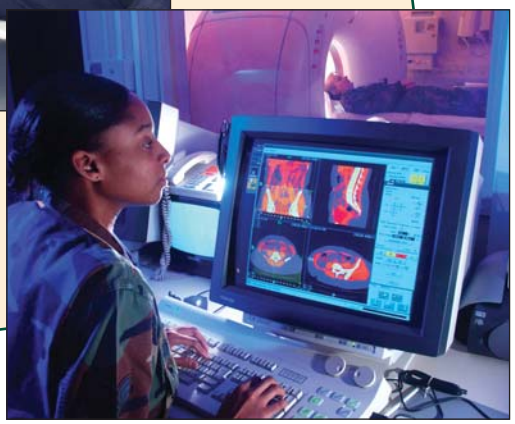
Evaluation of the TRICARE Program

TRICARE

FY 2006
Report to Congress



DEPARTMENT OF DEFENSE
UNITED STATES OF AMERICA

TRICARE's 10th Anniversary
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Evaluation of the TRICARE Program

March 13, 2006

THE FY 2006 EVALUATION OF THE TRICARE PROGRAM IS PROVIDED BY:

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A MESSAGE FROM WILLIAM WINKENWERDER, JR., MD, MBA
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A MESSAGE FROM WILLIAM WINKENWERDER, JR., MD, MBA ASSISTANT SECRETARY OF DEFENSE, HEALTH AFFAIRS, ASD(HA)

It is with great pleasure I am reporting to the Congress this year's annual assessment of the effectiveness of the Department's premier health care benefits program, TRICARE. As in previous reports, we present data over the most current three fiscal years (Fiscal Years 2003 to 2005). However, in this year's report we also reflect back on TRICARE's first 10 years since becoming operational in 1995 with the first regional contract. We have improved TRICARE significantly over these past 10 years, in terms of major enhancements to the overall benefits structure and consolidation of multiple support contracts. TRICARE's initial implementation began at the same time the fourth round of Base Realignments and Closures (BRAC) was being finalized and reductions were underway in our direct care system of military treatment facilities (MTFs). TRICARE will continue to offer our beneficiary population that private-sector based "safety net" as we embark on the fifth round of BRAC changes over the next several years. Program enhancements have been attuned to our changing beneficiary population, by meeting the needs of our increasing Medicare-eligible retirees with the TRICARE for Life (TFL) and TRICARE Senior Pharmacy (TSRx) programs in FY 2001, the TRICARE Mail Order Pharmacy (TMOP) and network pharmacy programs, and, in the past four years, expanded access to TRICARE for eligible National Guard and Reserve members and their families. Since September 11, 2001, we have seen our population eligible for the TRICARE benefit increase by about a million mobilized Reservists and their family members in support of the Global War on Terrorism (GWOT). As addressed this year and in previous reports, Congress has supported Reservist access to TRICARE with important enhancements to the benefits, including the most recent addition of TRICARE Reserve Select (TRS) to our benefits options.

As in previous reports, this report responds to the National Defense Authorization Act (NDAA) for FY 1996 (Section 717) requiring such an assessment. The report was required following the 1994 evolution, development, and deployment of the TRICARE managed care program. Beyond a requirement, I find this a tremendous opportunity to report on our disciplined focus on performance results based on targeted metrics. It presents many of the Balanced Scorecard metrics I rely on supporting the President's Management Agenda and to measure near- and mid-term performance in those areas critical to our longer-term TRICARE Goals. Linking TRICARE performance through standardized metrics assessed over time to relevant civilian-sector benchmarks is critical to achieving my vision for a world class Military Health System (MHS).

Safeguarding the health and well-being of our service members is my top priority. The mission of the MHS in supporting the security of our nation is reflected in our commitment to individual and unit medical readiness to ensure the health and well-being of our Active Component and mobilized Reserve and Guard personnel. The Surgeons General of the Army, Navy, and Air Force and I are fully committed to the philosophy that the health and well-being of our fighting forces extends to the care and wellness of their family members, retirees, and their family members. These beneficiaries are integral to the readiness mission and to the recruitment and retention of soldiers, sailors, airmen, and marines. The successful performance of our TRICARE health benefits program is instrumental to accomplishing this mission.

MISSION

To enhance DoD's and our nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.

VISION

A world class health system that supports the military mission by fostering, protecting, sustaining, and restoring health.

KEY PRIORITIES AND GOALS

- Improve force health protection and medical readiness;
- Improve performance of the TRICARE health program;
- Improve coordination, communication, and collaboration with other key entities; and
- Address issues related to the attraction, retention, and appropriate training of military medical personnel.

In 2005, my key TRICARE priorities continued:

- Complete the transition to the new TRICARE contracts, regional consolidation, and new governance and organizational structure with the TRICARE Regional Offices (TRO).
- Ensure TRICARE is readily accessible to the family members of National Guard and Reservists who are mobilized and deployed in support of the GWOT.
- Engage DoD leadership to create a culture of change embracing healthy communities and lifestyles.
- Emphasize "managing the business" and critical programs to ensure adequate funding and to promote increased efficiencies.

MHS STRATEGY ARCHITECTURE

I rely on a Balanced Scorecard approach as a useful framework for translating our MHS strategy into operational objectives to drive performance improvement in our system. This Balanced Scorecard is predicated on seven perspectives or "themes" underlying our MHS strategy as shown below: Stakeholders, Financial, External Customers, Readiness, Quality, Efficiency, and Learning and Growth (for our internal customers). These themes provide the framework for this year's report, and their supporting metrics are reflected throughout. While we track these metrics every month, they are presented in this report on an annual basis to provide clearer understanding of critical long-term trends in our performance. Improving patient satisfaction and providing access to high-quality health care are key to the overall success of the military health care system. By listening to our beneficiaries, we gain important information about our effectiveness in meeting these goals.

MHS STRATEGY ARCHITECTURE

STAKEHOLDER PERSPECTIVE

Our stakeholders are the American people, expressed through the will of the President, Congress, and the Department of Defense.

Goal:

- To enhance DoD's and our nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.

FINANCIAL PERSPECTIVE

Accomplish our mission in a cost-effective manner that is visible and fully accountable.

Goals:

- Determine and account for costs
- Obtain appropriate resources
- Optimize stewardship of resources

EXTERNAL CUSTOMER PERSPECTIVE

Our customers are the Armed Forces and all those entrusted to our care.

Goals:

- Deliver a fit, healthy, and medically protected force
- Deliver high quality care anywhere
- Improve customer service
- Build healthy communities

INTERNAL PERSPECTIVE

READINESS THEME

Focus on activities to enhance readiness of military forces and the medical assets that support them.

Goals:

- Provide a medically ready total force
- Provide a ready medical capability

QUALITY THEME

Ensure benchmark standards for health and health care are met.

Goals:

- Improve patient safety
- Increase patient-centered focus
- Improve health outcomes
- Provide quality claims processing

EFFICIENCY THEME

Obtain maximum effectiveness from the resources we are given.

Goals:

- Enhance system productivity
- Manage demand
- Gain efficiency through Information Management/ Information Technology
- Improve interoperability with partners

LEARNING AND GROWTH PERSPECTIVE (INTERNAL CUSTOMERS)

Our people and our support systems are critical to giving us the capabilities to execute all we set out to achieve.

Goals:

- Leverage science and technology
- Recruit, retain, and develop personnel
- Complete, accurate, and timely data collection
- Patient/provider focused information systems that enhance capability
- Enhance jointness

EXECUTIVE SUMMARY: KEY FINDINGS FY 2005

Stakeholder Perspective

TRICARE—A 10-Year Retrospective

- Over the past 10 years, since the first TRICARE Region began operations in March 1995, overall benefits have increased and been transformed commensurate with an eligible population that has increased by 8.6 percent overall, but especially in the 65 and over (36 percent) and mobilized Reservist populations (Ref. pages 13–14).
- The Unified Medical Program (UMP) has grown along with the population and benefits structure. From FY 1995 to FY 2005 the UMP increased by almost 133 percent to almost $35.9 billion in FY 2005, including the DoD normal cost contribution to the Medicare-Eligible Retiree Health Care Fund (MERHCF, or the "Accrual Fund") (Ref. page 15).
- Consistent with four previous rounds of Base Realignment and Closure (BRAC) actions, combined with Service-specific infrastructure changes, the number of U.S.-based military hospitals has declined by 60 percent while the number of ambulatory clinics has declined by 20 percent (Ref. page 16).

Beneficiary and Plan Enrollment Trends

- The number of beneficiaries eligible for DoD medical care increased from 9.1 million in FY 2003 to 9.2 million in FY 2004 and remained at that level in FY 2005. The increase is largely due to the mobilization of Guard/Reserve members and the extension of benefits to their family members (Ref. page 21).
- Because of base closures and changes in the beneficiary mix over time (especially given the addition of Reservists and their family members), there has been a downward trend in the number of beneficiaries living in MTF catchment areas (i.e., within about 40 miles of a military hospital). This trend has implications for the proportion of workload performed in direct and purchased care facilities (Ref. page 25).
  - Active duty family members (ADFMs) experienced the largest decline in the number living in catchment areas, decreasing by 6.4 percent since FY 1999.
  - The continued mobilization of National Guard and Reserve members has contributed disproportionately to the total number of beneficiaries living in noncatchment areas. Most Guard/Reserve members already live in noncatchment areas when called to active duty and their families continue to live there.
- Over 5 million beneficiaries, or about two thirds of the MHS population eligible for TRICARE Prime, were enrolled by the end of FY 2005 (Ref. page 26).
- The number of users of MHS services has steadily increased since FY 2003. Active duty personnel and their family members experienced a 6 percent increase while retirees and family members experienced a 10 percent increase (Ref. page 27).

FINANCIAL PERSPECTIVE

Unified Medical Program Funding Trends

- The Unified Medical Program (UMP) is projected to increase from $30.08 billion in FY 2003 to almost $38.40 billion in FY 2006 (estimated). This funding includes the normal cost contribution to the DoD Medicare-Eligible Retiree Health Care Fund (MERHCF, or the "Accrual Fund"), as well as funding in support of the Global War on Terrorism (GWOT) (Ref. page 29).
- In constant FY 2006 dollars, programmed FY 2006 funding of $38.40 billion is about 8 percent more than the FY 2003 purchase value of $35.50 billion (Ref page 29).
- UMP expenditures, including the normal cost contribution to the Accrual Fund, were approximately 6.9 percent of the FY 2003 DoD Total obligational Authority (TOA), and expected to increase to about 9 percent in FY 2006 (Ref. page 30).
- The rate of growth in UMP expenditures from FY 2005 to FY 2006 is expected to be 7.3 percent (including GWOT and Accrual funding) (Ref. page 30).

MHS Workload Trends and Impact of New Benefits From FY 2003 to FY 2005

- MHS workload totals increased for all major components of care between FY 2003 and FY 2005. Total inpatient dispositions (direct and purchased care combined) increased by 8 percent between FY 2003 and FY 2005 and an intensity-weighted measure of dispositions increased by 11 percent (both excluding TFL workload). Both outpatient encounters and an intensity-weighted measure of encounters increased by 17 percent. Finally, total MHS prescription workload (direct, retail, and mail-order combined) increased by 11 percent, excluding TRICARE Senior Pharmacy (TSRx)

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2005 *(CONT'D)*

benefit workload, discussed below (Ref. pages 31–32).

- For all major components of care, workload increases were driven by increased purchased care utilization. Direct care inpatient, outpatient, and prescription workloads remained essentially unchanged between FY 2003 and FY 2005.

➤ For inpatient, outpatient, and prescription drug care costs, the proportion of total health care costs provided in DoD facilities declined between FY 2003 and FY 2005. Overall, the proportion of direct care costs to total costs (direct and purchased care) declined from 62 percent to 56 percent during this time, with the greatest percentage shift occurring for prescription drugs (Ref. page 33).

➤ Most DoD Medicare-eligible beneficiaries have already taken advantage of the TFL benefit, with about 80 percent filing health care claims in each year from FY 2003 to FY 2005 (Ref. page 34).

➤ The percentage of TFL-eligible beneficiaries filing at least one claim for prescriptions under the TSRx benefit continued to rise, from 62 percent in FY 2003 to 77 percent in FY 2005 (Ref. page 34).

➤ Prescription drugs (direct and purchased care) accounted for more than half (53 percent) of the $5.7 billion in TFL/TSRx expenditures in FY 2005 (Ref. page 35).

External Customer Perspective

Overall Customer Satisfaction With TRICARE

➤ MHS beneficiaries' satisfaction with the overall TRICARE plan and one's personal physician improved between FY 2003 and FY 2005, while satisfaction with overall health care, or one's specialty physician, remained stable during this three-year period. MHS rates continue to lag civilian benchmarks (Ref. page 37).

➤ Satisfaction of Prime enrollees with a military Primary Care Manager (PCM) improved between FY 2003 and FY 2005 while satisfaction remained stable for enrollees with civilian PCMs and non-enrollees. Also, during each of the past three years (FY 2003 to FY 2005), MHS beneficiaries enrolled with civilian network providers reported a level of satisfaction the same as or higher than that of their civilian counterparts (Ref. page 38).

➤ Active duty satisfaction with TRICARE improved each year from FY 2003 to FY 2005. In general, while the rates for active duty personnel and their family members continued to lag civilian counterparts for the past three years, the gap may be closing given the downward trend in the civilian benchmark (Ref. page 39).

➤ Between FY 2003 and FY 2005, MHS beneficiaries' satisfaction with their health *care* remained unchanged for both enrollees and non-enrollees. Prime enrollee satisfaction with health care (both military and civilian primary care managers) lags the civilian benchmark. Non-enrollee satisfaction is comparable to, or exceeds, the civilian rate (Ref. page 40).

Building Healthy Communities

➤ **Tobacco Use:** The overall self-reported rate of non-smoking among all MHS beneficiaries (78 to 79 percent) remained the same from FY 2002 through FY 2005 to date. While the proportion of non-smoking MHS beneficiaries appears higher than the overall U.S. population, it continues to lag the HP 2010 goal of an 88 percent non-smoking rate (Ref. page 43).

➤ The proportion of MHS beneficiaries identified as non-obese has remained constant over the past four quarters. At 79 percent non-obese since implementing this measure using self-reported data from MHS beneficiaries, it has not reached the HP 2010 goal of 85 percent, but does exceed the most recently identified U.S. population average of 69 percent (Ref. page 44).

➤ **Meeting Preventive Care Standards:** Over the past three years, the MHS has met or exceeded targeted Health People 2010 goals in providing mammograms (for ages 40–49 years as well as 50+ categories) and testing for cholesterol. Efforts continue toward achieving Healthy People 2010 standards for Pap smears, prenatal exams, flu shots (for people age 65 and older), and blood pressure screenings (Ref. page 45).

Internal Customer Perspective: Readiness

➤ The overall MHS 95 percent target rate for dental readiness in Classes 1 and 2 continues to be elusive. While the gap has narrowed since measurement began in 1997, there was a 2.7 percentage point decline between FY 2004 and FY 2005 (Ref. page 47).

➤ TRICARE continues to support the GWOT that began shortly after September 11, 2001. The total number of National Guard and Reservists, and their family members eligible for TRICARE, has exceeded the numbers eligible in the 1991 Gulf War (Ref. page 48).

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2005 *(CONT'D)*

- The level of satisfaction reported by family members of Reserve and Active Component personnel has been the same over the past three years (Ref. page 49).
- Surveyed family members of Reservists using TRICARE predominantly report there was no change in seeing their personal doctor or preferred specialist before and after the Reservist sponsor was mobilized. However, 16 percent found that access to personal doctors and specialists worsened since relying only on TRICARE, while a smaller group reported improved access to their personal doctors and their specialists (10 and 11 percent, respectively) (Ref. page 50).
- By the end of the program's first year, enrollment in TRICARE Reserve Select reached almost 1,400 member-only plans, almost 3,400 family plans, with 14,000 covered lives (Ref. page 52).

Internal Customer Perspective: Quality

Access to Care

- **Overall Outpatient Access.** Access to and use of outpatient services remains high, with over 85 percent of Prime enrollees reporting having at least one outpatient visit during the year. This measure lags, but is close to, the civilian counterparts in managed care plans (Ref. page 53).
- **Availability and Ease of Obtaining Care.** MHS beneficiary ratings for getting necessary care and waiting for a routine appointment remained stable between FY 2003 and FY 2005, while lagging an improving civilian benchmark. Retired beneficiaries continue to report higher levels of satisfaction with their ability to get care than active duty personnel or their family members (Ref. pages 54–55).
- **TRICARE Provider Participation.** The number of TRICARE participating providers increased by 46 percent from FY 2001 to FY 2005. The Prime network increased by 95 percent over that same period. Furthermore, the numbers of primary care providers and specialists have increased at about the same rate (Ref. page 57).
- **Customer Service.** MHS customer service responsiveness, beneficiary ease of understanding written materials, and dealing with paperwork remained stable over the three-year period from FY 2003 to FY 2005, rising and then falling in FY 2004 (Ref. page 58).
- **Claims Processing:** MHS beneficiary satisfaction with their claims being processed in a reasonable period of time increased between FY 2003 and FY 2005 (reaching 82.5 percent in FY 2005), and remained stable across these three years for claims being processed properly (about 83 percent). MHS satisfaction levels, however, continue to lag behind the civilian benchmark (Ref. page 59).
- The number of claims processed continues to increase, reaching over 143 million in FY 2005, due to increases in purchased care workload (including TRICARE for Life, pharmacy and TRICARE dual eligible beneficiaries), and due to a change in how pharmacy claims are reported. The processing of retained claims within 30 days exceeded the TRICARE performance standard of 95 percent over the past four years, reaching 100 percent for the first time in FY 2005 (Ref. page 60).

Special Study: Assessment of Civilian Physician Acceptance of New TRICARE Standard Patients

- The Department is currently in the second year of an ongoing study of civilian physician acceptance of TRICARE Standard patients. For the new question added in this year's survey there is generally a high level of awareness of TRICARE among responding physicians (90 percent), ranging from 99 percent (Watertown, NY) to 55 percent (Brooklyn, NY) (Ref. page 62).
- An average of 81 percent of physicians accepted new TRICARE Standard patients across all 29 HSAs of those accepting any new patients, ranging from 96 percent (Peoria, IL) to 60 percent (Brooklyn, NY). This range is similar to that of FY 2004 results, where overall acceptance was about 82 percent, ranging from almost 95 percent (Fayetteville, TN) to almost 60 percent (Anchorage, AK) (Ref. pages 62–64).

MTF Results on Core Quality of Care Measures from Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

- JCAHO is the nationally recognized organization that provides an accreditation status based on onsite surveys conducted at least every three years. The MHS MTFs are currently involved in many of the JCAHO Quality of Care measures.
  - On a quarterly basis, MHS military treatment facilities have maintained the expected high rate of aspirin therapy for Acute Myocardial Infarction (AMI) patients, relative to the Joint Commission's target (Ref. page 65).
  - However, while MHS documentation of smoking cessation counseling for those adults admitted for AMI appears to be generally improving, it remains below the Commission's expectations (Ref. page 66).

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2005 *(CONT'D)*

Direct Care Appointment Access

- The level of satisfaction reported by MHS beneficiaries did not meet the revised goal of 84 percent this year, and appears to have decreased by almost 1 percent since last year (Ref. page 67).
- **Satisfaction With MTF Care:** MHS beneficiaries responding to a survey regarding their specific direct care visit(s) reported almost 89 percent satisfaction with their MTF encounter in FY 2004. The MHS goal of at least 90 percent continues to remain elusive (Ref. page 67).

TRICARE Dental Programs Satisfaction
The overall TRICARE dental benefit consists of several delivery programs serving the MHS beneficiary population.

- The overall DoD dental patient satisfaction with the ability of the DTFs to take care of their dental needs increased to just over 97 percent in FY 2005 (97.1 percent) (Ref. page 68).
- The FY 2005 composite average enrollee satisfaction for the voluntary, premium-sharing insurance program called TRICARE Dental Program (TDP) remained at 94 percent, similar to FY 2004 (Ref. page 68).
- Overall full-premium TRICARE Retiree Dental Program enrollee satisfaction rates increased from 86.1 percent in FY 2004 to 90.7 percent in FY 2005 (Ref. page 68).

Internal Customer Perspective: Efficiencies

MTF Market Share Trends

- The percentage of inpatient and outpatient workload accomplished in MTFs relative to all TRICARE workload in catchment areas has declined (from FY 2002 to mid-FY 2004) by 6 percentage points each (Ref. page 71).

Health Care Services Utilization

- Utilization of inpatient, outpatient, and prescription services by Prime enrollees was 68 percent, 33 percent, and 18 percent higher, respectively, than that of civilian HMO enrollees in FY 2005 (Ref. pages 72, 79 and 83).
- Utilization of inpatient services by non-enrolled beneficiaries was 61 percent higher than that of civilian PPO participants in FY 2005. On the other hand, utilization of outpatient and prescription services by non-enrolled beneficiaries was 29 percent and 19 percent lower, respectively, than that of civilian PPO participants (Ref. pages 73, 80 and 84).

Beneficiary Family Out-of-Pocket Costs

- TRICARE beneficiary families have much lower out-of-pocket costs than their civilian counterparts.
  - For enrolled active duty families, costs were about $3,100 less than their civilian HMO counterparts in FY 2005. For non-enrolled active duty families, costs were about $3,200 less than their civilian PPO counterparts (Ref. pages 89–90).
  - For enrolled retiree families under age 65, costs were about $2,900 less than their civilian HMO counterparts in FY 2005. For non-enrolled retiree families, costs were about $3,100 less than their civilian PPO counterparts (Ref. pages 89–90).
  - For Medicare-eligible MHS beneficiary families in FY 2005, costs were $3,300 less than their civilian counterparts. The lower costs were due to the TFL and TSRx benefits programs, which enabled MHS seniors to reduce their expenses for supplemental insurance, deductibles, and copayments (Ref. page 92).

Learning and Growth Perspective

- **Information Technology:** The Armed Forces Longitudinal Technology Application (AHLTA) has replaced MHS legacy systems, and replaced or upgraded the inpatient system solution known as the Clinical Information System (CIS). The robust, standards-based interoperability provided by AHLTA is designed to allow seamless connectivity to deployed forces, sustaining the MHS and the Veterans Administration. By the end of the fourth quarter, FY 2005, over 30,000 were trained and 71 MTFs implemented AHLTA, or about 50 percent of the targeted 140 MTFs and 63,000 personnel targeted for December 2006 (Ref. page 93).

WHAT IS TRICARE?

TRICARE is the health plan of the MHS. TRICARE responds to the challenge of maintaining medical combat readiness while providing the best health services for all eligible beneficiaries. TRICARE brings together the worldwide health resources of the Army, Navy, Air Force, Coast Guard and commissioned corps of the Public Health Service (often referred to as "direct care") and supplements this capability with network and non-network civilian health professionals, hospitals, pharmacies, and suppliers (referred to as "purchased care") to provide better access and high quality service while maintaining the capability to support military operations. In addition to receiving care from MTFs, where available, TRICARE offers beneficiaries three primary options:

- **TRICARE Standard** is the non-network benefit, formerly known as CHAMPUS, open to all eligible DoD beneficiaries, except active duty service members. Once eligibility is recorded in the Defense Eligibility Enrollment Reporting System (DEERS), no further application is required from our beneficiaries to obtain care from TRICARE-authorized civilian providers. An annual deductible (individual or family) and cost shares are required.
- **TRICARE Extra** is the network benefit for beneficiaries eligible for TRICARE Standard. When non-enrolled beneficiaries obtain services from TRICARE network professionals, hospitals, and suppliers, they pay the same deductible as TRICARE Standard but TRICARE Extra cost shares are reduced by 5 percent. TRICARE network providers file claims for the beneficiary.
- **TRICARE Prime** is the HMO-like benefit offered in many areas. Each enrollee chooses or is assigned a Primary Care Manager (PCM), a health care professional who is responsible for helping the patient manage his or her care, promoting preventive health services (e.g., routine exams, immunizations) and arranging for specialty provider services as appropriate. Access standards apply to waiting times to get an appointment, and waiting times in doctors' offices. A point-of-service option permits enrollees to seek care from providers other than the assigned PCM without a referral, but with significantly higher deductibles and cost shares than those under TRICARE Standard.

NEW BENEFITS AND PROGRAMS IN FY 2005

TRICARE continues to keep pace with changing beneficiary needs and expectations through program refinements and enhancements. New benefits, services and programs implemented or scheduled for implementation in FY 2005 include the following:

Organizational/Structural/Contractual Changes

The MHS underwent a momentous transformation beginning in late FY 2004 and ending in early FY 2005. TRICARE contracts moved from requirements-based to performance-based with an emphasis on beneficiary satisfaction. Beneficiary and provider experience with previous contracts was carefully considered, as was the health care industry's best-business practices.

Consolidated Regions and Contracts

- By November 1, 2004, the previous 11 geographic regions (supported by seven contracts) had consolidated into three TRICARE regions. The three new regional contracts simplify management by reducing administrative duplication and overhead fees while the regional consolidation carves out fewer geographic regions for a highly mobile population of beneficiaries.
- The contracts feature metrics for performance and efficiencies, and offer incentives for meeting and exceeding established standards. One example of measurable performance is contractor success in growing the TRICARE network of providers so that beneficiaries have convenient access to quality care. Offering incentives to contractors based on key performance indicators, such as telephone access, claims processing, and network capability, should dramatically improve beneficiary satisfaction. Award determination includes input from those most affected by contractor performance—beneficiaries and commanders of MTFs.
- In addition to the three broad regional contracts, the TRICARE family of contracts includes other focused contracts, such as pharmacy or marketing, so that a contractor can concentrate on its core competency with increased efficiency. The best example is the new, single, dedicated contract that processes claims for TRICARE-and-Medicare dual-eligible beneficiaries. Beneficiaries who are eligible for Medicare (due to age, disability, or end-stage renal disease), no matter where they live, now enjoy a single processor for claims, with one mailing address, Web site, telephone number, and group of customer service representatives.
- Administrative costs have been further reduced by the new retail pharmacy contract that provides the TRICARE network of retail pharmacies nationwide. Beneficiaries can fill prescriptions at more than 53,000 TRICARE network retail pharmacies around the nation at clearly stated prices, with one computer database tracking the information and accessible by the claims processor. The same sort of efficiencies and convenience can be found in the new TRICARE Global Remote Overseas contract. Now, there is one contractor supervising local providers, processing claims, and providing customer service for Uniformed Service members and families living in remote areas outside of the continental United States.
- While the transition to the new TRICARE contracts has made a strong program better and ultimately resulted in higher patient satisfaction, it was anticipated that some beneficiaries would experience transition problems. The TMA dedicated transition teams to trouble-shoot and monitor the progress of regional changes and contract implementation. For example:
  - The new TRICARE retail pharmacy (TRRx) contractor experienced software problems in the first hours of the contract, causing delays in processing claims and confusion for some beneficiaries. The problem was quickly identified and a remedy put in place.
  - The changes in regional contractors caused some beneficiaries to be reassigned to new PCMs, as well as modifications to the processes for referrals and authorizations. Again, affected beneficiaries were promptly identified and their issues continue to be addressed as each phase in the transition is completed.
  - Many callers to the regional contractor's toll-free customer service initially experienced longer wait times due to high call

NEW BENEFITS AND PROGRAMS IN FY 2005 *(CONT'D)*

volume during transition. Beneficiaries were encouraged to take advantage of new Web-based services provided by each regional contractor. New call center staff were hired and trained in response to the increased call volume.

New Governance Structure in Place

- The Assistant Secretary of Defense (Health Affairs) and the Services' Surgeons General established a new governance structure for the three new TRICARE regions. The governance structure is designed to monitor performance and resolve problems at the lowest possible level for managing the military health benefit with force readiness as the first priority followed closely by beneficiary satisfaction.
- Three TRICARE Regional Offices (TROs) replaced the former Lead Agent Offices in the 50 United States. The Overseas TRICARE Regional office, headquartered in the TMA, with three overseas TRICARE Area Offices (TAO), governs TRICARE outside the United States. The TROs serve as health plan managers with visibility on both purchased and direct care to ensure integrated health delivery.

Benefit Changes

- **Guard & Reserve Benefits:**
  - **TRICARE Reserve Select (TRS).** TRS coverage began April 26, 2005. TRS is a new premium-based TRICARE health plan offered for purchase by Reserve Component (RC) members who qualify. To qualify for TRS coverage, National Guard and Reserve members must have served on active duty for 90 days or more in support of a contingency operation on or after September 11, 2001, and executed a service agreement with their Service/Reserve Component to continue serving in the Selected Reserve.
    - As of the end of FY 2005, about 1,400 RC members had purchased TRS member-only plans and over 3,300 had purchased TRS member and family plans, for a total of almost 13,000 covered lives. The monthly premiums for calendar year 2005 were $75 for TRS member-only coverage and $233 for TRS member and family coverage.
    - TRS offers comprehensive health care coverage similar to TRICARE Standard and TRICARE Extra. TRS members and covered family members can access care by making an appointment with any TRICARE authorized provider, hospital, or pharmacy—TRICARE network or non-network. TRS members may access care at a MTF on a space-available basis only. Pharmacy coverage is available from an MTF pharmacy, TMOP, and TRICARE network and non-network retail pharmacies.
  - **Extended the Transitional Assistance Management Program (TAMP)**, from 60 or 120 days to 180 days for some active duty and RC members separating from active duty service. In 2005, the 180-day TAMP benefit period became permanent.
  - **Early Access to TRICARE.** When an RC member is activated in support of a contingency operation for more than 30 days. With delayed-effective orders, TRICARE benefits are available for them and their family members for up to 90 days prior to the member's activation. Originally scheduled to terminate December 2004, Congress made this permanent in 2005.
  - **Extended the TRICARE Reserve Family Demonstration.** For RC members called to active duty for more than 30 days in support of federal contingency operations, this demonstration offers continuity of care and reduced out of pocket expenses for their family members (over 601,000 through August, 2005). In FY 2005, legislation gave the DoD authority for the demonstration project's waiver of certain deductibles to become permanent. The DoD, TMA published a notice in the *Federal Register* (October 12, 2005), extending the Nationwide TRICARE Demonstration Project (66 FR 55928-55930) through October 31, 2007.
- **Special Needs Benefits:**
  - **TRICARE Extended Care Health Option.** TRICARE's Extended Care Health Option (ECHO) became available for beneficiaries of ADFMs with defined qualifying conditions on September 1, 2005. Beneficiaries

NEW BENEFITS AND PROGRAMS IN FY 2005 *(CONT'D)*

who were receiving care through the Program for Persons with Disabilities and did not qualify for ECHO continued to receive care through the basic TRICARE benefit. ECHO delivers financial assistance and additional benefits, including supplies and services, beyond those available from the basic benefit in TRICARE Prime, Standard or Extra. The benefit increases from $1,000 (through PFPWD) to $2,500 per eligible family member under ECHO. Additionally, beneficiaries who are homebound may qualify for extended in-home health care through ECHO.

- **ECHO Home Health Care.** ECHO Home Health Care (EHHC) provides medically necessary skilled services to eligible homebound beneficiaries who generally require more than 28–35 hours per week of home health services or respite care. Beneficiaries are considered homebound if they lack the ability to leave home or if leaving home requires considerable and taxing effort. However, leaving the house to get health services, including therapeutic, psychosocial, medical or certified adult day care services, will not disqualify beneficiaries from EHHC. The benefit also helps eligible beneficiaries stay home rather than having to go to an institutional/acute care facility or skilled nursing home. Beneficiaries must be registered in the ECHO program to be eligible for EHHC. ADFMs covered by the Custodial Care Transition Program (CCTP) on September 1, 2005, who needed more skilled medical services than offered through EHHC, could continue to receive coverage under CCTP, as long as necessary. The beneficiary's PCM and TRICARE regional contractor conduct annual assessments to ensure beneficiaries are receiving needed care and services needed. The following medically necessary services may be covered when provided in the beneficiary's home by a TRICARE-authorized home health agency:
  - Skilled nursing care from a registered nurse, or by a licensed or vocational nurse under the direct supervision of a registered nurse
  - Services provided by a home health aide under the direct supervision of a registered nurse
  - Physical therapy, occupational therapy and speech-language pathology services
  - Medical social services under the direction of a physician
  - Teaching and training activities
  - Medical supplies.

➤ **EHHC Respite Benefit.** Respite care provides temporary relief or rest period for the primary caregiver to promote well-being for both the caregiver and the homebound beneficiary. The EHHC respite benefit is tailored for families with homebound beneficiaries who have medical conditions that require frequent interventions by a primary caregiver. These beneficiaries may receive eight hours of respite care, five days per calendar week. This benefit is different from the 16 hours of respite care that are available through ECHO. The respite care through EHHC cannot be used with the ECHO respite allowance or as babysitting/child care services. Respite benefits cannot be used for sibling-care, employment, deployment or pursuing education and they are not accumulative. The maximum annual EHHC benefit is equal to what TRICARE would pay if the beneficiary resided in a skilled nursing facility. This amount is based on the beneficiary's geographic location.

Making TRICARE Easier

During FY 2005, a number of other program enhancements were offered, including:

➤ TRICARE Prime retirees can now pay enrollment fees by allotment from their retirement pay, or by an electronic funds transfer to supplement the previous year's expansion of retiree Prime enrollment payments on a monthly basis, in addition to the quarterly and annual basis originally offered.

➤ Automatic issuance of a Certificate of Creditable Coverage to a Uniformed Services sponsor or family member who loses eligibility for TRICARE benefits. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the certificate serves as proof of previous health care coverage to eliminate exclusions for preexisting medical condition in most cases.

➤ Implementing online appointments for TRICARE Prime, TRICARE Plus and some

NEW BENEFITS AND PROGRAMS IN FY 2005 *(CONT'D)*

specialty care in 95 percent of all MTFs through TRICAREOnline.com.

- Implementing new functionality in DEERS in conjunction with the stand-up of the 3 new TRICARE regions. Now DEERS aligns TRICARE Prime enrollment year with the FY, makes PCM assignments, centralizes other health insurance information, consolidates catastrophic cap accruals, and much more.
- Implementing a single contract to service claims for all TRICARE beneficiaries entitled to Medicare Parts A and B.
- Implementing a single contract to provide health care services and support in Puerto Rico through TRICARE Overseas Prime for active duty service members and their families stationed in the Commonwealth of Puerto Rico; health care delivery began in May 2004.

Pharmacy

- Established a process for assigning certain prescription drugs to nonformulary status, where higher cost shares are charged. Based upon relative clinical and cost effectiveness, drugs are placed into one of three cost-share tiers: generic, formulary (brand-name) or nonformulary.
- Established a single contract to administer the TRRx program, providing nationwide prescription services for TRICARE beneficiaries in the United States and its territories through an expanded network of more than 53,000 retail pharmacies.

Dental

- **Improved Reservists Access to TRICARE Retiree Dental Program.** Effective February 1, 2005, National Guard and Reserve personnel who elect to enroll in the TRICARE Retiree Dental Program (TRDP) within 120 days after retirement could avoid the 12-month waiting period normally required for certain TRDP benefits. Additionally, this new waiver applies retroactively to February 1, 2004, for any Guard and Reserve enrollees who can document their enrollment in the TRDP within 120 days after their retirement effective date.
- **Dental Contract Award.** United Concordia Companies Inc. (UCCI), Harrisburg, Pa., was awarded the TRICARE Dental Program (TDP) contract. Worldwide, comprehensive dental coverage including preventive, diagnostic, restorative and maintenance services may be purchased for all eligible Uniformed Services ADFMs, members of the Selected Reserve and Individual Ready Reserve and their eligible family members. Out of the total eligible population of approximately 3.6 million beneficiaries, coverage has been purchased for approximately 1.7 million. The contract is a fixed-price premium-based contract. The total eligible population is approximately 3.6 million beneficiaries, of which approximately 1.7 million are currently enrolled. Network dentists are available in the 50 United States, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands. Other contracted functions include enrollment, billing, premium collection, claims processing, management and beneficiary services.

Program Cost Changes

- TRICARE Standard ADFM civilian inpatient cost-shares were increased slightly from $13.32 to $13.92 per day, or $25.00, whichever is greater. TRICARE Standard retiree civilian inpatient cost-shares increased from $459 to $512 per day.

Technology Initiatives

- **Electronic Health Records System.** The DoD's new electronic health records system (AHLTA) is now operational at nearly one-half the targeted MTFs, with more than 80 percent of the records having been transferred to this system. By the end of 2006, all Army, Navy, and Air Force MTFs and medical professionals will use the system to manage patients' health care and information in all DoD medical facilities. This capability will provide immediate access through a computer for over 60,000 MTF clinicians to a patient's life-long medical records. Several of DoD's largest MTFs have launched training programs to familiarize their medical staffs with the system's capabilities.
- **New Web-Based Pharmacy Search Tool.** The new pharmacy "Formulary Search Tool" is an automated Web tool that checks the availability of medications at MTFs. The tool is an interactive application on the TRICARE Web site. Copayment information for Food and

NEW BENEFITS AND PROGRAMS IN FY 2005 *(CONT'D)*

Drug Administration-approved medications, including injectable medications, and generic equivalents for brand-name medications, is also available on the site. The Formulary Search Tool allows the user to search by medication or medical condition and provides details on side effects as well as common and unusual prescription interactions.

Disaster Relief

- **DoD Health Care Outreach Effort to Military Personnel Affected by Hurricane Katrina.** As part of recovery efforts in the aftermath of Hurricane Katrina, TMA embarked on an aggressive outreach to nearly 360,000 active duty military personnel, retirees and their families displaced by the storm. Outreach efforts included dispatching staff to a number of sites to provide face-to-face counseling for affected beneficiaries; providing TRICARE eligibility for federally activated National Guard Members in support of Hurricane Katrina relief efforts; suspending the pharmacy copay for beneficiaries affected by the hurricane disasters and working closely with TRICARE network retail pharmacies to ensure access to prescription benefits; and providing licensed mental health counselors to deploy to military installations/locations supporting troops and families impacted by Hurricane Katrina.
- **Asian Tsunami Disaster and the MHS.** Unprecedented devastation ensued from the tsunami and associated events in Asia on December 26, 2004. The DoD and the MHS demonstrated substantial, flexible and often essential capabilities to support our nation and its role in the world. Military medics within the Pacific Command theater played critical roles assessing and responding to initial health needs, and working with host nations and nongovernmental organizations. The Surgeons General and Joint Staff worked together to assess Service and MHS response capabilities, and in several cases, actively supported relief missions assigned to the Pacific Command.

REPORT APPROACH AND SCOPE

In addition to presenting trend data over the most recent three fiscal years, as in previous reports, this year's report begins with a brief retrospective of TRICARE's first decade since becoming operational in March 1995 in Region 11. This report then continues the approach used previously of comparing TRICARE with civilian-sector benchmarks (where available). This report summarizes nationwide trends under TRICARE and, unless otherwise noted, compares the continental U.S. (CONUS) regions of TRICARE with comparable U.S. civilian-sector benchmarks.

TRICARE BENEFIT CHANGE TIMELINE

The TRICARE benefit has been expanded and improved since its inception in FY 1995. The timeline below shows the major benefit enhancements that have occurred over the past 10 years.

March 1995

- TRICARE benefit begins in the Northwest Region.

October 1995

- Copayment for inpatient mental health care increased from $9.50 per day to $20 per day for ADFMs.

November 1995

- Catastrophic cap for nonactive duty enrollees reduced from $7,500 to $3,000.
- Expanded Active Duty Dental Benefit Plan begins.

January 1996

- Cancer Treatment Clinic Trial Demonstration begins.

September 1996

- National Mail Order Pharmacy program begins.
- TRICARE Standard/Extra get comprehensive preventive benefits.

September 1997

- Health Promotion, Disease Prevention & Immunization (preventive care) begins.
- Requirement for Outpatient Nonavailability Statement dropped.

October 1997

- Catastrophic cap for unenrolled retirees, their family members, and survivors reduced from $7,500 to $3,000.
- DoD waives charges for active duty Prime Remote family members through 31 August 2000.
- TRICARE benefits expanded to cover school physicals.

December 1997

- TRICARE Retiree Dental Program begins.

June 1998

- TRICARE implementation complete.

September 1998

- TRICARE Senior Prime demonstration begins.

October 1999

- TRICARE Prime Remote benefit begins.
- Nonavailability Statements required for maternity care.

August 2000

- Expansion of TRICARE Retiree Dental Program to Dependents begins.

October 2000

- TRICARE eliminated Prime copays for active duty family members.
- TRICARE Senior Pharmacy benefit begins.
- TRICARE simplifies and reduces copay structure for prescription drugs.
- Copayments for enrolled ADFMs eliminated.

April 2001

- Active duty service members get permanent chiropractic care benefit.
- TRICARE Plus primary care benefit begins.
- TRICARE for Life benefit begins.

October 2001

- TRICARE Senior Prime ends.

December 2001

- TRICARE Prime Remote for ADFMs benefit begins.

September 2002

- TAMP coverage is permanently extended to180 days following active duty. Makes "early benefit" permanent for National Guard and Reserve Members called to active duty.

March 2003

- TRICARE Prime Remote modified to allow family members residing in Prime Remote locations to remain enrolled when sponsors PCS on unaccompanied tour.
- Requirement for Guard/Reserve sponsor's activation orders to be for 179 or more days reduced to 31 or more days for family members to gain eligibility for enrollment in TRICARE Prime.

September 2003

- TRICARE Global Remote Overseas benefit begins.

December 2003

- Requirements for TRICARE Standard beneficiaries to obtain a Nonavailability Statement eliminated.

October 2004

April 2005

- TRICARE Reserve Select benefit begins.

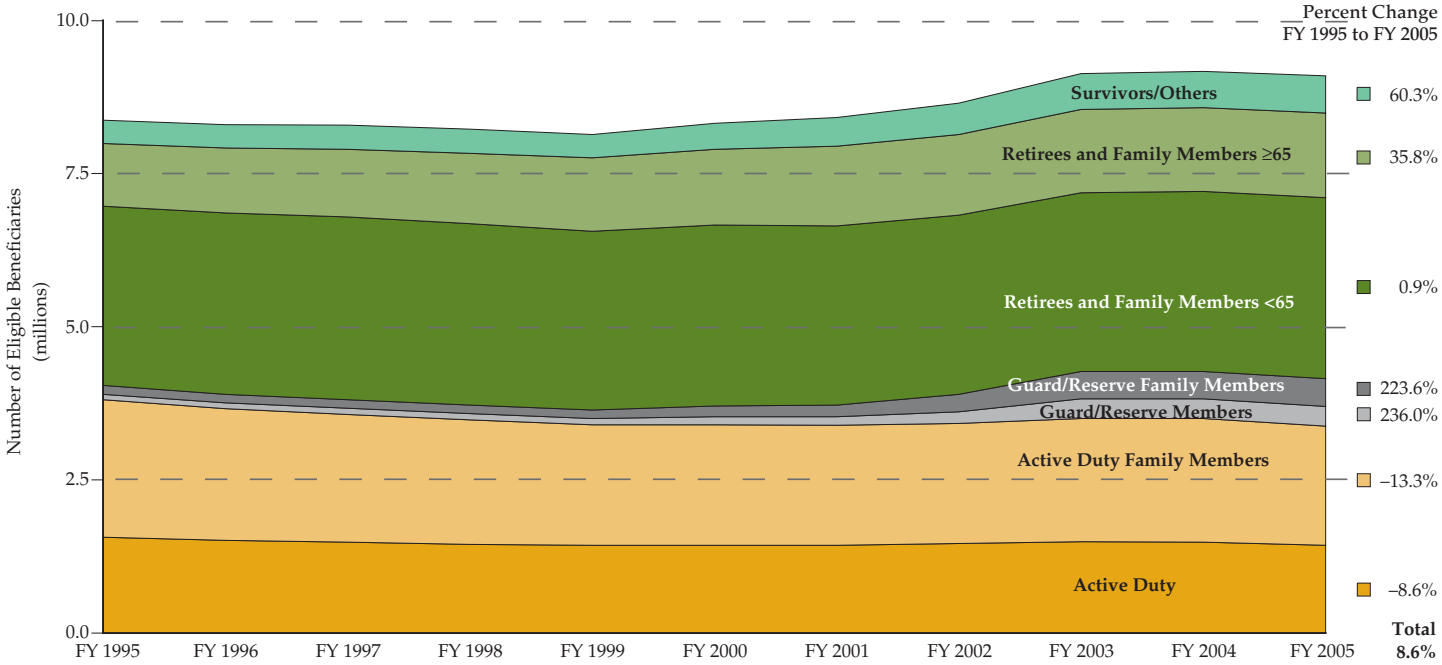
MHS POPULATION: FY 1995 TO FY 2005

MHS Eligible Population Trend Between FY 1995 and FY 2005

In addition to increasing by 8.6 percent overall since the beginning of the TRICARE contracts in 1995, the make-up of the MHS eligible beneficiary population has also changed in significant ways.

