OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

APR 22 2010

HEALTH AFFAIRS

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

We are pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year (FY) 2010 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for FY 1996, Public Law 104-106.

Our nearly $49 billion FY 2010 Unified Medical Program (UMP) supports the physical and mental health of over 9.5 million beneficiaries worldwide, from theater medical care for deployed active and reserve forces, to the daily health and health care services provided in our Military Treatment Facilities and purchased from the private sector. The UMP has increased 15 percent since FY 2007, commensurate with increases in population served, workload, and medical inflation. Beneficiary satisfaction improved for several measures during this time, while remaining stable for others.

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In doing so, we will employ and assess our efforts around a strategic framework known as the "Quadruple Aim" – readiness of our force, families and communities; improved population health; enhanced experience of patient care; and creating value while responsibly managing health care costs.

Thank you for your continued support of the Military Health System.

Sincerely,

Charles L. Rice, M.D.
President, Uniformed Services University of the Health Sciences
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

APR 22 2010

HEALTH AFFAIRS

The Honorable James H. Webb
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

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Enclosure:
As stated

cc:
The Honorable Lindsey O. Graham
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

APR 22 2010

HEALTH AFFAIRS

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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Enclosure:
As stated

cc:
The Honorable Howard P. "Buck" McKeon
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

APR 22 2010

HEALTH AFFAIRS

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

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cc:
The Honorable Joe Wilson
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
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APR 22 2010

HEALTH AFFAIRS

The Honorable Daniel K. Inouye
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510

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cc:
The Honorable Thad Cochran
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

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Ranking Member

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WASHINGTON, DC 20301-1200

APR 22 2010

HEALTH AFFAIRS

The Honorable Norm Dicks
Vice Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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Enclosure:
As stated

cc:
The Honorable C.W. Bill Young
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

APR 22 2010

HEALTH AFFAIRS

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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Performing the Duties of the
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Enclosure:
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

APR 22 2010

HEALTH AFFAIRS

The Honorable Joseph R. Biden
President of the Senate
Washington, DC 20510

Dear Mr. President:

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Enclosure:
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OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

APR 22 2010

HEALTH AFFAIRS

The Honorable Nancy Pelosi
Speaker of the House of Representatives
U.S. House of Representatives
Washington, DC 20515

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(Health Affairs)

Enclosure:
As stated

Keeping Warfighters Ready. For Life.

Evaluation of the TRICARE Program

Fiscal Year 2010 Report to Congress

TRICARE

Evaluation of the TRICARE Program

To enhance DoD 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.

FEBRUARY 28, 2010

The **Evaluation of the TRICARE Program Fiscal Year 2010 Report to Congress** is provided by:

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Richard R. Frye, Ph.D.

Front cover photos courtesy of U.S. Army, www.navy.mil, www.usmc.mil and www.af.mil/photos.

Front cover photos descriptions, from left to right:

A – A USAF airman, deployed to the Zabul PRT, is working with local health officials in Afghanistan, to combat the causes of the high infant mortality rate. She is wearing the scarf in an effort to honor the customs of this region of the country.

B – Navy Medical Corps Expeditionary Medical Facility OIC examines 3rd Army/U.S. Area Central Command team members stationed at Life Support Area, Kuwait.

C – Soldiers preparing to walk to the remote village of Balik during a patrol in the rugged Titin Valley in the Nuristan province of Afghanistan.

D – A USAF airman embraces his newborn, whose birth he missed while deployed to Joint Base Balad, Iraq.

E – Joint Task Force-129 pararescuemen rescue a hurricane victim Sept. 13 in Galveston, TX.

F – An F-15E Strike Eagle from Bagram Air Base deploys flares over Afghanistan.

G – A U.S. soldier hands an Afghan girl a bottle of water during Operation Champion Sword in Khost province, Afghanistan.

H – Soldiers in the Wounded Warrior program set the pace in ladder drills, during the Agility with Prosthesis session, at the Military Amputee Advanced Skills Training High Performance workshop, Brooke Army Medical Center and the Center for the Intrepid.

I – Chief Hospital Corpsman visits with an Air Force veteran at Chicago's Westside VA Hospital during Chicago CPO Pride Day.

J – The USS Dwight D. Eisenhower (CVN 69) Carrier Strike Group operating in the U.S. 6th Fleet area of responsibility after a scheduled five-month deployment in the U.S. 5th Fleet area of responsibility supporting OEF and maritime security operations.

K – A Marine gives a stuffed animal to a boy while on patrol in Rutbah, Iraq.

L – Members of the Veterans of Foreign Wars attend a memorial ceremony April 6 at the National Memorial Cemetery of the Pacific commemorating the 67th Philippine national holiday "Araw ng Kagitingan" or "Day of Valor."

A MESSAGE ON BEHALF OF THE ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

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A MESSAGE FROM CHARLES L. RICE, MD, PRESIDENT, UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES, PERFORMING THE DUTIES OF THE ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

It is with profound pride that I am reporting to the Congress our annual assessment of the effectiveness of TRICARE, the Department's premier health care benefits program. In addition to responding to Section 717 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 1996 (Public Law 104-106), this report allows me to evaluate many of the measures we routinely use to assess the performance of the entire Military Health System (MHS) in terms of cost, quality, and access. These measures help identify the extent to which we are meeting our strategic vision, strategy, and goals covering the TRICARE health benefits program and related aspects of our operational and humanitarian mission.

As Secretary Gates has said, "At the heart of the all-volunteer force is a contract between the United States of America and the men and women who serve … A contract that is … legal, social, and sacred. When young Americans step forward of their own free will to serve," he said, "they do so with the expectation that they, and their families, will be properly taken care of …"

We proudly serve more than 9.5 million eligible beneficiaries through a nearly $49 billion annual program, employing 135,000 military and civilian personnel who provide health care services worldwide. Our infrastructure of fixed military medical, dental, public health, and research facilities is extensively supported by private sector institutions and health care providers, which provide tremendous flexibility and coverage, especially when our medical forces are deployed to operational theaters or humanitarian missions.

This report presents data for each of our four mission elements or strategic objectives: (1) maintaining casualty care and humanitarian assistance, (2) creating and sustaining a healthy, fit, and protected force, (3) promoting healthy and resilient individuals, families, and communities, and (4) improving education, training, and research. As in prior annual reports, where feasible and appropriate, data are trended over the most recent three fiscal years (usually FYs 2007–2009, in this year's report), where programs are sufficiently mature. Where available and appropriate, we also continue the approach used in past years of comparing TRICARE with civilian-sector benchmarks, such as in our beneficiary surveys of access and satisfaction.

It is an incredible honor and privilege to serve with the world's finest team of men and women, who are dedicated to defending our freedom by caring for the nation's uniformed Service members, retirees, and their families. We appreciate the support and guidance Congress has extended to help us provide the very best health care for our forces and their families, and in particular for the wounded, ill, and injured. While there is always much more that must be done, I believe we have made significant progress toward each of our goals, and I would like to tell you where we are, and what we have accomplished. — *Dr. Charles L. Rice*

A FUTURE WORTH CREATING

Purpose, Mission, Vision, and Strategy

In late 2007 and early 2008, the senior medical leadership, the Surgeons general, and our staffs reexamined our fundamental purpose, our vision for the future, and strategies to achieve that vision. This effort culminated in an updated MHS Strategic Plan published in the summer of 2008. MHS senior leaders have used the Strategic Plan and supporting metrics to monitor and improve performance of the MHS, including using many of the measures in this report presenting data through FY 2009.

Our efforts are focused on the core business in which we are engaged: creating an integrated medical team that provides optimal health services in support of our nation's military mission—anytime, anywhere. We are ready to go into harm's way to meet our nation's challenges at home or abroad, and to be a national leader in health education, training, research, and technology. We build bridges to peace through humanitarian support whenever and wherever needed—across our nation and the globe—and we provide premier care for our warriors and the military family.

Our ability to provide the continuum of health services across the range of military operations is contingent upon the ability to create and sustain a healthy, fit, and protected force. Each of the MHS mission elements is interdependent and cannot exist alone. A responsive research, innovation, and development capacity is essential to achieving improvements in operational care and evacuation. A medical education and training system that produces the quality clinicians demanded for an anytime, anywhere mission is critical, and we cannot produce the quality of medical professionals without a uniformed sustaining base and platform that can produce healthy individuals, families, and communities.

We have a singular opportunity to build bridges to peace in hostile countries. In many circumstances, the MHS will serve as the tip of the spear and a formidable national strategy tool for the nation. And, we can take advantage of a one-time opportunity to design and build health facilities that promote a healing environment during the clinical encounter, empower our patients and families, relieve suffering, and promote long-term health and wellness. We will employ evidence-based design principles that link to improved clinical outcomes, patient and staff safety, and long-term operational efficiencies.

MILITARY HEALTH SYSTEM MISSION

Secretary Gates calls our work sacred. Caring for America's heroes is not a motto. It is what we do. Our commitment is to provide the strategy, policy, and resources to achieve excellence. We are indebted to the sacrifice of our forces, and are honored to serve them.

Much has changed since we last published the MHS Strategic Plan in 2006. Leadership has responded to enormous challenges, and we have renewed our focus on quality. We have received suggestions and guidance from Secretary Gates's Independent Review Group, the President's Commission, the Task Force on the Future of Military Health Care, the Mental Health Task Force, and other thoughtful organizations. We have taken bold steps to redefine how we work collaboratively with the Department of Veterans Affairs (VA) and our civilian partners to address the issues identified at Walter Reed, and to improve coordinated care for wounded warriors and all whom we have the honor to serve.

This report reflects our new mission and vision statements, updates and refines descriptions of our core values, and presents key results of the metrics supporting our strategic plan. This plan focuses on how we define and measure mission success, and how we plan to continuously improve performance. The MHS purpose, mission, vision, and strategy are open, transparent, and available at *http://www.health.mil/StrategicPlan/Default.aspx*.

MILITARY HEALTH SYSTEM MISSION ELEMENTS

Our team provides optimal Health Services in support of our nation's military mission—anytime, anywhere. The key Mission elements are: (1) maintaining Casualty Care and Humanitarian Assistance, (2) creating and sustaining a Healthy, Fit and Protected Force, (3) promoting Healthy and Resilient Individuals, Families and Communities, and (4) sustaining Education, Research and Performance Improvement.

