entry-age normal cost method) of a single level dollar amount for members of the uniformed services on active duty (other than active duty for training) or full-time National Guard duty (other than full-time National Guard duty for training only); and

(B) a determination (using the aggregate entry-age normal cost method) of a single level dollar amount for members of the Ready Reserve of the uniformed services and other than members on full-time National Guard duty other than for training) who are not otherwise described by subparagraph (A).

Such single level dollar amounts shall be used for the purposes of subsection (b) and section 1116(a) of this title.

(2) If at the time of any such valuation there has been a change in benefits under the Department of Defense retiree health care programs for Medicare-eligible beneficiaries that has been made since the last such valuation and such change in benefits increases or decreases the present value of amounts payable

from the Fund, the Secretary of Defense shall determine an amortization methodology and schedule for the amortization of the cumulative unfunded liability (or actuarial gain to the Fund) created by such change and any previous such changes so that the present value of the sum of the amortization payments (or reductions in payments that would otherwise be made) equals the cumulative increase (or decrease) in the present value of such amounts.

(3) If at the time of any such valuation the Secretary of Defense determines that, based upon changes in actuarial assumptions since the last valuation, there has been an actuarial gain or loss to the Fund, the Secretary shall determine an amortization methodology and schedule for the amortization of the cumulative gain or loss to the Fund created by such change in assumptions and any previous such changes in assumptions through an increase or decrease in the payments that would otherwise be made to the Fund.

(4) If at the time of any such valuation the Secretary of Defense determines that, based upon the Fund's actuarial experience (other than resulting from changes in benefits or actuarial assumptions) since the last valuation, there has been an actuarial gain or loss to the Fund, the Secretary shall determine an amortization methodology and schedule for the amortization of the cumulative gain or loss to the Fund created by such actuarial experience and any previous actuarial experience through an increase or decrease in the payments that would otherwise be made to the Fund.

(5) Contributions to the Fund in accordance with amortization schedules under paragraphs (2), (3), and (4) shall be made as provided in section 1116(b) of this title.

(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.

(e) The Secretary of Defense shall provide for the keeping of such records as are necessary for determining the actuarial status of the Fund.

Sec. 1116. Payments into the Fund

(a) The Secretary of Defense shall pay into the Fund at the end of each month as the Department of Defense contribution to the Fund for that month the amount that is the sum of the following:

(1) The product of—

(A) the monthly dollar amount determined using all the methods and assumptions approved for the most recent (as of the first day of the current fiscal year) actuarial valuation under section 1115(c)(1)(A) of this title (except that any statutory

change in the Department of Defense retiree health care programs for Medicare-eligible beneficiaries that is effective after the date of that valuation and on or before the first day of the current fiscal year shall be used in such determination); and

(B) the total end strength for that month for members of the uniformed services on active duty (other than active duty for training) and full-time National Guard duty (other than full-time National Guard duty for training only).

(2) The product of—

(A) the level monthly dollar amount determined using all the methods and assumptions approved for the most recent (as of the first day of the current fiscal year) actuarial valuation under section 1115(c)(1)(B) of this title (except that any statutory change in the Department of Defense retiree health care programs for Medicare-eligible beneficiaries that is effective after the date of that valuation and on or before the first day of the current fiscal year shall be used in such determination); and

(B) the total end strength for that month for members of the Ready Reserve of the uniformed services other than members on full-time National Guard duty other than for training) who are not otherwise described in paragraph (1)(B). Amounts paid into the Fund under this subsection shall be paid from funds available for the Defense Health Program.

(b)(1) At the beginning of each fiscal year the Secretary of the Treasury shall promptly pay into the Fund from the General Fund of the Treasury the amount certified to the Secretary by the Secretary of Defense under paragraph (3). Such payment shall be the contribution to the Fund for that fiscal year required by sections 1115(a) and 1115(c) of this title.

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

(A) 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 for the amortization of the original unfunded liability of the Fund.

(B) The amount (including any negative amount) for that year under the most recent amortization schedule determined by the Secretary of Defense under section 1115(c)(2) of this title for the amortization of any cumulative unfunded liability (or any gain) to the Fund resulting from changes in benefits.

(C) The amount (including any negative amount) for that year under the most recent amortization schedule determined by the Secretary of Defense under section 1115(c)(3) of this title for the amortization of any cumulative actuarial gain or loss to the Fund resulting from actuarial assumption changes.

(D) The amount (including any negative amount) for that year under the most recent amortization schedule determined by the Secretary of Defense under section 111(c)(4) of this title for the amortization of any cumulative actuarial gain or loss to the Fund resulting from actuarial experience.

(3) The Secretary of Defense shall promptly certify the amount determined under paragraph (2) each year to the Secretary of the Treasury.

Sec. 1117. Investment of assets of Fund

The Secretary of the Treasury shall invest such portion of the Fund as is not in the judgment of the Secretary of Defense required to meet current withdrawals. Such investments shall be in public debt securities with maturities suitable to the needs of the Fund, as determined by the Secretary of Defense, and bearing interest at rates determined by the Secretary of the Treasury, taking into consideration current market yields on outstanding marketable obligations of the United States of comparable maturities. The income on such investments shall be credited to and form a part of the Fund.'.

(2) The tables of chapters at the beginning of subtitle A, and at the beginning of part II of subtitle A, of title 10, United States Code, are amended by inserting after the item relating to chapter 55 the following new item:

56. Department of Defense Medicare-Eligible Retiree Health Care Fund

Appendix E

Abbreviations

AAPCC	Adjusted average per capita cost
ABC	activity-based cost
ACR	adjusted community rate
APG	ambulatory procedure grouping
APR	average payment rate
ASA	adjusted standardized amount
AWU	ambulatory workload unit
BBA	Balanced Budget Act
BPD	Bureau of Public Debt
CRS	Congressional Research Service
DEER	Defense Eligibility Enrollment System
DFAS	Defense Finance and Accounting Service
DHP	Defense Health Program
DMDC	Defense Manpower Data Center
DoD	Department of Defense
DRG	diagnosis-related group
FASAB	Federal Accounting Standards Advisory Board
FASB	Financial Accounting Standards Board
FFS	fee-for-service
FI	Fiscal Intermediary
FTE	full-time equivalent
FYDP	Future Years Defense Plan

GAO	Government Accounting Office
GME	graduate medical education
HCFA	Health Care Financing Administration
HCSR	Health Care Standard Record
HHS	Department of Health and Human Services
HMO	healthcare maintenance organization
JFMIP	Joint Financial Management Improvement Program
LMI	Logistics Management Institute
MCO	managed care organization
MRHL	Military Retirement Health Care Liability
MERHCF	Medicare-Eligible Retiree Health Care Fund
MEPRS	Medical Expense and Performance Reporting System
MilCon	military construction
MilPers	military personnel
MRF	Military Retirement Fund
MTF	medical treatment facility
NMOP	National Mail Order Pharmacy
NOAA	National Oceanographic and Atmospheric Administration
O&M	operations and maintenance
OMB	Office of Management and Budget
OOA	Office of the Actuary
OP	other procurement
PPS	prospective payment system
SGL	Standard General Ledger
RWP	relative weighted product

TMA	Tricare Management Activity
TPC	third-party cost
U.S.C.	United States Code
UAL	unfunded accrued liability
UBO	Uniform Business Office
USFHP	Uniformed Services Family Health Program
VA	Department of Veterans Affairs

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