- The most apparent change is in the number of Guard/Reservists and their family members. Although expected to abate in FY 2006, the number of Guard/Reservists will still be approximately double the levels they attained prior to the GWOT.
- The number of active duty service members steadily declined between FY 1995 and FY 2005 but is expected to remain constant through FY 2011. A similar pattern holds for active duty family members.
- The number of senior retirees (age 65 and older) and family members has steadily grown since FY 1995 and that trend is expected to continue through FY 2011.

AVERAGE NUMBER OF ELIGIBLE MHS BENEFICIARIES BETWEEN FY 1995 AND FY 2005 BY BENEFICIARY CATEGORY



Sources: DEERS and MHS administrative data, 11/1/2005

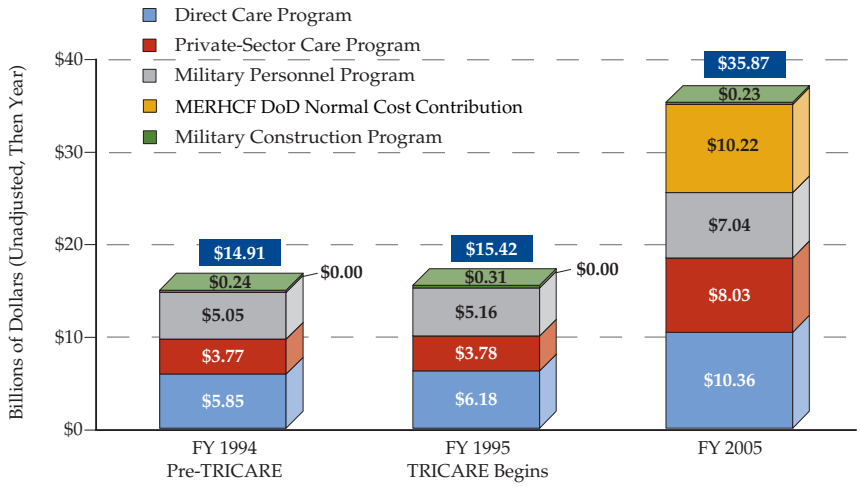
DEFENSE HEALTH FUNDING: FY 1995 TO FY 2005

Consistent with the health care industry in general, and the increase in benefits for a larger and aging eligible population, the Unified Medical Program (UMP) has increased since TRICARE's inception in 1995. As shown below, the UMP, was $14.9 billion in FY 1994, the year prior to the first TRICARE regional support contracts and Lead Agent Offices. It was $15.4 billion the end of FY 1995.

- Since FY 1995, the UMP has grown by about 133 percent, from $15.4 billion to almost $35.9 billion in FY 2005 ($25.7 billion, excluding the DoD normal cost contribution to the Medicare-Eligible Retiree Health Care Fund, MERHCF—the "Accrual Fund"), and unadjusted for inflation (i.e., in "then-year" dollars). The MERHCF became effective October 1, 2002 to pay the cost of DoD health care programs for Medicare-eligible retirees, retiree family members, and survivors. Two of the major cost drivers for the Accrual Fund are the TRICARE Senior Pharmacy benefit (beginning April 2001), and the TRICARE for Life benefit (beginning October 2001).

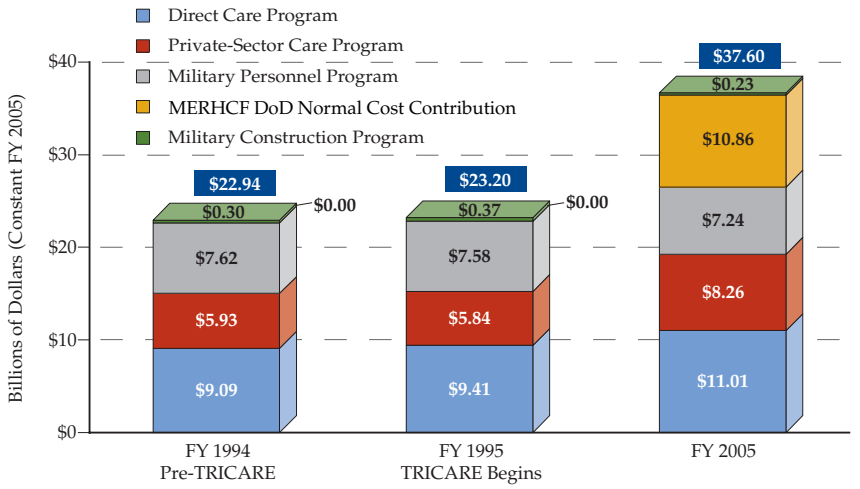
- As shown further below, when actual expenditures are adjusted for inflation based on constant FY 2006 dollars, the UMP increased 62 percent in purchasing value, from $23.2 billion in FY 1995 to almost $37.6 billion in FY 2005 (including the normal cost contribution to the Accrual Fund).

UNIFIED MEDICAL PROGRAM FUNDING SINCE INCEPTION OF TRICARE (UNADJUSTED, THEN-YEAR DOLLARS): FY 1994 TO FY 2005



Source: Comptroller Information System reports, FY 2006 President's Budget (2/13/06)

UNIFIED MEDICAL PROGRAM FUNDING SINCE INCEPTION OF TRICARE (CONSTANT FY 2006 DOLLARS): FY 1994 TO FY 2005

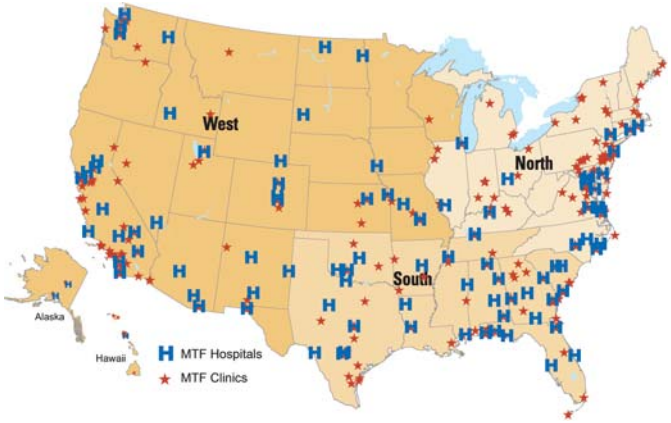


Source: Comptroller Information System reports, actual execution, and the FY 2007 President's Budget Estimate (2/13/06);
Deflators: OSD Comptroller table for MILPers, Procurement, RDT&E and MILCON and TMA for DHP O&M and TFL Accrual fund.

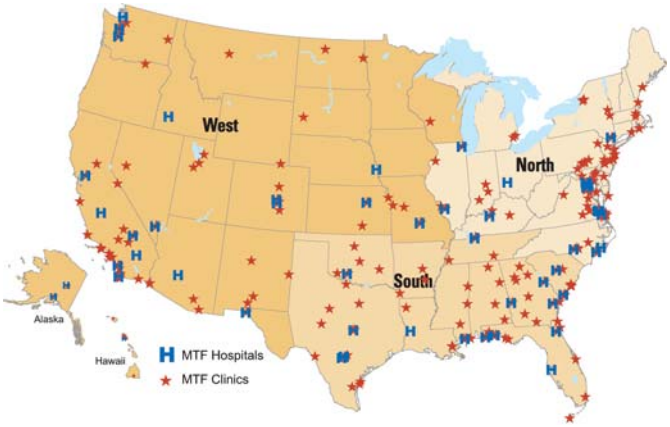
MTFs IN FY 1995 COMPARED WITH FY 2005

Consistent with the Base Realignment and Closure process, as well as Service-generated infrastructure changes, the number of military hospitals in the U.S. declined by 60 percent between FY 1995 and FY 2005, from 130 to 52, respectively. During this period, military hospitals were either closed or downsized to ambulatory clinics. Similarly, by 2005, the total number of clinics in the U.S. was 20 percent fewer than in 1995 (from 388 to 309, respectively). Overall, the MHS direct care infrastructure in terms of fixed MTF locations has diminished by approximately one-third since 1995 (from 518 to 361 fixed facilities).

U.S. MTFs IN FY 1995



U.S. MTFs IN FY 2005



BASE REALIGNMENT AND CLOSURE: CONUS

Base Realignment and Closure, FY 1988 to FY 1995, Process and History

Approximately 17 years ago, in December 1988, the first military base closure commission recommended the closing and realignment of 145 U.S. domestic bases and facilities. This action was the consequence of the Department of Defense's broad reevaluation of its mission in conjunction with the weakening and ultimate collapse of the Soviet Union. There was little need, according to the Pentagon, to continue to retain the vast Cold War-era infrastructure. Funds saved from closing down underutilized bases, DoD further noted, could be used to enhance development of new weapons and improve readiness.

The 1988 round of infrastructure reductions was followed by three additional rounds in 1991, 1993, and 1995. The four base closure and realignment (BRAC) commissions recommended, individually, a total of 534 actions to close, realign, or otherwise affect specific bases, facilities, and activities. The closing of all 451 BRAC installations (major, minor and "other") from the four rounds was completed by the end of FY2001, as originally scheduled.

FY 2005 Round 5 BRAC Decision

The 2005 BRAC is the largest, most joint-service-oriented round DoD has ever attempted. More than 800 installations across the country from the Active, National Guard and Reserve Components will be affected and 40 percent of the changes will affect more than one service. This BRAC is necessary for the transformation of the Armed Forces and the transformation of DoD's business practices to set about this broad realignment of American domestic military infrastructure.

The final BRAC recommendations approved by the Congress will result in closing 33 major bases, realigning 29 others, and realigning or closing an additional 775 minor facilities or

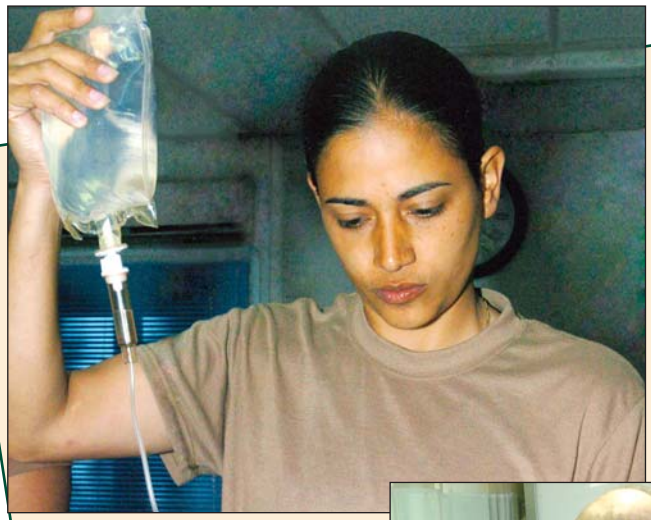
BASE REALIGNMENT AND CLOSURE: CONUS *(CONT'D)*

functions over the next six years. The net effect on the MHS will be the closure of two MTFs (Brooks City Base Clinic, TX and Walter Reed Medical Center's fixed facility in Washington D.C., with operations shifting to, and consolidating with, the National Naval Medical Center, Bethesda, MD complex) and the realignment of 11 others. Realignment includes significant downsizing of direct care medical capacity at such locations as Wilford Hall Medical Center to clinic status and transfer and consolidation of inpatient services to Brooke Army Medical Center in San Antonio, TX. It will also include the downsizing of several hospitals to clinics as shown in the table below. Downsizing direct care capacity will likely increase purchased care expenditures in those areas where residual MHS beneficiary populations switch from MTF to civilian health care sources.

The Department of Defense's recommendations also called for an investment of $2.4 billion in medical activities that were expected to result in over $5 billion dollars in reduced spending over the following 20 years, and over $400 million in ongoing annual savings. The plan would call for close to $1 billion to be invested in the National Capital Region to create the new Walter Reed National Military Medical Center, a jointly-staffed facility, on the National Naval Medical Center campus, while also constructing a new 165-bed community hospital at Fort Belvoir, VA. Another recommendation called for creating a new joint center for medical enlisted training at Fort Sam Houston, TX, and six new joint centers of excellence in biomedical research. The medical center at Andrews Air Force Base would, under the plan, be converted to a clinic with an ambulatory surgery center.

MEDICAL TREATMENT FACILITIES (MTFs) AFFECTED BY BRAC 2005

Service	Existing Facility Type	MTF Name	BRAC 2005	End State	Installation	State	City	Zip
Air Force	Clinic	62nd Med. Grp.–McChord	Realign	Consolidate with Army's Madigan Med. Ctr.	McChord AFB	WA	Tacoma	98438
Air Force	Clinic	311th Med. Squad–Brooks	Close	No Clinic	Brooks City Base	TX	San Antonio	78235
Air Force	Hospital	10th Med. Grp.–USAF Academy CO	Realign	Downsize to Clinic	USAF Academy	CO	Colorado Springs	80840
Army	Hospital	Walter Reed AMC–Washington DC	Realign	Consolidation in National Capital Region	Washington DC	DC	Washington	20307
Air Force	Hospital	6th Med. Grp.–MacDill	Realign	Downsize to Clinic	MacDill AFB	FL	Tampa	33621
Air Force	Hospital	375th Med. Grp.–Scott	Realign	Downsize to Clinic	Scott AFB	IL	Belleville	62225
Navy	Hospital	NH Great Lakes	Realign	Downsize to Clinic	Great Lakes	IL	Great Lakes	60088
Army	Hospital	Ireland ACH–Ft. Knox	Realign	Downsize to Clinic	Ft. Knox	KY	Ft. Knox	40121
Air Force	Hospital	89th Med. Grp.–Andrews	Realign	Downsize to Clinic	Andrews AFB	MD	Andrews AFB	20762
Air Force	Hospital	81st Med. Grp.–Keesler	Realign	Downsize to Clinic	Keesler AFB	MS	Biloxi	39534
Navy	Hospital	NH Cherry Point	Realign	Downsize to Clinic	Cherry Point	NC	Cherry Point	28533
Air Force	Hospital	59th Med. Wing–Lackland	Realign	Downsize to Clinic	Lackland AFB	TX	San Antonio	78236
Army	Hospital	McDonald ACH–Ft. Eustis	Realign	Downsize to Clinic	Ft. Eustis	VA	Ft. Eustis	23604



TRICARE WORLDWIDE PROGRAM OPERATIONS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2006

Total Beneficiaries	9.2 million
Military Facilities—Direct Care System	
Inpatient Facilities (Hospitals & Medical Centers)	70 (52 in U.S.)
Ambulatory Medical Clinics	411 (309 in U.S.)
Ambulatory Dental Clinics	417
Veterinary Facilities	259
Military Health System Personnel	136,600
Military	88,400
Civilian	48,200
Total Unified Medical Program (UMP):	$34.7 billion*
(Includes estimated FY 2006 receipts for Accrual Fund)	$7.1 billion**

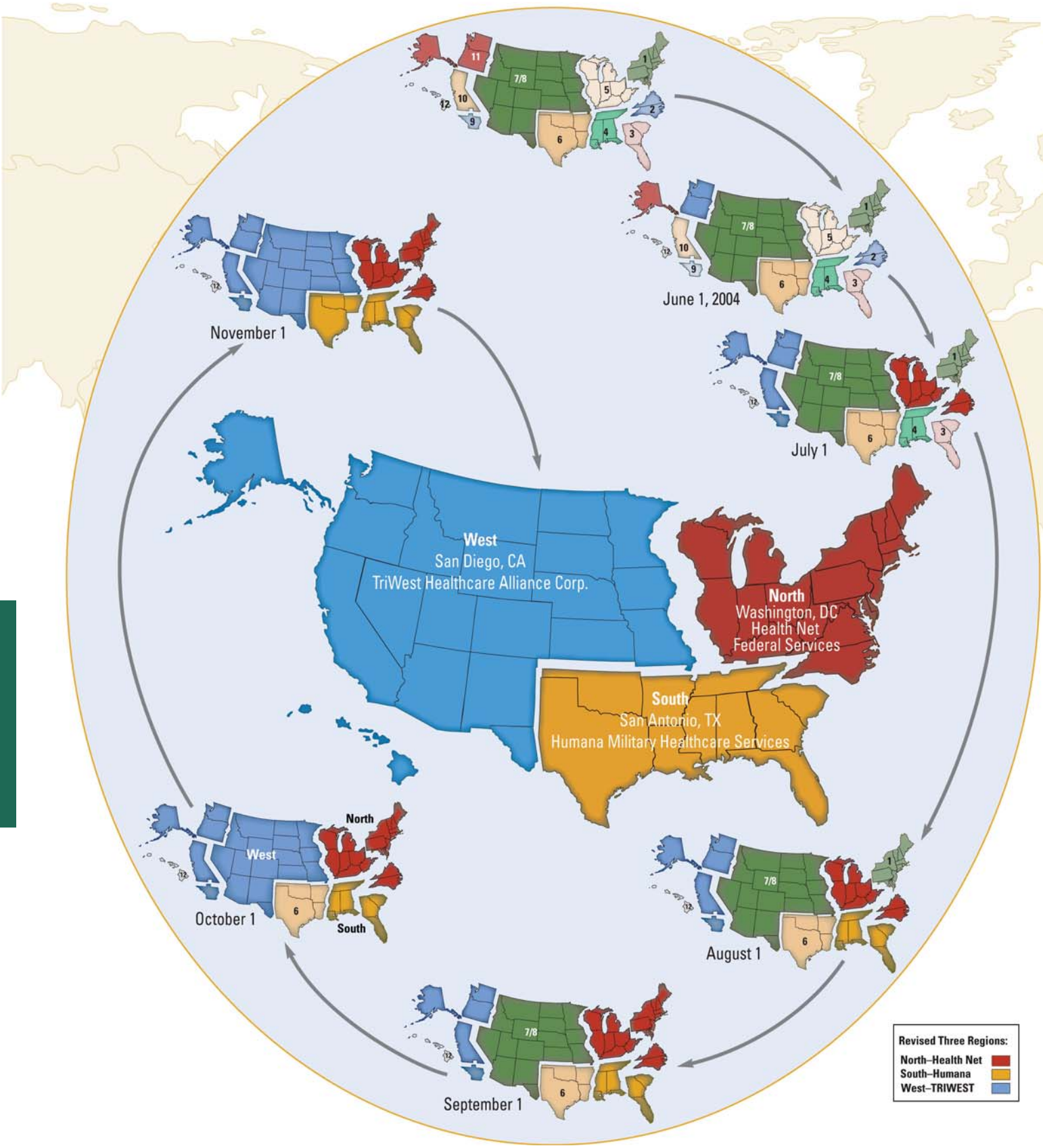
* Includes direct and private sector care funding, Military Personnel, military construction and Accrual Fund.

** The DoD Medicare-Eligible Retiree Health Care Fund, implemented in FY 2003, is an Accrual Fund that pays for health care provided in DoD/Coast Guard facilities to DoD retired, dependent of retired, and survivors who are Medicare-eligible beneficiaries. The Fund also supports purchased care payments through the TFL benefit first implemented in FY 2002.

TRICARE is administered on a regional basis, with three regional contractors working with their TRICARE regional offices (TROs) to manage purchased care operations and coordinate medical services available through civilian providers with the MTFs. These three regions are the result of the successful, time-phased consolidation during FY 2004 and early FY 2005 of 12 regions and five support contractors originally established with the implementation of TRICARE operations beginning in March 1995. The TROs and regional support contracts help:

- establish TRICARE provider networks
- operate TRICARE service centers and provide customer service to beneficiaries
- provide administrative support, such as enrollment, disenrollment, and claims processing
- communicate and distribute educational information to beneficiaries and providers

TRANSITION OF TRICARE HEALTH SERVICE REGIONS IN FY 2004 AND FY 2005 FROM 12 TO 3 REGIONS



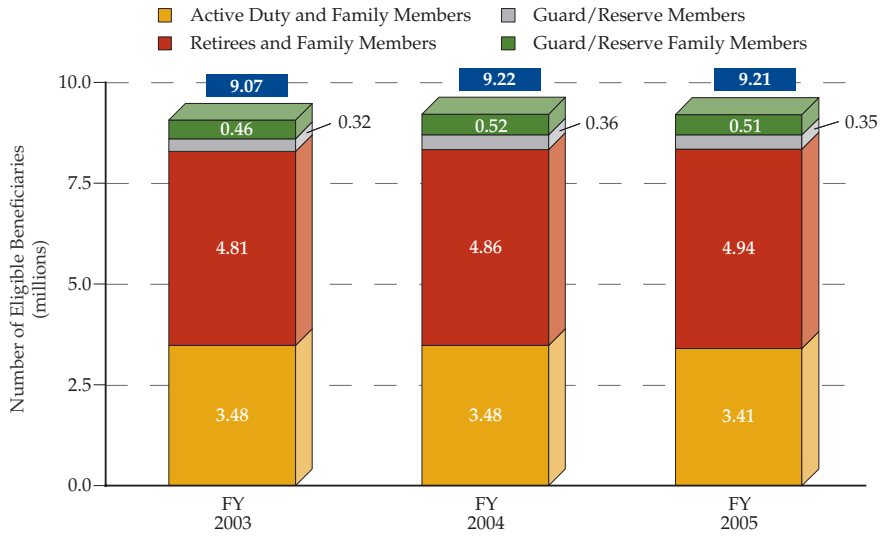
Source: OASD(HA)/TMA; Comptroller Information System final reports for President's Budget Submissions

BENEFICIARY TRENDS AND DEMOGRAPHICS

Number of Eligible Beneficiaries Between FY 2003 and FY 2005

The number of beneficiaries eligible for DoD medical care increased from 9.1 million at the end of FY 2003 to 9.2 million at the end of FY 2004 and remained at that level in FY 2005. The increase in FY 2004 was largely due to the mobilization of additional Guard/Reserve members and the extension of benefits to their family members. But in FY 2005, there was very little change in the number of eligible Guard/Reserve and family members while an increase in retirees and family members was offset by a decrease in active duty and family members.

TRENDS IN THE NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP



Source: Defense Enrollment Eligibility Reporting System (DEERS), 10/24/05

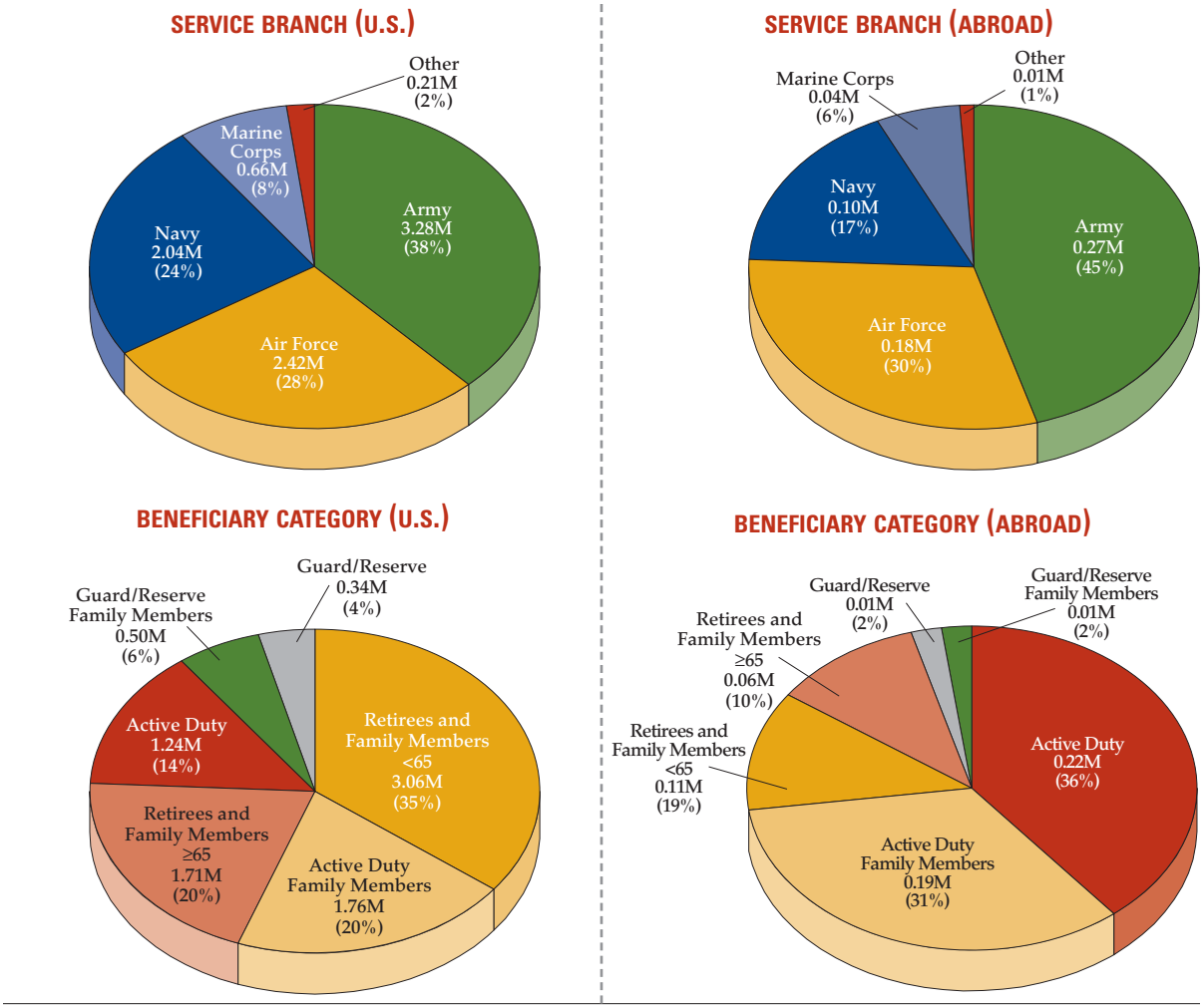
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Eligible Beneficiaries in FY 2005

Of the 9.2 million eligible beneficiaries in FY 2005, 8.61 million (almost 94 percent) are stationed or reside in the United States and 0.60 million are stationed or reside abroad. The Army has the most beneficiaries eligible for Uniformed Services health care benefits, followed (in order) by the Air Force, Navy, Marine Corps, and other Uniformed Services (Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration). Although the proportions are different, the Service rankings (in terms of eligible beneficiaries) are the same both in the U.S. and abroad.

Whereas retirees and their family members comprise the largest percentage of the eligible population (55 percent) in the U.S., active duty personnel (including Guard/Reserve Component members on active duty for at least 30 days) and their family members comprise the largest percentage (72 percent) of the eligible population abroad.

BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS IN FY 2005



Source: DEERS, 10/24/2005

Note: Percentages may not add to 100 percent due to rounding.

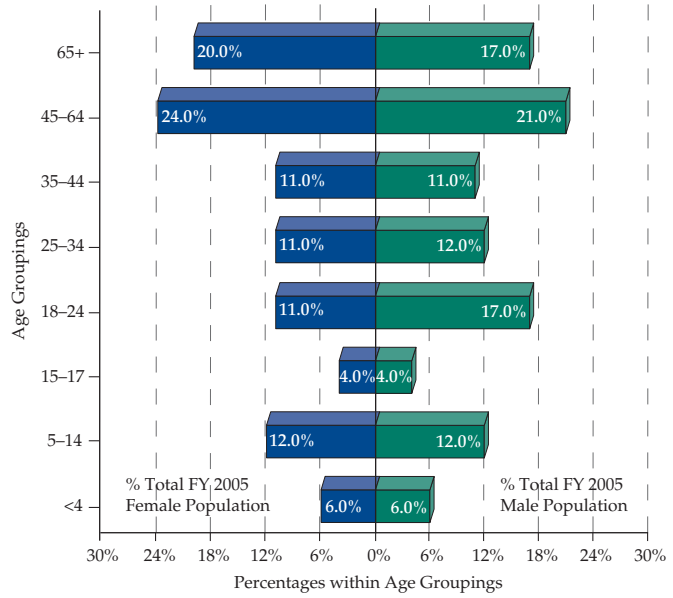
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

MHS Population Distribution by Age and Gender: FY 2005 and FY 2012

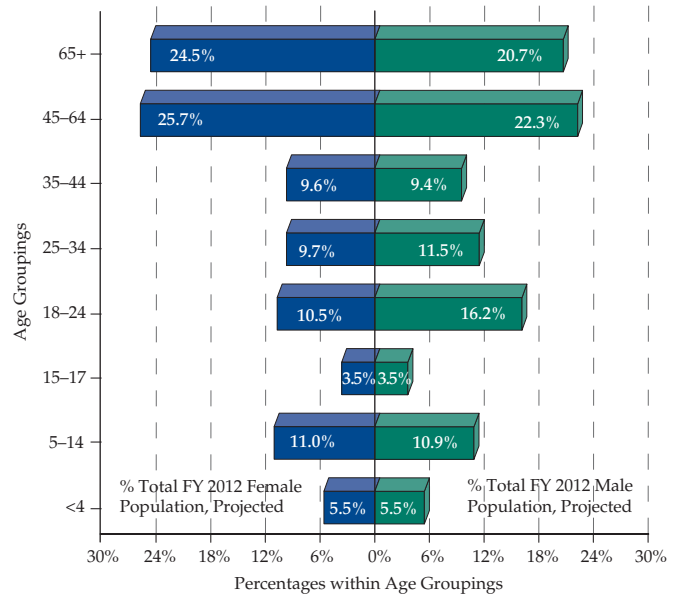
The chart below left portrays the distribution of the 9.2 million MHS eligible beneficiaries as of the end of FY 2005. The middle of the population age brackets (the three groupings containing ages 18–44) reflects the age ranges typically found for most of the active duty and family members in the MHS. This bracket represents 3.3 million beneficiaries, or 37 percent of the total eligible population (33 percent of females, 40 percent of males). The 3.8 million beneficiaries most likely to be of military retirement age (the two brackets age 45 and above) constitute 41 percent of the total population (44 percent of the women, 38 percent of the males). The 2 million eligible for pediatric and adolescent care constitute approximately one-fifth of the population (about 22 percent; sum of three age brackets: under 4, 5–14 and 15–17). The overall MHS population is relatively evenly distributed by gender, with a slightly higher proportion of women than men in the two older age brackets (45 to 64 and 65 years of age and older).

The chart further below projects the MHS population to FY 2012, reflecting a decrease of the overall population to around 8.9 million with the return of most Guard and Reserve personnel and their family members to nonactive status (this level will therefore be close to the FY 2002 level of 8.7 million as presented in the FY 2004 TRICARE Evaluation Report, page 13). Under this projection, the relative proportion of males to females does not change, however, the MHS population in the two older age brackets (45-64 and 65+) will increase relative to the other age groupings.

FY 2005 MHS POPULATION



PROJECTED FY 2012 MHS POPULATION



TOTAL MHS POPULATION DISTRIBUTION BY AGE AND GENDER: CURRENT FY 2005 AND PROJECTED FY 2012

	Age Group (in millions)								Total by Gender	Total MHS Population
	<4	5–14	15–17	18–24	25–34	35–44	45–64	65+		
FY 2005 Female MHS Beneficiaries	0.27	0.55	0.18	0.51	0.47	0.50	1.06	0.89	4.42	9.2
FY 2005 Male MHS Beneficiaries	0.28	0.57	0.19	0.81	0.57	0.51	1.01	0.84	4.79	9.2
FY 2012 Female MHS Beneficiaries, Projected	0.25	0.50	0.16	0.74	0.52	0.43	1.01	0.94	4.55	8.9
FY 2012 Male MHS Beneficiaries, Projected	0.24	0.48	0.15	0.46	0.42	0.42	1.12	1.07	4.38	8.9

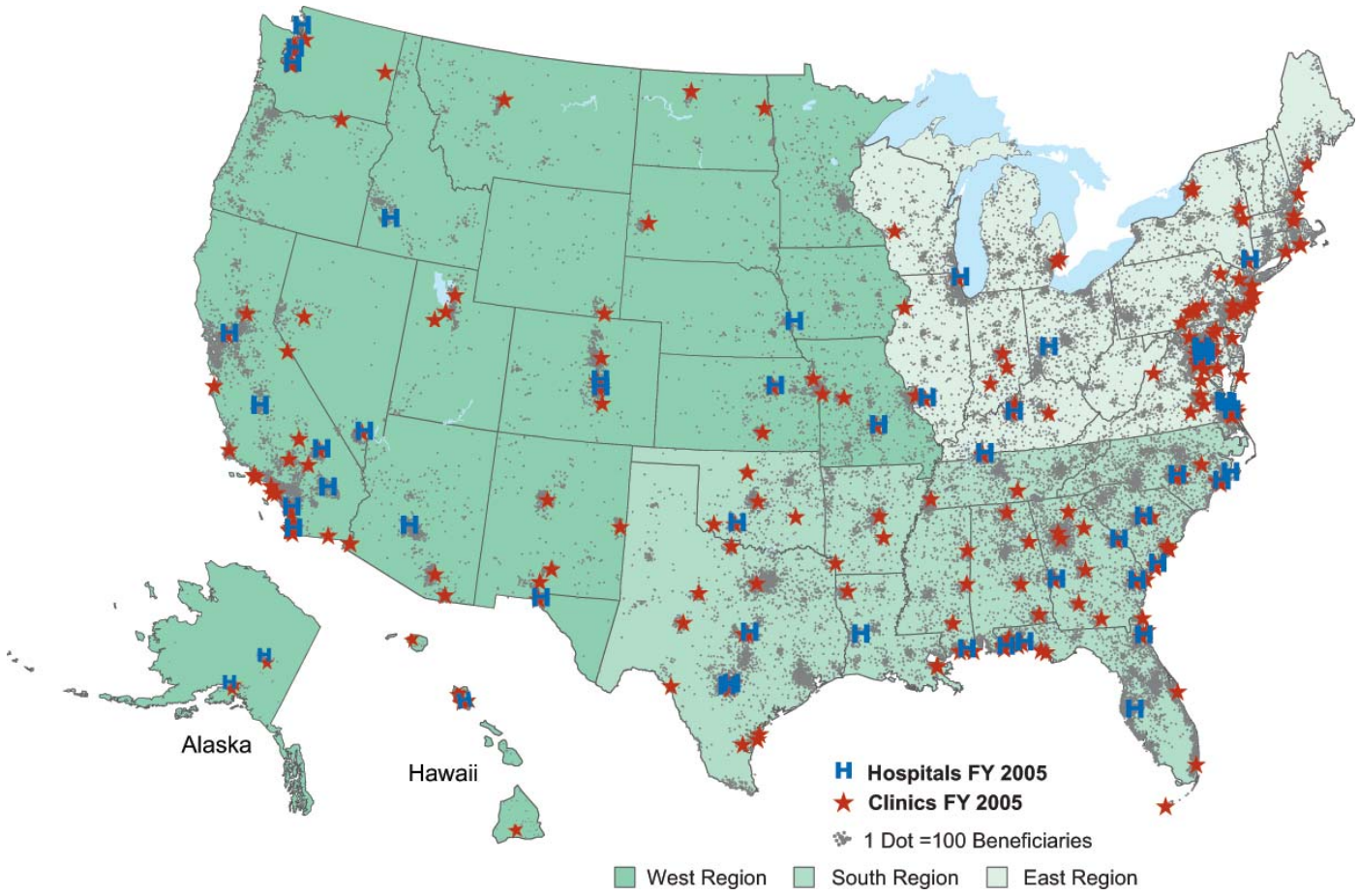
Source: MHS administrative data for the Managed Care Forecasting and Analysis System, as of 11/1/2005

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Locations of U.S. Military Medical Treatment Facilities (Hospitals and Ambulatory Care Clinics) in FY 2005

The map below presents the geographic diversity of that proportion of the MHS beneficiary population residing within the United States (94 percent of the total 9.2 million beneficiaries). An overlay of the major DoD MTFs (medical centers and community hospitals, as well as medical clinics) reflects the extent to which the MHS population does and does not reside near the direct care system.

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MILITARY MEDICAL TREATMENT FACILITIES (HOSPITALS AND AMBULATORY CARE CLINICS) IN FY 2005



Source: MTF information from TMA Portfolio Planning Management Division; residential population and GIS information from TMA/HPA&E, 11/23/2005

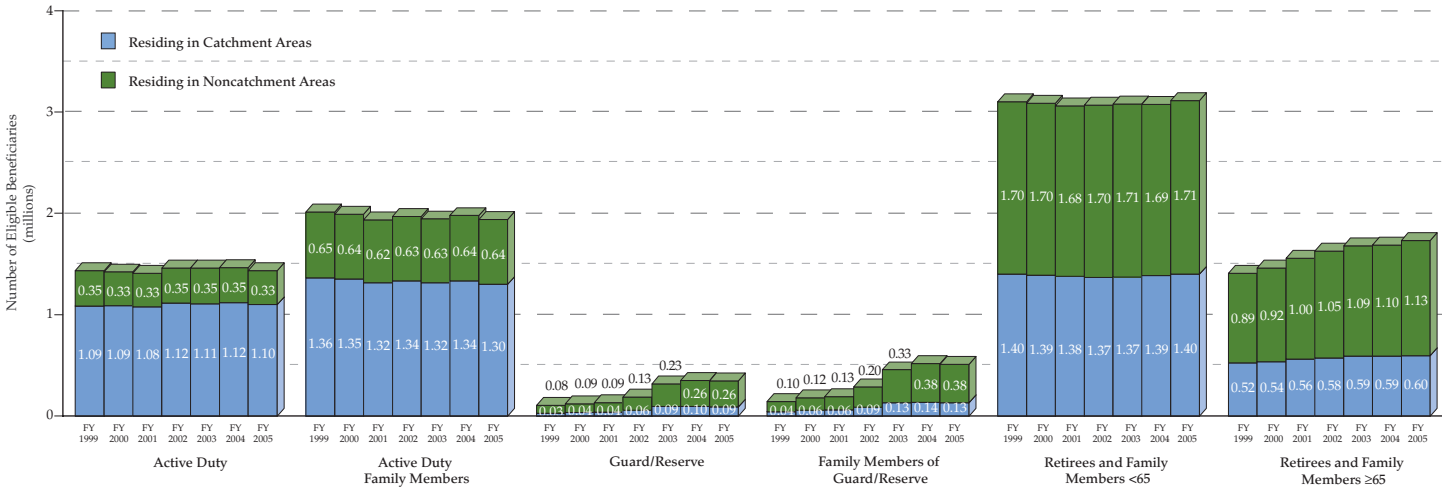
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Eligible Beneficiaries Living in Catchment Areas

A catchment area is defined as the area within approximately 40 miles of a military hospital, allowing for natural geographic boundaries and transportation accessibility. Noncatchment areas lie outside catchment area boundaries. Because of Base Realignment and Closure (BRAC) actions and changes in the beneficiary mix over time, there has been a downward trend in the proportion of beneficiaries living in catchment areas (from 54 percent in FY 1999 to 50 percent in FY 2005). This trend has implications for the proportion of workload performed in direct care and purchased care facilities.

- Active duty family members (ADFMs) were the only beneficiary group to experience a decline in the number living in catchment areas.
- The recent call-ups of National Guard and Reserve members have contributed disproportionately to the total number of beneficiaries living in noncatchment areas. Most Guard/Reserve members already live in noncatchment areas when recalled to active duty and their families continue to live there.

TREND IN THE NUMBER OF ELIGIBLE BENEFICIARIES LIVING IN AND OUT OF MTF CATCHMENT AREAS



Source: DEERS, 10/24/2005

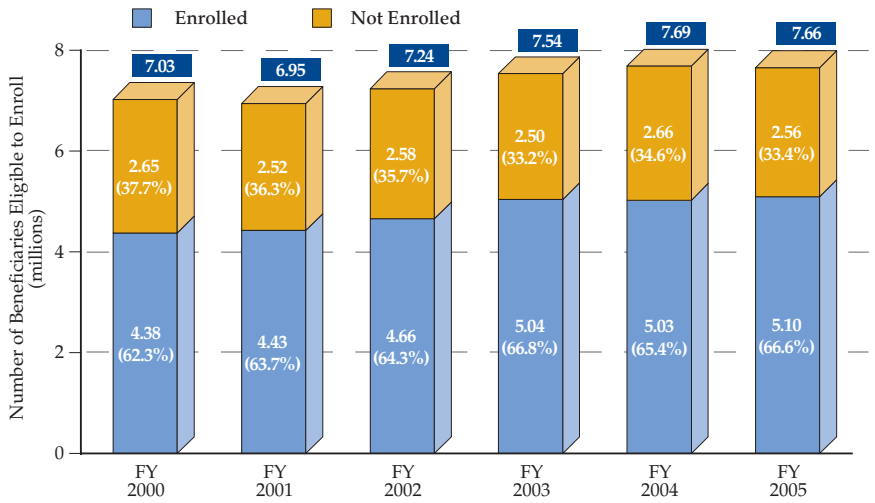
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Eligibility and Enrollment in TRICARE Prime

Eligibility for and enrollment in TRICARE Prime was determined from the Defense Enrollment Eligibility Reporting System (DEERS). For the purpose of this presentation, all active duty personnel are considered to be enrolled. The eligibility counts exclude most beneficiaries age 65 and over (some were eligible for TRICARE Senior Prime in FY 2001 and early FY 2002) but include beneficiaries living in remote areas where Prime may not be available. The enrollment rates displayed below may therefore be somewhat understated.

- TRICARE Prime enrollment, both in raw numbers and as a percentage of those eligible to enroll, has steadily increased since FY 2000.
- Beneficiaries enrolled in TRICARE Plus (a primary care enrollment program that is offered at selected MTFs) are excluded from the enrollment counts below; they are included in the non-enrolled counts. The number of beneficiaries enrolled in TRICARE Plus increased from 163,690 at the end of FY 2004 to 169,893 at the end of FY 2005.
- By the end of FY 2005, 67 percent of all eligible beneficiaries were enrolled in Prime (5.10 million enrolled of the 7.66 million eligible to enroll).

HISTORICAL END-OF-YEAR ENROLLMENT NUMBERS



Source: DEERS, 10/24/2005

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

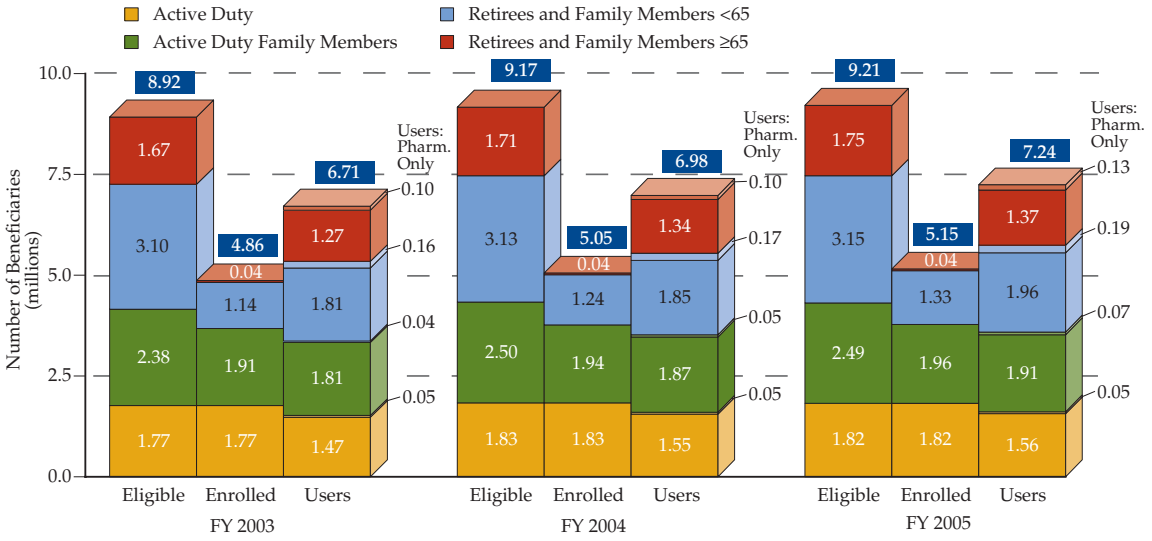
Average Eligibles, Enrollees, and Users Between FY 2003 and FY 2005

The average numbers of eligibles and TRICARE Prime enrollees by beneficiary category from FY 2003 to FY 2005 were determined from the Defense Enrollment Eligibility Reporting System (DEERS). The eligible counts include all beneficiaries eligible for some form of the military health care benefit and therefore include those who may not be eligible to enroll in Prime. TRICARE Plus enrollees are not included in the enrollment counts.