- **Casualty Care and Humanitarian Assistance:** We maintain an agile, fully deployable medical force and health care delivery system, so that we can provide state-of-the-art health services—anytime, anywhere. We use this medical capability to treat casualties, restore function, support humanitarian assistance and disaster relief: building bridges to peace around the world.
- **Healthy, Fit, and Protected Force:** We help the Services' commanders create and sustain the most healthy and medically prepared fighting force—anywhere.
- **Healthy and Resilient Individuals, Families, and Communities:** The MHS provides long-term health coaching and health care for over 9 million Department of Defense (DoD) beneficiaries. Our goal is a sustained partnership that promotes health and creates the resilience to recover quickly from illness, injury, or disease.
- **Education, Research and Performance Improvement:** Sustaining our mission success relies on our ability to adapt and grow in the face of a rapidly changing health and national security environment. To accomplish this, we must be an actively learning organization that values personal and professional growth and supports innovation.

MHS VISION STATEMENT

The provider of premier care for our warriors and their families

- We maintain an agile, fully deployable medical force and health care delivery system so that we can provide state-of-the-art health services—anytime, anywhere. The MHS provides long-term health coaching and health care for more than 9 million DoD beneficiaries. Our goal is a sustained partnership that promotes health and creates the resilience to recover quickly from illness, injury, or disease.

An integrated team ready to go in harm's way to meet our nation's challenges at home or abroad

- We help the Services' commanders create and sustain the most healthy and medically prepared fighting force anywhere.

A leader in health education, training, research and technology

- Sustaining our mission success relies on our ability to adapt and grow in the face of a rapidly changing health and national security environment.

A bridge to peace through humanitarian support

- We use our medical capability to support humanitarian assistance and disaster relief: building bridges to peace around the world.

A nationally recognized leader in prevention and health promotion

- We must be a learning organization that values both personal and professional growth and supports innovation.

KEY MHS MISSION ELEMENTS

Casualty care and humanitarian assistance

- Reduce combat losses
- Effective medical transition to VA and civilian care
- Improve rehabilitation and reintegration into the Force
- Increase interoperability
- Reconstitution of Host Nation medical capability

Healthy, fit, and protected force

- Reduce medical noncombat loss
- Improve mission readiness
- Optimize human performance

Healthy, resilient individuals, families, and communities

- Healthy communities/healthy behaviors (public health)
- Health care quality
- Access to care
- Beneficiary satisfaction and perceptions of MHS quality

Education, training, and research

- Capable MHS work force and medical force
- Contribution to the advancement of medical science
- Contribution to advances in global public health
- Create and sustain a healing environment (facilities)
- Performance-based management and efficient operations
- Deliver information to people so they can make better decisions

CORE VALUES

We are a values-based organization. Our core value system is the never-changing bedrock that reflects who we are and drives our behavior every day.

Selfless and Courageous Service

We are honored to serve those who serve, the warfighters and beneficiaries who trust us to always meet their needs—anytime, anywhere. Our high calling demands the courage to take risks, do what is right, and go into harm's way.

Caring, Healing, and Creating Health

We are healers who have an obligation to the life-long health and well-being of all those entrusted to our care. We are compassionate and committed to doing the right thing for our patients to eliminate disease, ease suffering, and achieve health. We build trusting relationships with our patients to permit them to take control of their health.

Helping our People Achieve Greatness

We work in teams, with passion, respect, and loyalty, constantly demanding mission success. It is this fusion of principles that brings out the potential of our people and creates a constant flow of leaders.

GUIDING PRINCIPLES

The MHS is a global system delivering health services—anytime, anywhere. In everything we do, we adhere to common principles that are essential for accomplishing our mission and achieving our vision. We must embed these principles into our processes and culture.

Health care is the ultimate team sport

We work as an integrated team, using Service capabilities, in partnership with the VA, our contract partners, and other governmental agencies to find the best way to accomplish our mission. We accept the inherent risk of being interdependent, because it is the only way to get the job done.

You have to know the score to win the game

We know that the best information leads to the best decisions, so we are committed to creating a true electronic, personal health record fully accessible to the patient. We also know that sharing our results freely builds knowledge and creates wisdom to better serve the people who trust us with their lives.

Breakthrough performance through innovation

We encourage our people to be curious and take risks in creating new solutions to the challenges of a constantly changing world. We hold leaders accountable for providing the environment and resources that foster innovation.

Reward outcomes, not outputs

We employ incentives to reward mission success, because we know that focusing on quality is the best way to improve efficiency.

Health-creating partnerships

We are committed to a caring, long-term relationship that allows patients to control their health and fitness. We will educate and coach our patients to be experts on their own health and achieve their trust by employing the highest quality healing methods.

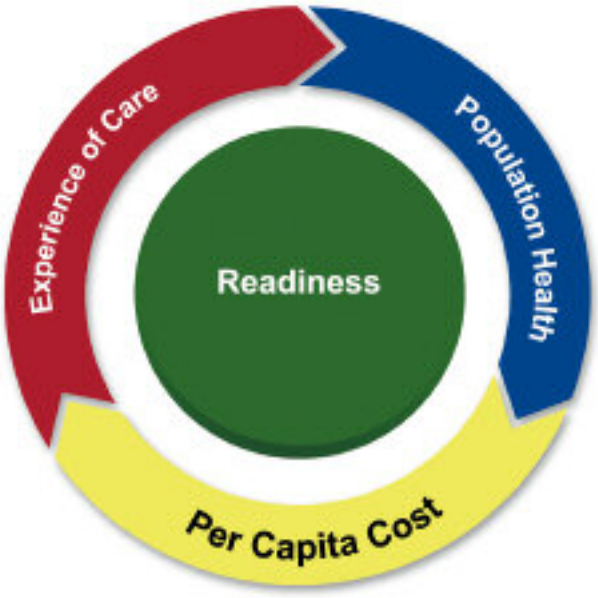
MHS STRATEGIC DIRECTION AND PRIORITIES IN FY 2010 AND BEYOND

This report reflects the most recent MHS Strategic Plan, published in 2008. MHS leadership has used the plan and supporting metrics to monitor and improve performance. In the fall of 2009, MHS leaders recognized that MHS strategic efforts were consistent with the concept of the Triple Aim proposed by the Institute for Healthcare Improvement (IHI) (http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm.) and agreed to align the MHS strategic plan around the unifying construct of the Triple Aim, consistent with the primacy of our readiness mission.

The Triple Aim is intended to describe the kind of results that could be achieved when all of the elements of a true health care system worked together to serve the needs of a population. The MHS is a system dedicated to the health of the military family, and it seemed reasonable to adopt the Triple Aim with the addition of one key element—readiness. Readiness reflects our core mission and reason for being; it is first among our aims.

The MHS Quadruple Aim:

- **Readiness**
  Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.
- **Population Health**
  Improving the health of a population by encouraging healthy behaviors and reducing the likelihood of illness through focused prevention and the development of increased resilience.
- **Experience of Care**
  Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.
- **Responsibly Managing the Total Health Care Costs**
  Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.



EXECUTIVE SUMMARY: KEY FINDINGS FY 2009

Stakeholder Perspective

- The $47 billion ($46.64B) FY 2009 UMP was 9.5 percent larger than the FY 2007 expenditures of almost $43 billion. As currently programmed, the FY 2010 budget, at $48.9 billion (estimated), will be over $2 billion, or almost 5 percent more than FY 2009, with almost half due to increase in purchased care costs. The UMP was 8 percent of the FY 2009 total Defense budget (including the normal cost contribution to the accrual fund), and is programmed to be 9.2 percent of the FY 2010 Defense budget, up from 7 percent in FY 2007 (Ref. pages 23–24).
- The number of beneficiaries eligible for DoD medical care increased from 9.2 million in FY 2007 to almost 9.6 million at the end of FY 2009 (Ref. page 16).
- The number of enrolled beneficiaries increased from 5.16 million in FY 2007 to 5.40 million in FY 2009 (Ref. page 21).
- The percentage of beneficiaries using MHS services increased from 80.2 percent in FY 2007 to 81.7 percent in FY 2009 (Ref. page 22).

MHS Workload and Cost Trends*

- Total MHS workload increased from FY 2007 to FY 2009 for all major components—inpatient (+1 percent), outpatient (+17 percent), and prescription drugs (+5 percent); these trends were predominantly due to increases in purchased care workload excluding TRICARE For Life (TFL) (Ref. pages 26–28).
- Direct care inpatient workload declined by 4 percent, prescription workload was unchanged, and outpatient workload increased by 5 percent from FY 2007 to FY 2009. Overall, direct care costs increased by 14 percent. Purchased care workload increased for all service types, especially for outpatient services, which increased by 25 percent. Overall, purchased care costs increased by 24 percent (Ref. pages 26–29).
- By the end of FY 2009, the purchased care portion of total MHS health care expenditures had increased to 51 percent from about 49 percent in FY 2007. As a proportion of total MHS health care expenditures (excluding TFL), FY 2009 purchased care expenditures were 61 percent for prescription drugs, 56 percent for inpatient care, and 45 percent for outpatient care (Ref. page 29).
- Out-of-pocket costs for MHS beneficiary families under age 65 are between $4,200 and $4,500 lower than those for their civilian counterparts. Out-of-pocket costs for MHS senior families are $2,200 lower than those for their civilian counterparts (Ref. pages 81, 83, 86).

* All workload trends in this section refer to intensity-weighted measures of utilization (RWPs for inpatient, RVUs for outpatient, and days supply for prescription drugs). These measures are defined on the referenced pages.

Providing Quality Care

- **Overall Customer Satisfaction With TRICARE:** MHS beneficiary global ratings of satisfaction with the TRICARE health plan, personal provider and specialty physician improved from FY 2007 to FY 2009 (exceeding the civilian benchmark in FY 2009 for health plan). Global satisfaction ratings of health care remained stable and lagging the civilian benchmark. (Ref. pages 39-43)

  Health care satisfaction levels remained stable. TRICARE Prime enrollee satisfaction with the health plan, for those with military as well as private sector civilian primary care managers (PCMs), reported the same or higher satisfaction levels as their civilian counterparts in FY 2009. Satisfaction of non-enrollees also exceeded that of their civilian counterparts in FY 2009 (Ref. pages 39–43).
- **Meeting Preventive Care Standards:** For the past three years, the MHS has exceeded targeted Healthy People (HP) 2010 goals in providing mammograms. Efforts continued toward trying to achieve HP 2010 standards for Pap smears, prenatal exams, flu shots (for people age 65 and older), and blood pressure screenings. The overall FY 2009 self-reported rates for nonsmoking (85 percent) and non-obese (75 percent) beneficiaries remained below the desired HP 2010 adjusted goals (88 percent nonsmoking; 85 percent non-obese) (Ref. page 60).
- **Force Protection:** Overall MHS dental readiness remained stable between FY 2007 and FY 2009 (Ref. page 37).