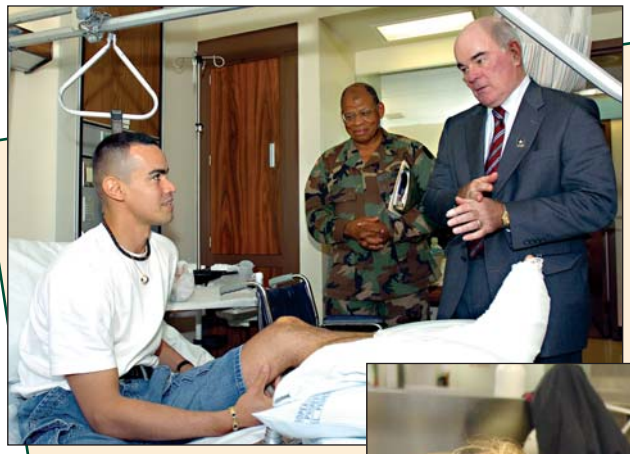
Two types of users are defined in this section: (1) users of inpatient or outpatient care, regardless of pharmacy utilization; and (2) users of pharmacy only. No distinction is made here between users of direct and purchased care. The sum of the two types of users is equal to the number of beneficiaries who had any MHS utilization.

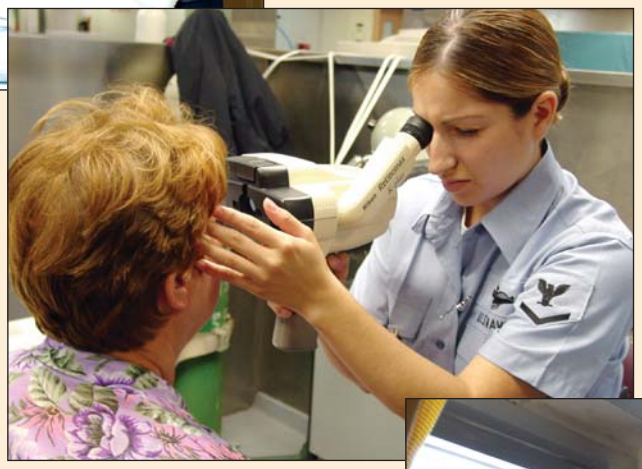
- ADFMs and retirees and family members age 65 and older each experienced an increase of 4.5 percent in the number of eligible beneficiaries between FY 2003 and FY 2005.
- The percentage of retirees and family members under age 65 enrolled in TRICARE Prime increased from 37 percent in FY 2003 to 42 percent in FY 2005. The increase is due primarily to formerly non-MHS-reliant retirees dropping their private health insurance because of rising premiums.
- The user rate increased from FY 2003 to FY 2005 for all beneficiary groups.
- Retirees and family members under age 65 have the greatest number of users of the MHS but the lowest user rate.

AVERAGE NUMBER OF FY 2003 TO FY 2005 ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY



Sources: DEERS and MHS administrative data, 12/16/2005



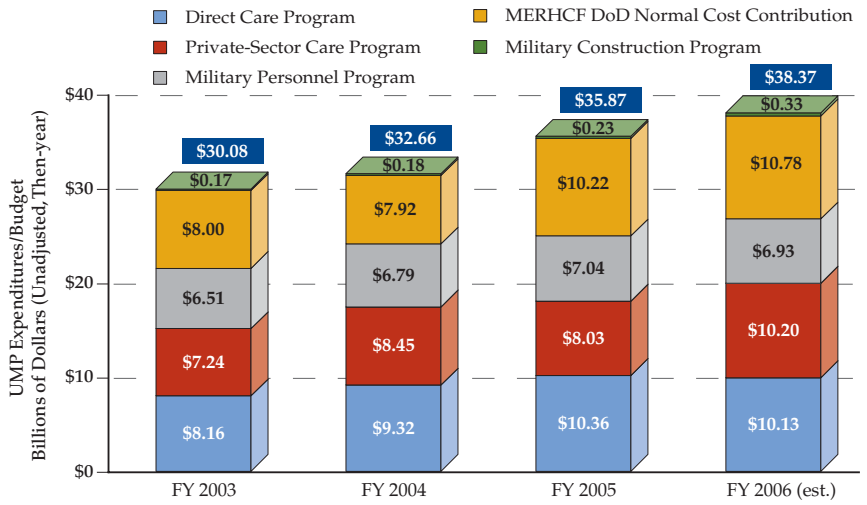


Top left photo: Secretary of the Army Francis J. Harvey visits with a soldier wounded during Operation Iraqi Freedom.

UNIFIED MEDICAL PROGRAM FUNDING

As shown in the first chart below, in terms of unadjusted expenditures (i.e., "then year" dollars, unadjusted for inflation), the Unified Medical Program increased from $30.08 billion in FY 2003 to $35.87 billion in FY 2005. It is programmed to reach almost $38.40 billion in FY 2006. The FY 2003 to FY 2005 funding includes the normal DoD cost contribution to the Medicare-Eligible Retiree Health Care Fund (the "Accrual Fund"). This fund (effective October 1, 2002) pays the cost of DoD health care programs for Medicare-eligible retirees, retiree family members and survivors. Two of the major cost drivers for the Accrual Fund are the TRICARE Senior Pharmacy benefit, which began in April 2001, and the TRICARE for Life (TFL) benefit, which began in October 2001.

FY 2003 TO FY 2006 (EST.) UNIFIED MEDICAL PROGRAM ($ BILLIONS) (UNADJUSTED, THEN-YEAR DOLLARS)

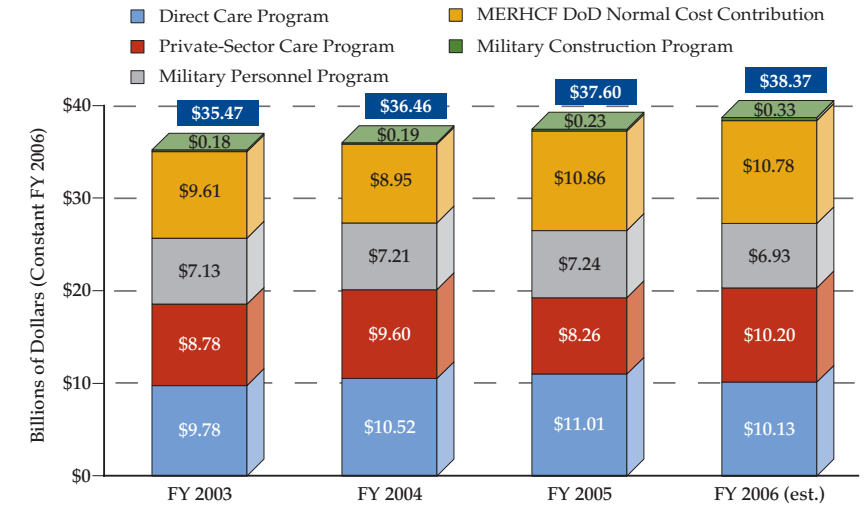


Notes: Numbers may not sum to totals due to rounding.

1. FYs 2003–2005 reflect Comptroller Information System actual execution; and FY 2006 is reflected in the FY 2007 President's Budget position estimates as of February 2006.
2. FY 2004 budget includes $658.4 million (M) for GWOT; FY 2004/FY 2005 Title IX Funding of $683M (executed in FY2005); $400M for NDAA Reserve Health Care Benefit; FY 2005 budget includes the FY 2004/FY 2005 Title IX funding of $683M (executed in FY 2005), $210.6M in GWOT supplemental, $20.5M for Hurricane/Tsunami Supplement.

In constant-year funding, when actual expenditures or projected funding are adjusted for inflation (using constant FY 2006 dollars), the FY 2006 purchasing value of nearly $38.4 billion reflects an 8 percent increase over the FY 2003 purchase value of about $35.5 billion.

FY 2003 TO FY 2006 (EST.) UNIFIED MEDICAL PROGRAM ($ BILLIONS) (CONSTANT FY 2006 DOLLARS)



Notes: Numbers may not sum to totals due to rounding.

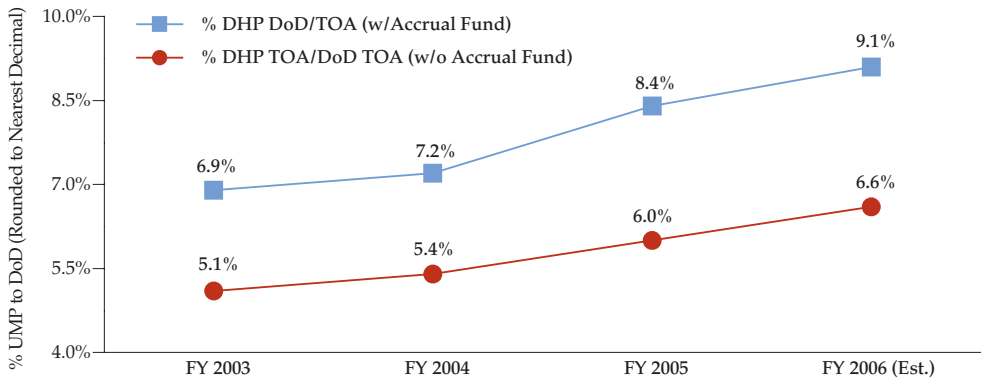
1. FYs 2003–2005 reflect Comptroller Information System actual execution; and FY 2006 is reflected in the FY 2007 President's Budget position estimates as of February 2006.
2. Source of data for deflators: (1) FY 2006 OSD Comptroller table for MilPers, Procurement, RDT&E and MILCON; and (2) TMA for DHP O&M and Accrual fund.
3. TRICARE for Life (TFL) and other NDAA enhancements commenced in FY 2002 resulting in an approximate $4 billion (B) increase.
4. FY 2004 budget includes $658.4M for GWOT; FY 2004/FY 2005 Title IX Funding of $683M (executed in FY 2005); $400M for NDAA Reserve Health Care Benefit; FY 2005 budget includes the FY 2004/FY 2005 Title IX funding of $683M (executed in FY 2005), $210.6M in GWOT supplemental, $20.5M for Hurricane/Tsunami Supplement.

UNIFIED MEDICAL PROGRAM FUNDING

UMP Share of Defense Budget

UMP expenditures are expected to increase from slightly under 7 percent of DoD Total Obligational Authority (TOA) in FY 2003 to 9.1 percent estimated for FY 2006, including the Accrual Fund. When the Accrual Fund is excluded, the UMP's share is expected to increase by 1.5 percentage points between FY 2003 and FY 2006, from 5.1 percent to 6.6 percent.

UMP EXPENDITURES AS A PERCENTAGE OF DEFENSE BUDGET: FY 2003 TO FY 2006 (EST.)

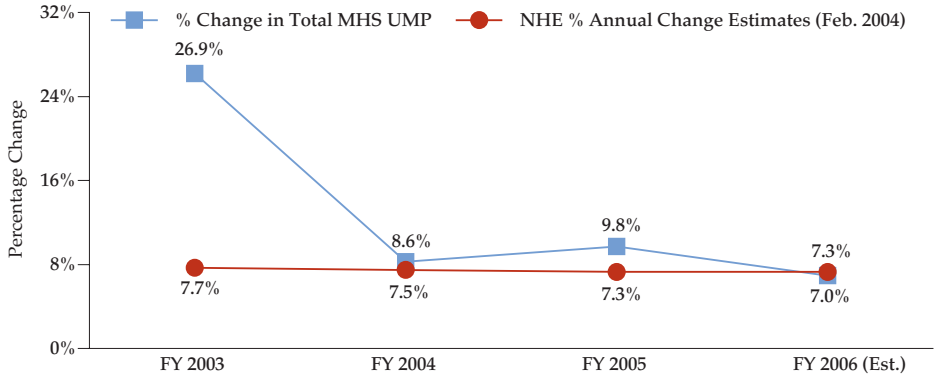


Source: FYs 2003–2005 reflect Comptroller Information System actual execution; and FY 2006 is reflected in the FY 2007 President's Budget position estimates as of February 2006. The percentages reflected above are estimates only, given availability of overall DoD TOA at print time of this report.

Comparison of Unified Medical Program and National Health Expenditures Over Time

The 27 percent rate of growth in UMP expenditures experienced in FY 2003 declined to under 10 percent in FY 2005. As noted previously, the large percentage jump between FY 2002 and FY 2003 was due to the establishment of MERHCF. As currently budgeted, UMP expenditures are expected to decrease to just over 7 percent from FY 2005 to FY 2006 (including GWOT and TFL funding), relatively consistent with published expected National Health Expenditures (NHE) over the same period (unadjusted, then-year dollars).

COMPARISON OF CHANGE IN ANNUAL UNIFIED MEDICAL PROGRAM AND NATIONAL HEALTH EXPENDITURES OVER TIME: FY 2003 TO FY 2006 (EST.)



Sources: Unified Medical Program and DHP Expenditures: Comptroller Information System final reports for President's Budget Submissions (percentages from data reflected in the chart on the previous page entitled "FY 2003 to FY 2006 (Est.) Unified Medical Program"), as of 2/13/2005. The MHS UMP and associated annual percentage changes used above include the MERHCF DoD normal cost contribution reflected beginning in FY 2003.

National Health Expenditures: Heffler, S. Smith, Keehan, S., et al. U.S. Health Spending Projections for 2004–2014: Health Affairs. 23 February 2005 W5–75. Actual expenditures (in $ billions): 2002 ($1,559.00) 2003 ($1,678.9), 2004 ($1,804.7 projected), 2005 ($1,936.5 projected) and 2006 ($2,077.5) projected.

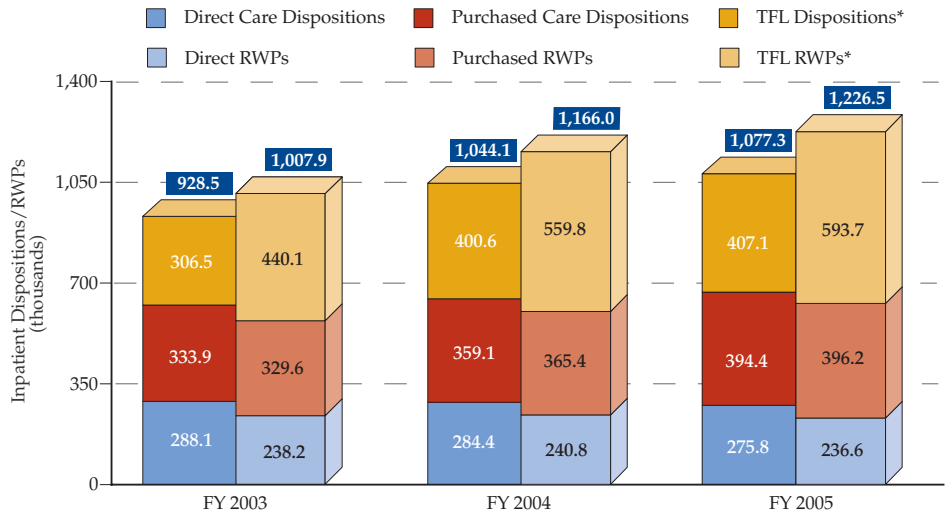
MHS WORKLOAD TRENDS

MHS Inpatient Workload

Total MHS inpatient workload is measured two ways: as the number of inpatient dispositions and as the number of Relative Weighted Products (RWPs). The latter measure reflects the relative resources consumed by a hospitalization as compared to the average of all hospitalizations. It gives greater weight to procedures that are more complex and involve greater lengths of stay. Total inpatient workload (direct and purchased care combined) increased between FY 2003 and FY 2005 (dispositions increased by 8 percent and RWPs by 11 percent), excluding the effect of TFL.

- Direct care inpatient dispositions declined by 4 percent over the past three years but total RWPs remained about the same. This indicates that more intensive inpatient workload is being performed in MTFs.
- Purchased care inpatient dispositions increased by 18 percent excluding TFL workload and by 25 percent including TFL.
- Purchased care inpatient RWPs increased by 20 percent excluding TFL workload and by 29 percent including TFL.
- While not shown, about 13 percent of direct care inpatient dispositions and 11 percent of RWPs were performed abroad during FYs 2003–2005. Purchased care and TFL inpatient workload performed abroad accounted for less than 3 percent of the worldwide total.

TRENDS IN MHS INPATIENT WORKLOAD



Source: MHS administrative data, 12/26/2005

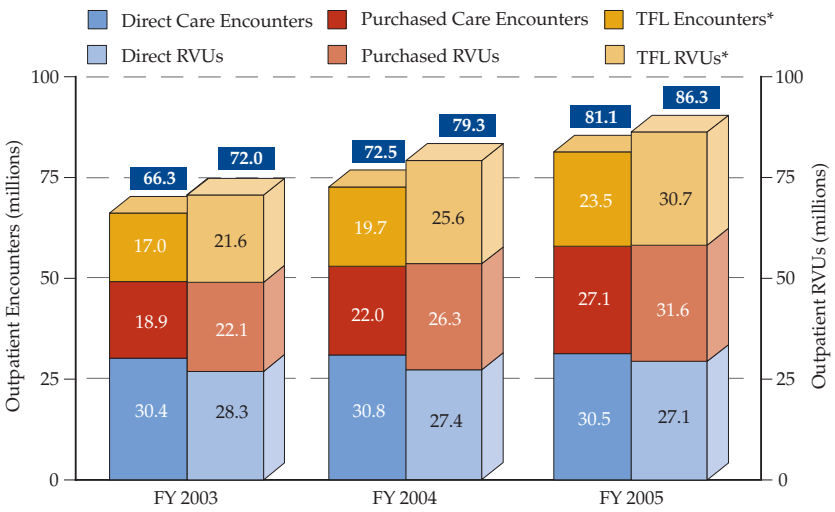
* Purchased care only.

MHS WORKLOAD TRENDS *(CONT'D)*

MHS Outpatient Workload

Total MHS outpatient workload is measured two ways: as the number of encounters (outpatient visits and ambulatory procedures) and as the number of Relative Value Units (RVUs). The latter measure reflects the relative resources consumed by an encounter as compared to the average of all encounters. Total outpatient workload (direct and purchased care combined) increased between FY 2003 and FY 2005 (both encounters and RVUs increased by 17 percent), excluding the effect of TFL.

TRENDS IN MHS OUTPATIENT WORKLOAD



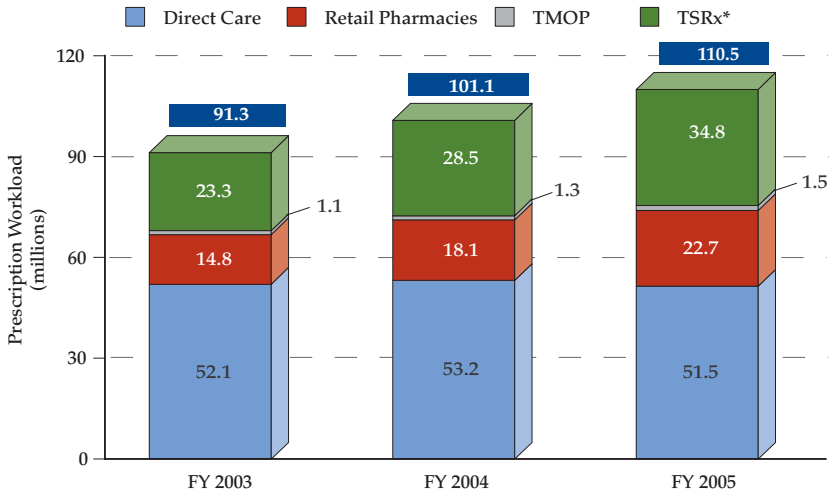
Source: MHS administrative data, 12/26/2005 * Purchased care only.

- Direct care outpatient encounters were essentially constant the past three years but RVUs decreased by 4 percent, indicating less intensive workload being performed in MTFs.
- Both purchased care outpatient encounters and RVUs increased by 43 percent whether or not TFL workload is included.
- While not shown, about 11 percent of direct care outpatient workload (both encounters and RVUs) was performed abroad. Purchased care and TFL outpatient workload performed abroad accounted for less than 2 percent of the total.

MHS Prescription Drug Workload

Total prescription drug workload (direct and purchased care combined) increased by11 percent between FY 2003 and FY 2005, excluding the effect of TSRx.

TRENDS IN MHS PRESCRIPTION WORKLOAD



Source: MHS administrative data, 12/26/2005

* Purchased care only.

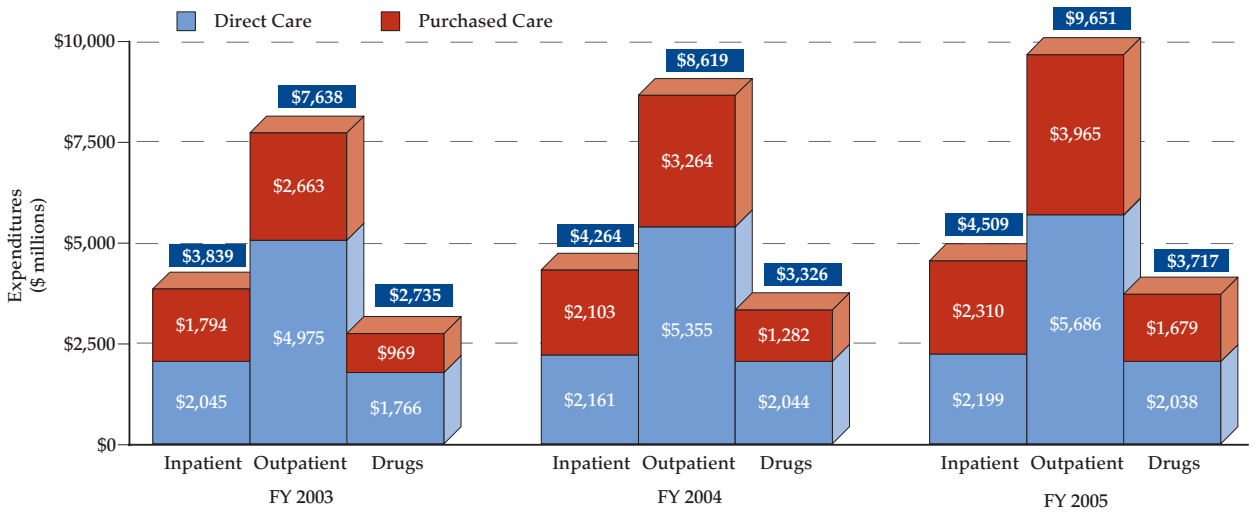
- Direct care prescription workload rose by 2 percent in FY 2004 and fell by 3 percent in FY 2005.
- Purchased care prescription workload increased by 52 percent from FY 2003 to FY 2005 (22 percent in FY 2004 and 25 percent in FY 2005), excluding the impact of the TSRx benefit. Including the impact of TSRx, purchased care prescription workload increased by 22 percent in FY 2004 and by another 23 percent in FY 2005.
- While not shown, just under 8 percent of direct care prescriptions were issued abroad. Purchased care prescriptions issued abroad accounted for less than 1 percent of the total.

MHS COST TRENDS

Total MHS costs increased between FY 2003 and FY 2005 for all three major components of health care services: inpatient, outpatient and prescription drugs, although the relative proportions remained about the same.

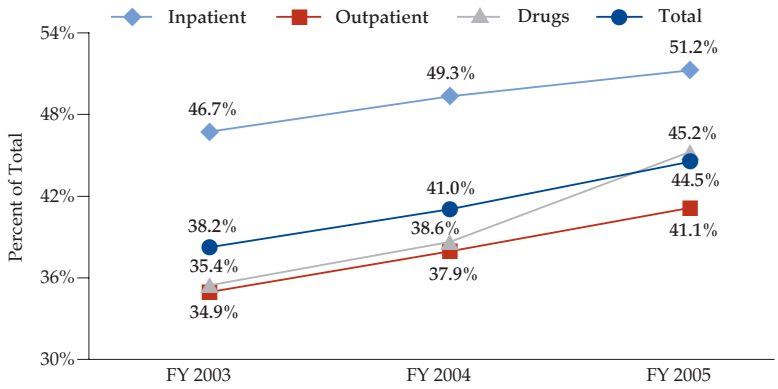
- The share of DoD expenditures on outpatient care relative to total expenditures on inpatient and outpatient care remained at about 67–68 percent from FY 2003 to FY 2005. For example, in FY 2005, DoD expenses for inpatient and outpatient care totaled $14,160 million, of which $9,514 million was for outpatient care for a ratio of $9,651/$13,917 = 68 percent.
- In the interval from FY 2003 to FY 2005, DoD spent an average of about $2 for outpatient care for every $1 spent on inpatient care.
- For inpatient, outpatient, and prescription drug care, the proportion of total expenses for care provided in DoD facilities fell. Overall, the proportion of total expenses for care provided in DoD facilities fell from 62 percent in FY 2003 to 56 percent in FY 2005.

TREND IN DoD EXPENDITURES FOR HEALTH CARE



Source: MHS administrative data, 12/26/2005
Note: TFL purchased care costs are excluded from the above calculations.

TREND IN PURCHASED CARE COST AS PERCENTAGE OF TOTAL MHS COST BY TYPE OF SERVICE



Source: MHS administrative data, 12/26/2005
Note: TFL purchased care costs are excluded from the above calculations.

- Between FY 2003 and FY 2005, the purchased care share of total MHS costs increased for inpatient, outpatient, and prescription drug services.

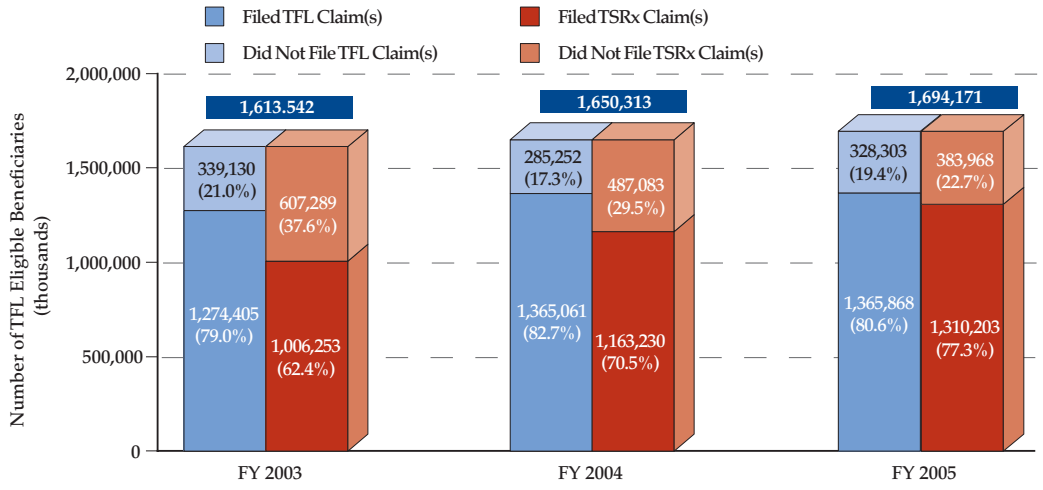
IMPACT OF TRICARE FOR LIFE (TFL) IN FYs 2003–2005

The TFL program began October 1, 2001, in accordance with the Floyd D. Spence National Defense Authorization Act for FY 2001. Under TFL, military retirees age 65 years and older, and those family members enrolled in Medicare Part B, are entitled to TRICARE coverage.

TRICARE for Life and TRICARE Senior Pharmacy Beneficiaries Filing Claims

- There were 1.83 million Medicare-eligible DoD beneficiaries at the end of FY 2005, compared with the same number at the end of FY 2004 and 1.76 million at the end of FY 2003.
  - At the end of FY 2005, 1.69 million were eligible for the TFL and TRICARE Senior Pharmacy (TSRx) benefits, whereas the remainder were ineligible for TFL because they did not have Medicare Part B coverage.
- The percentage of TFL-eligible beneficiaries who filed at least one claim increased slightly between FY 2003 and FY 2005.
  - The reasons some beneficiaries do not file claims are varied, including not receiving any care at all, retaining Medicare supplemental insurance that pays for most costs not covered by Medicare, and maintaining enrollment in a Medicare risk HMO that has small or no enrollment fees and copayments.
- The percentage of TFL-eligible beneficiaries who filed at least one TSRx claim increased from 62 percent in FY 2003 to 77 percent in FY 2005.

TFL-ELIGIBLE BENEFICIARIES FILING TFL AND TSRx CLAIMS IN FY 2003 TO FY 2005



Source: MHS administrative data, 12/26/2005

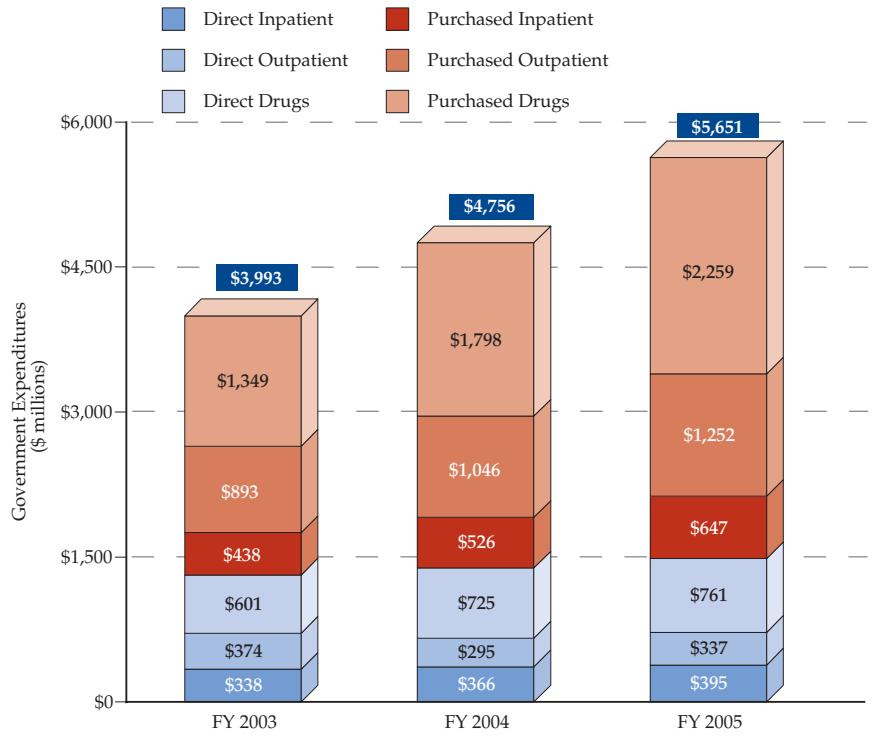
IMPACT OF TRICARE FOR LIFE IN FY 2003–2005 *(CONT'D)*

DoD Expenditures for TRICARE for Life and TRICARE Senior Pharmacy

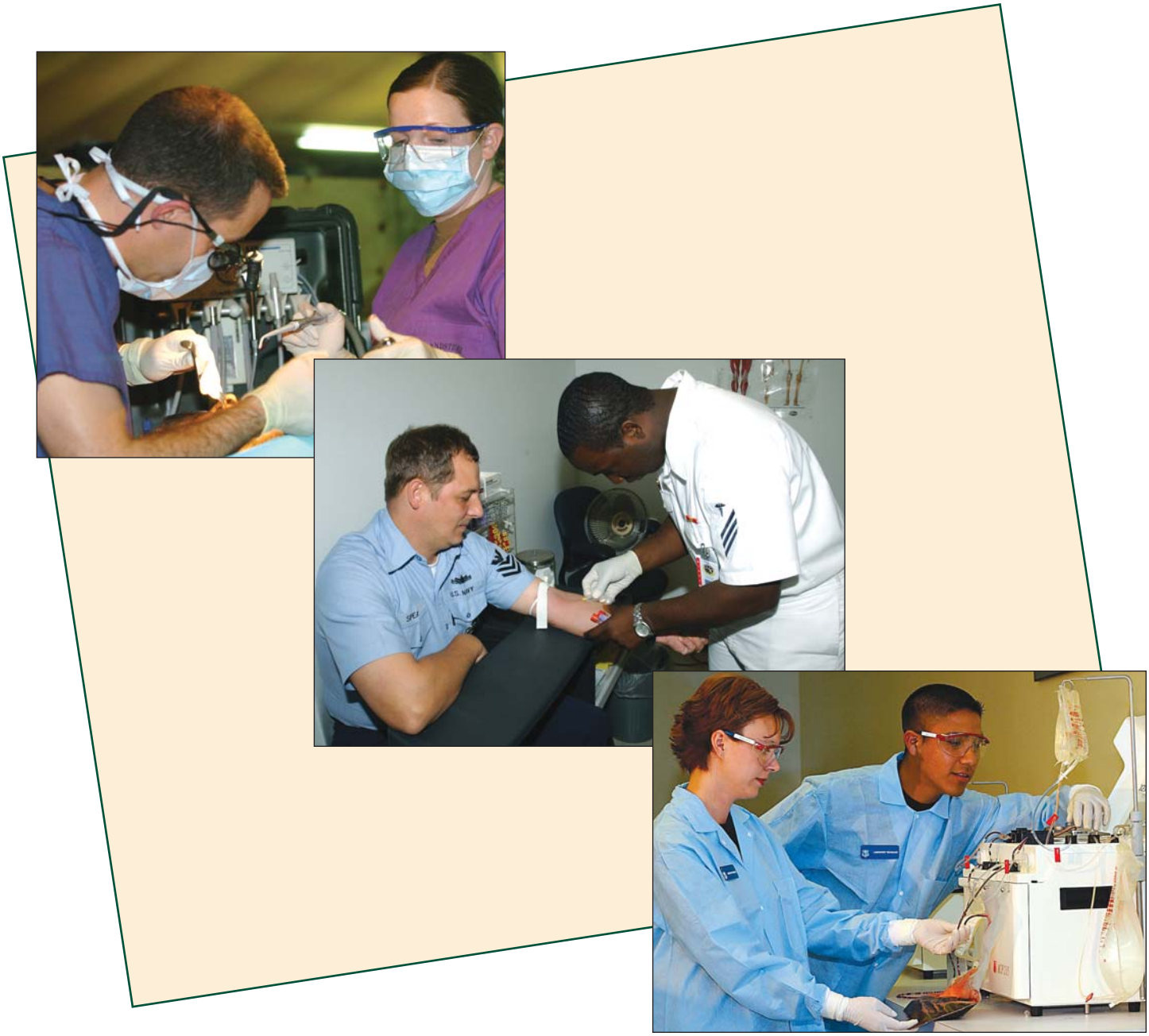
Total DoD TFL expenditures increased from $3,993 billion in FY 2003 to $5,651 billion in FY 2005 (42 percent).

- TFL had very little impact on DoD direct care inpatient and outpatient expenses from FY 2003 to FY 2005. However, DoD expenses for direct care prescription drugs increased by 27 percent over the same time period.
  - In FY 2003, TRICARE Plus enrollees accounted for 68 percent of DoD direct care inpatient and outpatient expenditures on behalf of TFL-eligible beneficiaries. That number held steady in FY 2004 and FY 2005.
  - Including prescription drugs, TRICARE Plus enrollees accounted for 49 percent of total DoD direct care expenditures on behalf of TFL-eligible beneficiaries in FY 2003. That percentage decreased slightly to 48 percent in FY 2005.
- Purchased care TFL expenditures increased from FY 2003 to FY 2005 for inpatient, outpatient, and prescription drugs. The most dramatic increase was for prescription drugs, where DoD costs increased by 67 percent in only two years.

DoD EXPENDITURES IN FY 2003 TO FY 2005 BY TYPE OF SERVICE



Source: MHS administrative data, 12/26/2005



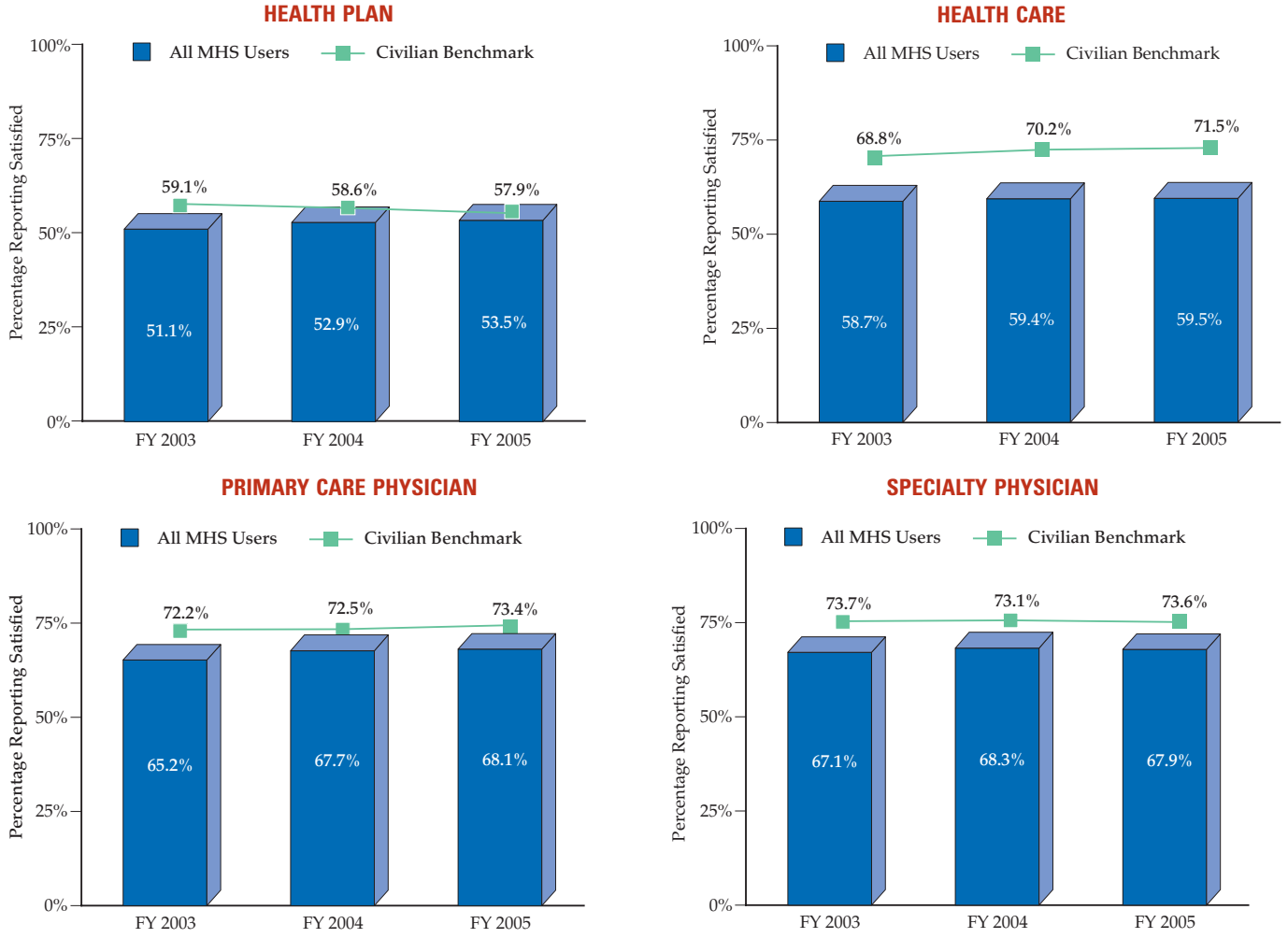
The External Customer theme focuses on scanning the health care environment for relevant benchmarks, applying their metrics, and striving to meet or exceed those standards. The metrics presented here focus on customer satisfaction and health promotion activities through Building Healthy Communities.

CUSTOMER SATISFACTION WITH KEY ASPECTS OF TRICARE

The health care consumer satisfaction surveys used by the MHS and many commercial plans ask beneficiaries to rate various aspects of their health care. MHS beneficiaries in the United States who have used TRICARE are compared with the civilian benchmark with respect to ratings of (1) the health plan, in general; (2) health care; (3) personal physician; and (4) specialty care. The civilian benchmark is based on health care system performance metrics from the national Consumer Assessment of Health Plans Survey (CAHPS). Health plan ratings depend on access to care and how the plan handles various service aspects such as claims, referrals and customer complaints.

- Satisfaction with the overall TRICARE plan and one's personal physician improved between FY 2003 and FY 2005. There was no statistically significant difference in satisfaction with overall health care or one's specialty physician during this three-year period.
- MHS satisfaction rates continue to lag civilian benchmarks.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS



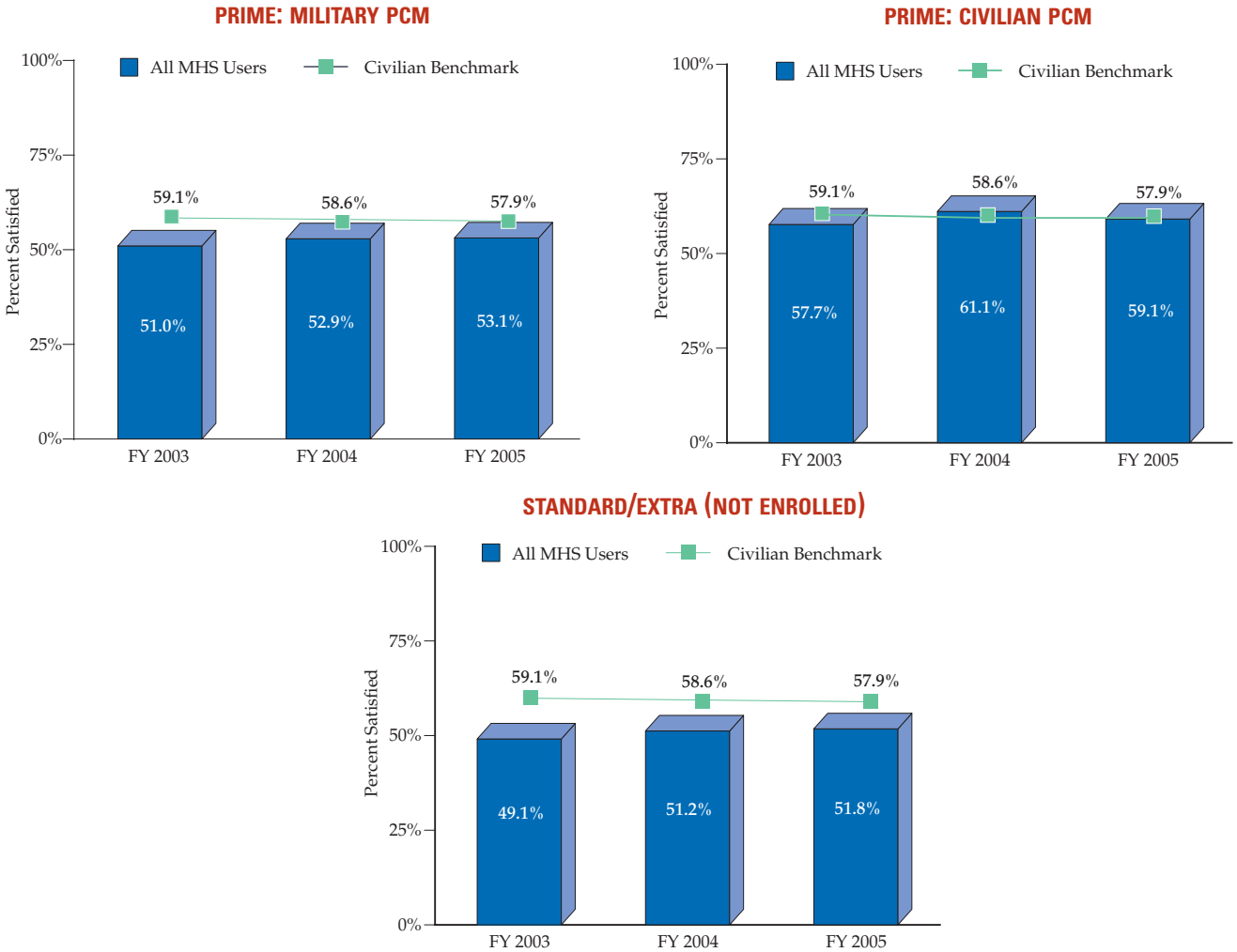
Note: DoD data were derived from the 2003–2005 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

SATISFACTION WITH THE HEALTH PLAN BASED ON ENROLLMENT STATUS

DoD health care beneficiaries can participate in TRICARE in several ways: by enrolling in the Prime option or by not enrolling and using the traditional indemnity option for seeing participating providers (Standard) or network providers (Extra). Satisfaction levels with one's health plan across the TRICARE options are compared with commercial plan counterparts.

- Overall satisfaction with the TRICARE plan improved between FY 2003 and FY 2005 for Prime enrollees with a military Primary Care Manager (PCMs). There has been no statistically significant change across the three-year period for enrollees with civilian PCMs and non-enrollees.
- During each of the past three years (FY 2003 to FY 2005), MHS beneficiaries enrolled with civilian network providers reported the same or greater level of satisfaction than their civilian counterparts (i.e., no statistically significant difference in the proportions).
- MHS beneficiaries enrolled with military PCMs and those not enrolled at all generally reported lower levels of satisfaction compared to their civilian plan counterparts (i.e., there is a statistically significant difference).

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BASED ON ENROLLMENT STATUS



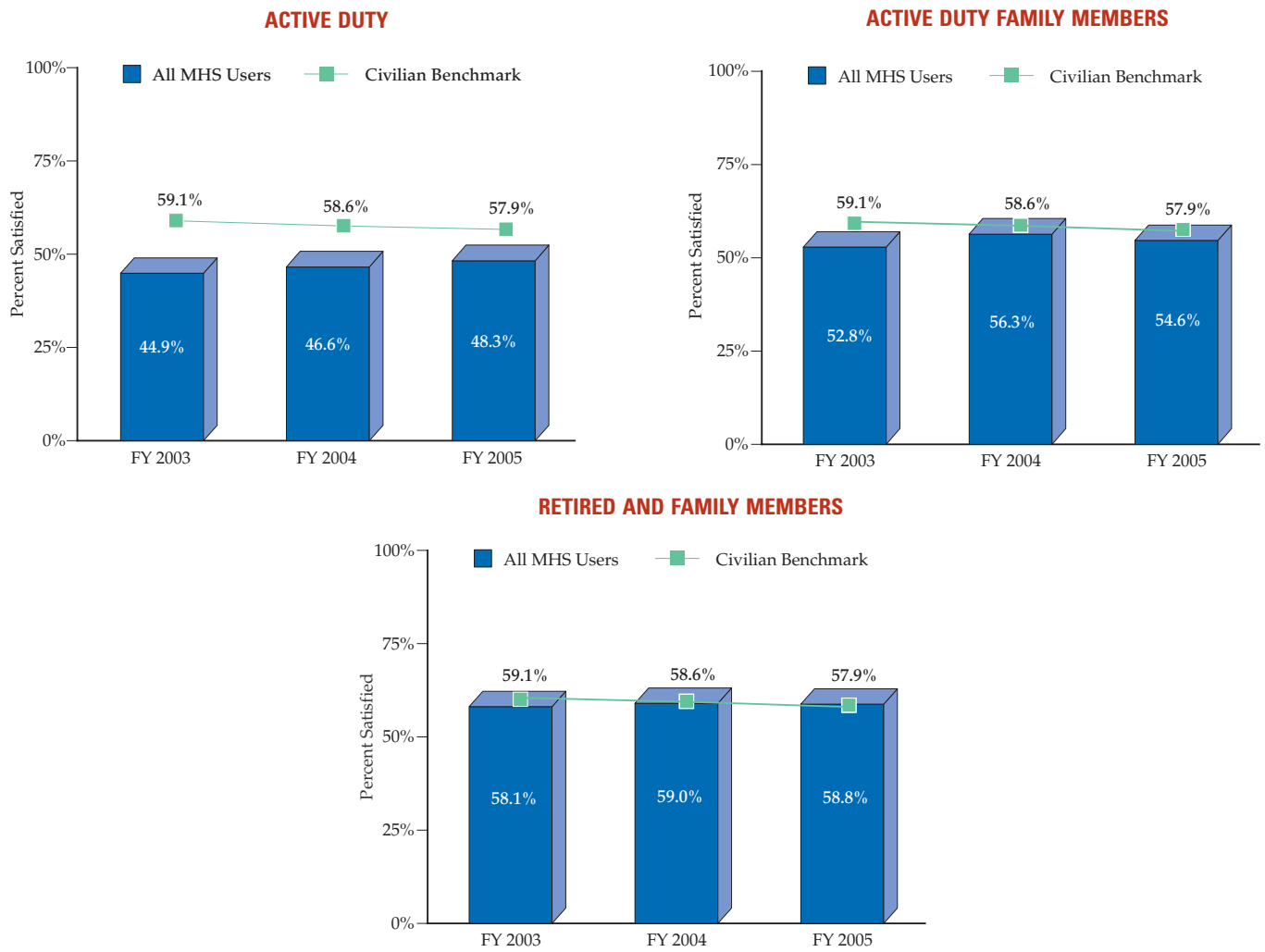
Note: DoD data were derived from the 2003–2005 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY

Satisfaction levels of different beneficiary categories are examined to identify any diverging trends among groups.

- Active duty satisfaction with TRICARE improved each year from FY 2003 to FY 2005.
- Both active duty and their family member ratings continued to lag the ratings of their civilian counterparts (i.e., there is a statistically significant difference).
- In general, while the rates for active duty personnel and their family members continued to lag civilian counterparts for the past three years (i.e., statistically significantly different), the gap may be closing given the downward trend in the civilian benchmark (also statistically significant).
- Satisfaction of retired DoD beneficiaries each year over the past three years is comparable to the general population using a commercial plan (no statistically significant difference). Unlike the MHS retirees trend, which is essentially level, the civilian benchmark has declined over the past three years.

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY



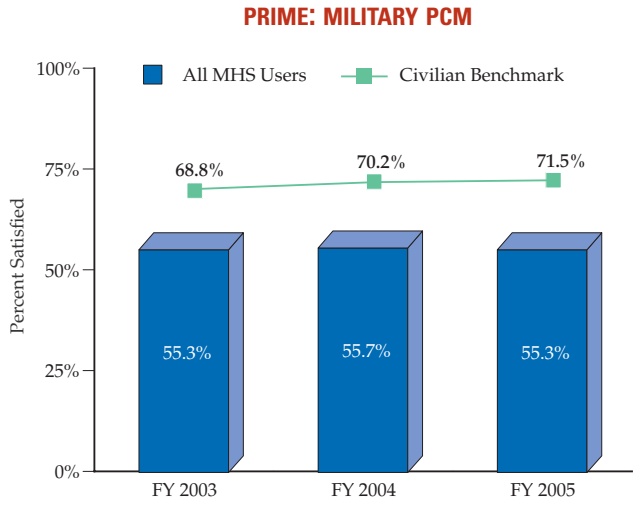
Note: DoD data were derived from the 2003–2005 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

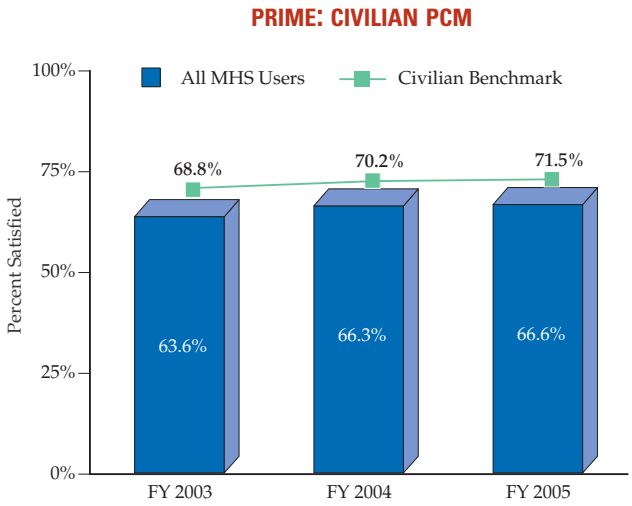
SATISFACTION WITH HEALTH *CARE* BASED ON ENROLLMENT STATUS

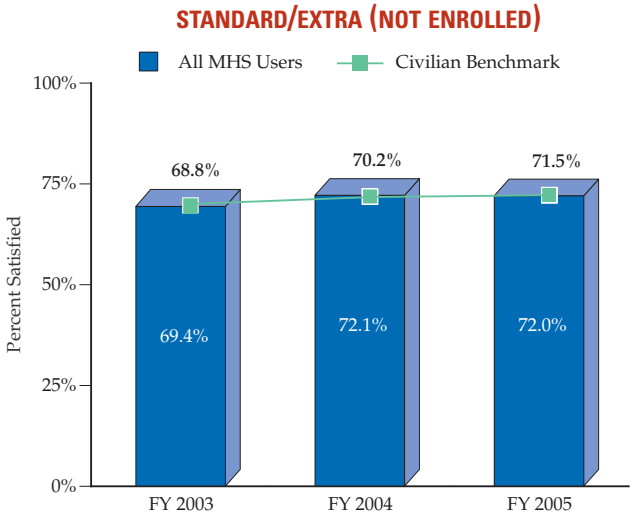
Similar to satisfaction with the TRICARE health plan, satisfaction levels with the health care received, differ by enrollment groups.

- Comparing the results on page 37 with the results below, while non-enrolled members on average reported lower satisfaction with the health *plan*, and those enrolled with civilian providers reported the highest satisfaction with the health *plan*, those enrolled with civilian providers reported lower satisfaction with their health *care* while non-enrolled reported higher satisfaction levels with their health *care*.
  - Between FY 2003 and FY 2005, MHS beneficiaries' satisfaction with their health care remained unchanged, irrespective of enrollment status (i.e., no statistically significant differences across time).
  - Prime enrollee satisfaction with health care (with both military and civilian primary care managers) lags the civilian benchmark. Non-enrollee satisfaction is comparable to, or exceeds, the civilian rate (i.e., not statistically different).

TRENDS IN SATISFACTION WITH HEALTH CARE BASED ON ENROLLMENT STATUS





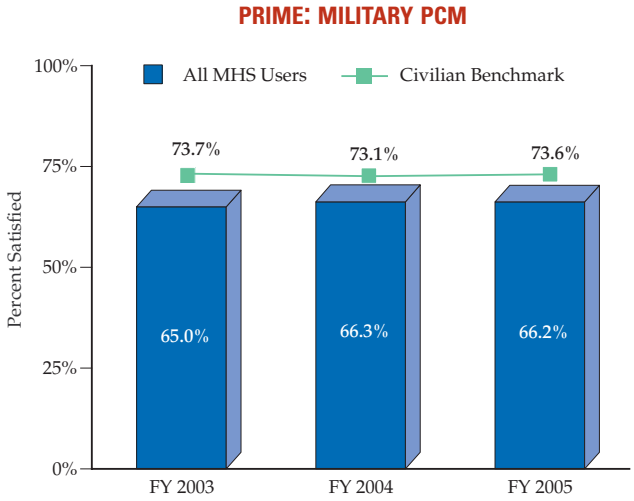


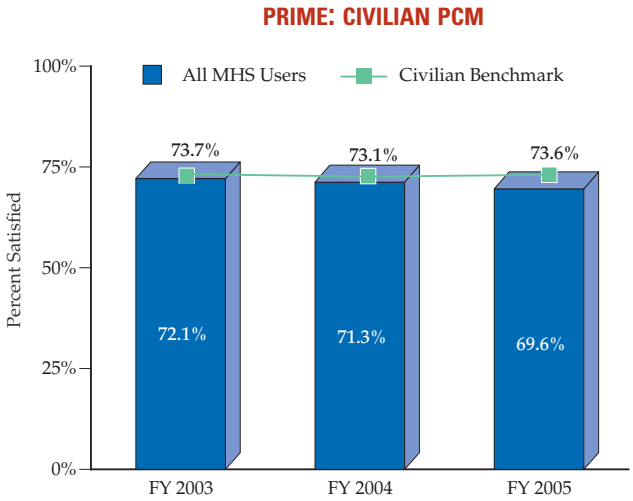
Note: DoD data were derived from the 2003–2005 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Prime" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

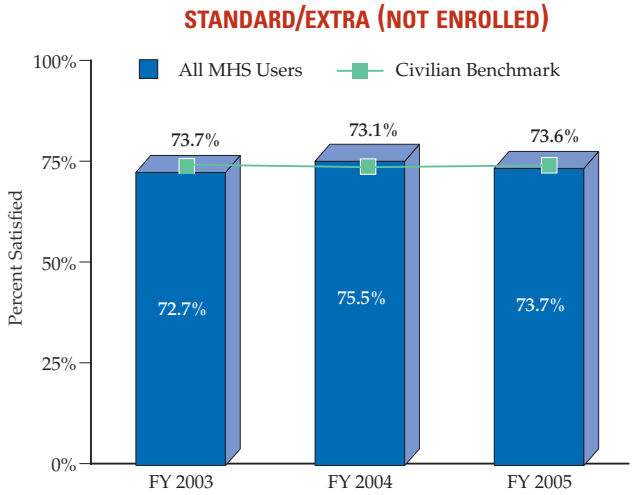
SATISFACTION WITH ONE'S SPECIALIST BASED ON ENROLLMENT STATUS

MHS enrollees, with either military or civilian PCMs, have not changed in their level of satisfaction with their specialist from FY 2003 to FY 2005, and continue to lag a similarly stable civilian benchmark. Non-enrollees, however, report satisfaction levels comparable to their civilian counterparts (i.e., no statistically significant difference).

TRENDS IN SATISFACTION WITH ONE'S SPECIALIST BASED ON ENROLLMENT STATUS







Note: DoD data were derived from the 2003–2005 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Prime" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

BUILDING HEALTHY COMMUNITIES

INITIATION OF THE DoD LIFESTYLE ASSESSMENT PROGRAM (DLAP)

The results of the most recent DoD Survey of Health-Related Behaviors Among Military Personnel study were presented in last year's Evaluation report, reflecting eight sequential survey findings over the past 22 years (*Evaluation of the TRICARE Program, FY 2005 Report to the Congress*, page 32). The ninth DoD Survey of Health Related Behaviors among Military Personnel completed fielding in FY 2005 and the results will be presented in next year's report. Data collected from this most recent survey, and surveys over the last 20 years, clearly show the influence (both positive and negative) of lifestyle behaviors on both the short- and long-term well-being of our military members. These lifestyle factors greatly impact their readiness and retention. During FY 2005, based on results from the 2002 survey, $13 million was allocated for demonstration projects to target lifestyle behaviors related to tobacco, alcohol, and weight management. Also during FY 2005, a $4.7 million DoD Lifestyle Assessment Program (DLAP) was approved and designed. The program includes a series of surveys and special studies aimed at understanding lifestyle behaviors which can improve retention and readiness of both our Active Duty and Reserve Component personnel and complements DoD's Human Resources Strategic Plan. This new DLAP continues surveying Active Duty members biennially; however, to truly assess the Total Force, similar surveys of representative RC personnel will be conducted in 2006. Also in 2006, using data collected from 2005 and other past surveys, in-depth installation and member level evaluations will help assess and ultimately improve command level intervention programs.

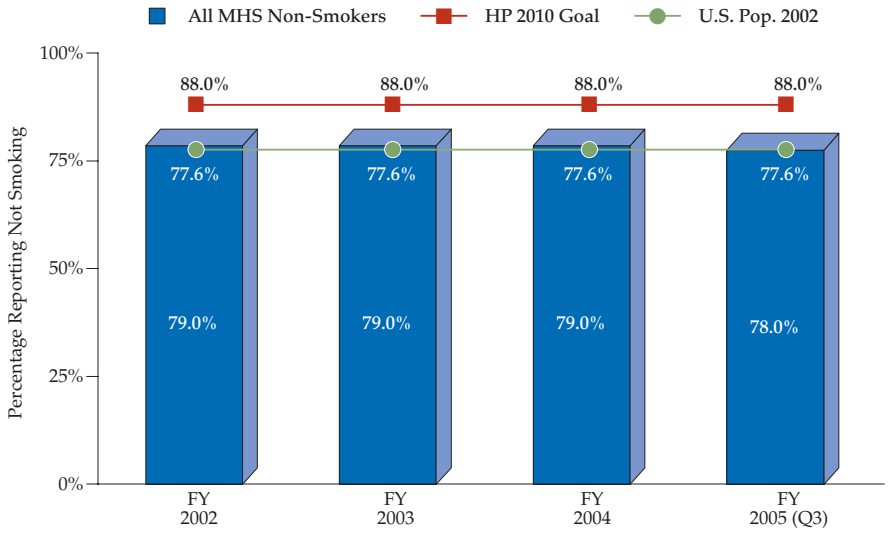
HEALTHY PEOPLE 2000 AND 2010 BENCHMARKS

Healthy People (HP) goals represent the prevention agenda for the nation over the past two decades *(www.healthypeople.gov/About/)*. Beginning with goals established for Healthy People 2000 (HP 2000) and maturing most recently in Healthy People 2010 (HP 2010), this agenda is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats. These strategic goals go beyond restorative care and speak to the challenges of institutionalizing population health within the MHS. There are many indices by which to monitor the MHS relative to HP goals and reported civilian progress. The MHS has improved in several key areas and strives to improve in others.

Tobacco Use

The overall self-reported rate of nonsmoking among all MHS beneficiaries remained the same from FY 2002 through FY 2005 to date. While the proportion of nonsmoking MHS beneficiaries appears higher than the overall U.S. population, it continues to lag the HP 2010 goal of an 88 percent nonsmoking rate (age and sex standardized against the HP goal of 12 percent rate in tobacco use for individuals smoking at least 100 cigarettes in a lifetime, and smoking in the last month).

BUILDING HEALTHY COMMUNITY TRENDS: MHS NON-SMOKING RATE



Source: MHS data: Health Care Survey of DoD Beneficiaries

HP 2010 goal and civilian use baseline: U.S. Department of Health and Human Services. Healthy People 2010: *wonder.cdc.gov/scripts/broker.exe*, accessed 12/6/05. Civilian tobacco use is based on the 1998 baseline, age adjusted to the year 2000 standard population.

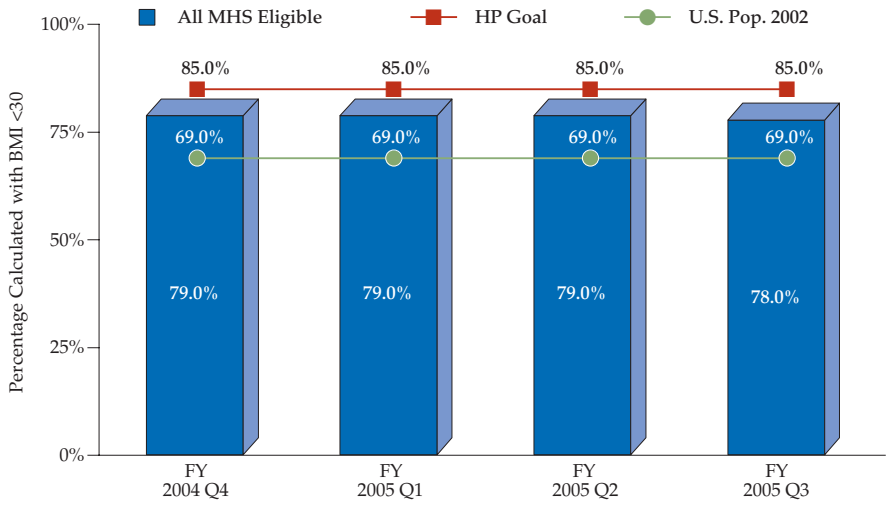
HEALTHY PEOPLE 2000 AND 2010 BENCHMARKS *(CONT'D)*

Obesity

Obesity is measured using the Body Mass Index (BMI), which is calculated from self-reported data from the Health Care Survey of DoD Beneficiaries. An individual's BMI is calculated using height and weight (BMI = 703 x weight in pounds divided by height in inches squared). While BMI is a risk measure, it does not measure actual body fat; as such, it provides a preliminary indicator of possible excess weight, which in turn, provides a preliminary indicator of risk associated with excess weight. It should therefore by used in conjunction with other assessments of overall health and body fat. Therefore, the metric of "non-obese" has been established to indicate more a general sense of the population likely to not be excessively overweight and at health risk due to obesity.

- The overall proportion of all MHS beneficiaries identified as non-obese has remained constant over the past four quarters. At 79 percent non-obese since implementing this measure using self-reported data from MHS beneficiaries, it has not reached the HP 2010 goal of 85 percent, but does exceed the most recently identified U.S. population average of 69 percent.

BUILDING HEALTHY COMMUNITY TRENDS: MHS NON-OBESE RATE



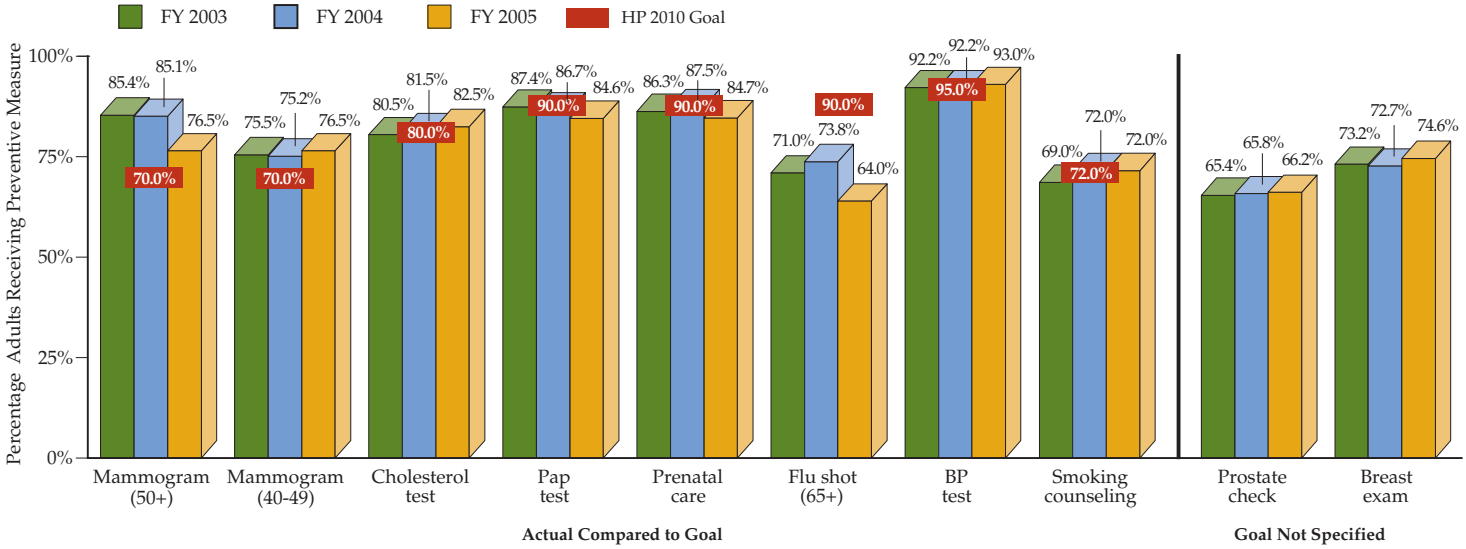
Source: Health Care Survey of DoD Beneficiaries and the National CAHPS Benchmarking Database

BMI	WEIGHT STATUS
Below 18.5	Underweight
18.5–24.9	Normal
25.0–29.9	Overweight
30.0 and Above	Obese

TRENDS IN MEETING PREVENTIVE CARE STANDARDS

- The MHS has set as goals selected national health-promotion and disease-prevention objectives specified by the Department of Health and Human Services in Healthy People 2010. These goals and objectives go beyond restorative care and speak to the need to institutionalize population health within the MHS. Over the past three years, the MHS has met or exceeded targeted Healthy People 2010 goals in providing mammograms (for ages 40–49 years as well as 50+ categories) and testing for cholesterol.
- Efforts continue toward achieving Healthy People 2010 standards for Pap smears, prenatal exams, flu shots (for people age 65 and older), and blood pressure screenings.
- Still other areas continue to be monitored in the absence of specified Healthy People standards, such as breast exams (for those age 40 and over), smoking-cessation counseling, and prostate exams.

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FY 2003 TO FY 2005



Source: Health Care Survey of DoD Beneficiaries and the National CAHPS Benchmarking Database

MHS TARGETED PREVENTIVE CARE OBJECTIVES

Mammogram: Women ages 40–49 who had mammogram in past two years; women age 50 or older who had a mammogram in past year.

Cholesterol test: People who had a cholesterol screening in last five years.

Pap test: All women who had a Pap test in last three years.

Prenatal: Women pregnant in last year who received care in first trimester.

Flu shot: People 65 and older who had a flu shot in last 12 months.

Blood Pressure test: People who had a blood pressure check in last two years and know results.

MHS GOALS NOT SPECIFIED BY CURRENT HEALTHY PEOPLE 2010 TARGETS

Prostate check: Men age 50 or older who had a prostate exam in last 12 months.

Smoking-cessation counseling: People advised to quit smoking in last 12 months.

Breast exam: Women age 40 or older who had a breast exam in last 12 months.

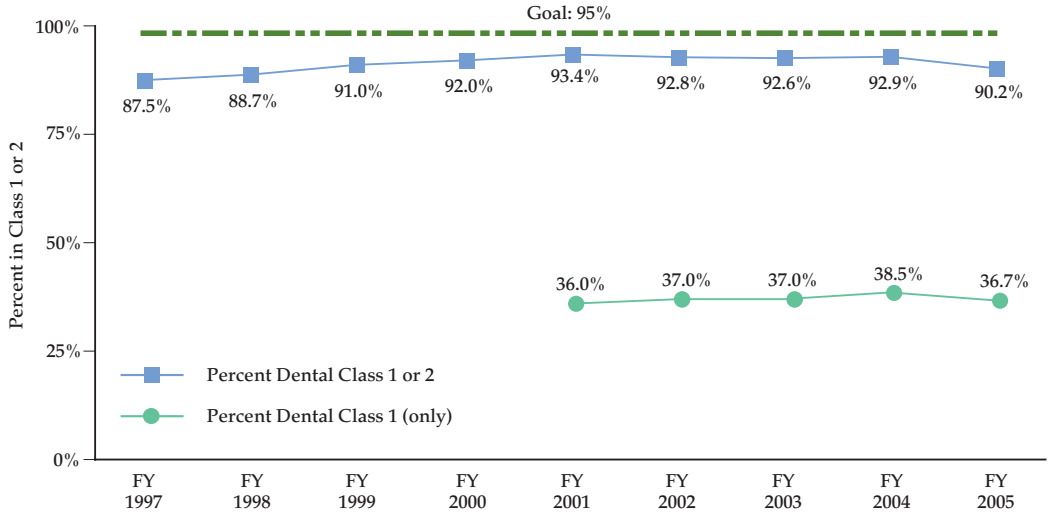
Most health care readiness metrics focus on those unique aspects germane to each of the Services, and are presented by the Surgeons General as appropriate to their combat leadership. Other readiness metrics are classified and presented elsewhere, as appropriate. One nonclassified measure monitored over the past several years has helped define the critical aspect of dental readiness of our active duty personnel.

DENTAL READINESS

In 1996, the Service Dental Corps Chiefs established a goal of maintaining at least 95 percent of all active duty personnel in Dental Class 1 or 2. While a measure of dental readiness, this goal also effectively measures active duty access to necessary dental services. Patients in Dental Classes 1 or 2 have a current dental examination, and do not require dental treatment (Class 1) or require nonurgent dental treatment or reevaluation for oral conditions that are unlikely to result in dental emergencies within 12 months (Class 2—see note below chart). The results from FY 1997 to FY 2005 are presented below.

- The overall MHS 95 percent target rate for dental readiness in Classes 1 and 2 continues to be elusive. While the gap has narrowed since measurement began in 1997, there was a 2.7 percentage point decline between FY 2004 and FY 2005.
- The rate for active duty personnel in Dental Class 1 similarly declined over the last two fiscal years as well (1.8 percentage points).

ACTIVE DUTY DENTAL READINESS: PERCENT DENTAL CLASS 1 OR 2



Source: The Services' Dental Corps–DoD Dental Readiness Classifications

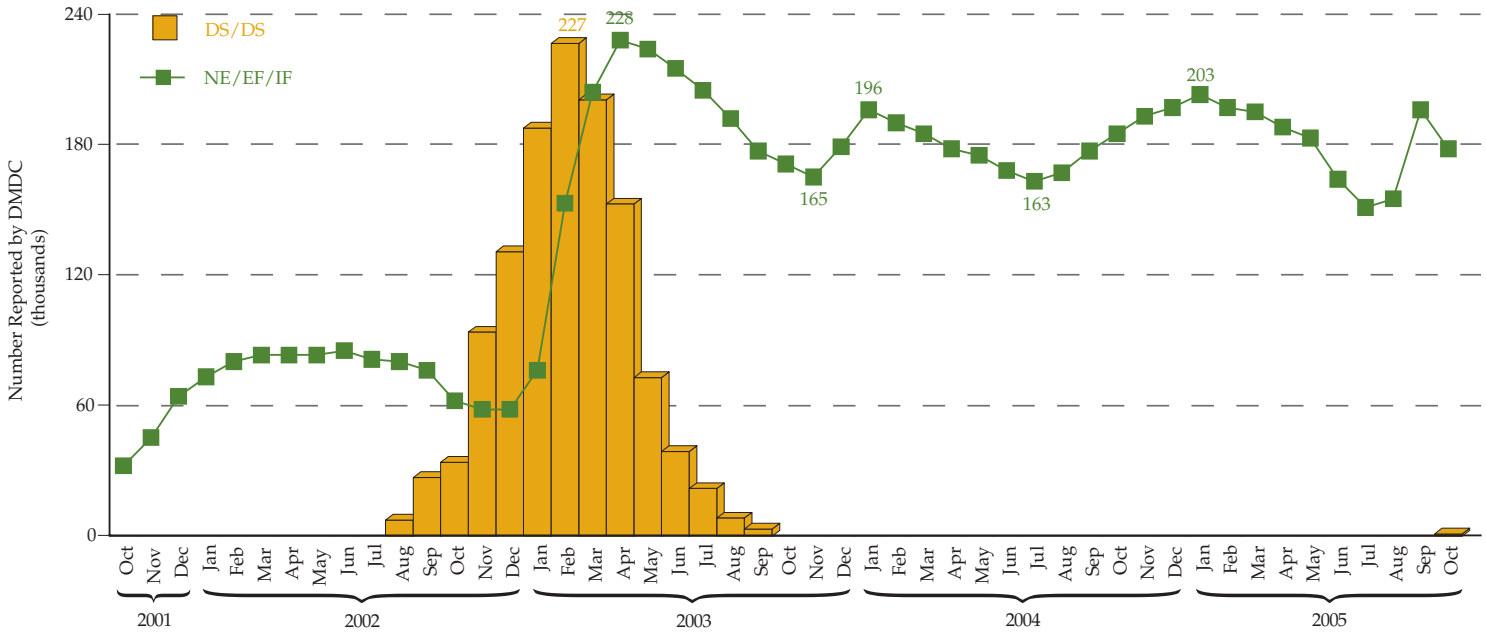
Dental Class 1: (Dental Health or Wellness): Patients with a current dental examination, who do not require dental treatment or reevaluation. Class 1 patients are world-wide deployable.

Dental Class 2: Patients with a current dental examination, who require nonurgent dental treatment or reevaluation for oral conditions, which are unlikely to result in dental emergencies within 12 months. Patients in Dental Class 2 are worldwide deployable.

IMPACT OF RESERVISTS MOBILIZED UNDER GLOBAL WAR ON TERRORISM COMPARED WITH THOSE UNDER DESERT SHIELD/DESERT STORM

Although TRICARE did not exist during the Gulf War (Desert Shield/Desert Storm) in 1991, mobilized Reservists and their family members were supported by the MHS direct care system and TRICARE's predecessor, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). While more MTFs were available to support those sponsor and family member beneficiaries residing near a military installation, the amount of time Reservists spent on mobilized duty was relatively short (between six months to one year or so). By extension, therefore, the amount of time in which their family members were eligible for CHAMPUS was relatively limited. When the mobilization period for the Gulf War, in months and number of Reservists mobilized, is superimposed on the mobilization period and Reservists supporting GWOT, there is a significant difference in the potential impact on the MHS of eligibility for TRICARE Reservists and their family members.

COMPARISON IN TRENDS OF MOBILIZED RESERVISTS: 1990 GULF WAR VS. 2001–2005 GLOBAL WAR ON TERRORISM



Source: OASD(RA), September 2001 to September 30, 2005

SPECIAL STUDIES: RESERVE COMPONENT FAMILY MEMBER SATISFACTION WITH, AND ACCESS TO, TRICARE AND DEPLOYMENT-RELATED STRESS

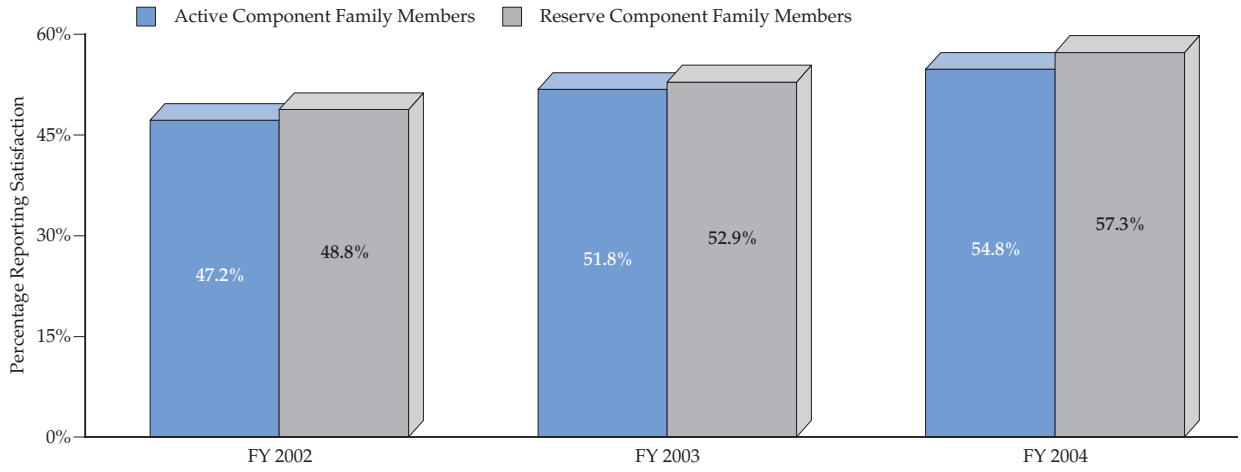
Two special studies pertaining to Reservist family member access to health care and supportive services were completed in FY 2005. One study compared the levels of satisfaction with TRICARE overall among Active Component family members and Reserve Component family members and also examined Reservist family member reported access to physicians under TRICARE relative to their prior civilian experience. The second study examined the extent of deployment-related stress on family members.

Satisfaction with the TRICARE Health Plan

The adult Health Care Survey of DoD Beneficiaries (HCSDB) is designed to measure a number of health care-related factors from a sample of all eligible MHS beneficiaries. For comparison purposes (benchmarking and external validation), the survey includes core questions from the Consumer Assessment of Health Plans Survey (CAHPS) used by many of the nation's civilian health plans. A special study re-examined survey data previously collected from eligible beneficiaries through random sampling. The study examined whether there was any difference in the overall satisfaction with TRICARE between Prime enrolled family members of the Active Component and family members of mobilized sponsors who were also enrolled in TRICARE Prime.

- There has been no statistically significant difference in the levels of satisfaction reported by family members of Reserve and Active Component personnel for the past three years.
- Overall satisfaction has improved for both groups, from FY 2002 to FY 2004.

COMPARISON OF MOBILIZED RESERVE AND ACTIVE COMPONENT FAMILY MEMBER SATISFACTION RATES WITH THE HEALTH PLAN AND HEALTH CARE



Source: Health Care Survey of DoD Beneficiaries (2002–2004)

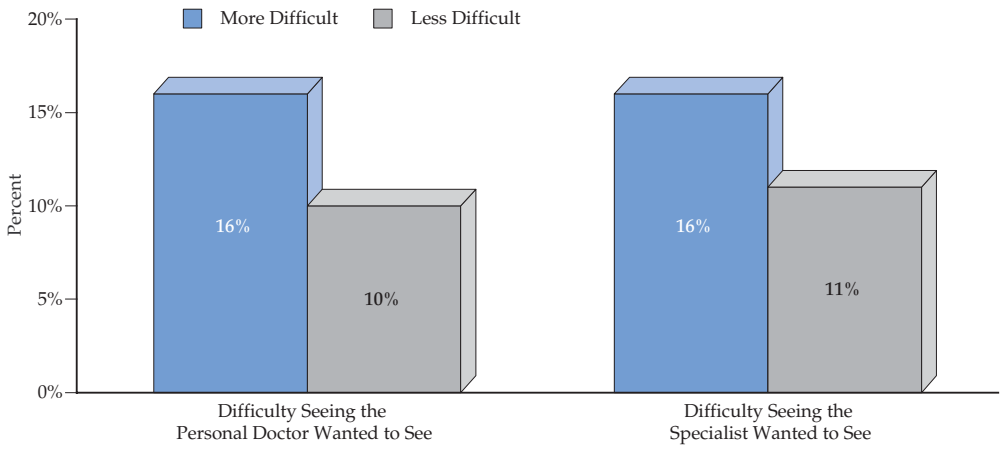
SPECIAL STUDIES: RESERVE COMPONENT FAMILY MEMBER SATISFACTION WITH, AND ACCESS TO, TRICARE AND DEPLOYMENT-RELATED STRESS *(CONT'D)*

Access to Physicians Under TRICARE

Surveyed family members of Reservists using only TRICARE report that any difficulty in seeing their personal doctor or preferred specialist was the same before and after the sponsor was mobilized. However, there are two groups of family members who have found opposite experiences in access to physicians since their sponsors were mobilized:

- The larger group found that access to personal doctors and specialists has worsened since relying only on TRICARE (16 percent).
- The other group reported their access to personal doctors and specialists has improved (10 and 11 percent, respectively).

FAMILY MEMBERS' ACCESS TO PHYSICIANS UNDER TRICARE FOLLOWING MOBILIZATION (THOSE RELYING ON TRICARE ONLY)



Sources: FY 2005 1st Quarter Supplemental HCSDB Survey

SPECIAL STUDIES: RESERVE COMPONENT FAMILY MEMBER SATISFACTION WITH, AND ACCESS TO, TRICARE AND DEPLOYMENT-RELATED STRESS *(CONT'D)*

Deployment-Related Stress and Its Impact

Along with the usual stresses faced by American families, military families face stresses unique to military service. Some are related to deployment, including separation from deployed spouses, and the exposure of a family member to the dangers of combat. Spouses of Guard or Reserve members may be less prepared than active duty spouses to cope with deployment-related stress.

- Results from the HCSDB shown in the table below indicate that spouses of active duty deployed to a combat zone experience more stress than do other active duty family members.
  - 63 percent with deployed spouses reported "more" or "much more" stress than usual, compared to 36 percent of other active duty family members.
  - 68 percent of deployed Reservists' spouses reported increased stress, as did 60 percent of other deployed active duty spouses.
- Unlike stress, self-reported mental health status differs little between those whose spouse has been deployed and those whose spouse has not. Compared to large differences in stress, differences are small and not statistically significant in the proportion rating their mental health fair or poor (7 percent when spouse is deployed, compared to 5 percent when spouse is not), or seeking treatment or counseling (21 percent when spouse is deployed, compared to 18 percent).

STRESS, MENTAL AND EMOTIONAL HEALTH: ACTIVE DUTY FAMILY MEMBERS

	Among those who do NOT have a deployed spouse	Among those who do have a deployed spouse	Among those whose deployed spouse is	
			Guard/ Reserve	Active Duty
More or much more stress than usual	36%	63%*	68%	60%
Self-reported mental health—fair/poor	5%	7%	7%	6%
Needed counseling for a personal or family problem	18%	21%	24%	19%

N = 2,512 ADFM of undeployed active duty, 526 ADFM of deployed, 145 ADFM deployed Guard/Reserve, 381 ADFM deployed active duty

* Difference is significant with $p<0.05$

Source: FY 2005 3rd Quarter Supplemental HCSDB Survey, Issue Brief

Getting Help

The resources available to assist beneficiaries in coping with their deployed spouses' absence include information, support groups, and counseling. As shown below, nearly half of the dependents surveyed have tried to get some kind of help. Fifty percent have sought information, 28 percent have tried support groups and 10 percent have sought counseling specifically to help cope with the deployment.

RESOURCE USE: PERCENT WHO SOUGHT A RESOURCE TO HELP DEAL WITH SPOUSE'S DEPLOYMENT

Resources Sought	Among those who have a deployed spouse	Among those whose deployed spouse is	
		Guard/Reserve	Active Duty
Information	50%	58%	46%
Support Groups	28%	40%	23%*
Counseling	10%	14%	8%

* Difference is significant with $p<0.05$

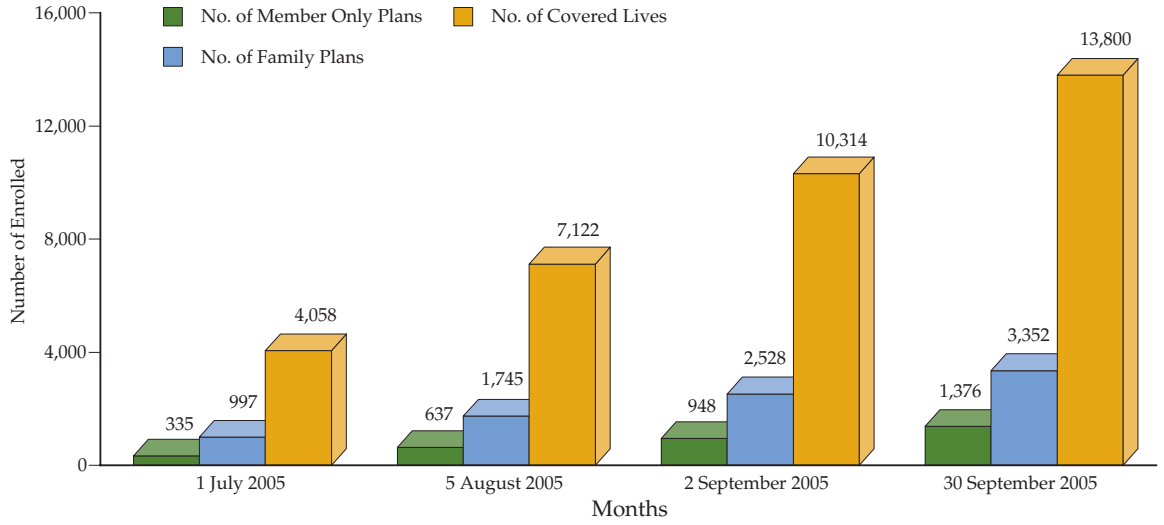
Source: FY 2005 3rd Quarter Supplemental HCSDB Survey, Issue Brief

NEW GUARD/RESERVE BENEFIT: TRICARE RESERVE SELECT

TRICARE Reserve Select (TRS) is the new premium-based TRICARE health plan offered for purchase by certain members and former members of the Reserve Component (RC) and their families, if specific eligibility requirements are met. Reserve members are eligible for TRS coverage if they were called or ordered to active duty, under Title 10, in support of a contingency operation on or after September 11, 2001. RC Members and their Reserve Component unit will need to agree for the member to stay in the Select Reserve for one or more whole years to qualify. TRS coverage must be purchased, with TRS members paying a monthly premium for health care coverage (for self-only or for self and family). The TRS premiums are adjusted January 1st each year. The program offers comprehensive health care coverage similar to TRICARE Standard and TRICARE Extra. Members access care by making appointments with any TRICARE authorized provider, hospital, or pharmacy, network or non-network. TRS members may also access care at an MTF on a space-available basis. Pharmacy coverage is available from an MTF pharmacy, TRICARE Mail Order Pharmacy (TMOP), and TRICARE network and non-network retail pharmacies.