Access to Care

- **MHS Provider Trends:** The number of TRICARE participating providers continues to increase, but at a much slower rate than during the earlier part of this decade. The number of Prime network providers has also been increasing, both in total numbers and as a percentage of total participating providers (Ref. page 49).
- **Overall Outpatient Access:** Access to and use of outpatient services remained high, with over 85 percent of Prime enrollees reporting at least one outpatient visit in FY 2009 (Ref. page 44).
- **Availability and Ease of Obtaining Care:** MHS beneficiary ratings for getting needed care and getting care quickly improved between FY 2007 and FY 2009 but continued to lag the civilian benchmark (Ref. page 45).
- **Doctors' Communication:** Satisfaction levels of TRICARE Prime enrollees with civilian primary care managers and non-enrollees with their providers equaled that of their civilian counterparts between FY 2007 and FY 2009. Prime enrollees' satisfaction with military primary care managers lagged the civilian benchmark (Ref. page 46).
- The first year of a four-year survey indicates that over 80 percent of physicians are aware of TRICARE in general, and 66 percent accept new TRICARE Standard patients if they accept any new patients. However, psychiatrists and nonphysician behavioral health providers reported lower awareness (about one-half) and acceptance (about one-third) of new TRICARE Standard patients (Ref. page 50).
- **Enrollment in TRICARE Reserve Select (TRS):** TRS enrollment more than tripled, from almost 12,000 plans and 35,000 covered lives at the end of FY 2007 to over 46,000 plans and almost 121,000 covered lives at the end of FY 2009 (Ref. page 38).

WHAT IS TRICARE?

TRICARE is a family of health plans for the MHS. TRICARE responds to the challenge of maintaining medical combat readiness while providing the best health services for all eligible beneficiaries. The TRICARE plans integrate and supplement the MHS capability in providing health benefits in peacetime 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 Military Treatment Facilities (MTFs), where available, TRICARE offers beneficiaries three primary options:

- **TRICARE Standard** is the non-network benefit, formerly known as Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), open to all eligible DoD beneficiaries, except Active Duty Service members (ADSMs). Beneficiaries who are eligible for Medicare Part B are also covered by TRICARE Standard for any services covered by TRICARE but not covered by Medicare. 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; however, 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 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 (POS) 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.
- **Other plans and programs:** Some beneficiaries may qualify for other benefit options depending on their location, Active/Reserve status, and/or other factors. These plans and programs provide additional benefits or offer benefits that are a blend of the Prime and Standard/Extra options with some limitations. Some examples are:
  - Dental Benefits (military dental treatment facilities [DTFs], claims management for Active Duty using civilian dental services, as well as the premium-based TRICARE Dental Program [TDP] and the TRICARE Retiree Dental Program [TRDP])
  - Pharmacy Benefits in MTFs, or via the national retail pharmacy contract, the national mail order program, and the TRICARE retail pharmacy benefits
  - Overseas purchased care and claims processing services
  - Programs supporting reserves, including the premium based TRS program and the Transitional Assistance Management Program (TAMP)
  - Supplemental programs including TRICARE Prime Remote (TPR) in the United States (U.S.) and overseas, DoD-VA sharing arrangements, joint services, and claims payment
  - Uniformed Services Family Health Plan (USFHP)
  - Continued Health Care Benefits Program
  - Clinical and educational services demonstration programs (such as chiropractic care and autism services demonstrations).

HOW TRICARE IS ADMINISTERED

TRICARE is administered on a regional basis, with three regional contractors in the United States working with their TRICARE Regional Offices (TROs) to manage purchased care operations and coordinate medical services available through civilian providers with the MTFs. 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.

NEW BENEFITS AND PROGRAMS IN FY 2009 SUPPORTING MHS MISSION ELEMENTS

MHS continues to meet the challenge of providing the world's finest combat medicine and aeromedical evacuation, while supporting the TRICARE benefit to DoD beneficiaries at home and abroad. Since its inception more than a decade ago, TRICARE continues to offer an increasingly comprehensive health care plan to Uniformed Services members, retirees, and their families. Even as we aggressively work to sustain the TRICARE program through good fiscal stewardship, we also refine and enhance the benefit and programs in a manner consistent with the industry standard of care, best practices, and statutes to meet the changing health care needs of our beneficiaries.

KEY MHS MISSION ELEMENT: CASUALTY CARE AND HUMANITARIAN ASSISTANCE

Caring for Wounded Warriors

TRICARE Assistance Program Reaches Out Over the Web to Ease Post-Deployment Stress

The Web-based TRICARE Assistance Program (TRIAP), launched August 1, 2009, brings short-term professional counseling assistance closer to Service members and veterans and their families recently returned from overseas. The TRIAP is a one-year demonstration to deliver information and counseling services through the use of Web-based technologies, and to determine if the use of these technologies increases efficiency of identifying beneficiaries who need behavioral health care, identifies behavioral health needs earlier, and refers and gets beneficiaries access to the appropriate level of behavioral health care more effectively.

The program is available in the United States to Active Duty Service members, those eligible for the TAMP and members enrolled in TRS. It is also available to these beneficiaries' spouses, no matter their age, and other eligible family members 18 years of age or older.

The Web site allows beneficiaries with a computer, Webcam and the associated software to speak "face-to-face" with a licensed counselor over the Internet 24 hours a day. Services include assessments, short-term counseling, and, if the TRIAP counselor determines more specialized care is necessary, a referral to a more comprehensive level of care. A referral or prior authorization is not needed to use TRIAP services. Eligible beneficiaries can link to their regional contractor's TRIAP site and get more information about the program at *http://www.tricare.mil/TRIAP.*

Other Web Resources

The National Resource Directory: The National Resource Directory (NRD) is an online tool for wounded, ill and injured Service members, veterans, their families, and those who support them. The NRD provides access to more than 11,000 services and resources at the national, state and local levels that support recovery, rehabilitation and community reintegration. Maintained by the Departments of Defense, Labor and Veterans Affairs, the NRD links to federal and state government agencies; veterans service and benefit organizations; non-profit and community-based organizations; academic institutions and professional associations, which provide assistance to wounded warriors and their families. The Web site is organized into six major categories: Benefits and Compensation; Education, Training and Employment; Family and Caregiver Support; Health; Housing and Transportation; and Services and Resources. The NRD can be accessed at *www.nationalresourcedirectory.gov. (http://www.health.mil/Press/Release.aspx?ID=429)*

Electronic Benefits Portal

The e-Benefits Web Portal is the official benefits Web site of the VA and the DoD with information on benefit and assistance programs. The President's Commission on the Care for America's Returning Wounded Warriors recommended the DoD and the VA jointly develop an interactive portal that provides a single information source for all users. The e-Benefits portal can be accessed at *www.ebenefits.va.gov*.

Wounded Warrior Resource Center

The Wounded Warrior Resource Center (WWRC) Web site is a DoD Web site which provides wounded Service members, their families, and caregivers with information they need on military facilities, health care services, and benefits. It supports access to the Wounded Warrior Resource Call Center and trained specialists who are available 24 hours a day, 7 days a week by phone at 1-800-342-9647 or by e-mail at *wwrc@militaryonesource.com*. The WWRC Web site can be accessed at *www.woundedwarriorresourcecenter.com/.*

New DoD Center Helps with Psychological Health & Traumatic Brain Injury

A new 24-hour outreach center provides information and referrals to military Service members, veterans, their families and others with questions about psychological health and traumatic brain injury. Operated by the Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury (TBI), staff at the center are available by phone at 866-966-1020 and by e-mail at *resources@dcoeoutreach.org*.

The center can deal with everything from routine requests for information about psychological health and traumatic brain injury (TBI), to questions about symptoms a caller is having, to helping a caller find appropriate health care resources.

Additional information is available under the mental health and behavior section of the TRICARE Web site at *http://tricare.mil/mybenefit*. More information about the DCoE is available at *http://www.dcoe.health.mil.*

Vision Center of Excellence

The Vision Center of Excellence (VCE) is a new, interagency effort between the DoD and the VA. The mission of the VCE is to improve the health and quality of life for members of the Armed Forces and veterans through the development of initiatives focused on the prevention, diagnosis, mitigation, treatment, research and rehabilitation of disorders of the visual system.

As currently planned, the VCE will have five broad divisions: Informatics and Information Management, Clinical Care, Research and Surveillance, Rehabilitation, and Restoration and Global Outreach. One of the center's primary focus areas is the development of the Defense and Veterans Eye Injury Registry (DVEIR).

Family and Medical Leave Act

Recent changes to the Family and Medical Leave Act (FMLA) will extend the period of unpaid, job-protected leave that eligible family members can take to care for Wounded Warrior spouses.

Legislative amendments provide new entitlements that pertain to military families and enable them to take caregiver leave. The changes, authorized by the NDAA of 2008, give military families special job-protected leave rights to care for servicemen and women who are wounded or injured and helps families of members of the National Guard and Reserves manage their affairs when their service member is called up for Active Duty.

Eligible employees who are family members of covered Service members who qualify may be able to take up to 26 work weeks of leave in a 12-month period to care for a covered service member with a serious illness or injury incurred in the line of duty while on Active Duty. This change extends the period of available unpaid leave beyond the original 12-week leave period.

A second amendment makes the normal 12 work weeks of FMLA job-protected leave available to family members of National Guardsmen or Reservists for qualifying exigencies when Service members are on Active Duty or called to active-duty status.

Qualifying exigencies include: short-notice deployment; military events and related activities; child-care and school activities; financial and legal arrangements; counseling; rest and recuperation; post-deployment activities; and additional activities not encompassed in the other categories by which the employer and employee can agree to the leave.

Pilot Program Helps Streamline Disability Evaluation Process for Wounded Service Members

The DoD and the VA are expanding a pilot program that simplifies the current disability evaluation process for wounded, injured, and ill Service members. The Disability Evaluation System (DES) pilot program helps wounded Service members obtain faster disability determinations from both agencies through a single medical examination used by both DoD and VA, with a single source disability evaluation done by VA and accepted by DoD.

Currently, the branch of service evaluates the service member for conditions that may make him or her unfit for duty. This evaluation initiates the medical examination board process. Following separation or retirement from service, the member is again evaluated by the VA for disability and compensation. Under the pilot program, only one evaluation is necessary after a member is referred for a service medical evaluation board.

The pilot was initially tested at three MTFs in the National Capitol Region. Since the pilot program began, more than 700 Service members have participated in the pilot. To collect and evaluate data from other geographic regions, 19 more installations have been added to the study.

For more information about how TRICARE works for medically retired Service members, visit *http://www.tricare.mil*. For more information about VA benefits, visit *http://www.vba.va.gov/VBA*.

Assistive Technology will be more Widely Available to Wounded Service Members

The Computer/Electronic Accommodations Program (CAP), MTFs, and other DoD agencies are working together to bring Assistive Technology (AT) to wounded, ill and injured Service members and their families through a program called the CAP Wounded Service Member Initiative.

Department of Defense Instruction (DoDI) 6025.22, Assistive Technology for Wounded Service members was signed in August 2008. The DoDI outlines the development of a successful, interdependent AT system between the MTFs and CAP. This allows CAP to work closely with MTFs to increase awareness and availability of AT to wounded Service members at no charge to them.

AT is incorporated into the recovering Service member's rehabilitation process, allowing them to learn to use the accommodations for their next assignment or job. CAP has an established partnership with several MTFs, and beginning early 2009, CAP will work closely with other MTFs to provide training to staff to implement AT programs. CAP conducts a needs assessment on a case-by-case basis to ensure the proper assistive devices and training is provided. The staff looks at the individual, their job, and possible solutions when conducting the assessment.

For more information about the CAP Wounded Service Member Initiative or to request a presentation, e-mail *WSM@tma.osd.mil*. For additional information on CAP, visit *http://www.tricare.mil/cap/*.

Humanitarian Mission Completed—Pacific Partnership Evolves in 2009

Pacific Partnership 2009 (PP09) completed its five-country, three month humanitarian civic assistance mission when the team departed the Republic of the Marshall Islands September 18.

Pacific Partnership traveled for the first time to Samoa, Tonga and Kiribati and returned for a second visit to Solomon Islands and Republic of the Marshall Islands in Oceania, staying in each country for 10 to 14 days to deliver a variety of medical, dental, veterinary, preventative health, engineering, and community relations programs.

Pacific Partnership treated a total of 22,037 patients, the medical team saw 11,248 patients, and the dentists saw 4,487 patients. The biomedical repair team assessed 107 pieces of equipment, repairing 77 and performing preventive maintenance on 23.

The preventive medicine team tested water sources, suggested ways to improve public health through improved engineering solutions, and sprayed for mosquitoes.

KEY MHS MISSION ELEMENT: HEALTHY, FIT AND PROTECTED FORCE AND HEALTHY, RESILIENT INDIVIDUALS, FAMILIES AND COMMUNITIES

Dental Benefits

New Active Duty Dental Plan Launched August 1

The new Active Duty dental program (ADDP) was launched on August 1, 2009 to provide private sector dental care to ADSMs. United Concordia Companies, Inc. is the contractor for this program. The ADDP augments dental care provided by the Military DTFs and provides care for ADSMs in remote locations. No enrollment is required, but ADSMs must utilize network providers. Reserve and National Guard members activated for more than 30 consecutive days on federal orders, or who receive delayed-effective-date-Active Duty orders for more than 30 days in support of a contingency operation, are eligible for ADSM dental services, including the ADDP.

The ADDP provides two sources of dental care. The DTFs may refer ADSMs to the civilian network for specialty care, to maintain access standards or to expedite treatment required to ensure dental readiness. The ADDP also provides Remote Care to ADSMs who live and work more than 50 miles from a DTF.

Of the more than 250,000 dental claims filed each year by ADSMs, approximately one third of claims come from Service members living and working in remote locations. In the past, the Military Medical Support Office of the TMA handled remote dental claims and DTF referrals.

Service members who live and work in remote areas, receive letters and brochures to inform them of the new ADDP. Learn more at *http://www.addp-ucci.com* and *http://www.tricare.mil/dental*.

Pharmacy Benefits

TRICARE Pharmacy program. The TRICARE Pharmacy program (TPharm) $2.8B management contract that combines mail order and retail pharmacy was awarded to Express Scripts Inc. (ESI) on June 28, 2008, and went live on November 4, 2009. TPharm offers improvements such as a single call center for pharmacy needs, easier prescription transfers between retail, MTF and mail order pharmacies, and added specialty services for mail order.

Beneficiaries were sent letters explaining the new benefits during September 2009. The new help desk became available on September 23, 2009.

TRICARE Standard pays for preventive care

Section 711 of the NDAA of 2009 encourages eligible TRICARE Standard beneficiaries to use preventive health services by waiving all cost shares for six of these services starting September 1, 2009. These services include screenings for colorectal cancer, breast cancer, cervical cancer and prostate cancer; immunizations; and well-child visits for children under 6 years of age.

The cost share waiver applies to non-Medicare eligible, TRICARE Standard or Extra beneficiaries, even if the beneficiary hasn't met the annual deductible. Beneficiaries enrolled in TRICARE Prime are unaffected, as they do not have copayments for preventive services.

Criteria such as age and frequency of care have to be met in order to waive cost shares for the preventive services. All other preventive services not included in the services listed in Section 711 are subject to cost shares and deductibles. This benefit can be applied to any services received on or after October 14, 2008. Beneficiaries can request reimbursement for services received after October 14, 2008, and before the implementation date of September 1, 2009.

Expanded Access to Chiropractic Care for ADSMs

The 2009 NDAA called for the DoD to expand the number of military facilities offering chiropractic services to ADSMs. A chiropractic workgroup added 11 new locations to the 49 military clinics and hospitals currently providing chiropractic care to ADSMs. ADSMs overseas will have access to chiropractic services with two of the new locations in Germany and one in Okinawa, Japan.

The new sites are: 1st Special Operations Medical Group, Hurlburt Field, FL; Irwin Army Community Hospital, Fort Riley, KS.; Lyster Army Health Clinic, Fort Rucker, AL; Bayne-Jones Army Community Hospital, Fort Polk, LA; Bassett Army Community Hospital, Fort Wainwright, AK; Landstuhl Regional Medical Center and Grafenwoehr Army Health Clinic, Germany; Naval Health Clinic Quantico, VA.; Naval Branch Health Clinic Groton, CT.; Naval Hospital Lemoore, CA.; U.S. Naval Hospital, Okinawa, Japan.

The Chiropractic Care Program is only available to ADSMs at designated MTFs. A Service member's PCM determines if chiropractic care is appropriate.

TRICARE does not cover chiropractic care, but family members may be referred to nonchiropractic health care services—physical therapy, family practice or orthopedics—for treatment as appropriate. *http://www.tricare.mil/ChiropracticCare*

TRICARE Increases Payments for Beneficiaries with Special Needs

The NDAA for FY 2009 called for TRICARE to increase the amount it will pay for certain Extended Care Health Option (ECHO) benefits. ECHO assists eligible family members of Active Duty sponsors who are diagnosed with moderate or severe mental retardation, a serious physical disability, or an extraordinary physical or psychological condition.

The total TRICARE cost share for training, rehabilitation, special education, and assistive technology devices was increased to $36,000 per fiscal year. The cap also covers institutional care in private nonprofit, public and state institutions and facilities and, if appropriate, transportation to and from such institutions and facilities. The TRICARE Enhanced Access to Autism Services "Demonstration" is also included.

Some ECHO benefits are still subject to the prior cap of $2,500 per month and ECHO Home Health Care has its own unique reimbursement limits. For more information on ECHO services, costs and limitations go to *http://www.tricare.mil/ECHO* or contact the appropriate regional managed care support contractor (MCSC) found at *http://www.tricare.mil/contactus*.

TRICARE Lowers Prices for Diabetic Supplies

The Department of Defense Pharmacy and Therapeutic committee (DoD P&T) reviewed and selected blood glucose monitor test strips that will save money for beneficiaries and DoD. Accuracy of blood sample size, alternate site testing, result time, memory capacity, manufacturer customer support, and ease of use were some of the criteria taken into consideration for the review.

Four self-monitoring test strips are included in the DoD Uniform Formulary. The Uniform Formulary is a standardized list of covered prescription medications available to the 9.5 million beneficiaries of the MHS. Co-pays are determined by "tier." The four approved test strips are now available to beneficiaries at a co-pay of $9 (Tier 2).

The committee reviewed all the available glucose strips and their respective meters. Costs to the government are reduced by narrowing the number of options in Tier 2 and moving others to Tier 3 on the Uniform Formulary list.

Beneficiaries are encouraged to switch to one of the preferred test strips, which saves money for beneficiaries and the DoD. Additional options for test strips on Tier 3 are still available for the $22 co-pay.

Beneficiaries who have used glucose test strips within the past year should have received a letter communicating details of the change. For more on glucose test strips click the medication tab, then over-the-counter medications and supplies at *http://www.tricare.mil/pharmacy*.

TRICARE Global Remote Overseas Alarm Center to Obtain Emergency Care Assistance

Active Duty family members (ADFMs) who are enrolled in any TRICARE Prime option, whether in the United States or overseas, may contact the TRICARE Global Remote Overseas (TGRO) Alarm Center to obtain emergency care assistance when traveling overseas. The change only applies to emergency care and emergency evacuation in an overseas area. Urgent care is not covered under this change. ADFMs who are not enrolled in a TRICARE Prime option are not eligible to use the TGRO Alarm Center, nor are retirees and their family members, regardless of TRICARE Prime status. TGRO will assist all Prime-enrolled ADFMs, but those with other health insurance must coordinate with their primary insurer to ensure payment for medical services.