- By the end of the program's first year, enrollment in TRS reached almost 1,400 member-only plans and almost 3,400 family plans, with 14,000 covered lives.

TREND IN ENROLLMENT IN TRICARE RESERVE SELECT (BECAME OPERATIONAL IN 2005)



Source: TRS enrollment data

QUALITY

Quality metrics in 2004 addressed several patient-focused areas: (1) self-reported access to MHS care overall, (2) satisfaction with various aspects of the MHS (e.g., the availability and ease of obtaining care, getting providers of choice, and receiving responsive customer service), (3) quality and timeliness of claims processing (both patient reported as well as tracking through administrative systems), (4) Joint Commission accreditation results for MTFs, (5) access to and satisfaction with MTF care, and (6) two special studies this year (one comparing AC and RC family member access to care and the other assessing access to TRICARE Standard civilian providers).

Access to MHS Care

Using survey data, four categories of access to care were considered:

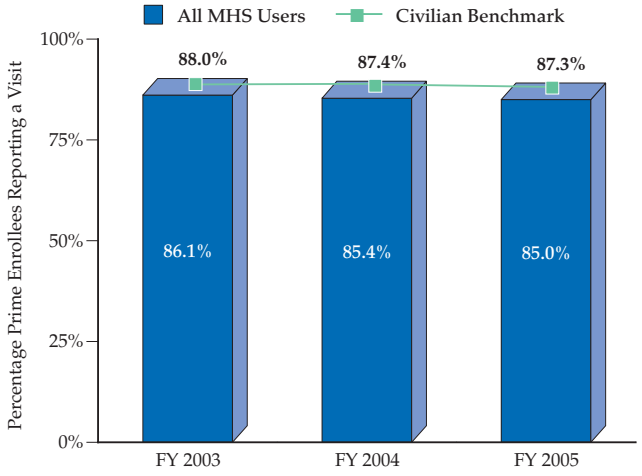
- Access based on reported use of the health care system in general.
- Availability and ease of obtaining care, and getting a provider of choice.
- Responsive customer service.
- Quality and timeliness of claims processing.

Overall Outpatient Access

The ability to see a doctor reflects one measure of successful access to the health care system, as depicted below when Prime Enrollees are asked whether they had at least one outpatient visit during the past year.

- Access to and use of outpatient services remains high with 85 percent of all Prime enrollees (with military as well as civilian providers) reporting having at least one visit in the past 12 months in FY 2005.
- The MHS Prime enrollee rate continuing slightly lower than the civilian benchmark (statistically significantly different each year, from FY 2003 to FY 2005).

TRENDS IN PRIME ENROLLEES HAVING AT LEAST ONE OUTPATIENT VISIT DURING THE YEAR



Note: DoD data were derived from the 2003–2005 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to Survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

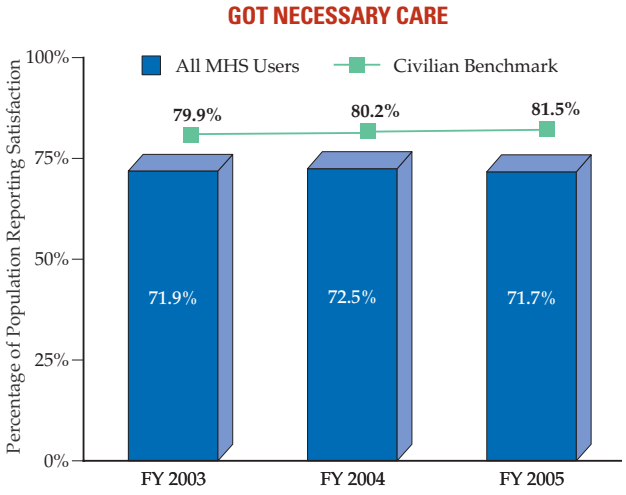
ACCESS TO MHS CARE *(CONT'D)*

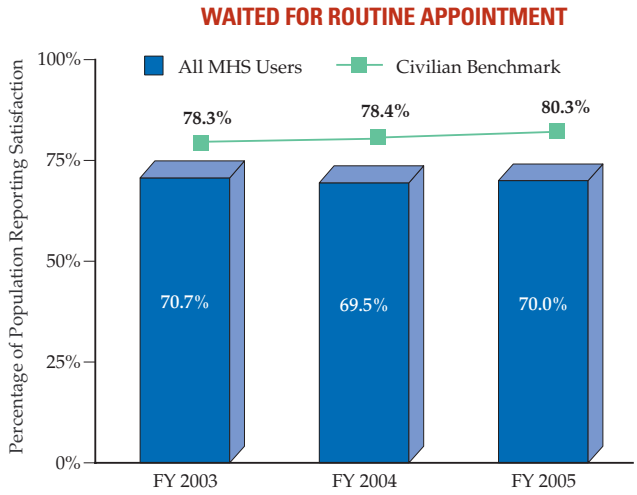
Availability and Ease of Obtaining Care

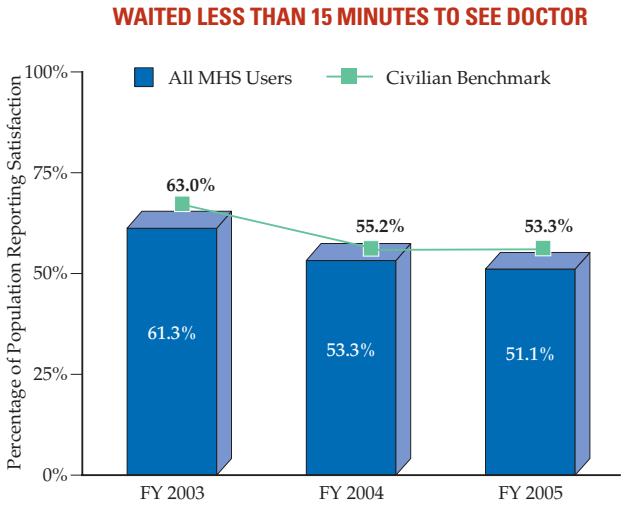
Availability and ease of obtaining care can be characterized by the extent to which beneficiaries report their ability to (1) receive care when needed, (2) obtain appointments in a timely fashion, and (3) face minimal, unnecessary waits in the doctor's office.

- MHS beneficiary ratings for getting necessary care and waiting for a routine appointment remained stable between FY 2003 and FY 2005, while lagging an improving civilian benchmark.
- Both the MHS and the civilian benchmark ratings for "waiting less than 15 minutes to see the doctor" declined between FY 2003 and FY 2005. The change in these ratings between FY 2003 and FY 2004 may be related to the change in survey instrument question wording between CAHPS versions 2.0 and 3.0 during this time (see note below)

TRENDS IN AVAILABILITY AND EASE OF OBTAINING CARE FOR ALL MHS BENEFICIARIES (ALL SOURCES OF CARE)







Note: DoD data were derived from the 2003–2005 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Also note the change in the responses to "waiting… to see the doctor" may have been influenced by the CAHPS 2.0 to 3.0 question change between FY 2003 and FY 2004.

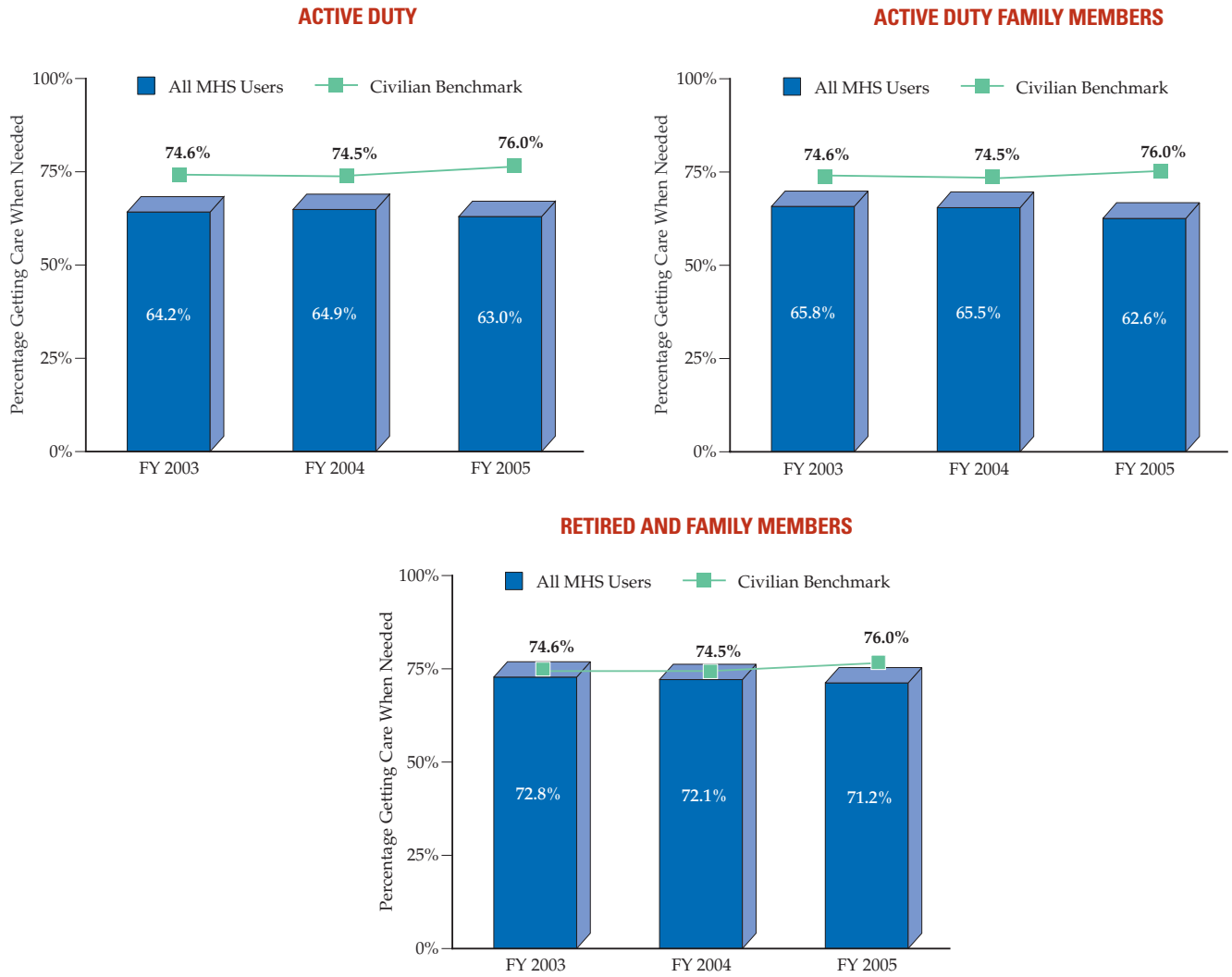
ACCESS TO MHS CARE *(CONT'D)*

Ability to Obtain Care by Beneficiary Category

In focusing on beneficiary ability to obtain necessary care, differences among beneficiary categories are considered to identify significant disparities of concern.

- Retired beneficiaries continue to report higher levels of satisfaction with their ability to get care than active duty personnel or their family members.
- MHS beneficiaries, in all three categories, lag their civilian counterparts in reporting access to care when needed.

TRENDS IN AVAILABILITY OF OBTAINING CARE BY BENEFICIARY CATEGORY (ALL SOURCES OF CARE)



Note: DoD data were derived from the 2003–2005 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

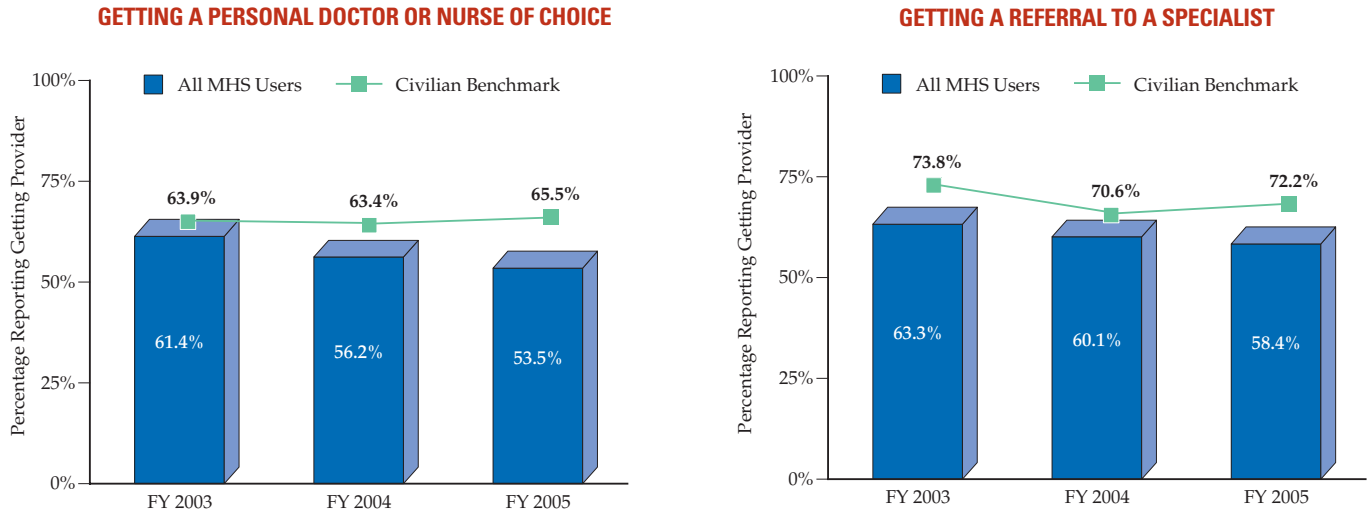
ACCESS TO MHS CARE *(CONT'D)*

Opportunity to Get a Health Provider of Choice

A major determinant of an individual's satisfaction with a health plan includes being able to access necessary providers. The graphs below depict MHS patient reported satisfaction in (a) getting a personal doctor or nurse of one's choice, and (b) obtaining a referral to a specialty provider.

- The civilian benchmark appears to have rebounded for both measures of access to physicians (getting a personal doctor or a referral to a specialist) after reflecting a dip in FY 2004. This change is likely due to the change in the survey questions for this domain between between FY 2003 and FY 2004 in the civilian transition from CAHPS 2.0 to 3.0. The changed questions were mirrored in the MHS HCSDB survey instrument and in the decrease in overall ratings, however, the MHS rates have not shown a reversal similar to their civilian counterparts, and reflect a downward trend since FY 2003 (statistically significant difference between each year).

TRENDS IN GETTING ACCESS TO PERSONAL OR SPECIALTY PROVIDERS



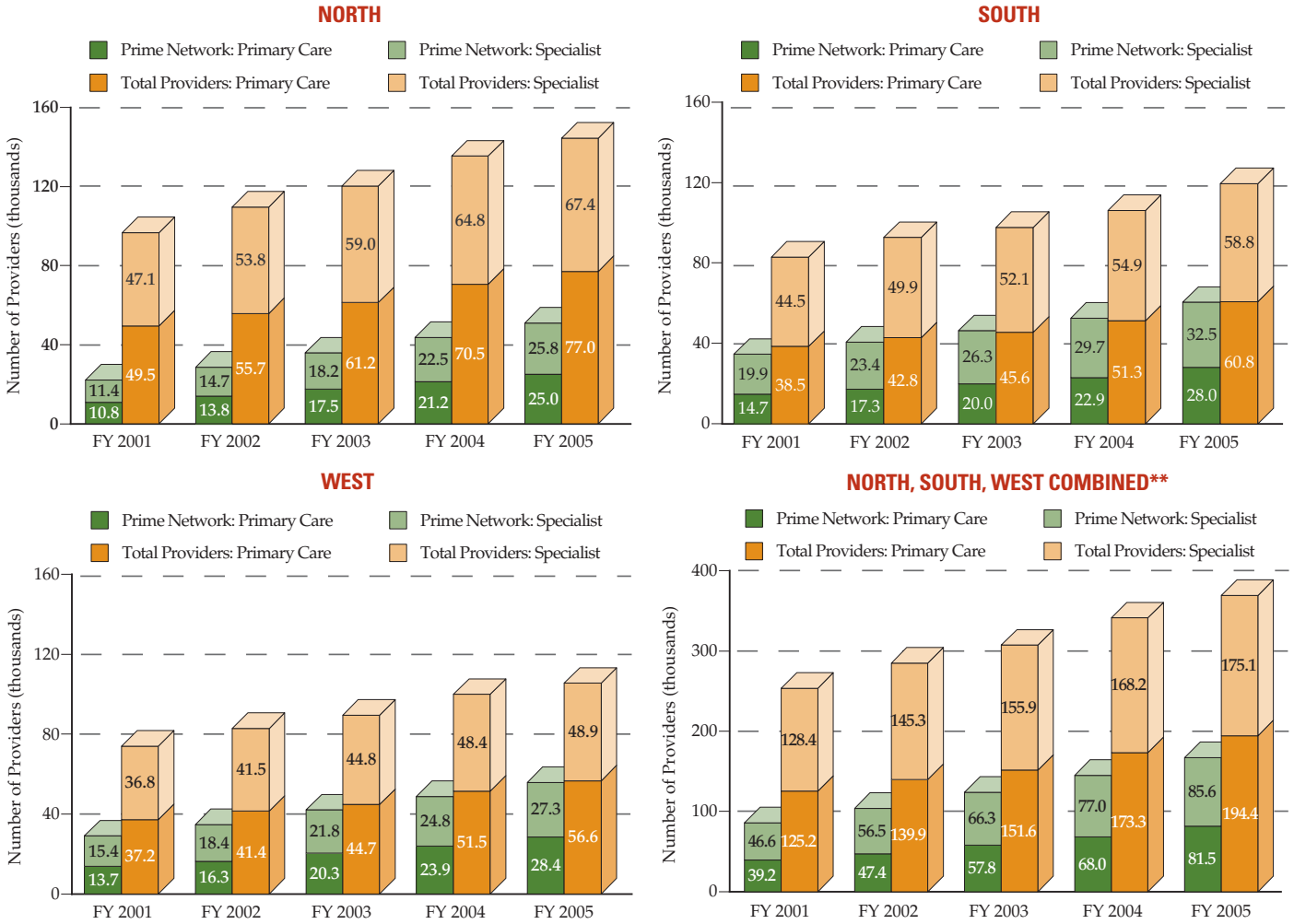
Note: DoD data were derived from the 2003–2005 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Also note the change in the responses to "… getting a personal doctor of choice" may have been influenced by the CAHPS 2.0 to 3.0 question change between FY 2003 and FY 2004.

TRICARE PROVIDER PARTICIPATION

Beneficiaries' satisfaction with access to care is influenced in part by the choice of providers available to them. The number of TRICARE participating providers, as determined by the number of unique providers filing TRICARE claims, has steadily increased from FY 2001 to FY 2005. The increase has been evident for both Prime and Standard/Extra providers. Furthermore, as evidenced by the claims data, the numbers of primary care providers* and specialists have increased at about the same rate.

- The North Region saw the largest increase in the total number of TRICARE providers (50 percent), followed by the South Region (44 percent) and the West Region (43 percent).
- The North Region also saw the largest increase in the number of Prime network providers (130 percent), followed by the West Region (92 percent) and the South Region (75 percent).
- The total number of TRICARE providers increased by almost 46 percent in both catchment and noncatchment areas (not shown).
- The number of Prime network providers increased by 81 percent in catchment areas and by 101 percent in noncatchment areas (not shown).

TRENDS IN PRIME NETWORK AND TOTAL PARTICIPATING PROVIDERS



Source: MHS administrative data, 12/18/05.

* Primary care providers were defined as General Practice, Family Practice, Internal Medicine, Obstetrics/Gynecology, Pediatrics, Physician's Assistant, Nurse Practitioner, and clinic or other group practice.

** Numbers may not sum to regional totals due to rounding.

Note: The source for the provider counts shown above was the TRICARE purchased care claims data for each of the years shown, where a provider was counted if he/she was listed as a TRICARE participating provider. In the case of Prime network providers, the counts were based on claims for Prime enrollees only where the provider produced at least 12 visits per year. The latter condition was added to reduce the possibility of counting out-of-network referrals.

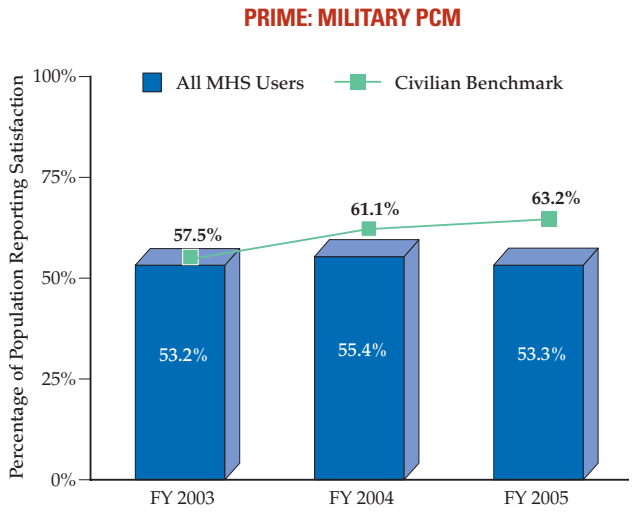
ACCESS TO MHS CARE *(CONT'D)*

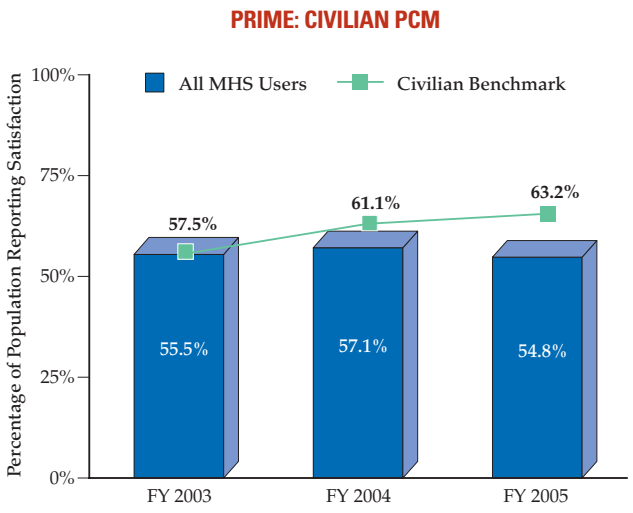
Satisfaction with Customer Service

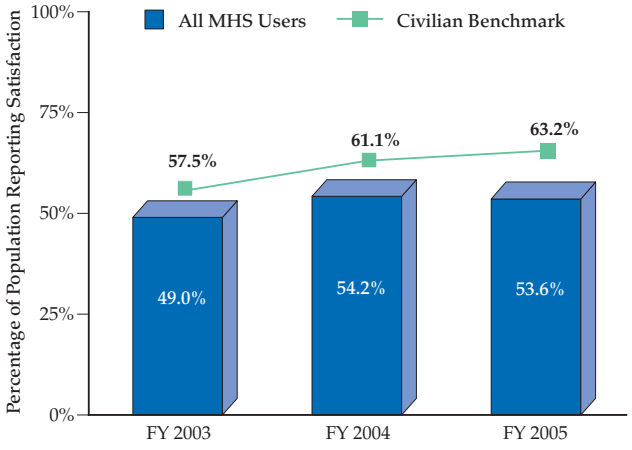
Access to and understanding written materials about one's health plan are important determinants of overall satisfaction with the plan.

- MHS customer service responsiveness, beneficiary ease of understanding written materials, and dealing with paperwork remained stable over the three-year period from FY 2003 and FY 2005, rising and then falling in FY 2004.
- MHS ratings for TRICARE customer service were not as high as those reported by enrollees in commercial plans.

TRENDS IN RESPONSIVE CUSTOMER SERVICE:
COMPOSITE MEASURE OF FINDING, UNDERSTANDING WRITTEN MATERIAL; GETTING CUSTOMER ASSISTANCE; & PAPERWORK







Note: DoD data were derived from the 2003–2005 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Also note the change in the responses to "… paperwork" may have been influenced by the CAHPS 2.0 to 3.0 question change between FY 2003 and FY 2004.

CLAIMS PROCESSING

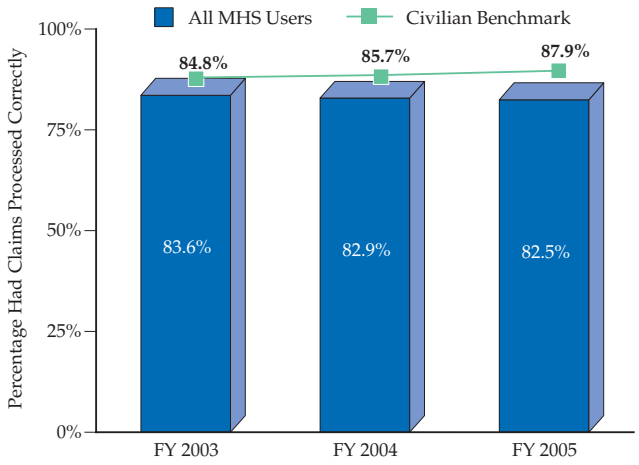
Claims processing is often cited as a "hot button" issue for beneficiaries as well as their providers. This is usually the case for both the promptness of processing, as well as the accuracy of claim and payment. The MHS monitors the performance of TRICARE claims processing through two means—surveys of beneficiary perceptions, and administrative tracking through internal government and support contract reports. This section reflects how MHS beneficiaries report their satisfaction with claims processing, and the next section reflects internal administrative monitoring.

Beneficiary Perceptions of Claims Filing Process

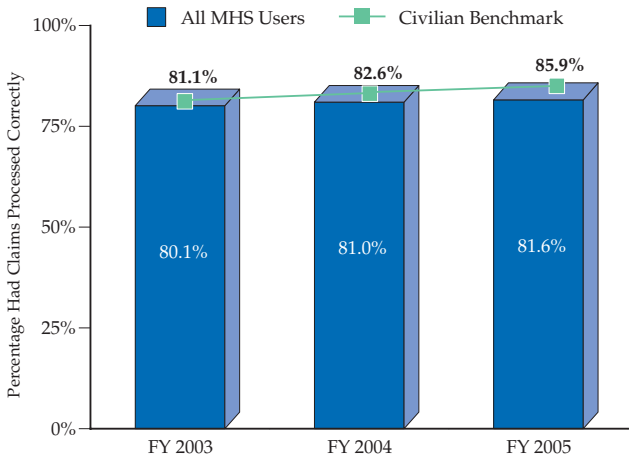
- MHS beneficiaries' satisfaction with their claims being processed in a reasonable period of time increased between FY 2003 and FY 2005 (reaching 82.5 percent in FY 2005), and remained stable across these three years for claims being processed properly (about 83 percent).
- MHS satisfaction levels, however, continue to lag the civilian benchmark.

TRENDS IN SELF-REPORTED ASPECTS OF CLAIMS PROCESSING (ALL SOURCES OF CARE)

CLAIMS PROCESSED PROPERLY (IN GENERAL)



CLAIMS PROCESSED IN A REASONABLE TIME



Note: DoD data were derived from the 2003–2005 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

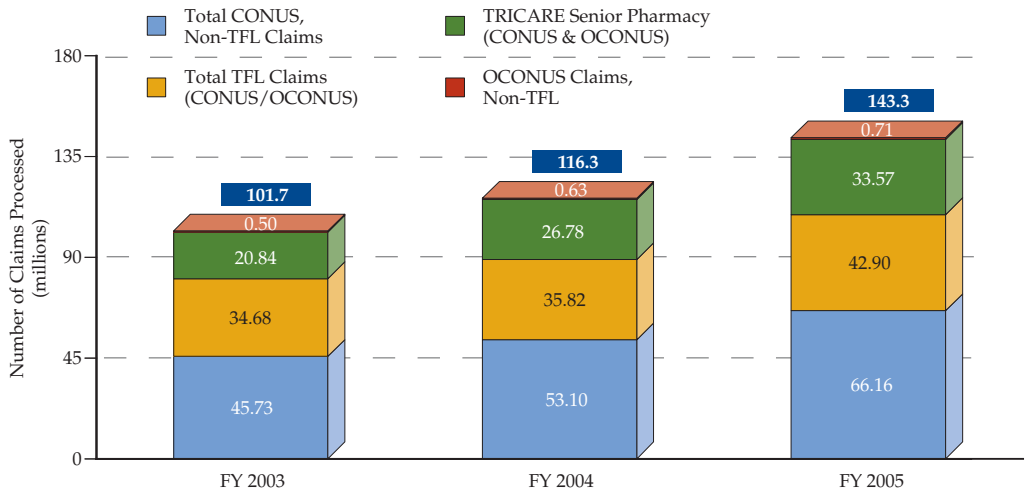
CLAIMS PROCESSING *(CONT'D)*

Administratively Tracked Claims Filing Process

The number of claims processed continues to increase, due to increases in purchased care workload, including claims from seniors for TRICARE for Life, pharmacy and TRICARE dual eligible beneficiaries. Claims processing volume tripled between FY 2001 (38.8 million, not shown) and FY 2004 (116.3 million). While the FY 2005 total number of claims represents a large increase over FY 2004, that increase is due in part to a change in how pharmacy claims are reported. Prior to FY 2005, a pharmacy claim could include multiple prescriptions, whereas in FY 2005 individual pharmacy prescriptions were reported separately.

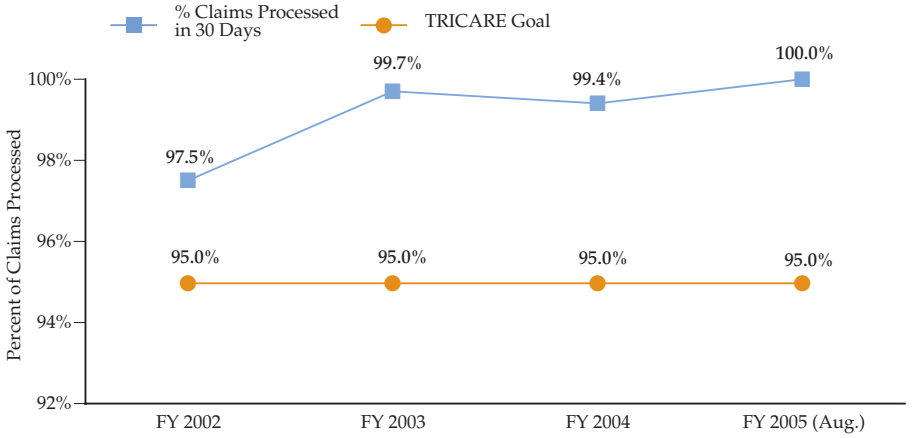
- TFL and TRICARE Senior pharmacy claims combined (CONUS and OCONUS) increased by 21 million claims between FY 2003 and FY 2005, or almost 38 percent.
- As shown in the second chart below, the processing of retained claims within 30 days exceeded the TRICARE performance standard of 95 percent over the past four years, reaching 100 percent for the first time in FY 2005.
- While not shown, as in previous years, 100 percent of claims continue to be processed within 60 days, consistent with the performance standard of 100 percent.

TREND IN THE NUMBER OF TRICARE CLAIMS PROCESSED, FY 2003 TO FY 2005



Source: MHS and Support Contractor administrative data, 1/12/2005

PERCENTAGE OF TRICARE RETAINED CLAIMS PROCESSED WITHIN 30 DAYS



Source: MHS administrative data, 11/15/2005

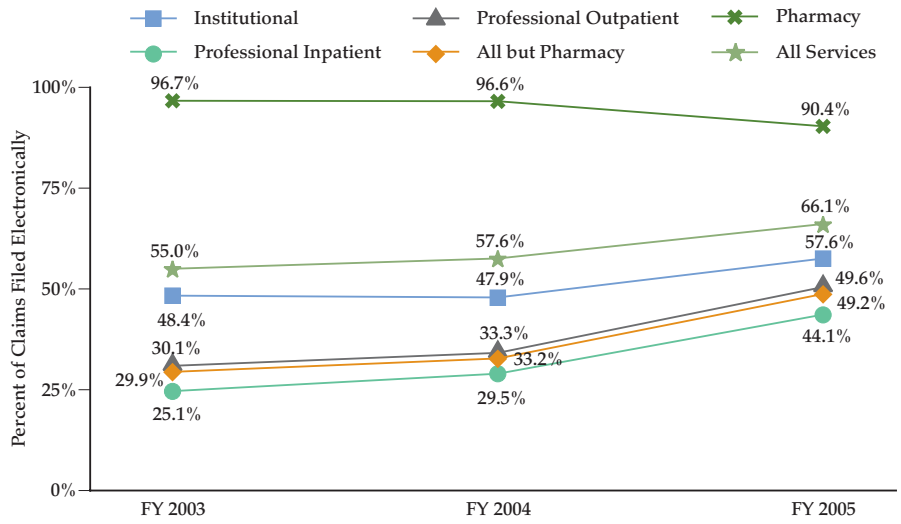
TRENDS IN ELECTRONIC CLAIMS FILING

Trends in Electronic Claims Filing

Electronic claims submissions use more efficient technology requiring less transit time between the provider and payer, are usually less prone to errors or challenges, and usually result in more prompt payment to the provider.

- The percentage of the over 66 million non-TFL claims processed electronically increased to over 66 percent by the end of FY 2005, up 11 percentage points from 55 percent in FY 2003.
- Excluding pharmacy claims, which are predominantly electronic, the percentage of all other claims (institutional and professional inpatient and outpatient services) has increased by 19 percent since FY 2003, reaching just shy of half of these claims (49 percent) by the end of FY 2005.
- The percentage of pharmacy claims processed electronically declined from almost 97 percent in FY 2003 to 90.4 percent in FY 2005 due to an increase in paper-based other health insurance (OHI) pharmacy claims and a shift in the proportion of Medicaid pharmacy claims paid by paper.
- The overall percentages would be much higher if TFL claims were included. TRICARE is second payer to Medicare and, as such, the TFL claims are predominantly electronic, irrespective of MHS involvement (while not shown, 88 percent of all TFL claims and 83 percent of TFL nonpharmacy claims were filed electronically in FY 2005).

EFFICIENCY OF PROCESSING TRICARE CLAIMS: PERCENTAGE OF CLAIMS FILED ELECTRONICALLY



Source: MHS administrative data

SPECIAL STUDY: CIVILIAN PHYSICIAN ACCEPTANCE OF TRICARE STANDARD PATIENTS

Purpose of Study

The Department is currently in the second year of an ongoing study of civilian physician acceptance of TRICARE Standard patients. The FY 2004 National Defense Authorization Act (Section 723) requires the Department to "conduct surveys in the TRICARE market areas in the US to determine how many health care providers are accepting new patients under TRICARE Standard in each such market area." This legislation required DoD to survey at least 20 market areas per year, giving priority to those areas where representatives of TRICARE beneficiaries/providers identified locations experiencing significant levels of access-to-care problems under TRICARE Standard. FY 2004 results were presented in last year's report (FY 2005 Report, page 49).

2005 survey results indicate there is wide variation in acceptance of new TRICARE Standard patients:

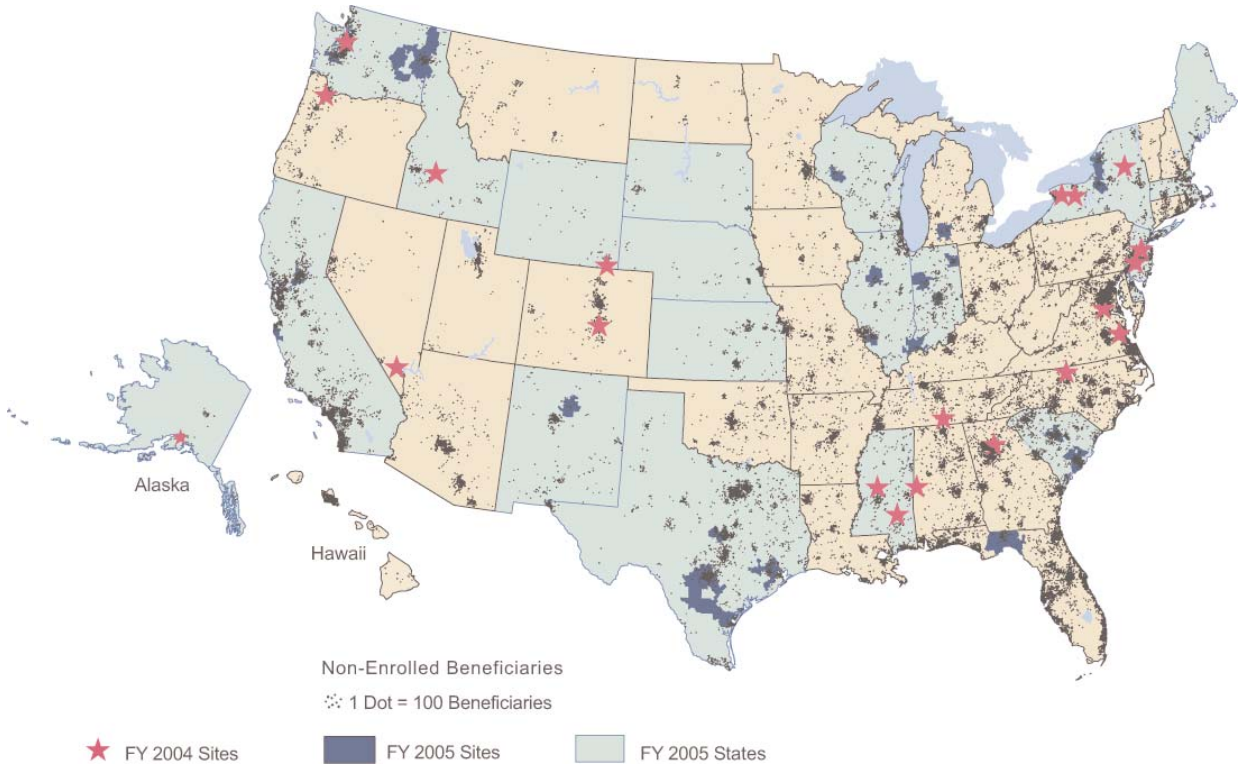
- For the new question added in this year's survey, there is generally a high level of awareness of TRICARE among responding physicians (90 percent), with substantial variation among the 29 Hospital Service Area (HSA) sub-market level sites ranging from 99 percent (Watertown, NY) to 55 percent (Brooklyn):
  - Highest awareness in Watertown, NY (99 percent), Killeen, TX (98 percent), Charleston, SC and Corpus Christi, TX (both 97 percent).
  - Lowest awareness in Brooklyn, NY (55 percent), Boca Raton, FL and Eau Claire, WI (both at 79 percent)
  - Awareness among primary care and specialty physicians was generally comparable, except in Tallahassee, FL and Spokane, WA, where specialists reported greater awareness (e.g., in Spokane, 90 percent compared to 82 percent, respectively).
- An average of 81 percent of physicians accepted new TRICARE Standard patients across all 29 HSAs of those accepting any new patients, ranging from 96 percent (Peoria, IL) to 60 percent (Brooklyn, NY). This range is similar to that of FY 2004 results.
  - Highest acceptance in Peoria, IL (96 percent), Fort Wayne, IN (94 percent), Battle Creek, MI (93 percent).
  - Lowest acceptance in Brooklyn, NY and Seattle WA (both 60 percent), Arlington, TX (62 percent) and Monterey, CA (67 percent).
- In FY 2005, over 90 percent of all physicians in the 29 HSAs accepting new TRICARE Standard patients accepted those patients for all claims, rather than on a claim-by-claim basis, ranging from 99 percent (Eau Claire, WI) to 79 percent (Monterey, CA):
  - Highest acceptance for all claims included: Eau Clare, WI (99 percent), Watertown, NY and Waukegan, IL (both 96 percent).
  - Lowest acceptance for all claims in: Monterey and Sacramento, CA (79 and 81 percent, respectively), and Columbia, SC (84 percent).
- In FY 2005, the two most frequent reasons physicians cited for not accepting new TRICARE patients were: (1) "Dr. is not available" (e.g., too busy, not accepting new patients, limited practice and (2) "Reimbursement"-related issues (e.g., low reimbursement, insufficient fees or fee schedules, and taking too long to get paid).