For contact information for TGRO alarm centers, please visit *http://www.tricare.mil/Pressroom/News.aspx?fid=468.*

TRICARE Requires Drive-time Waivers

Beginning October 1, 2009, non-Active Duty TRICARE Prime beneficiaries in the continental U.S. (CONUS) and Hawaii who live more than a 30-minute drive from the MTF where they are enrolled, must waive TRICARE's access-to-care drive-time standards to remain enrolled to that MTF. To provide the best possible care, a PCM should be located within a 30-minute drive of a beneficiary's residence.

Waivers approved for beneficiaries residing less than 100 miles from the MTF remain in effect until the beneficiary changes residency location. Waivers approved for beneficiaries who reside more than 100 miles from an MTF remain in effect through the beneficiary's current enrollment period, so long as they don't change residences. Since an MTF's provider availability can change over time, the MTF may not always renew a waiver at the end of the enrollment period for those beneficiaries residing more than 100 miles from the MTF. If this happens, the regional contractor will notify beneficiaries at least two months before their enrollment expires.

If a request is initially denied or a waiver is not renewed at the end of an enrollment period, there are several other TRICARE options. Beneficiaries whose current MTF PCM is outside of TRICARE's drive-time access standard will receive a letter from their regional contractor to ensure a waiver is on file and/or provide information and guidance regarding their TRICARE options.

Reduced Rates for TRICARE Reserve Select

The 2009 NDAA, section 704, amended the statute (10 USC 1076d(d)) to require TRICARE to base TRICARE Reserve Select (TRS) premiums for calendar year 2009 and for each calendar year thereafter on actual cost data from previous years.

Effective January 1, 2009, monthly premiums for TRS individual coverage dropped 44 percent from $81.00 to $47.51, and TRS family coverage dropped 29 percent from $253.00 to $180.17.

TRS is a premium-based health plan for National Guard and Reserve personnel available for purchase by members of the Selected Reserve who are not eligible for or enrolled in the Federal Employee Health Benefits program.

TRS provides a health plan option to members of the Selected Reserve and their families when they are not going on Active Duty for more than 30 days. The TRS plan delivers coverage similar to TRICARE Standard and Extra to eligible members who purchase the coverage and pay monthly premiums. TRS also features continuously open enrollment. *http://www.tricare.mil/Pressroom/News.aspx?fid=480*

Influenza Vaccine

TRICARE does not require Prime enrollees to obtain a referral and authorization for influenza and H1NI vaccines when provided by network providers, but does when provided by non-network providers. In 2009, TRICARE suspended referral and authorization requirements for administration of the H1N1 vaccine provided by non-network providers. This requirement is suspended from October 1, 2009–April 30, 2010.

Health Net Federal Services Expands Provider Network

Health Net Federal Services, LLC announced it is adding additional civilian Convenient Care and Urgent Care Clinics to the more than 1,000 in its TRICARE provider network. These clinics provide TRICARE North Region Service members, retirees and their families with easy access to care seven days a week that includes extended hours and no appointments necessary. Beneficiaries can receive treatment for minor illnesses such as sore throats, earaches and upper respiratory infections, and preventive care services including limited physical exams, flu vaccines, and other immunizations.

Convenient Care and Urgent Care Clinics can be located using Health Net Federal Services' online provider directory.

TRICARE awards contracts to six designated providers of the USFHP

On October 1, 2008, TMA awarded contracts to the six designated providers of the USFHP. The USFHP is a DoD-sponsored health plan, made available by nonprofit health care providers across the country. USFHP offers the TRICARE Prime benefit to over 100,000 military beneficiaries, including ADFMs, activated Guard and Reserve family members, and Retirees and their family members.

The six not-for-profit health care organizations awarded these five-year contracts are: Saint Vincent Catholic Medical Centers, New York, NY.; Brighton Marine Health Center, Boston, MA.; CHRISTUS Health Systems, Houston, TX; Johns Hopkins Medical Services Corporation, Baltimore, MD.; Martin's Point Health Care, Portland, ME; and Pacific Medical Centers, Seattle, WA.

Implementation of TRICARE Outpatient Prospective Payment System Projected to Save Millions

TRICARE has implemented an Outpatient Prospective Payment System (OPPS) that should result in savings of approximately $458 million per year to TRICARE.

OPPS aligns TRICARE with current Medicare rates for hospital reimbursement, ensures consistency of hospital outpatient payments throughout the United States, and reduces the denial and return of claims to providers for coding errors. Implementation started May 1, 2009.

To provide hospitals with time to adjust and budget for potential revenue reductions, Temporary Transitional Payment Adjustments will be in place for network and non-network hospitals. Based on public comments to proposed final rule, the DoD is adjusting implementation of the Temporary Military Contingency Payment Adjustments for network and non-network hospitals on a case-by-case basis to allow for timely access. A transitional adjustment information paper and more information on TRICARE OPPS is available on the TRICARE Web site at *http://www.tricare.mil/opps*

TRICARE Obtains Lower Prices on Retail Prescription Drugs

The Defense Department is projected to reduce spending by over $1.0 billion on prescription medications sold in retail pharmacies in FY 2010, following the full implementation of Section 703 of the NDAA for FY 2008.

The DoD has paid commercial rates for prescription drugs purchased in the TRICARE retail pharmacy network. However, DoD currently receives federal ceiling prices, the maximum price that can be charged for brand name drugs, in MTFs and the TRICARE Mail Order Pharmacy (TMOP). Through authority provided in Section 703 of the 2008 NDAA and the "final rule" implementing the regulation, DoD will now get these same discounts in the retail pharmacy network. The final rule was effective May 26, 2009.

TRICARE Implements New Fee Schedule for Panama

A new TRICARE provider fee schedule for medical services and procedures is in effect for Panama. The new fee schedule is expected to better reflect actual medical costs. There are no changes in payments for laboratory, radiology, and pathology services and procedures.

TRICARE Standard deductibles, cost-shares, and annual out-of-pocket caps will not change for beneficiaries in Panama under the new fee schedule.

The new reimbursement rates, which went into effect February 1, 2009, were implemented as a cost control

measure by using a country-specific index factor to account for variations in the cost of living and exchange rates for different countries.

In November 2008 TRICARE beneficiaries and providers in Panama who filed TRICARE claims during the past two years received letters from TMA notifying them of the fee schedule change.

The new allowable charges and inpatient per diem rates are available on the TRICARE Web site at *http://www.tricare.mil/CMAC*

TRICARE Standardizes Claims Payment Processes in Philippines

TMA recently implemented several new policies to streamline the claims payment process in the Philippine Islands. New providers in the Philippines now have more time to provide necessary credentialing information and documentation for certification before their claims are denied. Claims are now held for 90 days instead of 35 to facilitate this process. Other changes include the use of fax technology to overcome overseas mail delays, and new procedures designed to reduce data entry errors.

These changes accompany the implementation of a new Philippines fee schedule in November of 2008. The new reimbursement rates were implemented as a cost control measure by using a country-specific index factor to account for variations in the cost of living and exchange rates for different countries.

The reimbursement rates, also known as CHAMPUS Maximum Allowable Charges (CMAC), and inpatient per diem rates are available on the TRICARE Web site at *http://www.tricare.mil/tma/foreignfee/*.

KEY MHS MISSION ELEMENT: EDUCATION, TRAINING, AND RESEARCH

Customer Service

TRICARE Receives Two Magellan Awards for Communications Campaigns

TRICARE received two Magellan Awards in the 2008 Communications Campaign Competition. The Wounded, Ill, and Injured Service members campaign took first place platinum and the Childhood Obesity Prevention and Awareness campaign took second place gold in the Community Relations, Government, and Education category.

The Wounded, Ill, and Injured Service Member campaign also received the Special Achievement award for "Best on a Limited Budget" against all other submissions.

Both campaigns were also highly ranked in the Top 50 Communication campaigns. The Top 50 are awards given to the highest-scoring entries regardless of category. The Wounded Warrior campaign took the number eight spot and Childhood Obesity the number 24 spot out of more than 450 entries. TRICARE previously won seven Magellan Awards.

The Magellan Awards competition allows communications professionals to demonstrate the value they deliver to their organizations and clients. The awards are sponsored by the League of American Communications Professionals.

Emmy® Award Nomination for DoD's sponsored U.S. Family Health Plan Public Service Announcements

A joint public education campaign by the U.S. Family Health Plan, a health care plan for military family members, and the National Military Family Association, non-profit advocacy organization for military families, won an Emmy® Award. The series of four public service announcements, "Now is Our Time to Serve," was designed to raise awareness of the need to "support, befriend, remember and appreciate" America's military family members. The series was among only three nominees nationwide for an Emmy in the category of Local Public Service Announcement.

The series aired from July 2007 through February 2008, with total viewership topping 7.3 million, including broadcasts in several major U.S. television markets and airings in over 200 movie theatres. The public service announcements may be viewed online at *www.yearofthemilitaryfamily.org*.

The National Academy of Television Arts & Sciences announced the winners of this year's Public and Community Service Emmy Awards at a luncheon ceremony on Friday, November 7, 2008, in New York City.

The U.S. Family Health Plan is a DoD-sponsored health plan. It delivers the TRICARE Prime benefit to over 100,000 military beneficiaries, including ADFMs, activated Guard and Reserve family members, and Retirees and their family members.

TRICARE Launches New Web Page to Reduce Alcohol Abuse

A new TRICARE Web page, launched in April, *http://www.tricare.mil/alcoholawareness* sheds some light on alcohol abuse and promotes responsible drinking. Heavy alcohol consumption is a significant problem in the military that affects not just uniformed Service members, but also their families. The new Web page serves as a starting place for beneficiaries to find information, links and news about alcohol, underage drinking, alcoholism and substance abuse.

New Web Site Allows TRICARE Beneficiaries to Manage Health Care Information from Home

TRICARE Prime and Prime Remote beneficiaries in the United States including Hawaii and Alaska can enroll online with the new Beneficiary Web Enrollment (BWE). Prime and Prime Remote beneficiaries can log on to *https://www.dmdc.osd.mil/appj/bwe/* to enroll, disenroll, choose primary care managers, transfer regions, update

personal information, add other health care information and request enrollment cards. BWE allows Standard beneficiaries to update personal information, add other health care information and enroll in Prime.

BWE's link to the DEERS, allows beneficiaries to update their personal information for both TRICARE and DEERS at the same time. Sponsors and family members can access their TRICARE information by using their Common Access Card, Defense Finance and Accounting Service (DFAS) "myPay" Personal Identification Number (PIN) or Family Member Account PIN.

To date, the U.S. Family Health Plan, a TRICARE Prime option, is not available for enrollment on the BWE Web site. In addition to the new Web service, enrollment forms are still available at *http://www.tricare.mil/mybenefit/home/overview/Enrollment/WebEnrollment* to fill out and mail to a TRO. Beneficiaries can also visit a TRICARE Service Center to enroll and get assistance with other health care needs.

TRICARE Beneficiaries Can Access TRICARE Information Tailored for them Through the My Benefits Portal on *www.tricare.mil*

Upon entering the My Benefits portal, beneficiaries answer a few questions about themselves including their military status, where they live and their TRICARE health plan. By answering these three questions, content is tailored to meet their needs. If beneficiaries aren't sure about their TRICARE plan, the Plan Wizard shows them the plans for which they may be eligible.

A full tutorial on how to use the Web site to obtain information is available at *http://www.tricare.mil/overview/*.

New Web Page Guides TRICARE Beneficiaries to Behavioral Health Resources

A new Web page, *http://www.tricare.mil/mentalhealth*, provides beneficiaries with the most up-to-date information available about behavioral health resources. The Web page supports two DoD initiatives: promoting awareness about post-traumatic stress disorder treatment, and assisting returning Service members by providing expanded counseling services. It also provides information for family members dealing with deployment stress, moves and separation situations.

Service members and family members can access behavioral health information including recent news articles, self-assessment programs, and behavioral health flyers and brochures. The recently published "A TRICARE Guide: Understanding Behavioral Health" is also available on the page. It provides information on seven main topics: TRICARE and Your Behavioral Health; Understanding Behavioral Health; Covered Services, Limitations and Exclusions; Who to See for Care; Getting Care; Your Right to Privacy; and For Information and Assistance.

TRICARE Launches Beneficiary Bulletin Podcast

As part of a continuing effort to keep beneficiaries informed, TRICARE has added a news podcast to its Web site at *http://www.tricare.mil*. The TRICARE Beneficiary Bulletin brings listeners the latest news about their benefits every week. The debut podcast contains updates on TRS and points listeners to other useful online information sources.

The Beneficiary Bulletin features quick tips to promote a healthy lifestyle, news of other military health programs and news on upcoming changes to the TRICARE benefit. A new five minute TRICARE Beneficiary Bulletin will appear on the TRICARE Web site every Thursday at *http://www.tricare.mil/pressroom*. To be alerted when there is a new podcast and to sign up for other beneficiary news go to *http://www.tricare.mil* and click on "e-mail updates" in the press room section of the front page.

Study of TRICARE Beneficiary Data Associates Influenza Treatment With Reduction in Risk of Heart Attack and Stroke

A study using TRICARE beneficiary health data suggests that a common treatment for influenza may significantly decrease the risk of recurring cardiovascular (CV) events in patients with a history of CV disease. The influenza treatment is oseltamivir, more commonly known under its trade name of Tamiflu. Not a flu shot, the medication is used to help prevent the flu after exposure, or lessen the severity of symptoms.

The study findings are published in the March 2009 issue of "Circulation: Cardiovascular Quality and Outcomes" at *http://circoutcomes.ahajournals.org*. The article is among the "editor's picks."

Lead author, Dr. S. Ward Casscells, former ASD(HA), and colleagues including Army Major General Elder Granger, former deputy director of TMA, examined the electronic healthcare and pharmacy records of over 37,000 TRICARE beneficiaries. The examination focused on beneficiaries 18 and older with a history of CV disease and a subsequent diagnosis of influenza from October 1, 2003, through September 30, 2007.

Subjects were grouped according to whether they had filled a prescription for oseltamivir within two days of their influenza diagnosis. The incidence of recurrent CV events within 30 days after the influenza diagnosis among oseltavmivir-treated and untreated subjects was 8.5 percent and 21.2 percent respectively. Age was a persistent and significant contributor to the likelihood of recurrent CV issues.

After adjustment for demographic differences between those who were treated and those who were untreated, a significant protective effect was associated with oseltamivir treatment.

The findings warrant future controlled studies to confirm results, according to Casscells. Meanwhile, patients with CV disease should be sure to follow current guidelines for prevention and treatment of influenza in consultation with their doctor.

TMA Presents Findings During Annual Research Meeting

A panel of scientists were invited to present the results of four studies, conducted on behalf of the TMA, at Academy Health's Annual Research Meeting in Chicago on June 29, 2009.

AcademyHealth's Annual Research Meeting brings together health services researchers, providers, and key decision makers to address critical challenges confronting the nation's health care delivery system.

The panel presented four papers that examine proposed solutions to problems that face the MHS, including two on racial and ethnic disparities in health care, financial incentives for preventive care and patient perceptions of care.

Unlike other health plans, the MHS must guarantee the medical readiness of its Active Duty beneficiaries and provide care for the wounded, roles requiring greater flexibility and integration than is typical in civilian health plans.

To read TRICARE's abstracts visit: *http://www.academyhealth.org/files/arm/ARM-2009-Call-for-Panels-Abstracts-by-Session.pdf*.

Data Safeguards and Protections

During FY 2009 the TMA Privacy Office (the Privacy Office) undertook a series of both strategic and operational actions to address new and emerging challenges in data protection and information sharing. These significantly advanced TMA's ability to protect beneficiary information, while at the same time enabled information sharing between the DoD, the VA, and other national health care entities. The TMA Privacy Office accomplishments in FY 2009 include the following:

- Played an important role in the Nationwide Health Information Network (NHIN) Data Use and Reciprocal Support Agreement (DURSA) Team meetings facilitated by the Office of the National Coordinator (ONC) for Health Information Technology. The Privacy Office provided significant contributions to a well developed draft DURSA that will put DoD at the leading edge of information sharing in compliance with applicable privacy and security laws.
- Spearheaded TMA contributions to privacy compliance efforts in multiple DoD-VA integration and health information sharing projects in close coordination with the DoD-VA Interagency Program Office, the James Lovell Federal Health Care Center (FHCC) Administrative Task Group, and the Privacy Officer for the Veterans Health Administration. The Privacy Office participated in the Information Interoperability Plan (IIP) Working Group with personnel from seven other DoD/MHS offices in the planning and development of necessary actions to improve interoperability between DoD and VA in the future. Specific contributions included extensive analysis of complex proposals for the DoD-VA IIP, the Virtual Lifetime Electronic Health Record (VLER), the integration of the Naval Clinic Great Lakes, and the North Chicago VA Medical Center, and identifying privacy compliance issues with implications throughout TMA and other DoD Components.
- Established a TMA Privacy Board (the Board) in response to an identified gap in the review of research Data Use Agreements (DUA) pursuant to the Health Insurance Portability & Accountability Act (HIPAA), where the research involves MHS Protected Health Information (PHI) owned and/or managed by TMA. The Board's establishment ensures compliance with the HIPAA Privacy Rule and the approved revision, as well as the exception to policy regarding "DoD Health Information Privacy Regulation" (DoD 6025.18-R) when using or disclosing MHS PHI for research purposes.
- Supported implementation of agreements with federal partners to promote increased transparency and information sharing, expand research and treatment initiatives, and enhance efficiencies through the exchange of data and expertise. Included among the MHS's expanded data sharing efforts was a Memorandum of Understanding (MOU) between the DCoE and the Centers for Disease Control and Prevention (CDC) that established a direct interface to develop plans and technical approaches for TBI and psychological health (PH) research. Additional sharing efforts with other federal partners included revision of the draft DoD-VA Information Interoperability Plan. Collectively, these and other MHS sharing initiatives continue to promote increased cross-agency collaboration and effectiveness.
- Established a Compliance Assist Visit Program in order to measure compliance with the Privacy Act and HIPAA. This program will help ensure that TMA is able to demonstrate compliance with data protection requirements through regularly scheduled visits across TMA.

Participated in the DoD Privacy Impact Assessment (PIA) working group which is being facilitated by the Office of the ASD (Networks and Information Integration)/Office of the Chief Information Officer. This group was responsible for developing DoDI 5400.16, "DoD PIA Guidance," and Standard Form DD 2930, the DoD Privacy Impact Assessment template. Participation in this working group and development of the policy and template help ensure that the Department and Agency comply with the E-Government (E-Gov) Act of 2002, as well as ensuring that appropriate safeguards are in place for protection beneficiary information.

BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE AT A GLANCE: FACTS AND FIGURES—PROJECTED FOR FY 2010[1]

Total Beneficiaries	9.5 million[2]
Military Facilities—Direct Care System	**Total[3] U.S.**
Inpatient Hospitals and Medical Centers	59 (44 in U.S.)
Ambulatory Medical Clinics	364 (290 in U.S.)
Dental Clinics	282 (214 in U.S.)
Veterinary Facilities	288 (233 in U.S.)
Military Health System Personnel	135,437
Military	84,085 31,244 Officers 52,841 Enlisted
Civilian	51,352
Civilian Resources—Purchased Care System	
Network Individual Providers (primary care, behavioral health, and specialty care providers)	363,198
TRICARE-authorized Acute Care Hospitals	3,151
TRICARE Network Acute Care Hospitals	2,656
Contracted Retail Pharmacies	Approximately 61,500
Contracted Worldwide Pharmacy Mail Order Vendor	1
TRICARE Dental Program (TDP) (for Active Duty families, Reservists and families)	1,907,331 covered lives
Network dentists	65,099 52,711 General dentists 12,388 Specialists
TRICARE Retiree Dental Program (for retired uniformed service members and families)	1,185,663 covered lives
Dental provider offices (includes general and specialty dental practices)	136,841
Total Unified Medical Program (UMP)	$48.5 billion[4]
(Includes estimated FY 2010 receipts for Accrual Fund)	$10.8 billion[5]

[1] Note: Unless specified otherwise, this report presents budgetary, utilization and cost data for the DHP UMP only, not those related to deployment.

[2] Department of Defense (DoD) health care beneficiary population projected for the end of FY 2010 is 9,489,313, rounded to 9.5 million, based on the Managed Care Forecasting and Analysis System (MCFAS), as of OASD(HA) Acting CFO Memo September 21, 2009.

[3] MTF data from real property reports, Office of the Chief Financial Officer, December 15, 2009.