SPECIAL STUDY: CIVILIAN PHYSICIAN ACCEPTANCE OF TRICARE STANDARD PATIENTS *(CONT'D)*

The map below reflects where the MHS TRICARE Standard eligible population resides, as well as the 2004 (circles) and 2005 survey sites. FY 2005 sites included:

- HSAs (where b = a location recommended by beneficiary representatives or TRICARE Regional Office):
  - Sacramento, CA (b)
  - San Diego, CA
  - Monterey, CA (b)
  - Boca Raton, FL (b)
  - Tallahassee, FL (b)
  - Belleville, IL
  - Waukegan, IL
  - Peoria, IL (b)
  - Evansville, IN
  - Fort Wayne, IN (b)
  - Indianapolis, IN
  - Lafayette, IN (b)
  - Battle Creek, MI (b)
  - Kalamazoo, MI (b)
  - Santa Fe, NM (b)
  - Brooklyn, NY (b)
  - Syracuse, NY
  - Watertown, NY
  - Charleston, SC (b)
  - Columbia, SC
  - Killeen, TX
  - San Antonio, TX
  - Arlington, TX (b)
  - Corpus Christi, TX (b)
  - Houston, TX (b)
  - Olympia, WA
  - Spokane, WA
  - Seattle, WA (b)
  - Eau Claire, WI (b)
- As well as statewide market areas:
  - Alaska
  - California
  - Delaware
  - Idaho
  - Illinois
  - Indiana
  - Kansas
  - Massachusetts
  - Maine
  - Mississippi
  - Nebraska
  - New Jersey
  - New Mexico
  - New York
  - South Carolina
  - South Dakota
  - Texas
  - Washington
  - Wisconsin
  - Wyoming

FY 2004 AND FY 2005 TRICARE STANDARD SURVEY SITES AND MHS NON-ENROLLED (STANDARD) BENEFICIARY POPULATION

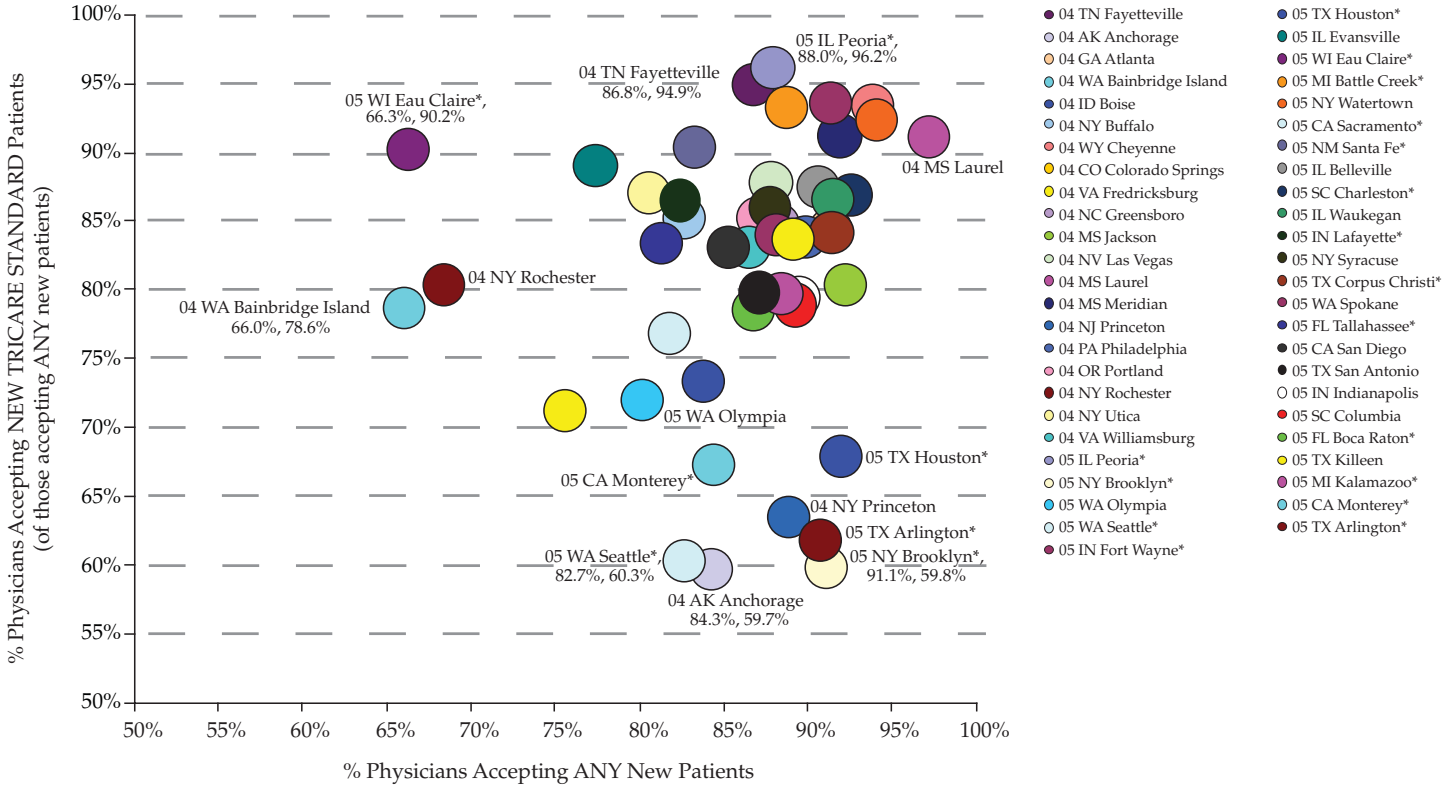


Source: OASD(HA)/TMA-HPA&E, 1/4/2006

PROVIDER ACCEPTANCE OF TRICARE STANDARD

The following chart reflects the relative physician acceptance of TRICARE Standard patients at each of 29 Hospital Service Areas surveyed in FY 2005 as well as the 20 cities surveyed in FY 2004. The higher the proportion of *acceptance of any patients*, the further to the right on the horizontal axis the location will be reflected (i.e., closer to 100% acceptance); while the higher the proportion of *acceptance of TRICARE patients* among those who accept any patients, the higher the location will be shown on the vertical axis. Thus Peoria, IL has both a high acceptance of any patients, as well as a high acceptance of TRICARE patients of those accepting any. Conversely, locations on the chart nearest the bottom right are those areas, relative to those studied, in which TRICARE has a lower acceptance relative to other types of patients the physicians are accepting. Thus, among all 49 locations studied in FY 2004 and FY 2005, acceptance of TRICARE patients is lowest in Anchorage, AK; Seattle, WA; and Brooklyn, NY while it is highest in Peoria, IL and Fayetteville, TN. Furthermore, although these locations are considered the lowest acceptors of TRICARE standard patients as self-reported by surveyed physicians, they still represent an acceptance of almost 60 percent or higher.

PROVIDER ACCEPTANCE OF TRICARE STANDARD: RELATIVE RANKING BY (1) ACCEPTING ANY NEW PATIENTS AND (2) ACCEPTING NEW TRICARE STANDARD PATIENTS (FY 2004 AND FY 2005 723 STUDY RESULTS)



Source: TMA/Health Programs Analysis and Evaluation Studies in FY 2004 and FY 2005.

Note: The 17 FY 2005 locations identified in the legend with an asterisk (*) were high-priority locations identified by beneficiary representatives for surveying, while the remaining 12 in 2005 were randomly selected. All 20 FY 2004 locations were specifically identified by beneficiary representatives.

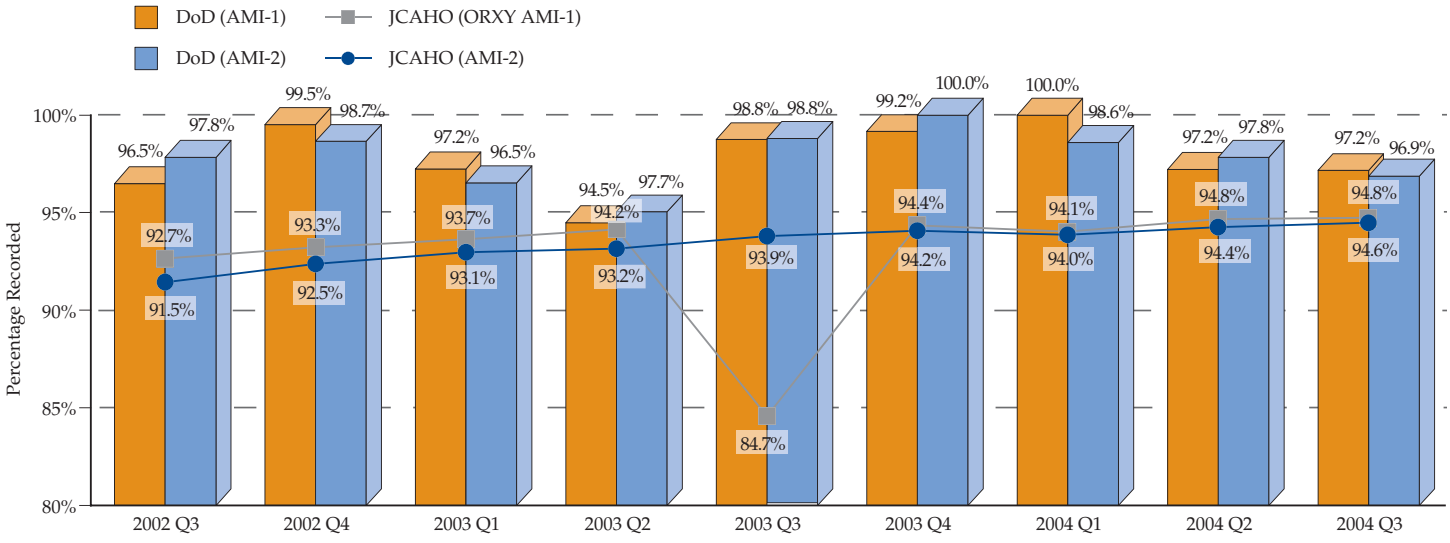
MILITARY TREATMENT FACILITY ASSESSMENT OF SELECTED JOINT COMMISSION ON THE ACCREDITATION OF HEALTH CARE ORGANIZATIONS (JCAHO) CORE QUALITY OF CARE MEASURES

In the United States, the JCAHO is the nationally recognized organization that surveys health care settings using pre-established, published criteria to determine the accreditation status based on a triennial onsite survey by health care professionals. Participation in the JCAHO survey process has been an institutionalized aspect of quality in the MHS for two decades. The Joint Commission has established the ORYX® initiative to incorporate the use of data for comparative analyses and public reporting as a method to enhance the quality improvement activities in accredited health care organizations.

The Joint Commission's *National Implementation of Hospital Core Measures* reflect the ongoing maturation of its ORYX® initiative. These measures have been designed to permit more rigorous comparisons using standardized, evidenced based measures and data gathering procedures. JCAHO has identified key measures with respect to acute myocardial infarction (AMI), heart failure, pneumonia, pregnancy and related conditions, and surgical infection prevention. These core measures are aligned with the Centers for Medicare and Medicaid Services (CMS) hospital quality initiative measures. MHS military treatment facilities are currently reporting data on three of the JCAHO core measure sets. The charts below provide a sample of a few of the measures focusing on key preventative aspects for managing the effects of AMI, with respect to the provision of aspirin within 24 hours before or after hospital arrival, a prescription upon discharge, and counseling to quit smoking. The quarterly MHS results are compared to the national average of all accredited U.S. institutions reported by the Commission for that quarter.

- On a quarterly basis, MHS military treatment facilities have maintained a high rate of aspirin therapy for AMI patients, and exceeded the Joint Commission's comparative national average.
- As shown on the next page, however, while MHS documentation of smoking cessation counseling for those adults admitted for AMI appears to be generally improving, it remains below the national average reported by the Commission. The isolated variation in the FY 2004 second quarter data does not appear to be significant and is likely due to the small size of this sample.

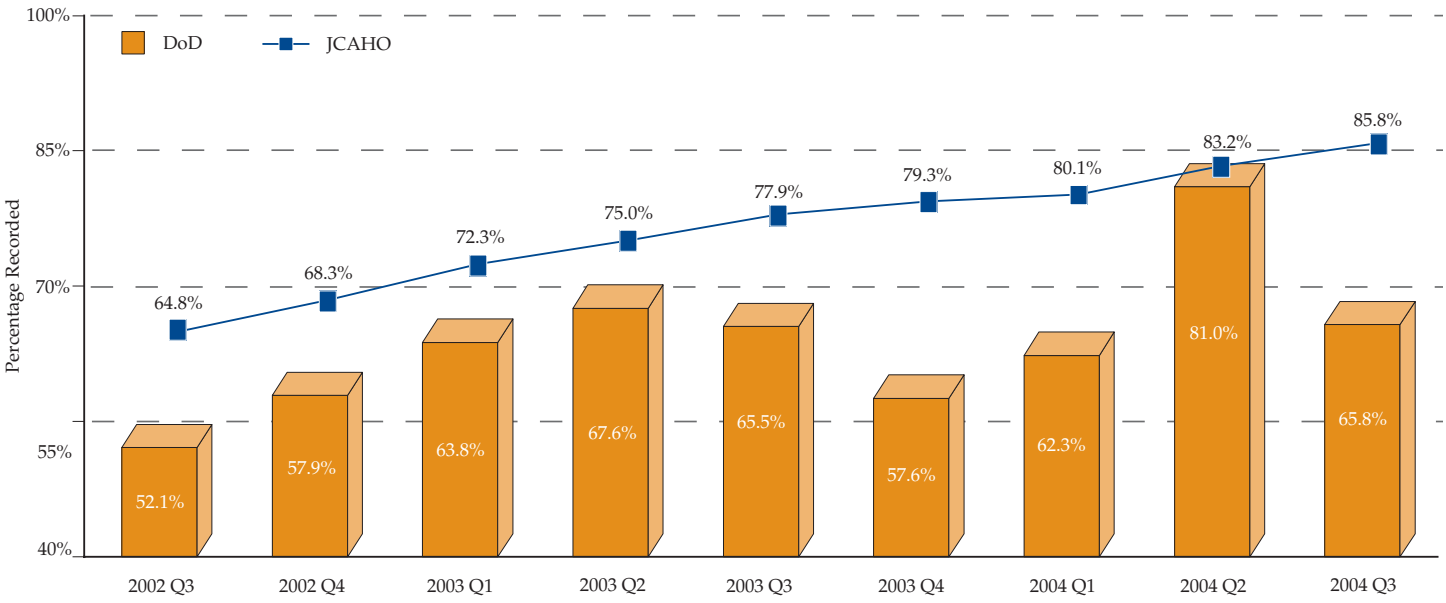
ACUTE MYOCARDIAL INFARCTION—ASPIRIN AT ARRIVAL AND UPON DISCHARGE (JCAHO ORYX MEASURES AMI-1 AND AMI-2)



Source: OASD(HA)/TMA, Office of the Chief Medical Officer, December 6, 2005

MILITARY TREATMENT FACILITY ASSESSMENT OF SELECTED JOINT COMMISSION ON THE ACCREDITATION OF HEALTH CARE ORGANIZATIONS (JCAHO) CORE QUALITY OF CARE MEASURES *(CONT'D)*

ACCREDITATION—CLINICAL QUALITY STANDARDS: ACUTE MYOCARDIAL INFARCTION–SMOKING COUNSELING FOR ADULTS ADMITTED FOR ACUTE MYOCARDIAL INFARCTION

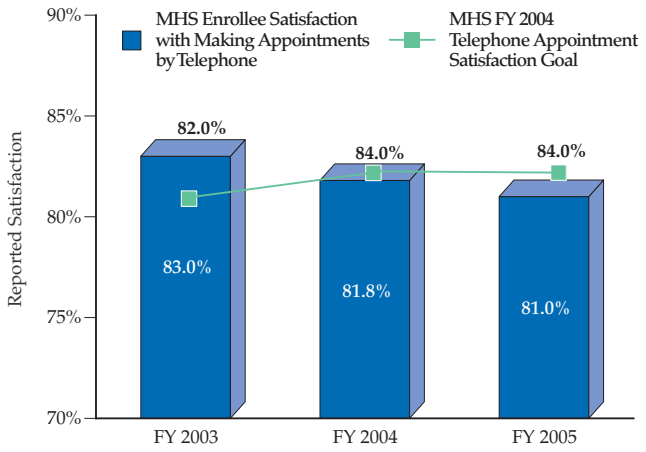


Source: OASD(HA)/TMA, Office of the Chief Medical Officer, December 6, 2005

APPOINTMENT ACCESS IN THE DIRECT CARE SYSTEM

The MHS is concerned about beneficiary satisfaction with telephone access to the direct care system in addition to the satisfaction metrics presented previously (External Customers: satisfaction with the health plan and care overall, as well as the primary care and specialty care physicians). This metric is designed to put MHS patients at the center of attention in the direct care system.

SATISFACTION WITH MAKING APPOINTMENTS BY TELEPHONE IN THE DIRECT CARE SYSTEM



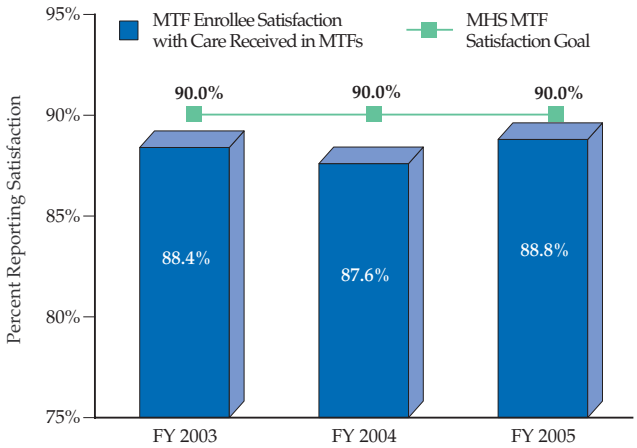
Source: DHP Performance Contract, Satisfaction with Access, 11/15/2005

The MHS goal was raised in FY 2004 to 84 percent from 82 percent the previous year, when patients reporting satisfaction exceeded the 82 percent goal in FY 2003. The level of satisfaction reported by MHS beneficiaries did not meet the revised goal of 84 percent this year, and appears to have decreased by almost 1 percent since last year.

SATISFACTION WITH CARE RECEIVED IN THE DIRECT CARE SYSTEM

The MHS is concerned about beneficiary satisfaction with the actual encounter in the MTF. Similar to measuring beneficiary access to MTFs via telephone, this metric is designed to put MHS patients at the center of attention in the direct care system. Patient satisfaction here is measured by a survey following a specific clinic visit.

SATISFACTION WITH THE OUTPATIENT VISIT IN THE DIRECT CARE SYSTEM



Source: DHP Performance Contract, Satisfaction with Access, 11/15/2005

The percentage of beneficiaries reporting satisfaction with the care received within military treatment facilities in the past three years has remained constant, and has not reached the MHS goal of at least 90 percent satisfaction.

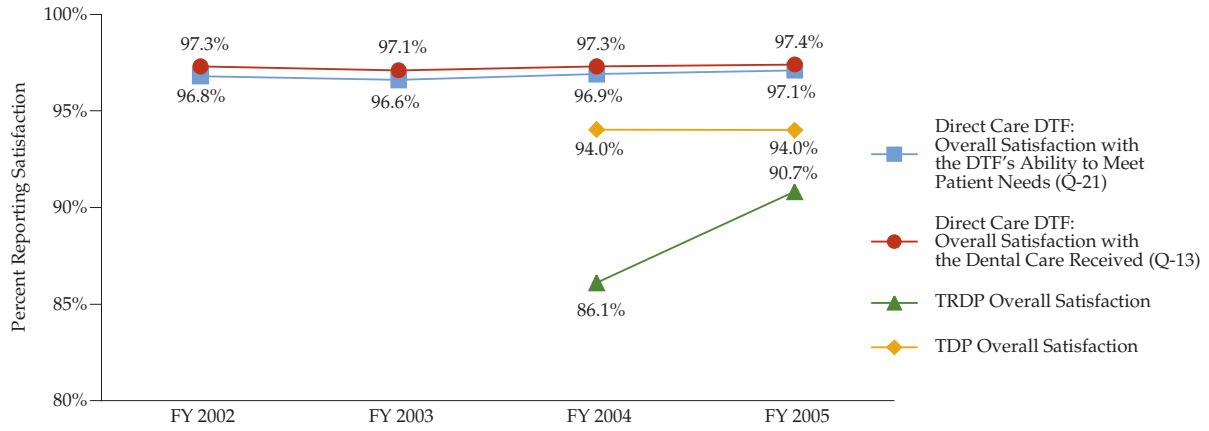
TRICARE DENTAL PROGRAMS CUSTOMER SATISFACTION

Dental Customer Satisfaction

The overall TRICARE dental benefit is comprised of several delivery programs serving the MHS beneficiary population. Beneficiary satisfaction is routinely measured for each of these important dental programs.

- Patients using **Military Dental Treatment Facilities (DTFs)** continue to report an **overall 97 percent** level of satisfaction with dental care received. DTFs are responsible for the dental care of 1.79 million active duty service members, as well as eligible OCONUS family members. During FY 2005, the Tri-Service Center for Oral Health Studies collected over 114,000 DoD Dental Patient Satisfaction Surveys from patients who received dental care at the Services' DTFs. The overall DoD dental patient satisfaction with the ability of the DTFs to take care of their dental needs increased to just over 97 percent in FY 2005 (97.1 percent).
- The **TRICARE Dental Program (TDP)** FY 2005 composite average enrollee satisfaction **remained at 94 percent**, similar to FY 2004. The TDP is a voluntary, premium-sharing dental insurance program that is available to eligible active duty family members, selected Reserve and individual ready Reserve members, and their family members. As of 30 September 2005, the TDP services over 718,988 contracts covering over 1,768,490 lives. While not shown, this measure includes satisfaction ratings for Network Access (95 percent), Provider Network Size and Quality (92 percent), Claims Processing (96 percent), Enrollment Process (94 percent), and Written and Telephonic Inquiries (94 percent).
- The **TRICARE Retiree Dental Program (TRDP)** overall enrollee satisfaction rates **increased** from 86.1 percent in FY 2004 **to 90.7 percent** in FY 2005. The TRDP is a full premium insurance program open to retired uniformed service members and their families. The TRDP demonstrated a 19.6 percent increase in enrollees from FY 2004 to FY 2005, ending the year with 421,695 contracts serving 898,232 lives.

SATISFACTION WITH TRICARE DENTAL PROGRAMS: MTF AND CONTRACT SOURCES



Source: Tri-Service Center for Oral Health Studies, DoD Dental Patient Satisfaction reporting Web site (Trending Reports) and TRICARE Operations Division, October 31, 2005

SYSTEM PRODUCTIVITY: MHS PROGRAM INTEGRITY

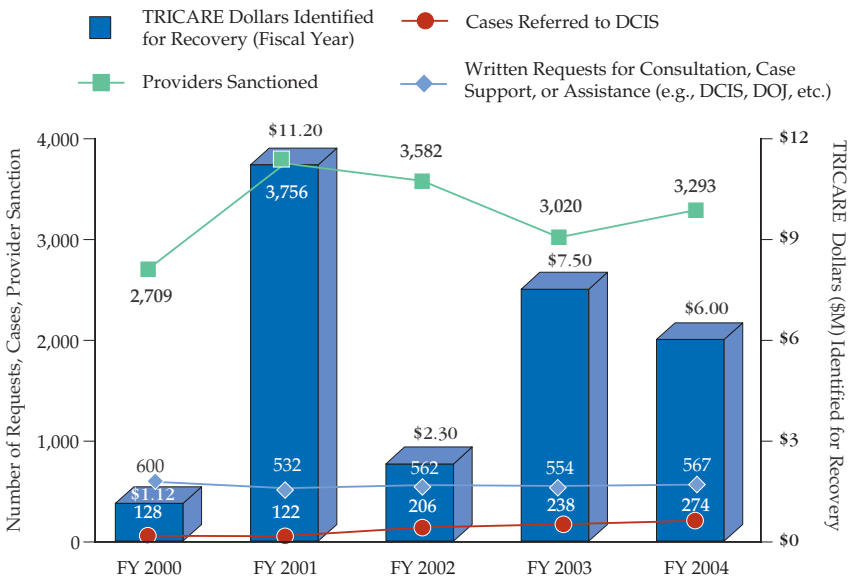
TRICARE Program Integrity

The TRICARE Management Activity (TMA) Program Integrity (PI) Office is responsible for all anti-fraud activities worldwide for the Defense Health Program. This includes both the purchased care and direct care settings within the Military Health System (MHS). TMA PI develops and executes policies and procedures regarding prevention, detection, investigation and control of TRICARE fraud, waste and program abuse, monitors contractor program integrity activities, coordinates with DoD and external investigative agencies and initiates administrative remedies as required. Because of the nature and scope of the work performed, the TMA PI reporting line is separate and distinct organizationally from the day-to-day operational activities of other departments to avoid the appearance or potential of undue influence or conflict of interest. TMA PI provides technical assistance, program expertise and support to the DoD Office of the Inspector General (IG) for Investigations, Department of Justice (DOJ) and the U.S. Attorneys in developing cases for prosecution. Specifically, TMA PI provides DOJ with trial preparation activities such as creating reports, charts and graphs for use as exhibits and expert witness testimony related to the TRICARE program and range of benefits. Through a Memorandum of Understanding, TMA PI refers its provider fraud cases to the Defense Criminal Investigative Service (DCIS). TMA PI also coordinates investigative activities with other agencies such as the Military Criminal Investigative Offices (MCIOs), as well as other federal, state and local agencies. This support is continuous and ongoing throughout the investigative phase of a case and on into the settlement or prosecution phase.

In April of 2002, TMA's Office of Administration became the central point of coordination for those DoD Hotline complaints previously handled by TMA PI. Although the responsibility for oversight has changed, TMA PI continues to investigate and respond to all DoD Hotline complaints assigned to TMA PI as potential fraud cases and/or cases that require independent investigation by an entity outside the chain of command of the alleged violation.

The chart below shows the results of TMA PI's activities over the last five years. Launched in late 1999, Operation TRICARE Fraud Watch, with its increased emphasis on anti-fraud programs, had an impact on the early identification of fraud, thus minimizing dollar losses within the program. The National Health Insurance Association of America has estimated that for every $1 spent on anti-fraud activities, $11 is saved.

TRICARE PROGRAM INTEGRITY: FY 2000 TO FY 2004



Source: TRICARE Program Integrity Operational Report, January 1, 2004 through December 31, 2004, September 2005

- The amount of TRICARE dollars identified for recovery has been between $6 and $7.5 million the past two fiscal years (FY 2004 and FY 2003, respectively), up substantially since Operation TRICARE Fraud Watch's first fiscal year yield of slightly over $1 million.
- The number of providers sanctioned in FY 2004 (3,293) increased by 9 percent over the number in FY 2003 (3,020), reversing a downward trend between FY 2001 and FY 2003, and continuing the general trend of sanctioning over 3,000 providers each year.
- The number of provider fraud cases TMA has referred to the DCIS continues the increasing trend over the past four years, with a 15 percent increase between FY 2003 (238 cases) and FY 2004 (274 cases).

SYSTEM PRODUCTIVITY: MHS WIC OVERSEAS PROGRAM

WIC Program Efficiencies

The DoD offers the Women, Infants, and Children (WIC) Overseas nutrition program to eligible MHS beneficiaries overseas. In 2000, Congress directed the Secretary of Defense to establish and fund a program to provide WIC services to eligible members of the Armed Forces, civilian employees, and DoD contractors living overseas, and their family members. WIC Overseas established and opened its first sites in January 2001.

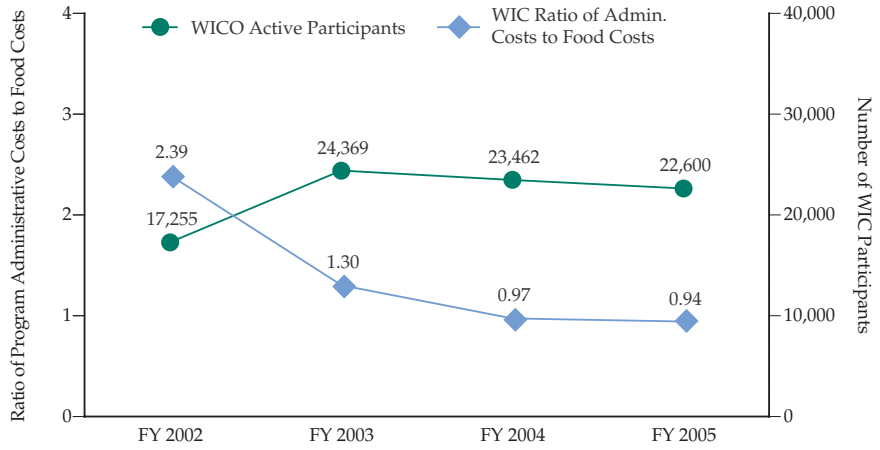
The WIC Overseas nutrition program provides eligible sponsors and their families with several important benefits, including: nutritious food that will contribute to a healthier diet; tips on how to prepare a balanced meal; nutrition and health screening; and access to other resources that will help them lead healthier lives. Now WIC is available to eligible mothers-to-be, mothers, and children who are part of the DoD family overseas.

The program provides benefits to women during pregnancy and after the birth of their child. Benefits may be provided to the mother until the infant is six months old, or, for mothers who are breastfeeding, until the child's first birthday. The program also provides nutritional benefits for children, helping them achieve a wholesome, well-balanced diet. Eligible children may participate up to age five.

Income and family size, as well as certain other criteria, are considered when determining eligibility. MHS beneficiaries residing overseas may be eligible for the program if they had participated in the stateside WIC program.

- Participants are the women, infants, and children receiving the WIC Overseas benefit. The following chart reflects the maturation of the WIC Overseas program since its beginning in FY 2002, with the total number of participants increasing by over 30 percent from FY 2002 (from slightly over 17,000) to almost 23,000 by FY 2005.
- One measure of program efficiency is the ratio of the overall administrative cost to the actual cost of food provided. In the first full year of the program, overall administrative costs were approximately $15 million, which, compared with actual food costs of slightly over $6 million, reflected an administrative-to-food cost of 2.39. This ratio has improved significantly, such that by FY 2005 the ratio for this $21 million program is down to .94, or equivalent to 94 cents spent for every dollar spent on food.

MHS WIC OVERSEAS PROGRAM EFFICIENCIES: RATIO OF ADMINISTRATIVE COSTS TO FOOD COSTS OVER TIME: FY 2002 TO FY 2005

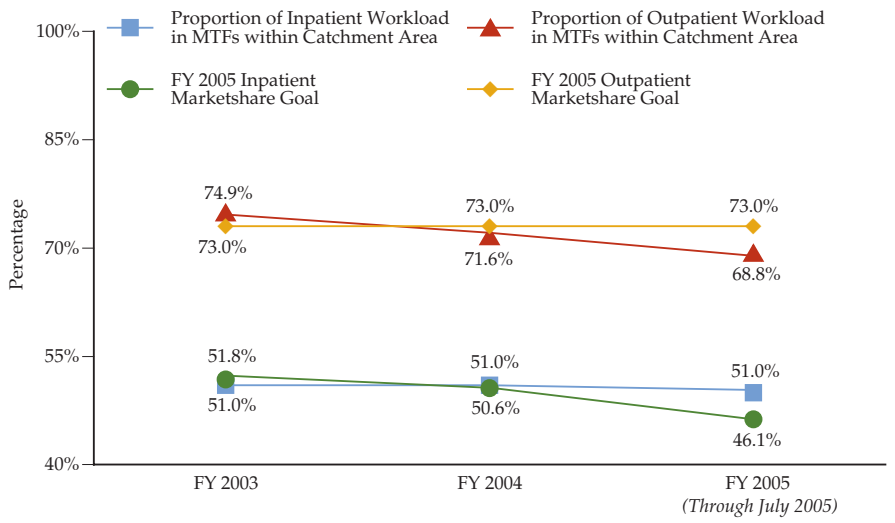


Source: TRICARE Operations administrative data, 11/30/05

SYSTEM PRODUCTIVITY: MTF MARKET SHARE TRENDS

As a measure of enrollment market share, the percentage of both inpatient and outpatient workload for TRICARE Prime enrollees accomplished in MTFs relative to all Prime workload in catchment areas (a radius of 40 miles for hospitals and 20 miles for ambulatory care facilities) has declined over the past three years.

PERCENTAGE OF ENROLLEE WORKLOAD PERFORMED BY MTFs IN CATCHMENT AREAS



Source: MHS administrative data reported in the Annual Defense Review, 11/15/2005

Note: Market share measures exclude TFL workload from purchased care. Inpatient workload is based on RWPs, and outpatient workload is based on visits. Inpatient workload is based on 40-mile catchment area; outpatient workload is based on catchment areas for stand-alone clinics and 20-mile catchment area surrounding the "Parent" MTF with inpatient services.

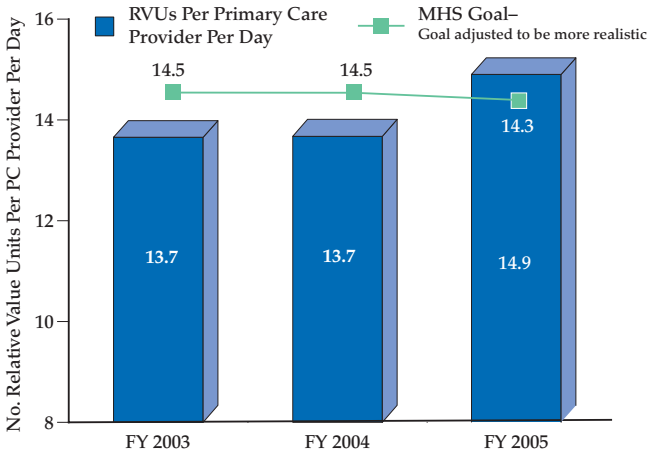
From FY 2003 to FY 2005 (year-to-date), MTF inpatient workload market share has declined by 5.7 percentage points while outpatient workload market shares have declined by about 6 percentage points.

No adjustments have been made to account for the effects of deploying military providers and support staff, nor for the significant influx in National Guard and Reservists mobilized since September 11, 2001, and their family members, who have become eligible for the TRICARE benefit.

SYSTEM PRODUCTIVITY: MTF PROVIDER PRODUCTIVITY

The purpose of this metric is to focus on the productivity of the direct care system at the provider level. Performance is measured as the number of RVU encounters (visits) per full-time equivalent (FTE) primary care provider in U.S. military clinics.

MTF PRIMARY CARE PROVIDER PRODUCTIVITY (RVUs/PROVIDER/DAY)



Source: MHS administrative data reported in the Annual Defense Review, 11/15/2005. Measure is defined as the number of RVUs per FTE provider per 8-hour day in U.S. military clinics.

MHS productivity increased in FY 2005 to 14.9 RVUs per primary care provider per day. Similar to the market share analysis above, no adjustments in actual productivity have been made to account for the effects of deploying military providers and support staff, nor for the influx of mobilized National Guard and Reservists and their family members.

INPATIENT UTILIZATION RATES AND COSTS

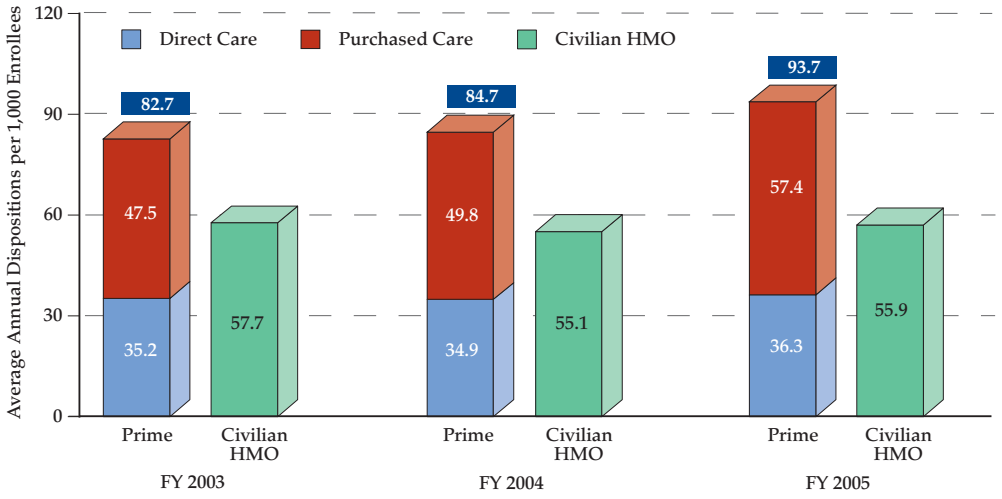
TRICARE Prime Inpatient Utilization Rates Compared with Civilian Benchmarks

TRICARE Prime Enrollees

This section compares the inpatient utilization of TRICARE Prime enrollees with that of civilian Health Maintenance Organization (HMO) enrollees. Inpatient utilization is measured as the number of dispositions because the civilian-sector data do not contain a measure of RWPs.

- The TRICARE Prime enrollee inpatient utilization rate (direct and purchased care combined) was 68 percent higher than the civilian HMO enrollee utilization rate in FY 2005 (93.7 discharges per thousand Prime enrollees compared with 55.9 per 1,000 civilian HMO enrollees).
- The direct care inpatient utilization rate remained steady between FY 2003 and FY 2005 but the purchased care utilization rate increased by 21 percent over the same period.

INPATIENT UTILIZATION RATES: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 12/7/2005

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2005 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

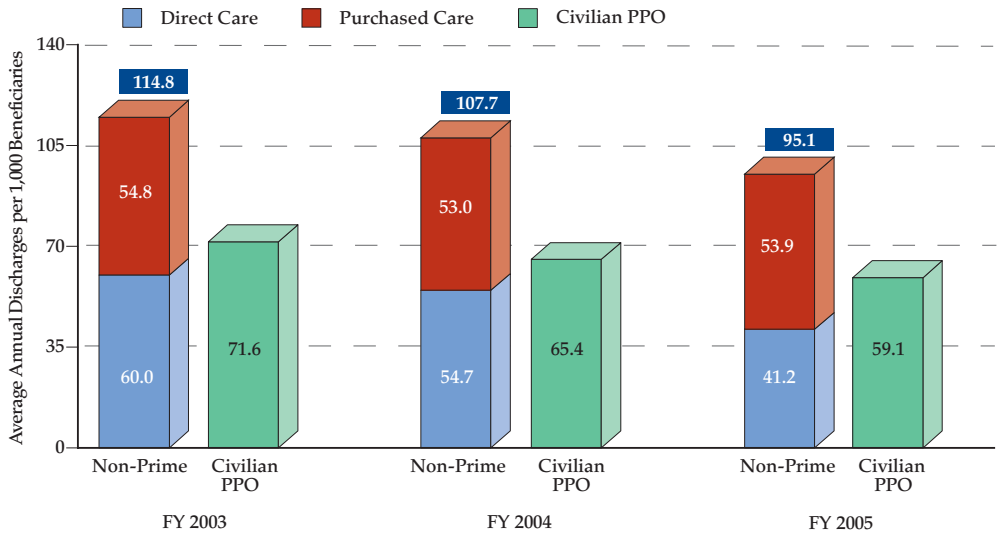
INPATIENT UTILIZATION RATES AND COSTS

Non-Enrolled Beneficiaries

This section compares the inpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of civilian participants in Preferred Provider Organization (PPO) plans. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Inpatient utilization is measured as the number of dispositions because the civilian-sector data do not contain a measure of RWPs.

- The inpatient utilization rate (direct and purchased care combined) for non-enrolled beneficiaries declined by 17 percent between FY 2003 and FY 2005. The civilian inpatient utilization rate declined by the same percentage over that time period.
- The purchased care inpatient utilization rate remained steady between FY 2003 and FY 2005 but the direct care utilization rate decreased by 31 percent over the same period.

INPATIENT UTILIZATION RATES: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 12/7/2005

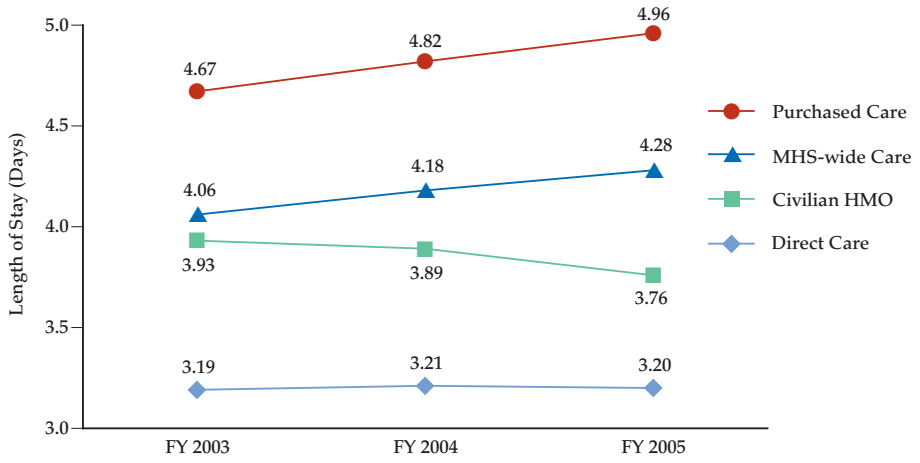
Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2005 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Average Lengths of Hospital Stays

- Average lengths of stay in DoD facilities (direct care) remained essentially constant from FY 2003 to FY 2005.
- Average lengths of stay in TRICARE purchased care facilities increased by 6 percent from FY 2003 to FY 2005 and remained well above those in DoD facilities. Hospital stays in purchased care facilities are longer on average than in DoD facilities because purchased care facilities perform more complex procedures (as determined by RWPs—a measure of inpatient resource intensity).
- Average lengths of stay in benchmark civilian facilities have declined slightly over the past three years and are shorter than those in MHS facilities (direct and purchased care facilities combined).

INPATIENT UTILIZATION: TRENDS IN TRICARE AVERAGE LENGTH OF STAY



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 12/7/2005

Note: Beneficiaries age 65 and over were excluded from the above calculations. Further, the civilian data for each year were adjusted to reflect the age/sex distribution of MHS inpatient dispositions (direct and purchased care combined). FY 2005 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

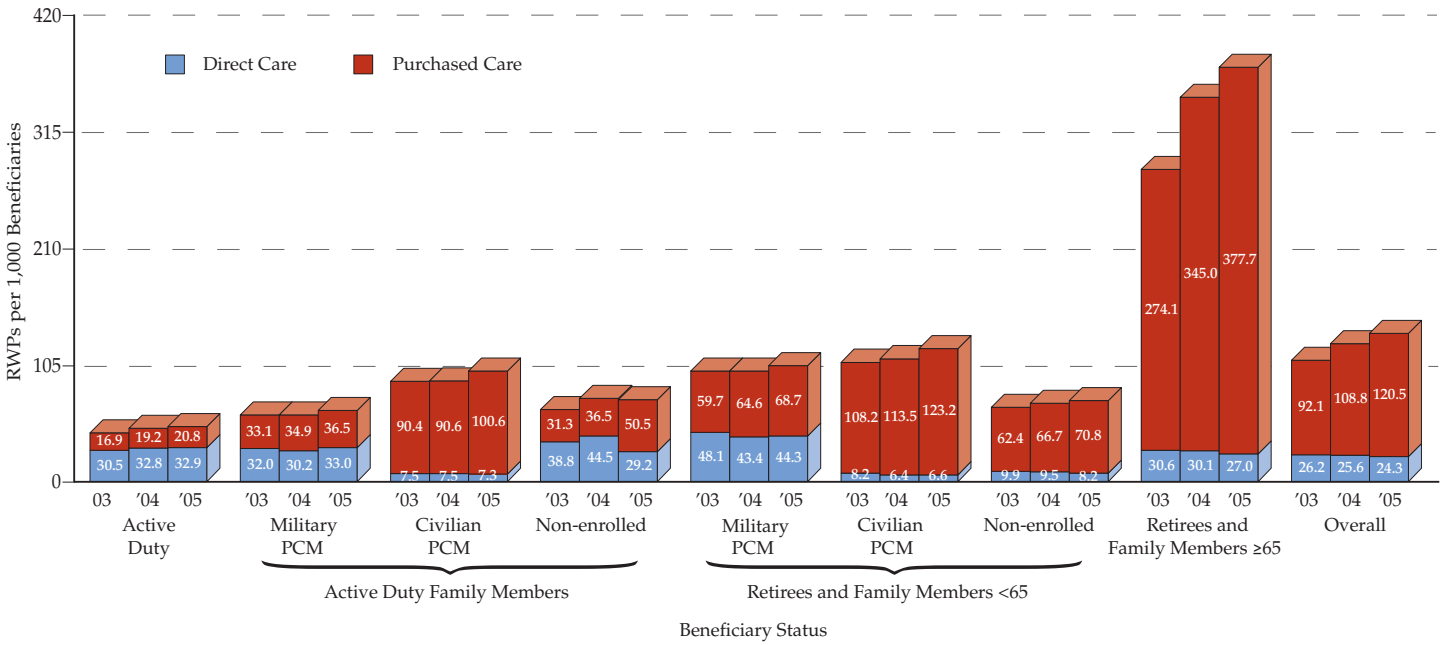
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Inpatient Utilization Rates by Beneficiary Status

When breaking out inpatient utilization by beneficiary group, RWPs per capita should more accurately reflect differences across beneficiary groups than discharges per capita.

- The direct care inpatient utilization rate (RWPs per 1,000 beneficiaries) declined for all retiree groups and increased for all active duty and enrolled family members.
- Non-enrolled beneficiaries experienced the largest drop in direct care utilization.
- Purchased care inpatient utilization rates increased for all beneficiary groups.
- The TFL inpatient utilization rate increased by 26 percent in FY 2004 and by another 3 percent in FY 2005.
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE has become second payer to Medicare), the percentage of total inpatient workload performed in purchased care facilities increased from 66 percent in FY 2003 to 70 percent in FY 2005.
- From FY 2003 to FY 2005, the percentage of inpatient workload (RWPs) referred to the network on behalf of beneficiaries enrolled with a military PCM (including active duty personnel) increased from 48 percent to 50 percent.

AVERAGE ANNUAL INPATIENT RWPs PER 1,000 BENEFICIARIES (BY FISCAL YEAR)



Source: MHS administrative data, 11/25/2005

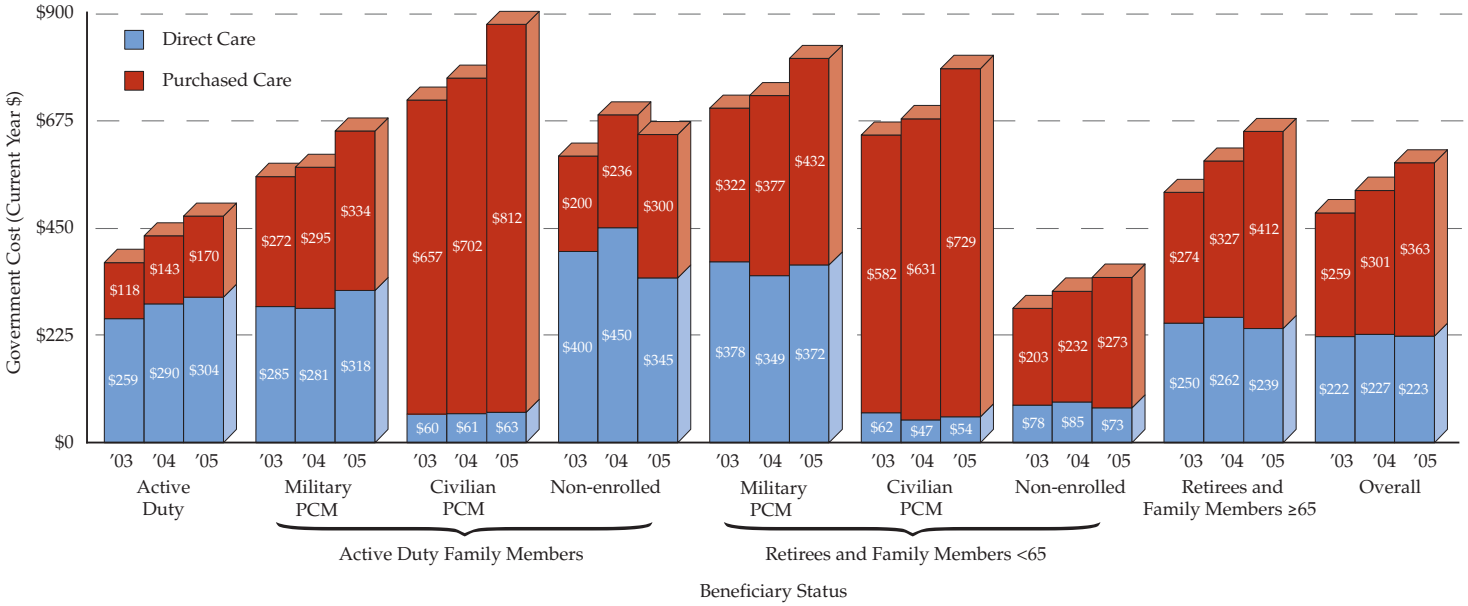
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Inpatient Cost by Beneficiary Status

Overall MHS inpatient costs (in then-year dollars) per beneficiary (far right columns below) increased by 10 percent in FY 2004 and by another 11 percent in FY 2005. The increases were due almost exclusively to higher purchased care costs.

- Exclusive of TFL, the direct care cost per RWP increased from $8,560 in FY 2003 to $9,288 in FY 2005 (8.5 percent).
- Exclusive of TFL, the purchased care cost per RWP increased from $5,357 in FY 2003 to $6,043 in FY 2005 (12.8 percent). The purchased cost per RWP is much lower than that for direct care because many beneficiaries using purchased care have other health insurance. When beneficiaries have other health insurance, TRICARE becomes second payer and the government pays a smaller share of the cost.

AVERAGE ANNUAL DoD INPATIENT COST PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 11/25/2005

INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Leading Inpatient Diagnoses by Volume

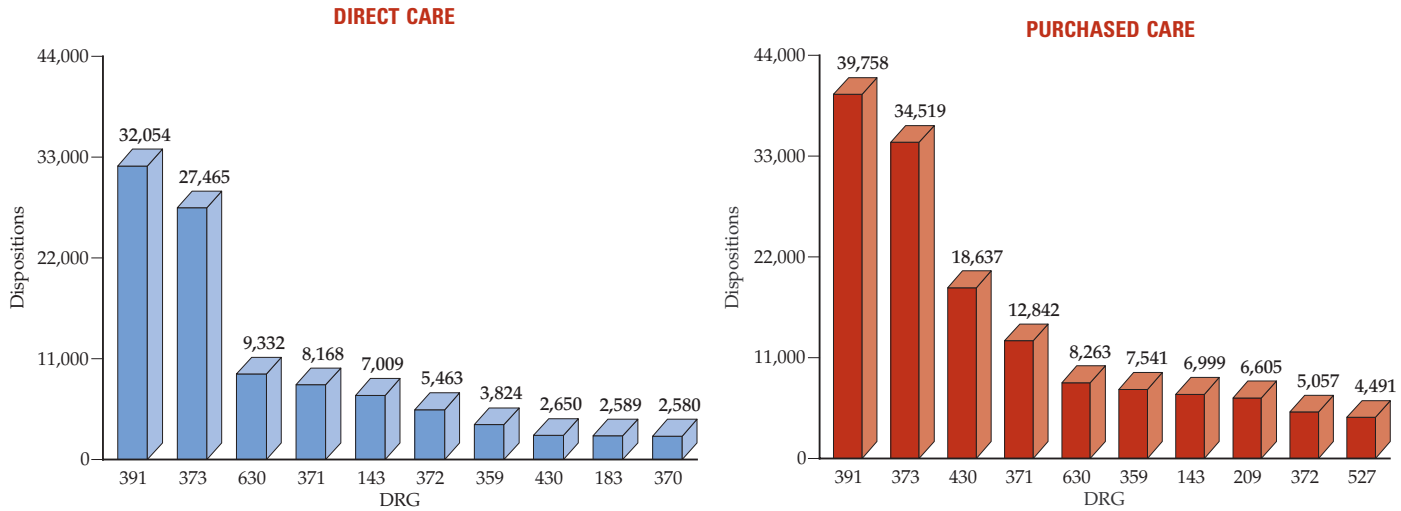
In military hospitals (direct care), the top 10 Diagnosis-Related Groups (DRGs) in terms of dispositions (discharges from the hospital) in FY 2005 accounted for 42 percent of all direct care inpatient dispositions.

- Half of these DRGs were associated with childbirth.
- The top two procedures, associated with normal childbirth, together account for more volume than the next eight procedures combined.

In civilian hospitals (purchased care), the top 10 DRGs accounted for 39 percent of all purchased care inpatient dispositions. TFL dispositions are excluded.

- Of the top 10 DRGs, four were related to childbirth.
- Similar to that noted in the direct care (above), the top two procedures in purchased care are associated with normal childbirth, and together account for more volume than the next eight procedures combined.

TOP 10 DIRECT CARE AND PURCHASED CARE DRGs IN FY 2005 BY VOLUME



Source: MHS administrative data, 11/17/05

DRG	DESCRIPTION
143	Chest pain
183	Esophagitis, gastroenteritis, and miscellaneous digestive disorders age >17 without complicating circumstances
209	Major joint and limb reattachment procedures of lower extremity (includes hip, knee, ankle replacements)
359	Uterine and adnexa procedure for non-malignancy without complicating circumstances
370	Cesarean section with complicating circumstances
371	Cesarean section without complicating circumstances
372	Vaginal delivery with complicating diagnoses
373	Vaginal delivery without complicating diagnoses
391	Normal newborn
430	Psychoses
527	Percutaneous cardiovascular procedures with drug-eluting stent without AMI
630	Neonate, birth weight >2499g, without significant operating room procedure, with other problems

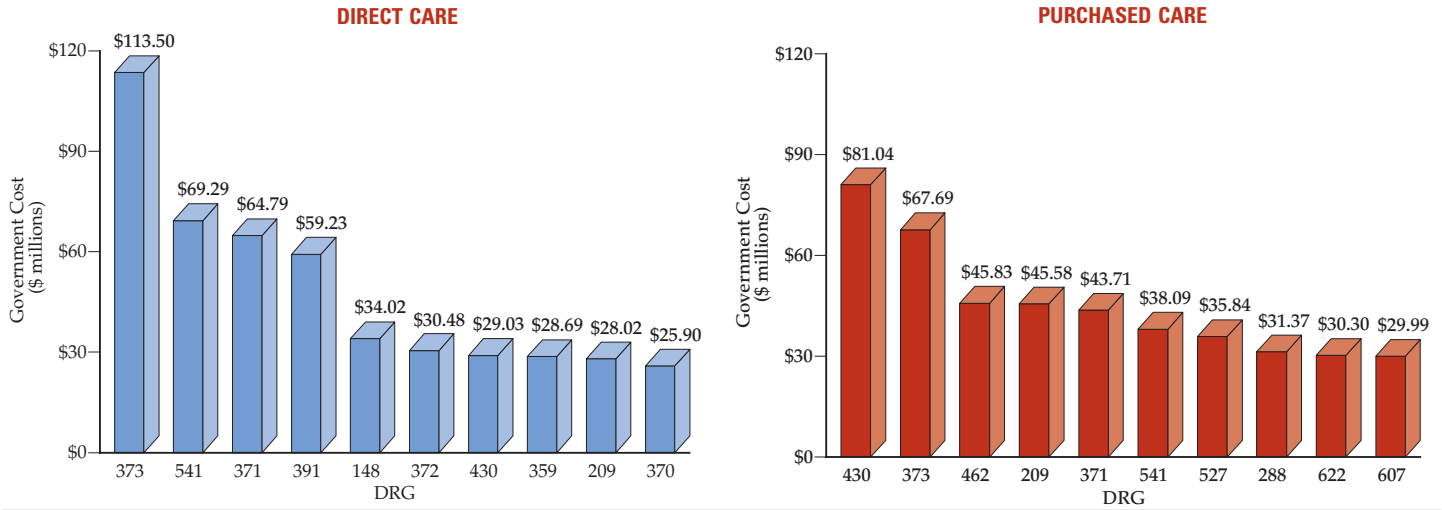
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Leading Inpatient Diagnoses by Cost

The leading diagnoses in terms of cost in FY 2005 were determined from institutional claims only, i.e., they include hospital charges but not attendant physician, laboratory, drug, or ancillary service charges.

- In military hospitals (direct care), the top 10 DRGs in terms of cost accounted for 25 percent of all direct care inpatient costs.
  - Four of these DRGs were associated with childbirth.
  - Although not one of the top 10 diagnoses in terms of volume, tracheostomies (except for face, mouth, and neck diagnoses) ranked second in terms of total inpatient expenditures at DoD facilities in FY 2005 because of their long average hospital stay (45 days).
- In civilian hospitals (purchased care), the top 10 DRGs accounted for 24 percent of all purchased care inpatient costs. TFL claims are excluded.
  - Psychiatric conditions accounted for the greatest MHS expenditures for a single DRG in purchased care facilities, followed by normal childbirth and major joint and limb reattachment procedures.

TOP 10 DIRECT CARE AND PURCHASED CARE DRGs IN FY 2005 BY COST



Source: MHS administrative data, 11/17/2005

DRG	DESCRIPTION
148	Major small and large bowel procedures with complications and comorbidities
209	Major joint and limb reattachment procedures of lower extremity (includes hip, knee, ankle replacements)
288	Operating room procedures for obesity
359	Uterine and adnexa procedure for non-malignancy without complicating circumstances
370	Cesarean section with complicating circumstances
371	Cesarean section without complicating circumstances
372	Vaginal delivery with complicating diagnoses
373	Vaginal delivery without complicating diagnoses
391	Normal newborn
430	Psychoses
462	Rehabilitation
527	Percutaneous cardiovascular procedures with drug-eluting stent witout AMI
541	Tracheostomy with mechanical ventilation 96+ hours or PDx except face, mouth, and neck diagnoses with major O.R.
607	Neonate, birth weight 1000–1499g, without significant operating room procedure, discharged alive
622	Neonate, birth weight >2499g, with significant operating room procedure, with multiple major problems

OUTPATIENT UTILIZATION RATES AND COSTS

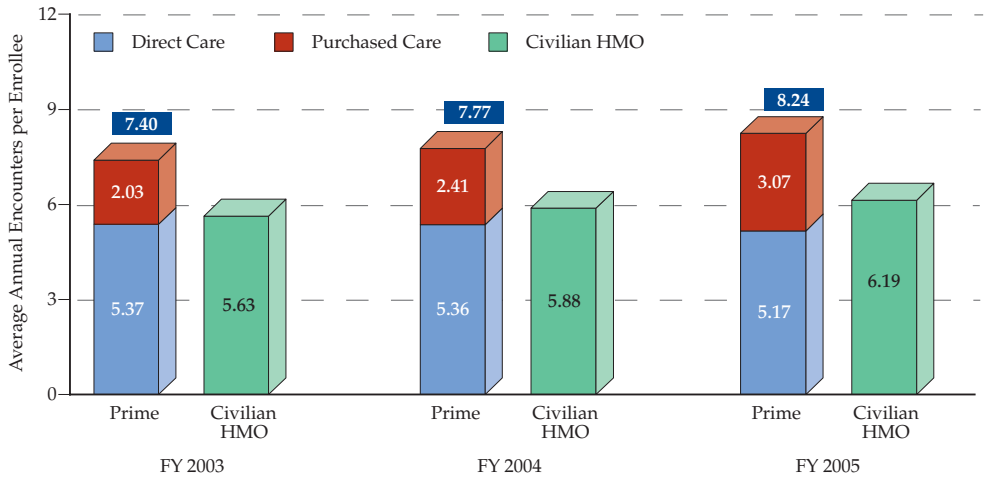
TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks

TRICARE Prime Enrollees

This section compares the outpatient utilization of TRICARE Prime enrollees with that of civilian HMO enrollees. Outpatient utilization is measured as the number of encounters because the civilian-sector data do not contain a measure of RVUs.

- The total TRICARE Prime outpatient utilization rate (direct and purchased care utilization combined) increased by 11 percent from 7.4 encounters per enrollee in FY 2003 to 8.2 in FY 2005.
- The direct care outpatient utilization rate for Prime enrollees declined by 4 percent from FY 2003 to FY 2005. During the same period, the purchased care outpatient utilization rate increased by 51 percent. The sharp increase in the purchased care utilization rate is partially due to the "squeeze-out" of non-active-duty beneficiaries from MTFs by increased numbers of mobilized Guard/Reserve personnel.
- The civilian outpatient utilization rate increased from FY 2003 to FY 2005 by 10 percent—about the same as under TRICARE.
- In FY 2005, Prime enrollee outpatient utilization was 33 percent higher than in civilian HMOs.

OUTPATIENT UTILIZATION RATES: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 12/7/2005

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2005 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

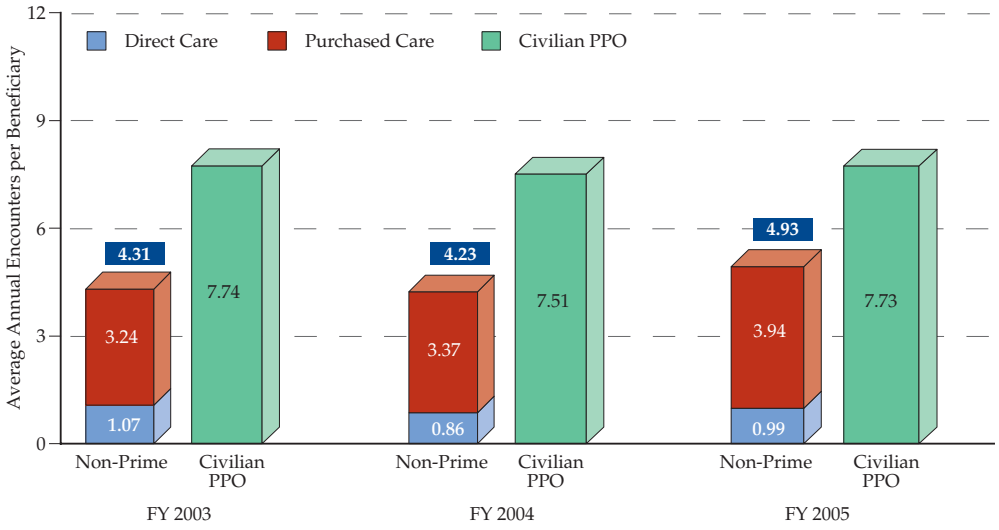
OUTPATIENT UTILIZATION RATES AND COSTS

Non-Enrolled Beneficiaries

This section compares the outpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of civilian participants in Preferred Provider Organization (PPO) plans. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Outpatient utilization is measured as the number of encounters because the civilian-sector data do not contain a measure of RVUs.

- The total TRICARE outpatient utilization rate (direct and purchased care utilization combined) for non-enrolled beneficiaries increased by 14 percent from 4.3 encounters per participant in FY 2003 to 4.9 in FY 2005.
- The direct care outpatient utilization rate for non-enrollees declined by 8 percent from FY 2003 to FY 2005. During the same period, the purchased care outpatient utilization rate increased by 22 percent.
- The civilian outpatient utilization rate remained steady from FY 2003 to FY 2005 while the TRICARE utilization rate increased. Consequently, the disparity between total TRICARE non-Prime outpatient utilization rates and the levels observed in civilian PPOs narrowed in FY 2005. However, the total TRICARE non-Prime outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2005, TRICARE non-Prime outpatient utilization was 29 percent lower than in civilian PPOs.

OUTPATIENT UTILIZATION RATES: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 12/7/2005

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2005 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

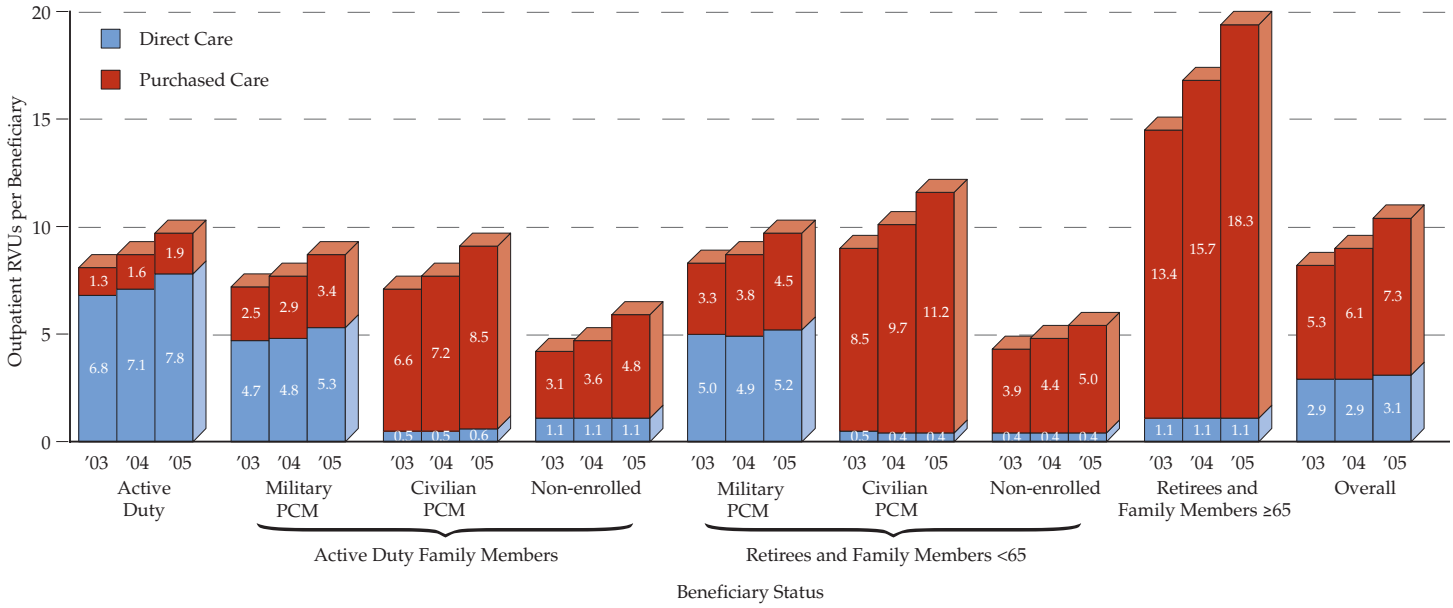
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Outpatient Utilization Rates by Beneficiary Status

When breaking out outpatient utilization by beneficiary group, RVUs per capita should more accurately reflect differences across beneficiary groups than encounters per capita.

- Direct care outpatient utilization increased between FY 2003 and FY 2005 for active duty personnel and their family members with a military PCM. For all other beneficiary groups, direct care outpatient utilization remained about the same.
- Purchased care outpatient utilization increased dramatically for all beneficiary groups, ranging from 26 percent for non-enrolled retirees and family members under age 65 to 53 percent for non-enrolled active duty family members.
- The TFL outpatient utilization rate rose by 17 percent in FY 2004 and again in FY 2005.*

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 12/26/2005

* The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there are a small number of beneficiaries age 65 and older who are not eligible for TFL and an even smaller number of beneficiaries under age 65 who are eligible.

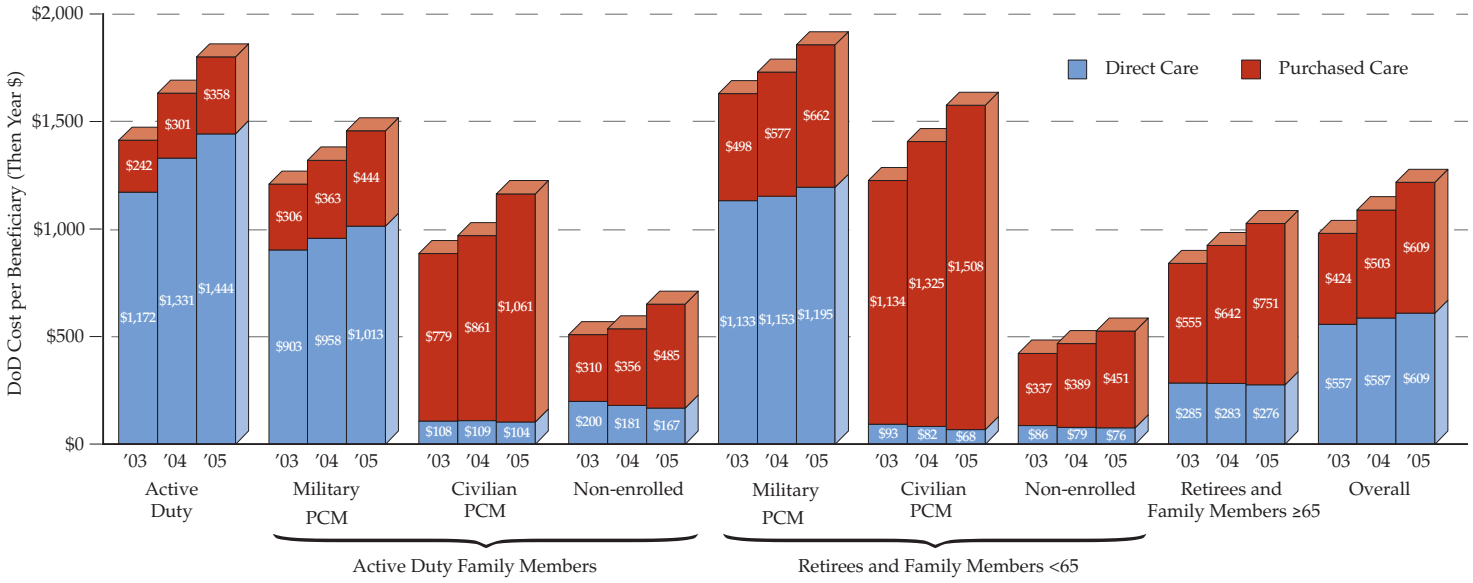
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Outpatient Cost by Beneficiary Status

Corresponding to higher purchased care outpatient utilization rates, DoD medical costs continued to rise.

- DoD purchased care costs increased by 19 percent in FY 2004 and by another 21 percent in FY 2005. The largest increase in FY 2005 was for non-enrolled active duty family members (36 percent). Enrolled active duty family members also experienced a large increase (23 percent).
- The TFL purchased care outpatient cost per beneficiary increased by 17 percent in FY 2005.*

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 12/26/2005

* The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there are a small number of beneficiaries age 65 and older who are not eligible for TFL and an even smaller number of beneficiaries under age 65 who are eligible.

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS

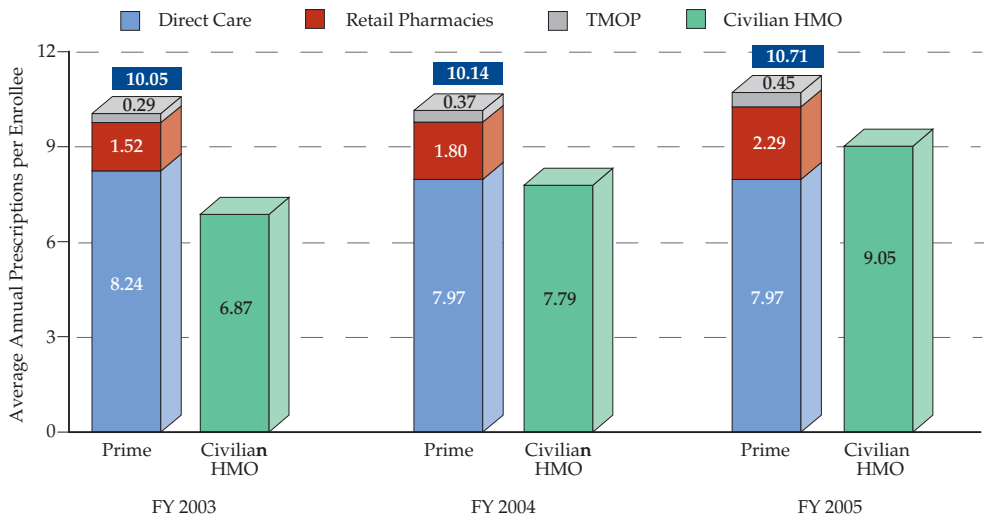
TRICARE Prime Prescription Drug Utilization Rates Compared with Civilian Benchmarks

Prescription utilization is difficult to quantify since prescriptions come in different forms (e.g., liquid or pills), quantities, and dosages. Moreover, TMOP and MTF prescriptions can be filled for up to a 90-day supply, whereas retail prescriptions are usually based on 30-day increments for copay purposes. Prescription counts from all sources (including civilian) were normalized by computing the total days supply for each and dividing by the average days supply for retail prescriptions (28.5 days).

TRICARE Prime Enrollees

- The total prescription utilization rate for TRICARE Prime enrollees rose by 7 percent between FY 2003 and FY 2005. Although the civilian HMO benchmark rate rose by 32 percent during the same period, the TRICARE Prime prescription utilization rate is still 18 percent higher than the civilian HMO rate.
- Prescriptions filled for Prime enrollees at DoD pharmacies declined slightly whereas prescriptions filled at retail pharmacies increased by 50 percent from FY 2003 to FY 2005.
- Enrollee mail order prescription utilization increased by 57 percent from FY 2002 to FY 2004. Nevertheless, TMOP utilization remains small compared to other sources of prescription services.

PRESCRIPTION UTILIZATION RATES: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 12/26/2005

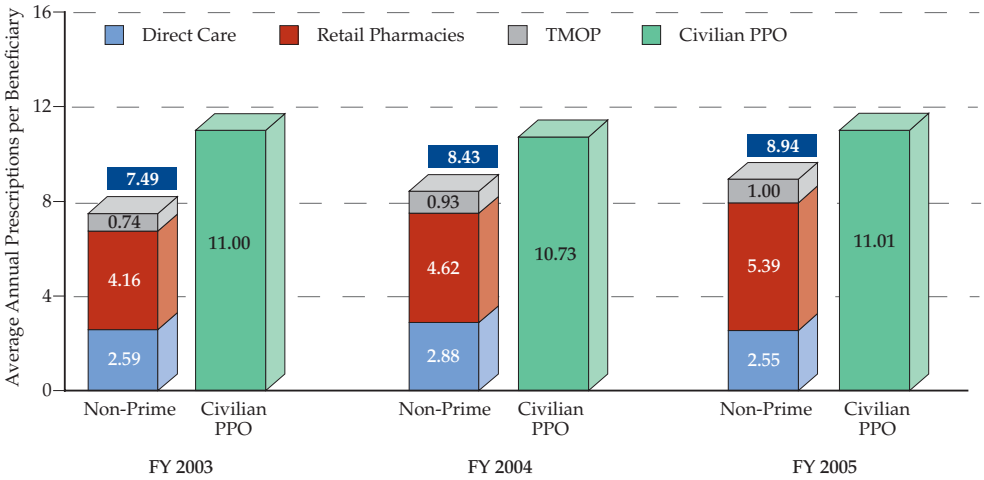
Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2005 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS

Non-Enrolled Beneficiaries

- The total prescription utilization rate for non-enrolled beneficiaries rose by 19 percent between FY 2003 and FY 2005. During the same period, the civilian PPO benchmark rate remained essentially unchanged. Although the gap is narrowing, the TRICARE prescription utilization rate is still 19 percent lower than the civilian PPO rate.
- Prescriptions filled for non-enrolled beneficiaries at DoD pharmacies remained about the same whereas prescriptions filled at retail pharmacies increased by 29 percent from FY 2003 to FY 2005.
- Non-enrollee mail order prescription utilization increased by 36 percent from FY 2003 to FY 2005. Nevertheless, TMOP utilization remains small compared to other sources of prescription services.

PRESCRIPTION UTILIZATION RATES: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 12/7/2005

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2005 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

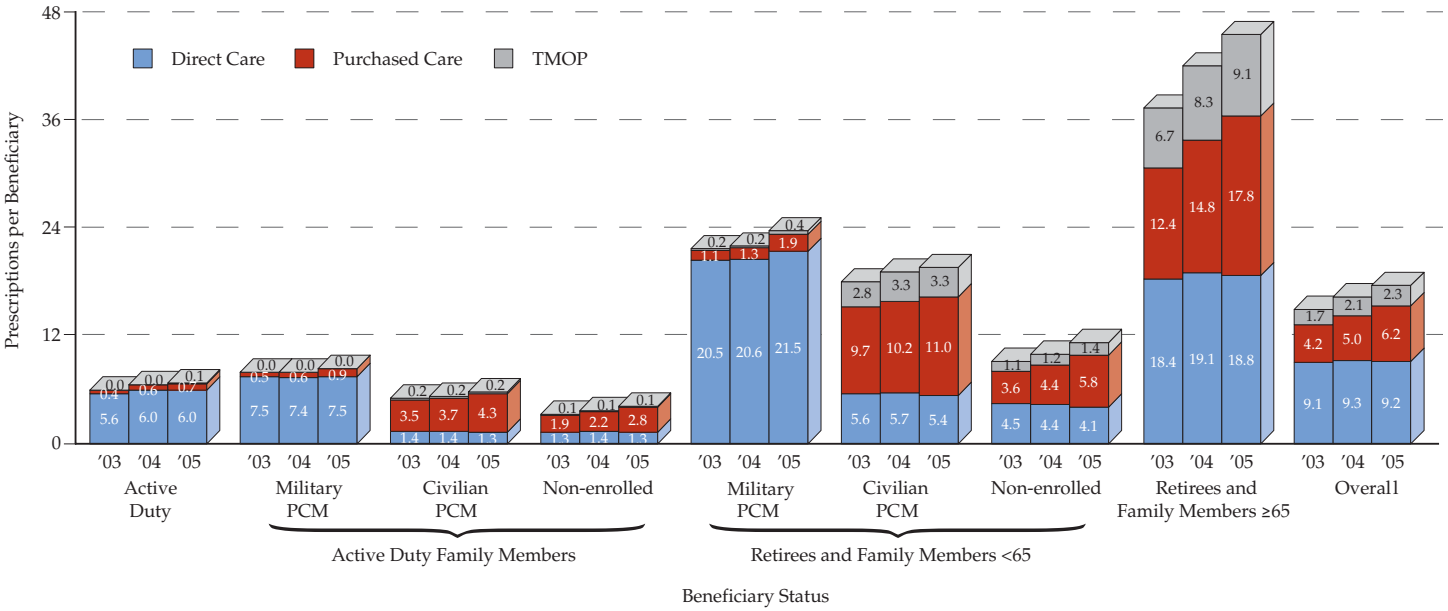
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

TRICARE Prescription Drug Utilization Rates by Beneficiary Status

Prescriptions include all initial and refill prescriptions filled at military pharmacies, retail pharmacies, and the TRICARE Mail Order Pharmacy (TMOP). Prescription counts from these sources were normalized by computing the total days supply for each and dividing by the average days supply for retail prescriptions (28.5 days).

- The total (direct, retail, and TMOP) number of prescriptions per beneficiary increased by 16 percent from FY 2003 to FY 2005, exclusive of the TSRx benefit. Including TSRx, the total number of prescriptions increased by 19 percent.
- Direct care prescription utilization rose almost 5 percent for retirees and family members under age 65 with a military PCM. Utilization remained roughly constant for all other beneficiary groups.
- Average prescription utilization through nonmilitary pharmacies (civilian retail and mail-order) increased for all beneficiary groups but most notably for beneficiaries enrolled with a civilian PCM and non-enrolled retirees and family members. These beneficiaries are most reliant on retail and mail-order pharmacies to fill their prescriptions.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY (BY FISCAL YEAR)



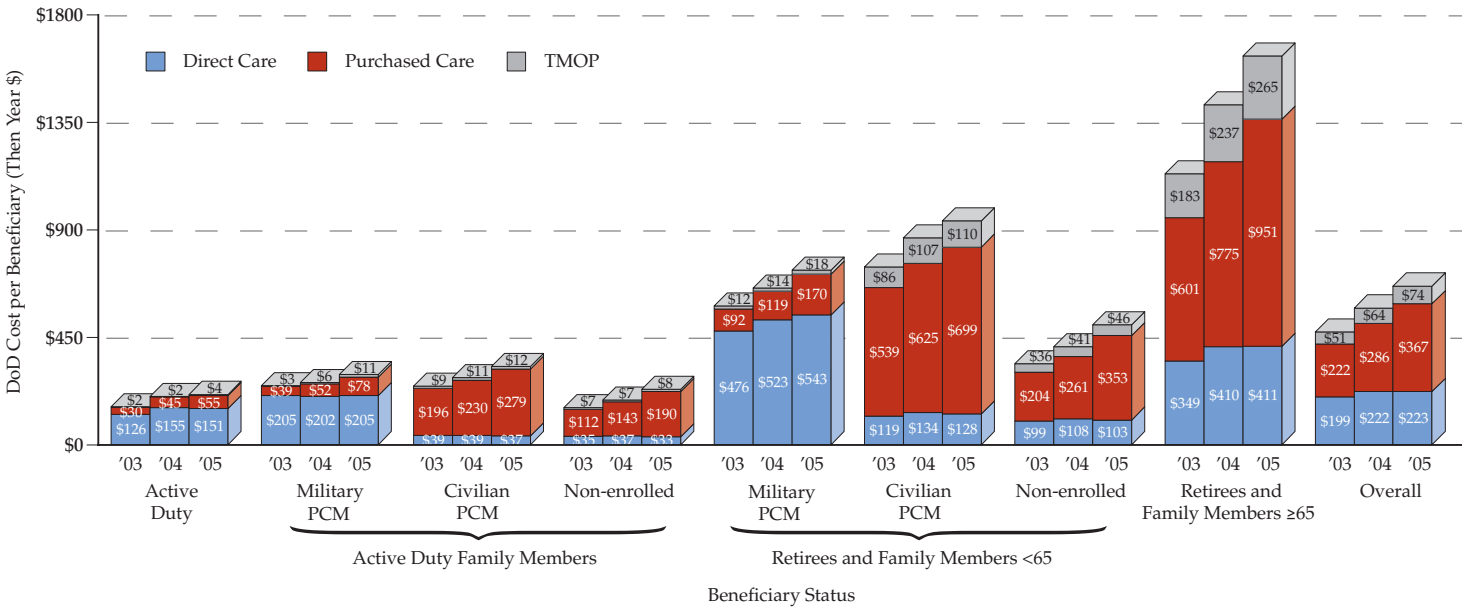
Source: MHS administrative data, 12/26/2005

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

Prescription Drug Cost by Beneficiary Status

- Prescription drug costs continued to rise at the fastest rate of any medical service, increasing by 38 percent exclusive of the TSRx benefit and by 41 percent including TSRx.
- Direct care costs were relatively steady but retail pharmacy costs rose by 73 percent exclusive of TSRx and by 65 percent including TSRx.
- TMOP costs increased as well but at a slower rate than retail pharmacy, increasing by 49 percent exclusive of TSRx and by 46 percent including TSRx.

AVERAGE ANNUAL PRESCRIPTION COSTS PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 12/26/2005

BENEFICIARY FAMILY OUT-OF-POCKET COSTS

Out-of-pocket costs are computed for active duty and retiree families grouped by sponsor age: (1) under 65, and (2) 65 and older (seniors). Costs include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. For beneficiaries less than 65, costs are compared with those of civilian counterparts (i.e., civilian families with the same demographics as the typical MHS family). Civilian counterparts are assumed to be covered by employer-sponsored health insurance. Added drug benefits in April 2001 and the TRICARE for Life (TFL) Program in FY 2002 dramatically reduced costs for MHS seniors. Costs for seniors are compared before and after these benefit changes.

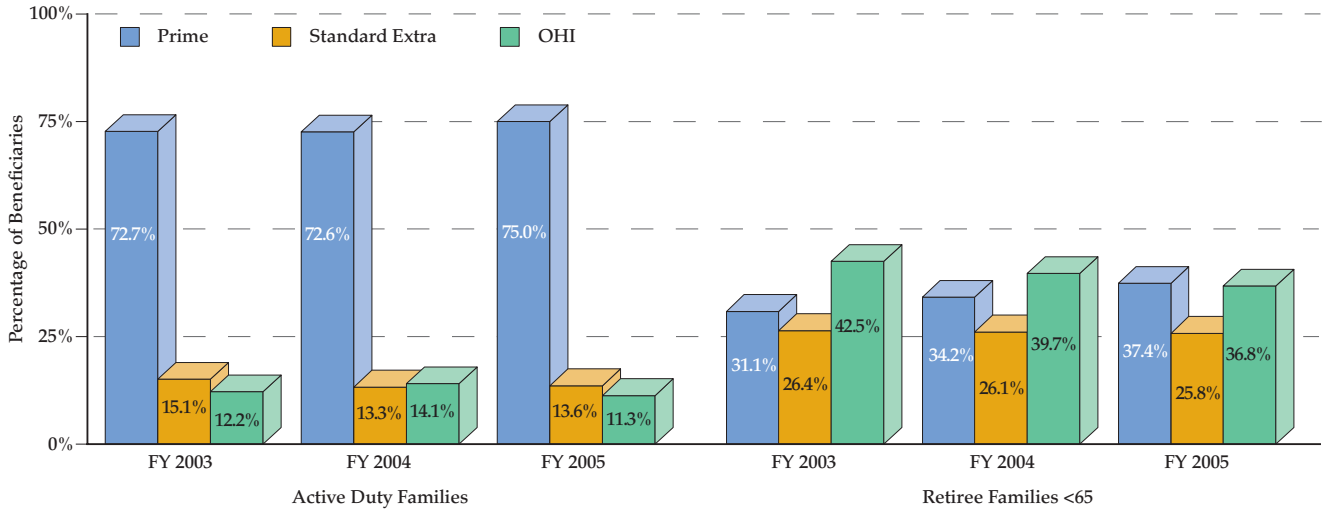
Health Insurance Coverage of MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of: (1) TRICARE Prime, (2) TRICARE Standard/Extra, and (3) other private health insurance (OHI). Most beneficiaries with OHI opt out of TRICARE entirely; some use TRICARE as a second payer.

Beneficiaries are grouped by their primary health plan:

- TRICARE Prime: Family enrolled in TRICARE Prime and no OHI. In FY 2005, 75.0 percent of active duty families and 37.4 percent of retiree families were in this group.
- TRICARE Standard/Extra: Family not enrolled in TRICARE Prime and no OHI. In FY 2005, 13.6 percent of active duty families and 25.8 percent of retiree families were in this group.
- OHI: Family covered by OHI. In FY 2005, 11.3 percent of active duty families and 36.8 percent of retiree families were in this group.

HEALTH INSURANCE PLAN USERS



Source: 2003–2005 administrations of the Health Care Surveys of DoD Beneficiaries (HCSDB)

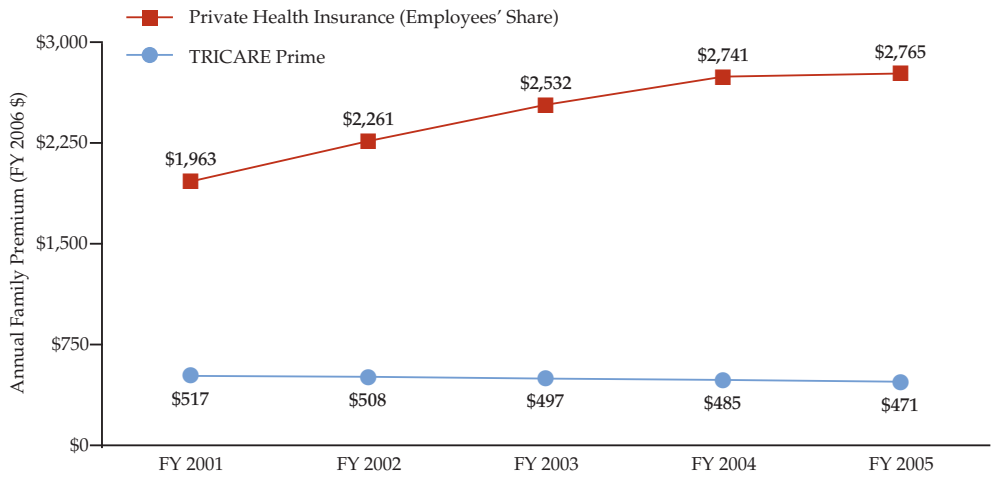
Note: The Prime group includes HCSDB respondents without OHI who are enrolled in Prime based on DEERS. The Standard/Extra beneficiary group includes HCSDB respondents without OHI who are non-enrollees based on DEERS. A small percentage of Prime enrollees are also covered by OHI. These beneficiaries are included in the OHI group.

BENEFICIARY FAMILY OUT-OF-POCKET COSTS *(CONT'D)*

Retirees and Family Members Under Age 65 Returning to the MHS

Since FY 2001, private health insurance premiums have been rising while the TRICARE enrollment fee has remained fixed at $460 per retiree family. In constant FY 2006 dollars, the private health insurance premium increased by $802 from FY 2001 to FY 2005, whereas the TRICARE premium declined by $46 during this period.

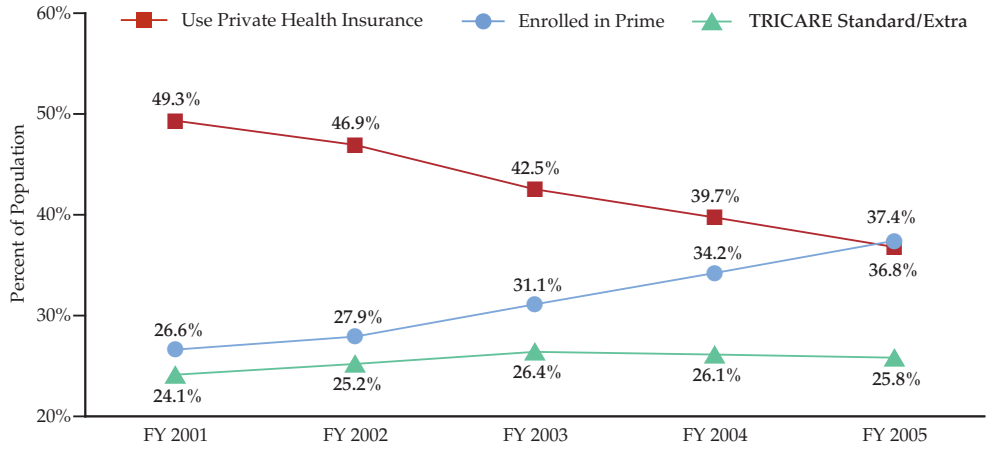
TREND IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT FEE



Sources: Civilian insurance premiums: Kaiser Family Foundation Health Benefits Surveys, 2001–05; Consumer Price Index: Bureau of Labor Statistics

The increasing disparity in premiums induced retirees to drop their private health insurance and enroll in Prime. The trend in insurance coverage translates into an additional 386,000 retirees and family members under age 65 who are using TRICARE instead of private health insurance.

TRENDS IN RETIREE (<65) HEALTH INSURANCE COVERAGE



Sources: DEERS and Retirees Under Age 65 Health Care Beneficiary Surveys of DoD Beneficiaries, 2001–2005

Note: The Prime enrollment rates above exclude those with other health insurance (about 4.5 percent of retirees).