[4] Includes direct and private sector care funding, military personnel, military construction, and the Medicare-Eligible Retiree Health Care Fund (MERHCF) ("accrual fund") DoD Normal Cost Contribution paid by the U.S. Treasury.

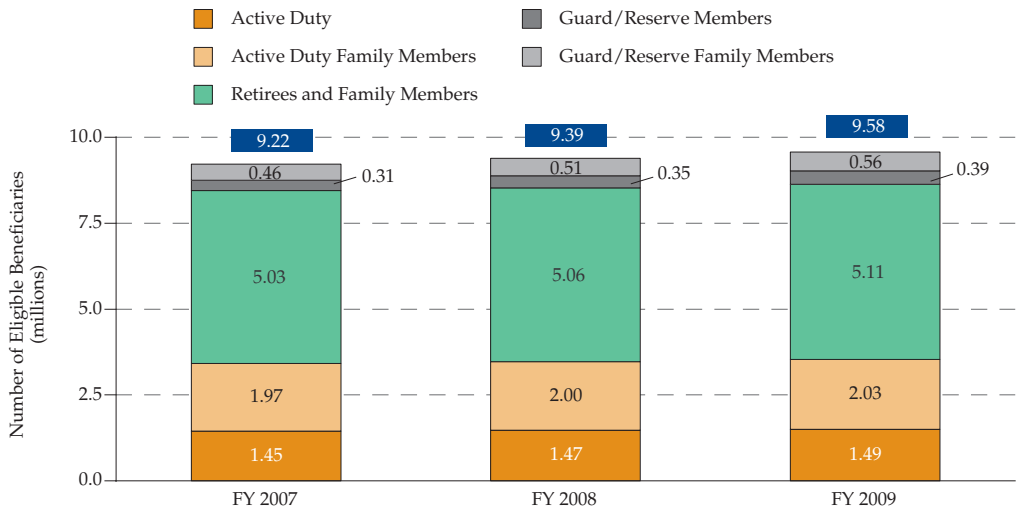
[5] The DoD (MERHCF), implemented in FY 2003, is an accrual fund that pays for health care provided in DoD/Coast Guard facilities to DoD retired, dependent of retired, and survivors who are Medicare-eligible beneficiaries. The fund also supports purchased care payments through the TFL benefit first implemented in FY 2002. There are three forms of contribution to Defense health care: (1) The accrual fund ($10.8B, normal cost contribution) discussed above is paid by the military Services for future health care liability accrued since October 1, 2002, for Active Duty, Guard, and Reserve beneficiaries and their family members when they become retired and Medicare-eligible; (2) $10.0B is paid by the Treasury to fund future health care liability accrued prior to October 1, 2001, for retired, Active Duty, Guard, and Reserves and their family members when they become retired and Medicare-eligible; and (3) $9.1B to pay for health care benefits provided today to current Medicare-eligible retirees, family members, and survivors (i.e., actual projected outlays from the trust fund—$7.5B for purchased care, $1.6B for direct (MTF) care, both Operations and Maintenance (O&M) as well as Military Personnel costs).

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Number of Eligible and Enrolled Beneficiaries Between FY 2007 and FY 2009

The number of beneficiaries eligible for DoD medical care (including TRS) increased from 9.22 million at the end of FY 2007 to 9.58 million* at the end of FY 2009. There were increases for all beneficiary groups, but the largest increase was for Guard/Reservists and their families. There was also a large increase in the number of retirees and family members age 65 and older (numbers included but not shown separately on the chart below).

TRENDS IN THE END-OF-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP

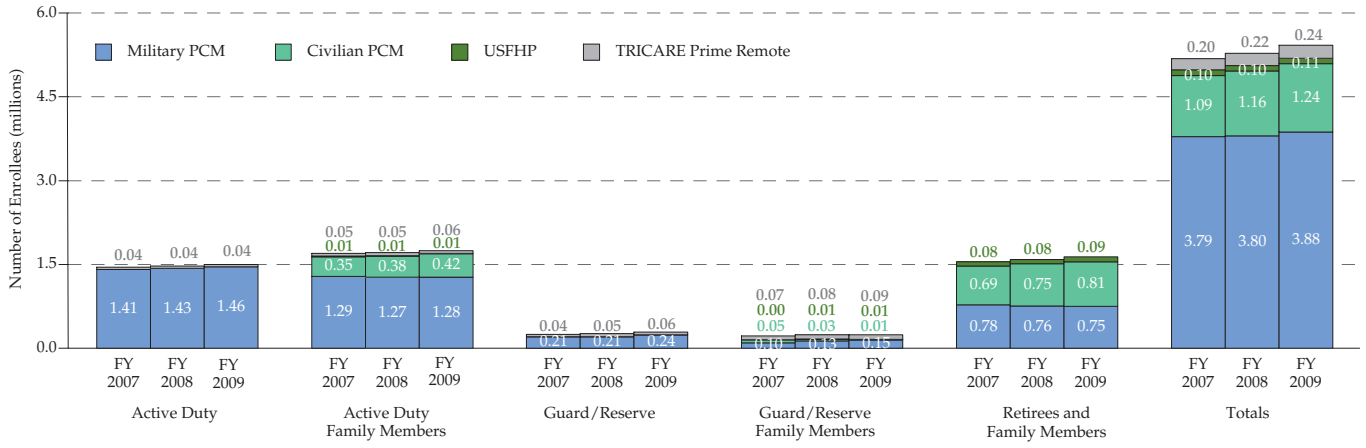


Source: DEERS 12/4/2009

* This number should not be confused with the one displayed under TRICARE FACTS AND FIGURES on page 15. The population figure on page 15 is a projected FY 2010 total, whereas the population reported on this page is the actual for the end of FY 2009.

- As MTF capacity remained tight as a result of the mobilization of Guard/Reserve members, more enrollees (especially retirees) were assigned to civilian PCMs.
- TPR enrollment grew substantially (19 percent) from FY 2007 to FY 2009, due largely to increased enrollment of Guard/Reservists and their family members.

TRENDS IN THE END-OF-YEAR NUMBER OF ENROLLED BENEFICIARIES BY BENEFICIARY GROUP



Source: DEERS 12/4/2009

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

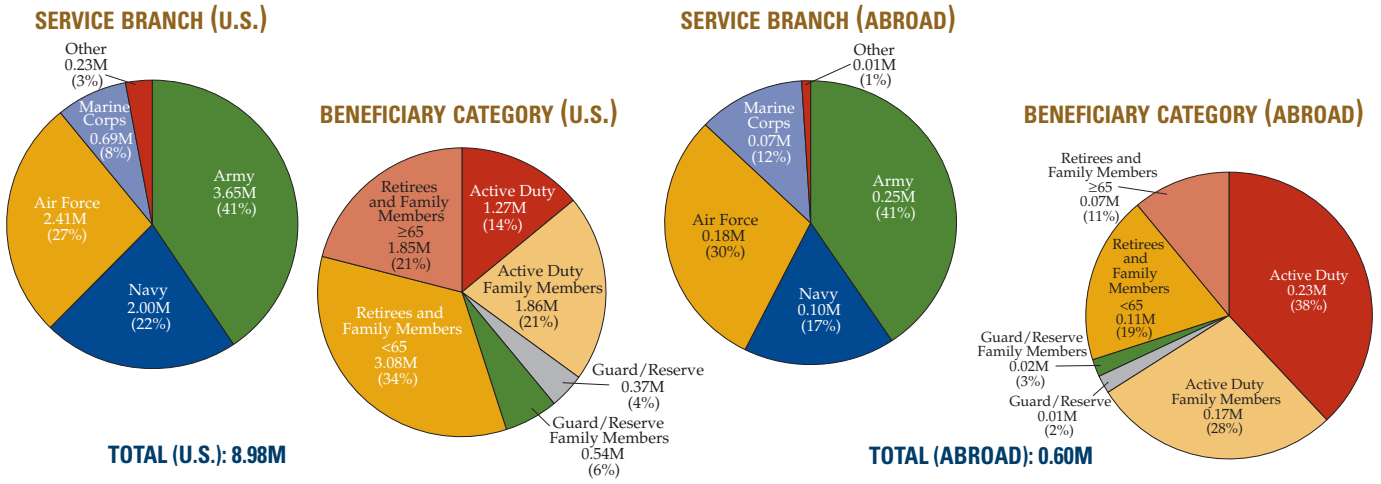
Eligible Beneficiaries in FY 2009

Of the 9.58 million eligible beneficiaries at the end of FY 2009, 8.98 million (94 percent) were stationed or resided in the U.S. and 0.60 million were 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 abroad as they are in the U.S.

Whereas retirees and their family members comprise the largest percentage of the eligible population (55 percent) in the United States (U.S.), Active Duty personnel (including Guard/Reserve Component [RC] members on Active Duty for at least 30 days) and their family members comprise the largest percentage (70 percent) of the eligible population abroad. The U.S. MHS population is presented at the state level on page 92, reflecting those enrolled in the Prime benefit and the total population, enrolled and non-enrolled.

Mirroring trends in the civilian population, the MHS will be confronted with an aging beneficiary population.