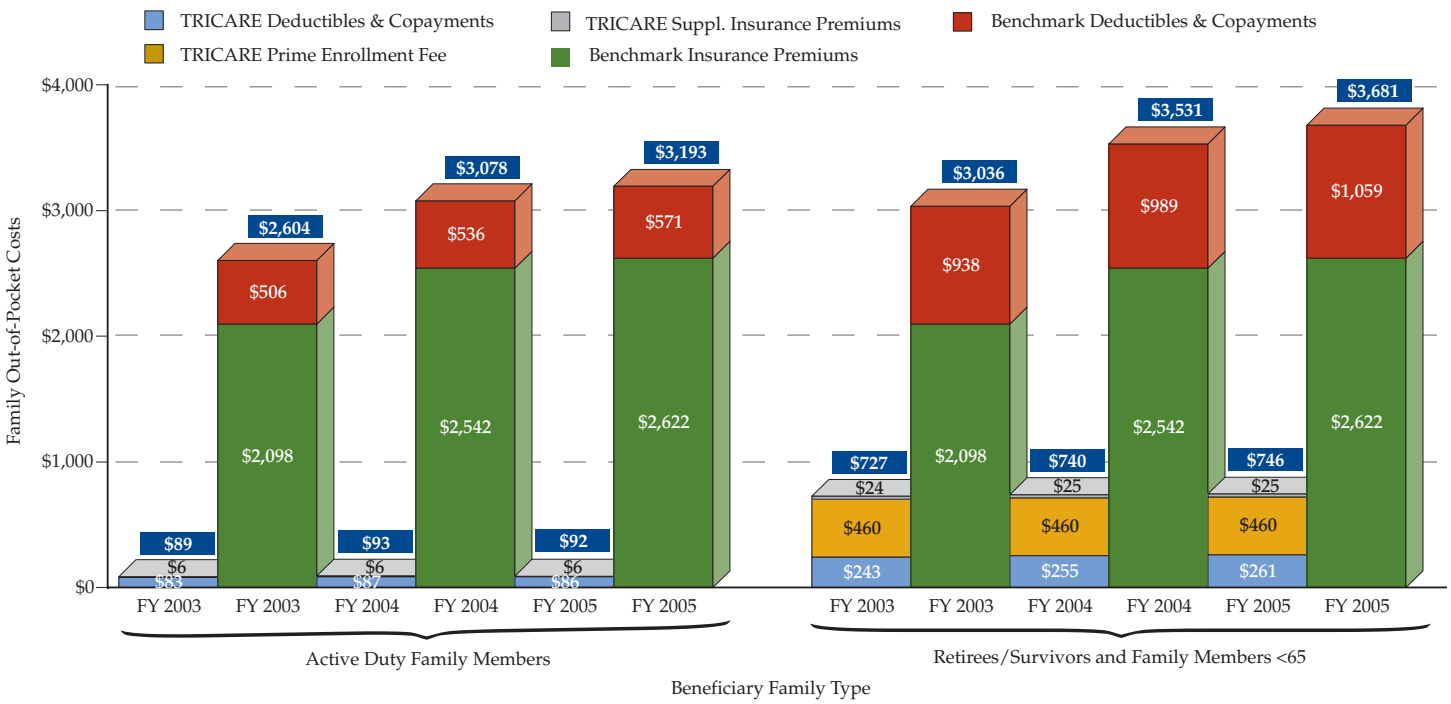
BENEFICIARY FAMILY OUT-OF-POCKET COSTS *(CONT'D)*

Out-of-Pocket Costs for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

In FYs 2003–2005, civilian counterpart families had substantially higher out-of-pocket costs than TRICARE Prime enrollees.

- Civilian HMO counterparts paid more for insurance premiums, deductibles, and copayments.
- In FY 2005, costs for civilian counterparts were:
  - $3,100 more than those incurred by active duty families enrolled in Prime.
  - $2,900 more than those incurred by retiree families enrolled in Prime.

OUT-OF-POCKET COSTS FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS (BY FISCAL YEAR)



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, 2003–05; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Survey projections, 2002–05, adjusted using Consumer Expenditure Surveys; civilian insurance premiums from Kaiser Family Foundation Employer Health Benefits surveys, 2003–05; TRICARE supplemental insurance premiums from *The Army Times*, March Supplement, 2003–05; OHI coverage from Health Care Surveys of DoD Beneficiaries (HCSDB), 2003–05; and TRICARE supplemental insurance coverage from the HCSDB in 2000.

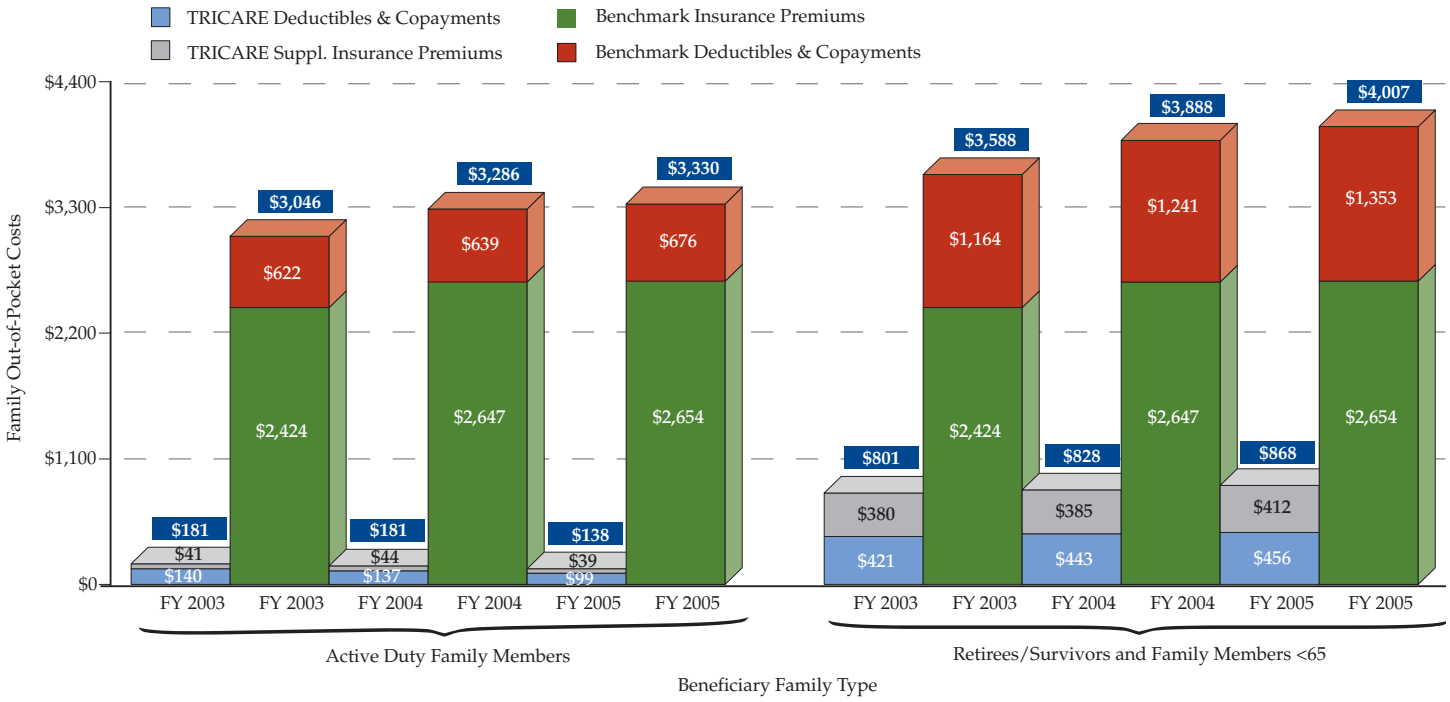
BENEFICIARY FAMILY OUT-OF-POCKET COSTS *(CONT'D)*

Out-of-Pocket Costs for Families Not Enrolled in TRICARE Prime vs. Civilian PPO Counterparts

In FYs 2003–05, civilian counterparts had much higher out-of-pocket costs than TRICARE Standard/Extra users.

- ➤ Civilian PPO counterparts paid more for insurance premiums, deductibles, and copayments.
- ➤ In FY 2005, costs for civilian counterparts were:
  - $3,200 more than those incurred by active duty families who relied on Standard/Extra.
  - $3,100 more than retiree families who relied on Standard/Extra.

OUT-OF-POCKET COSTS FOR FAMILIES WHO RELY ON TRICARE STANDARD/EXTRA VS. CIVILIAN PPO COUNTERPARTS (BY FISCAL YEAR)



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, 2003–05; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Survey projections, 2002–05, adjusted using Consumer Expenditure Surveys; civilian insurance premiums from Kaiser Family Foundation Employer Health Benefits surveys, 2003–05; TRICARE supplemental insurance premiums from *The Army Times*, March Supplement, 2003–05; OHI coverage from Health Care Surveys of DoD Beneficiaries (HCSDB), 2003–05; and TRICARE supplemental insurance coverage from the HCSDB in 2000.

BENEFICIARY FAMILY OUT-OF-POCKET COSTS *(CONT'D)*

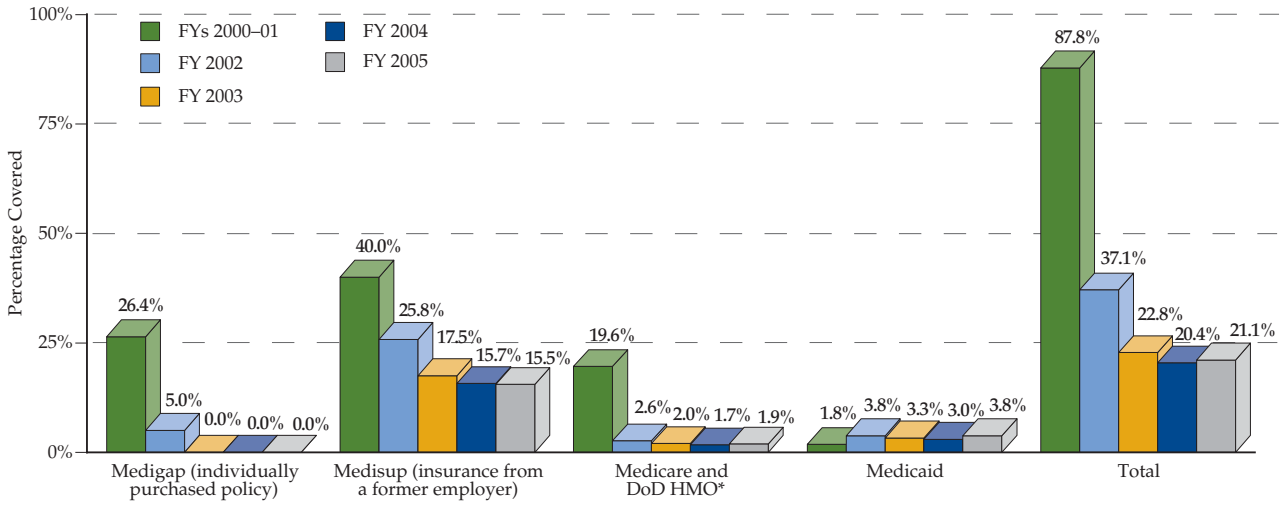
Health Insurance Coverage of MHS Senior Beneficiaries

Medicare provides coverage for medical services and requires substantial deductibles and copayments; it did not begin to cover prescription drugs until 2006. Until FY 2001, most MHS seniors purchased some type of Medicare Supplemental insurance. A small number were active employees with employer-sponsored insurance (OHI) or were covered by Medicaid. Out-of-pocket costs include deductibles/copayments and premiums for Medicare Part B, supplementary insurance, and OHI.

In April 2001, DoD expanded drug benefits for seniors and on October 1, 2001, implemented the TFL program, which provides free Medicare supplemental insurance. Because of these programs, most MHS seniors dropped their supplemental insurance. According to the Health Care Surveys of DoD Beneficiaries in 2000–2005:

- Before TFL (FY 2000-01), 87.8 percent of MHS seniors had some type of Medicare supplemental insurance or were covered by Medicaid.
- After TFL, the percentage of MHS seniors with supplemental insurance or Medicaid fell sharply to 37.1 percent in FY 2002 and to 22.8 percent in FY 2003. The percentage has remained slightly below that level since then.

MEDICARE SUPPLEMENTAL INSURANCE COVERAGE OF MHS SENIORS (PERCENT)



Source: 2001–2005 administrations of the Health Care Surveys of DoD Beneficiaries

* DoD HMOs include TRICARE Senior Prime in FY 2001 and the Uniformed Services Family Health Plan.

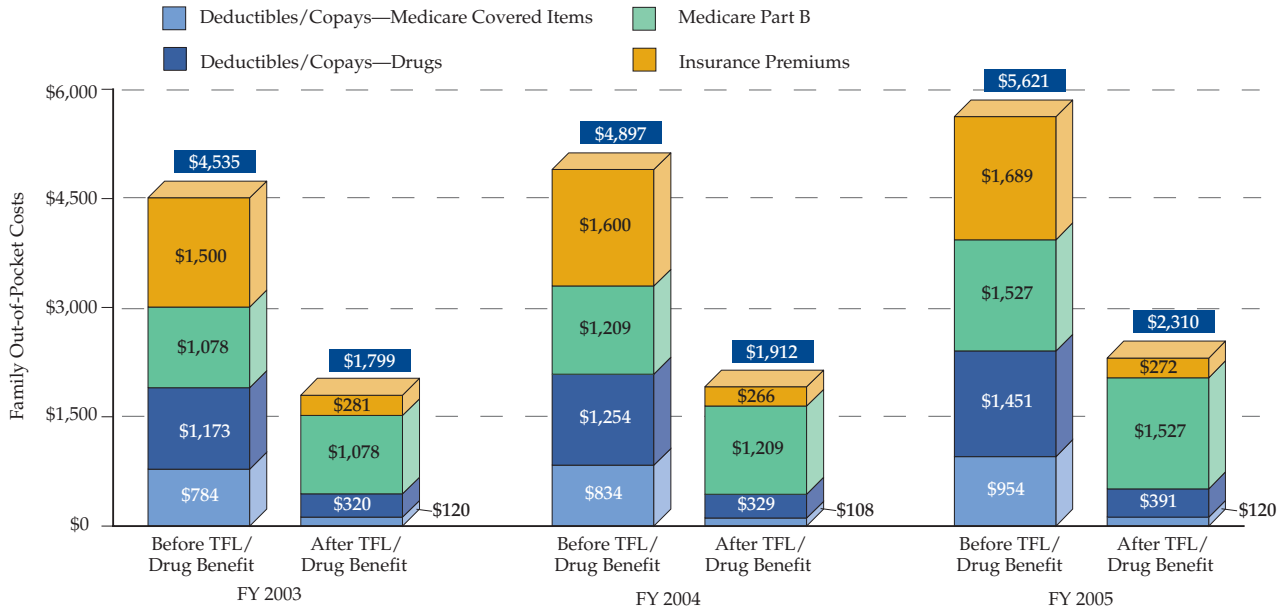
BENEFICIARY FAMILY OUT-OF-POCKET COSTS *(CONT'D)*

Out-of-Pockets Costs for MHS Senior Families vs. Civilian Counterparts

TFL and added drug benefits have enabled MHS seniors to reduce their expenses for supplemental insurance, deductibles, and copayments.

- MHS senior families saw their out-of-pocket expenses reduced by about 60 percent in FYs 2003–2005.
- In FY 2005, MHS senior families saved $3,300 as a result of TFL.

OUT-OF-POCKET COSTS OF MHS SENIOR FAMILIES VS. CIVILIAN COUNTERPARTS (BY FISCAL YEAR)



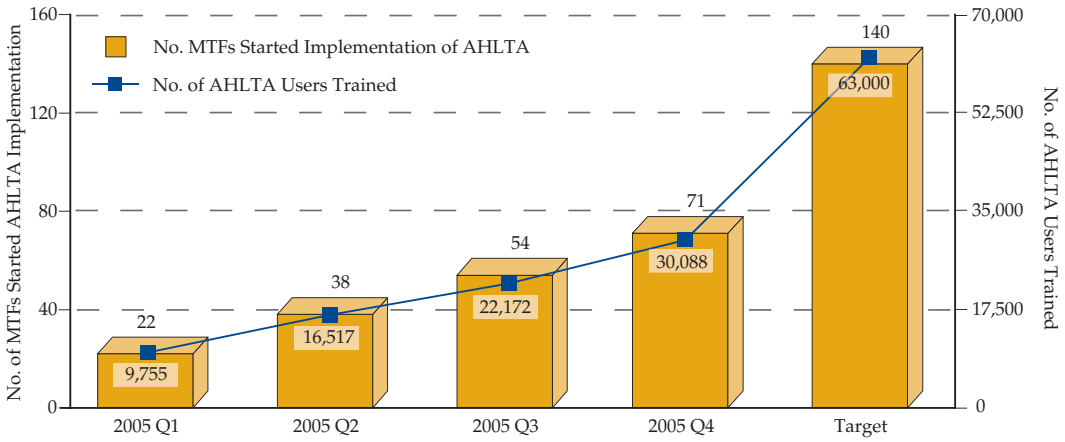
Sources: DoD beneficiary expenditures from MHS administrative data; civilian expenditures from Medical Expenditure Panel Survey projections, 2003–05, adjusted using Consumer Expenditure Surveys; civilian insurance premiums from Kaiser Family Foundation Employer Health Benefits surveys, 2003–05; TRICARE supplemental insurance premiums from The Army Times, March Supplement, 2003–2005; OHI and Medicare supplemental insurance coverage from Health Care Surveys of DoD Beneficiaries, 2003–05.

ARMED FORCES HEALTH LONGITUDINAL TECHNOLOGY APPLICATION

On November 21, 2005, the Department of Defense launched AHLTA, the largest electronic health record in the nation, serving 9.2 million MHS beneficiaries. When fully deployed to 140 planned Medical Treatment Facilities in 11 time zones around the globe in December 2006, it will provide a centralized repository of beneficiary health information for use by approximately 63,000 care providers throughout the MHS.

AHLTA marks a new era in health care for TRICARE beneficiaries and stands as a significant development in the electronic health record. AHLTA's capabilities will ultimately replace legacy systems, and replace or upgrade the inpatient system solution known as the Clinical Information System (CIS). The robust, standards-based interoperability provided by AHLTA is designed to allow seamless connectivity to deployed forces, sustaining the MHS and the Veterans Administration.

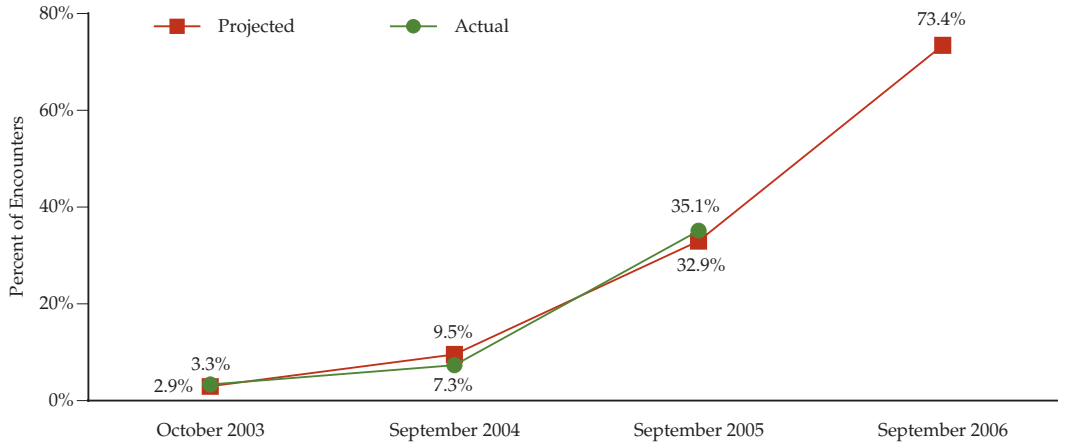
MHS ENTERPRISE-WIDE IMPLEMENTATION OF THE AHLTA



Source: Clinical Information Technical Program Office, December 5, 2005

➤ Key metrics for monitoring the successful deployment of AHLTA focus on both the number of MTFs implementing AHLTA, as well as the training of staff trained on the system. By the end of the fourth quarter, FY 2005, over 30,000 were trained and 71 MTFs implemented AHLTA, or about 50 percent of the targeted 140 MTFs and 63,000 personnel targeted for December 2006.

PERCENTAGE OF PATIENT ENCOUNTERS IN AHLTA (ENTERPRISE-WIDE)



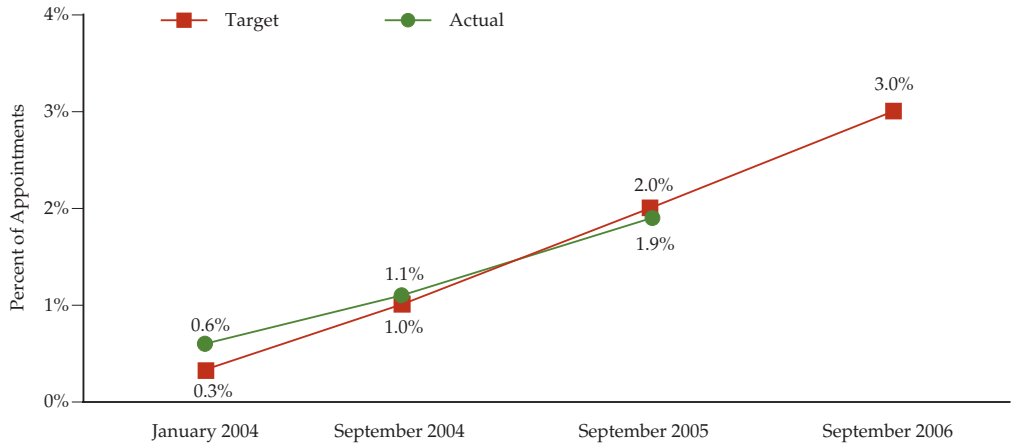
Source: MHS Balanced Scorecard Instrument Panel, October 2005

➤ Another metric used to monitor the maturation of AHLTA focuses on the application of the capability for patient access with respect to recording patient encounters in the new system which feeds into the overall electronic health record. The following chart shows the MHS is on line for recoding patient encounters in AHLTA meeting its target for the end of FY 2005 (35.3 actual relative to a target of 32.9 percent), and is almost halfway towards meeting the end of FY 2006 target of 73 percent.

PERCENTAGE OF MONTHLY APPOINTMENTS MADE THROUGH TRICARE ONLINE

TRICARE Online is the DoD Internet portal designed to provide MHS beneficiaries interactive health care services and information at military treatment facilities. TRICARE Online (TOL) was designed to meet DoD beneficiary needs for greater access and convenience in scheduling appointments, keeping a personal health journal and gathering information on medical and pharmaceutical care. The chart below shows that the MHS has exceeded preliminary targets of monthly appointments made through TOL through September 2004 (end of FY 2004), but did not reach the FY 2005 target of 2 percent.

PERCENTAGE OF MONTHLY APPOINTMENTS MADE THROUGH TRICARE ONLINE



Source: MHS Balanced Scorecard Instrument Panel, October 2005

Education

In 2004, a public use analytic dataset, or Public Use File (PUF) of the 2002 DoD Survey of Health Related Behaviors among Military Personnel, was made available, after a review and approval process, to DoD and the general public involved in health promotion and preventive medicine research activities. To protect the confidentiality of respondents, the 2002 PUF was created using the latest technology available. The technology, called MASSCSM, is the same technology used to produce public use datasets for surveys administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services. MASSCSM uses sophisticated statistical methodology to prevent the intentional discovery of a respondent's identity while still maintaining a dataset's full analytic potential. In FY 2005, over 20 requests for the PUF were received from DoD graduate students, Service representatives, and other national health care researchers in support health services research involving thesis completion, poster presentations, and journal publications. The PUF provided a wealth of information to DoD and other health care researchers without any additional costs to the MHS.

OASD(HA)/TMA CENTER FOR HEALTH CARE MANAGEMENT STUDIES

The Center for Health Care Management Studies (CHCMS) within the Health Program Analysis and Evaluation (TMA/HPA&E) Directorate was established in May 2003* to promote and protect the health of MHS beneficiaries. The Center is organized to achieve this mission by designing and directing health care studies that develop for MHS leadership the information required to make evidence-based decisions on outcomes, quality, access, cost, and use of health care services. Studies complement the ASD(HA) business plan with research along six broad domains of interest:

- **Health Services:** How can we change the way services are delivered to optimize health and resources?
- **Finance and Insurance:** What can we discover about the current coverage of beneficiaries and preference associated with their use of MHS benefits? Are national trends affecting MHS utilization?
- **Health Plan Performance:** How can we best measure plan performance in ways that provide valid and reliable estimates of intra- and inter-plan performance?
- **Information Technology:** What developments are in place or envisioned that improve health care forecasting and managerial feedback?
- **Health Outcomes:** What are the best means of measuring the health outcomes for MHS care? Are there gaps in performance by beneficiary group, DRG, locale?
- **Force Readiness:** What services can be wrapped around the force, and in what way that promote the delivery of high quality, effective health care services to forces at any stage of deployment? How can the MHS best organize to anticipate conflicting health system demands?

Recent developmental studies have helped provide a better understanding of the complex determinants of health care quality and health system improvement.

Overall Use of TRICARE Benefit Information

This study was a follow-on to an analysis in FY 2004 undertaken to help TMA develop more effective communication strategies for meeting beneficiary needs for health plan information. The FY 2004 study identified beneficiaries needs for TRICARE information, their usual sources of benefit information, and how they prefer to stay informed about TRICARE. These preliminary findings indicated a high level of awareness of TRICARE benefit information, with almost three-quarters of TRICARE users indicating awareness of at least one principal source of TRICARE information. More than three of every four (78.7 percent) users of TRICARE services who look for information about TRICARE are satisfied or very satisfied with available information. An important finding of this study is that there are significant differences across beneficiary groups of their preferred method of getting TRICARE information. Active duty personnel are more likely to prefer getting information face to face; Medicare eligible beneficiaries prefer mail; and spouses of active duty and activated Reservists prefer using the telephone to get answers.

The charts below examine the extent to which beneficiaries use five sources of TRICARE benefits information, as reported in a telephone survey.

These sources are:

- TRICARE written materials such as letters, pamphlets, handbooks or brochures.
- TRICARE beneficiary advisors at your local hospital, clinic or TRICARE service center.
- Medical staff, including doctors, nurses or technicians at your local hospital or clinic.
- Customer service agents at your regional TRICARE toll-free call center.
- TRICARE Web sites.

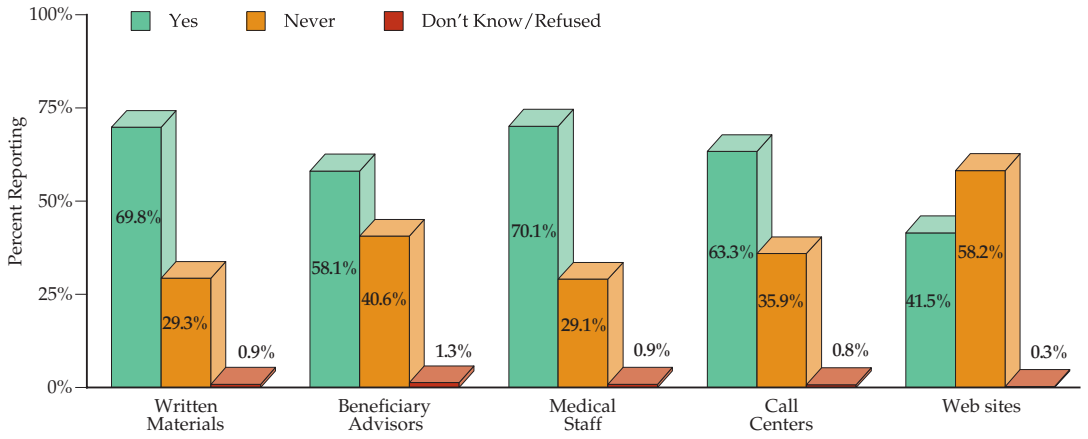
* OASD(HA) Memorandum, May 29, 2004

OASD(HA)/TMA CENTER FOR HEALTH CARE MANAGEMENT STUDIES

Findings:

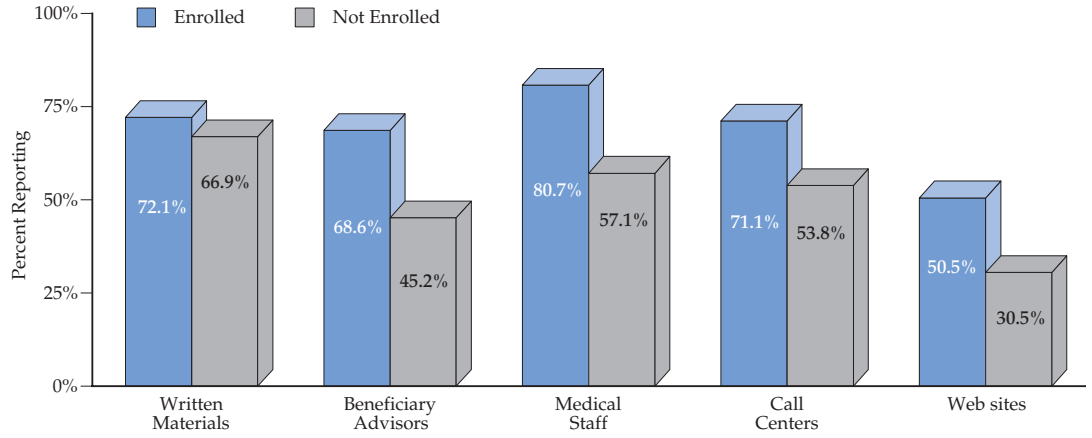
- Medical staff (doctors, nurses, technicians) most frequently cited source of benefit info—staff education is important.
- Web sources of information are the way of the future, but there remains a continuing need for other methods.
  - Most retirees over age 65 (52 percent) have never used the Web (for any reason).
- Over one third (36 percent) of TRICARE users have never used the Call Centers:
  - Most say they don't have a need (62 percent).
  - One-fifth are not aware of service (20 percent).
  - A small percentage (6 percent) either didn't have number or don't know where to call.
- The most frequent need for calls are for help in claims, appointments, finding a provider, and for general benefits information.
- Actually "Getting through" is the most cited negative satisfaction component, while issues related to claims are the most negative call reason.
- Lack of courtesy is not a commonly cited issue.

SOURCES OF TRICARE BENEFIT INFORMATION



Source: Center for Healthcare Management Studies and OASD(HA)/TMA- Communications & Customer Services

UTILIZATION OF INFORMATION SOURCES



Source: Center for Healthcare Management Studies and OASD(HA)/TMA- Communications & Customer Services

OASD(HA)/TMA CENTER FOR HEALTH CARE MANAGEMENT STUDIES

The Center also conducts analyses of topics that are relevant to both the MHS and national health services and healthy policy audience. A number of studies have been favorably considered for publication in peer-reviewed health care and health policy journals. The following studies were published in 2005 for their relevance to important and pressing health care challenges both inside and outside of the MHS:

1. Harriott, E.M.; Williams, T.V.; Peterson, M.R.
   Childbearing in U.S. military hospitals: dimensions of care affecting women's perceptions of quality and satisfaction. *Birth*, 2005 March, 32(1): 4–10.

2. Kress, A.M.; Hartzell, M.C.; Peterson, M.R.
   Burden of disease associated with overweight and obesity among U.S. military retirees and their dependents, aged 38–64, 2003. *Preventive Medicine*, 2005 July; 41(1): 63–9.

3. Linton, A.; Peterson, M.R.; Williams, T.V.
   Clinical case mix adjustment of Cesarean delivery rates in U.S. military hospitals, 2002. *Clinical Obstetrics and Gynecology*, 2005 March; 105(3): 598–606.

4. Masterson, B.J.; Mihara, T.G.; Miller, G.; Randolph, S.C.; Forkner, M.E.; Crouter, A.L.
   Using models and data to support optimization of the Military Health System: a case study in an intensive care unit. *Health Care Management Science*, 2004 August; 7(3): 217–24.

ARMY NATIONAL GUARD
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GENERAL METHOD

In this year's report, we compared TRICARE's effects on the access to and quality of health care received by the DoD population with the general U.S. population covered by commercial health plans (i.e., excluding Medicare and Medicaid). We made the comparisons using health care system performance metrics from the national Consumer Assessment of Health Plans Survey (CAHPS). In addition, we examined several issues unique to the DoD population, such as intention to enroll and disenroll from TRICARE Prime, for which there is no external benchmark.

We also compared the effects of TRICARE on beneficiary utilization of inpatient, outpatient, and prescription services, as well as on MHS and beneficiary costs. Wherever feasible, we contrasted various TRICARE utilization and cost measures with comparable civilian sector benchmarks derived from the MarketScan® Commercial Claims and Encounters (CCAE) database provided by The MEDSTAT Group, Inc.

We made adjustments to both the CAHPS and CCAE benchmark data to account for differences in demographics between the military and civilian beneficiary populations. In most instances, we used the most recent three years of data (FY 2003 to FY 2005) to gauge trends in access, quality, utilization, and costs.

Notes on methodology:

- Numbers in charts or text may not add to the expressed totals due to rounding.
- Unless otherwise indicated, all years referenced are federal fiscal years (1 October to 30 September).
- Unless otherwise indicated, all dollar amounts are expressed in then-year dollars for the fiscal year represented.
- All photographs in this document were obtained from Internet Web sites accessible by the public. These photos have not been tampered with other than to mask the individual's name.
- Differences between MHS survey-based data and the civilian benchmark, or MHS over time, were considered significant at less than or equal to 0.05.
- All workload and costs are estimated to completion based on separate factors for direct and purchased care. Because the purchased care completion factors were developed from historical claims experience, the completion factors for FY 2005 may be inaccurate if the claims experience under the new generation of contracts differs from the old.
- Data were current as of:
  - HCSDB/CAHPS—12/22/05
  - MHS Workload/Costs—12/26/05
- TMA regularly updates its encounters and claims databases as more current data become available. It also periodically "retrofits" its databases as errors are discovered. The updates and retrofits can sometimes have significant impacts on the results reported in this and previous documents if they occur after the data collection cutoff date. The reader should keep this in mind when comparing this year's results with those from previous reports.

DATA SOURCES

Health Care Survey of DoD Beneficiaries (HCSDB)

To fulfill 1993 National Defense Authorization Act requirements, the HCSDB was developed by TMA. Conducted continuously since 1995, the HCSDB was designed to provide a comprehensive look at beneficiary opinions about their Department of Defense (DoD) health care benefits. (Source: TMA Web site: *www.tricare.osd.mil/survey/hcsurvey/*).

The HCSDB is composed of two distinct surveys, the Adult and the Child HCSDB, and both are conducted as large-scale mail surveys. The Adult HCSDB is conducted once per calendar quarter every January, April, July, and October to a sample of all DoD beneficiaries

DATA SOURCES *(CONT'D)*

worldwide. The Child HCSDB is conducted annually in the third quarter in July to a sample of DoD beneficiaries.

Both surveys provide information on a wide range of health care issues such as the beneficiaries' ease of access to health care and preventative care services. In addition, the surveys provide information on beneficiaries' satisfaction with their doctors, health care, health plan and the health care staff's communication and customer service efforts.

HCSDB questions on satisfaction with and access to health care have been closely modeled on the CAHPS program. CAHPS is a standardized survey questionnaire used by civilian health care organizations to monitor various aspects of access to and satisfaction with health care.

CAHPS is a nationally recognized set of standardized questions and reporting formats that has been used to collect and report meaningful, reliable information about the health care experiences of consumers. It was developed by a consortium of research institutions and sponsored by the Agency for Health Care Policy and Research. It has been tested in the field and evaluated for validity and reliability. The questions and reporting formats have been tested to ensure that the answers can be compared across plans and demographic groups. Because the HCSDB uses CAHPS questions, TRICARE (DoD's health plan) can be benchmarked to civilian managed care health plans. More information on CAHPS can be obtained at www.ahcpr.gov.

From 1998 to 2003, the HCSDB included questions from CAHPS 2.0. In 2003, CAHPS 3.0 was introduced. This version of CAHPS included changes to the wording of a number of questions. Because MHS decision makers monitor scores based on CAHPS questions to track TRICARE performance over time, a strategy for comparing scores before and after the transition was followed. First, the revised CAHPS 3.0 questions were not incorporated into the HCSDB until 2004, when resulting civilian benchmark data reflecting the new questions would be available. Then, responses to CAHPS questions in the DoD population were compared and contrasted with responses in the civilian benchmarking database. This assessment was done in order to discover any large, unexplained changes in responses after the 3.0 version was implemented and to see if the changes affected both populations similarly. As a result of these analyses, three questions, whose wording changed from 2.0 to 3.0, were found to have disproportional response changes between the DoD and civilian populations. These questions (and their pages in this report), are as follows:

- Waiting in the Doctor's Office (54)
- Finding a Personal Doctor (56)
- Paperwork, reflected in the composite measure, Customer Service (58)

Finally, models were developed and applied to these questions' responses that adjusted for differences between the two populations and allowed a more accurate comparison. This method also allowed for a more accurate trending of the responses pre- and post-CAHPS 3.0.

HCSDB results are not adjusted for possible changes in the population's demographics (e.g., gender, age, etc.) between years. Tests of significance using the benchmark data assume that the benchmark is measured without error. The normal approximation is used. Differences between the MHS and the civilian benchmark were considered significant at p less than or equal to .05. The significance test for a change between years is based on the change in the MHS estimate minus the change in the benchmark, which is adjusted for age and health status to match the MHS. Within the context of the HCSDB, Prime enrollees are defined as those enrolled at least six months.

Relative Weighted Products (RWPs) and Relative Value Units (RVUs) are measures derived from inpatient and outpatient workload, respectively, to standardize differences in resource use as a means to better compare workload among institutions. RWPs, which are based on DRG weights and specific information on each hospital record, are calculated for all inpatient

DATA SOURCES *(CONT'D)*

cases in MTFs and purchased care hospitals. They reflect the relative resource intensity of a given stay, with adjustments made for very short or very long lengths of stay and for transfer status. A comparison of total RWPs across institutions therefore reflects not only differences in the number of dispositions but in the case-mix intensity of the inpatient services performed there as well. "Relative value units" (RVUs) are used by Medicare and other third-party payers to determine the comparative worth of physician services based on the amount of resources involved in furnishing each service. The MHS uses a modified version to reflect the relative costliness of the provider effort for a particular procedure or service.

Access and Quality

Measures of MHS access and quality were derived from the 2003, 2004, and 2005 administrations of the HCSDB. The comparable civilian-sector benchmarks came from the National CAHPS Benchmarking Database (NCBD) for the same time period. The NCBD is funded by the U.S. Agency for Healthcare Research and Quality and is administered by Westat, Inc.

With respect to calculating the Preventable Admissions rates, both direct care and CHAMPUS workload were included in the rates. Admissions for patients under 18 years of age were excluded from the data. Each admission was weighted by its Relative Weighted Product (RWP), a prospective measure of the relative costliness of an admission. Rates were computed by dividing the total number of dispositions/admissions (direct care and CHAMPUS) by the appropriate population. The results were then multiplied by 1,000 to compute an admission rate per 1,000 beneficiaries.

Utilization and Costs

Data on utilization and MHS and beneficiary costs came from several sources. We obtained the health care experience of eligible beneficiaries by aggregating Standard Inpatient Data Records (SIDRs—MTF hospitalization records); Standard Ambulatory Data Records (SADRs—MTF outpatient records); Health Care Service Records (HCSRs—purchased care claims information for the previous generation of contracts); TRICARE Encounter Data (TEDs— purchased care claims information for the new generation of contracts) for inpatient, outpatient, and prescription services; and TRICARE Mail Order Pharmacy (TMOP) claims within each beneficiary category. Costs recorded on HCSRs and TEDs were broken out by source of payment (DoD, beneficiary, or private insurer). Although the SIDR and SADR data indicate the enrollment status of beneficiaries, the DEERS enrollment file is considered to be more reliable. We therefore classified MTF discharges as Prime or space-available by matching the discharge dates to the DEERS enrollment file. Final data pulls used for this report were completed between the end of December and early January 2006 as referenced above.

The CCAE database contains the health care experience of several million individuals (annually) covered under a variety of health plans, including preferred provider organizations, point-of-service plans, health maintenance organizations, and indemnity plans. The database links inpatient services and admissions, outpatient claims and encounters and, for most covered lives, outpatient pharmaceutical drug data and individual-level enrollment information. We tasked MEDSTAT to compute quarterly benchmarks for HMOs and PPOs, broken out by several sex/age group combinations. The quarterly breakout, available through the second quarter of FY 2005, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2005 data to completion. The breakouts by sex and age group allowed us to apply DoD-specific population weights to the benchmarks and aggregate them to adjust for differences in the DoD and civilian beneficiary populations. We excluded individuals age 65 and over from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.

AC	Active Component
AD	Active Duty
ADFM	Active Duty Family Member
AHLTA	Armed Forces Longitudinal Technology Application
AMI	Acute Myocardial Infarction
ASD	Assistant Secretary of Defense
BMI	Body Mass Index
BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Health Plans Survey
CCAE	Commercial Claims and Encounters
CCTP	Custodial Care Transition Program
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHCMS	Center for Health Care Management Studies
CIS	Clinical Information System
CMS	Centers for Medicare and Medicaid Services
CONUS	Continental United States
DCIS	Defense Criminal Investigative Services
DEERS	Defense Enrollment Eligibility Reporting System
DHP	Defense Health Program
DLAP	DoD Lifestyle Assessment Program
DoD	Department of Defense
DOJ	Department of Justice
DRG	Diagnosis-Related Group
DTF	Dental Treatment Facility
DVA	Department of Veterans Affairs
ECHO	Extended Care Health Option
EHHC	ECHO Home Health Care
FFS	Fee for Service
FTE	Full Time Equivalent
FY	Fiscal Year
GDP	Gross Domestic Product
GWOT	Global War on Terrorism
HA	Health Affairs
HCSDB	Health Care Survey of DoD Beneficiaries
HCSR	Health Care Service Record
HIPAA	Health Insurance Portability Act
HMO	Health Maintenance Organization
HP	Healthy People
HPA&E	Health Program Analysis and Evaluation
HSA	Hospital Service Area
IG	Inspector General
IM/IT	Information Management/Information Technology
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MERHCF	Medicare-Eligible Retiree Health Care Fund
MHS	Military Health System
MTF	Military Treatment Facility
NAS	Nonavailability Statement
NCBD	National CAHPS Benchmarking Database
NDAA	National Defense Authorization Act
NHE	National Health Expenditures
OASD	Office of the Assistant Secretary of Defense
OCONUS	Outside Continental United States
OHI	Other Health Insurance
O&M	Operations and Maintenance
PCM	Primary Care Manager
PDTS	Pharmacy Data Transaction Service
PI	Program Integrity
PPO	Preferred Provider Organization
PUF	Public Use File
RC	Reserve Component
RVU	Relative Value Unit
RWP	Relative Weighted Product
SADR	Standard Ambulatory Data Record
SAMHSA	Substance Abuse and Mental Health Services Administration
SIDR	Standard Inpatient Data Record
TAO	TRICARE Area Offices
TAMP	Transitional Assistance Management Program
TDP	TRICARE Dental Program
TED	TRICARE Encounter Data
TFL	TRICARE for Life
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TOA	Total Obligational Authority
TOL	TRICARE Online
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TRDP	TRICARE Retiree Dental Program
TRFDP	TRICARE Reserve Family Demonstration Project
TRO	TRICARE Regional Office
TRS	TRICARE Reserve Select
TSRx	TRICARE Senior Pharmacy
TRRx	TRICARE Retail Pharmacy
UCCI	United Concordia Companies Inc.
UMP	Unified Medical Program
VA	Department of Veteran Affairs
WIC	Women, Infants and Children

national oceanic and atmospheric administration ■ army ■ navy ■ air force ■ marine corps ■ public health service ■ coast guard

TRICARE