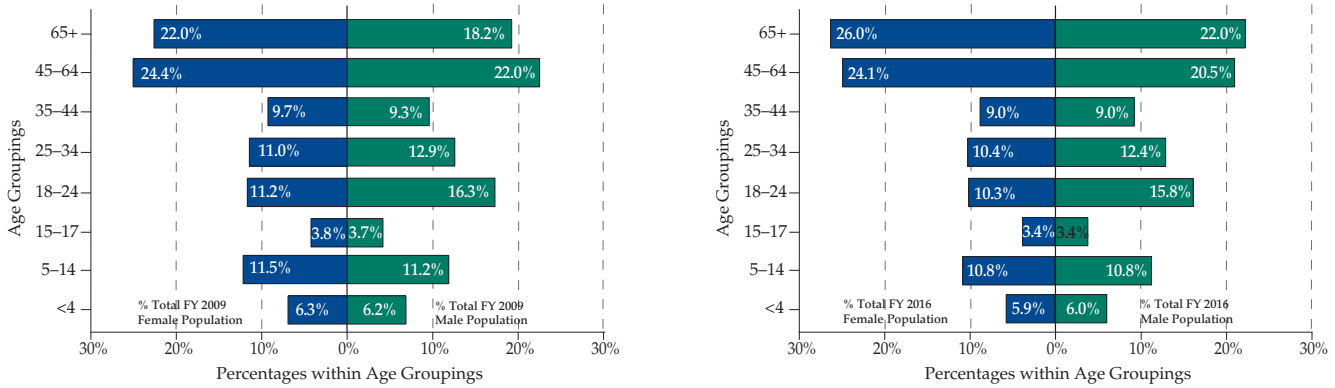
BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS AT THE END OF FY 2009



Source: DEERS, 12/4/2009

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

MHS END-YEAR POPULATION BY AGE AND GENDER, FY 2009 AND FY 2016



TOTAL MHS POPULATION (IN MILLIONS) BY AGE AND GENDER: CURRENT FY 2009 AND PROJECTED FY 2016

	Age Group								Total by Gender	Total MHS Population
	<4	5–14	15–17	18–24	25–34	35–44	45–64	65+		
FY 2009 Female MHS Beneficiaries	0.29	0.54	0.18	0.52	0.51	0.45	1.13	1.02	4.65	9.58
FY 2009 Male MHS Beneficiaries	0.31	0.55	0.18	0.80	0.64	0.46	1.09	0.90	4.93	9.58
FY 2016 Female MHS Beneficiaries, Projected	0.27	0.49	0.15	0.47	0.47	0.41	1.09	1.18	4.53	9.24
FY 2016 Male MHS Beneficiaries, Projected	0.28	0.51	0.16	0.74	0.59	0.43	0.97	1.04	4.71	9.24

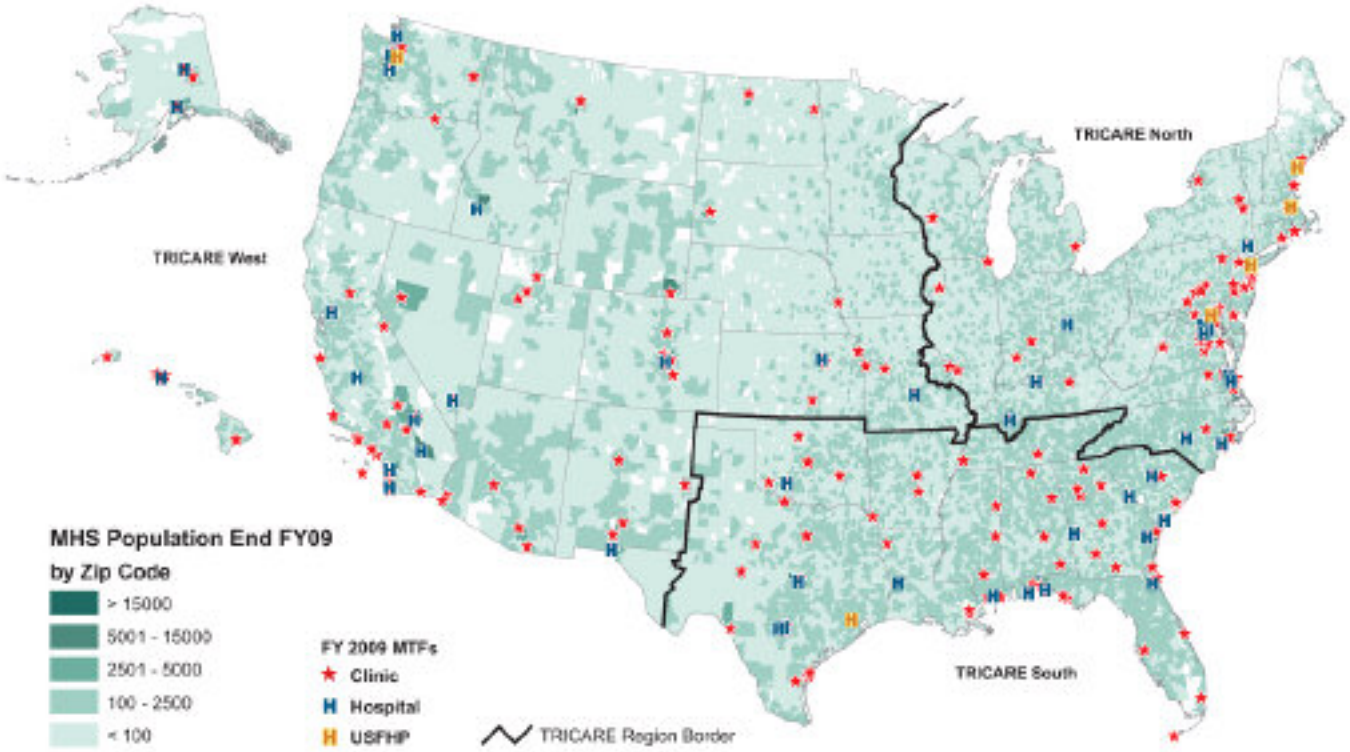
Source: MCFAS, as of 12/4/2009

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Locations of U.S. MTFs (Hospitals and Ambulatory Care Clinics) in FY 2009

The map below shows the geographic dispersion of the approximately 9 million beneficiaries eligible for the TRICARE benefit residing within the United States (94 percent of the almost 9.6 million eligible beneficiaries described on the previous pages). 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 has access to direct care and the Designated Provider Program benefit (the USFHP). As provided by law, the DoD has contracted with certain former US Public Health Service hospitals to be TRICARE Prime designated providers. The Uniformed Services Family Health Plan (USFHP) offers the TRICARE Prime benefits plan to approximately 100,000 ADFMS and military retirees and their eligible family members, including those 65 years of age and over, regardless of whether or not they participate in Medicare Part B.

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs IN FY 2009



Source: MTF information from TMA Portfolio Planning Management Division; residential population and Geographic Information Systems information from TMA/Health Program Analysis and Evaluation and DEERS 12/18/2009

MTFs OUTSIDE THE U.S.

Source: MTF information from TMA Portfolio Planning Management Division; residential population and GIS information from TMA/HPA&E and DEERS, 12/18/2009

Note: These two maps show only MTF locations, not population concentrations.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

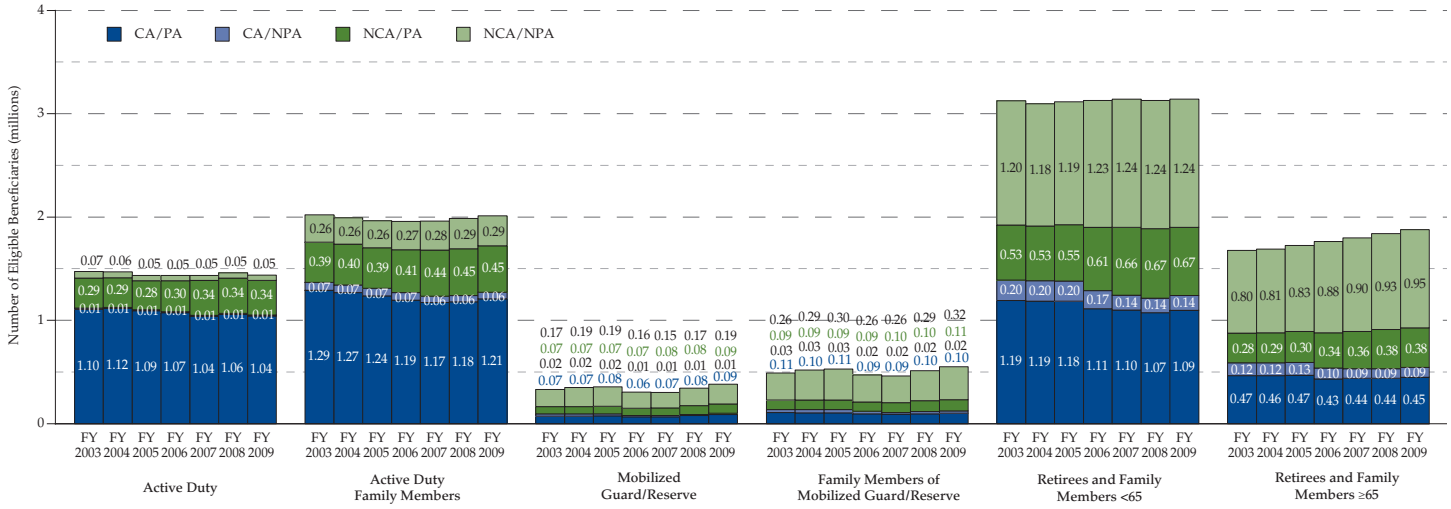
Eligible Beneficiaries Living in Catchment and PRISM Areas

Historically, military hospitals have been defined by two geographic boundaries or market areas: a 40-mile catchment area boundary for inpatient and referral care and a 20-mile Provider Requirement Integrated Specialty Model (PRISM) area boundary for outpatient care. Stand-alone clinics or ambulatory care centers have only a PRISM area boundary.[1] Non-catchment and non-PRISM areas lie outside catchment area and PRISM area boundaries, respectively.

Because of Base Realignment and Closure (BRAC) actions, other facility closings and downsizings, and changes in the beneficiary mix over time, there has been a downward trend in the proportion of beneficiaries living in catchment areas (from 52 percent in FY 2003 to 46 percent in FY 2009). The percentage living in PRISM areas has remained relatively constant at about 64 percent. These population trends partially explain the shift in MHS workload from direct care to purchased care facilities in the FYs 2003–2009 time frame.

- More beneficiaries live in PRISM areas because, though smaller than catchment areas, they are far more numerous (290 PRISM areas vs. 59 catchment areas).
- There has been a decreasing trend in the number of Active Duty and retiree family members living in catchment areas.
- There has been a steady increase in the number of beneficiaries living in non-catchment PRISM areas.
- The mobilizations of National Guard and Reserve members have contributed disproportionately to the total number of beneficiaries living in non-catchment areas. Most Guard/Reserve members already live in non-catchment 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 AND PRISM AREAS (END-YEAR POPULATIONS)



Source: DEERS, 10/27/2009

[1] The distance-based catchment and PRISM area concepts have been superseded within the MHS by a time-based geographic concept referred to as an MTF Enrollment Area. An MTF Enrollment Area is defined as the area within 30 minutes drive time of an MTF in which a commander may require TRICARE Prime beneficiaries to enroll with the MTF. However, because this is a relatively new concept, it has not yet been implemented within DEERS or in MHS administrative data and is consequently unavailable for use in this report.

Note: CA/PA refers to the area within 20 miles of a military hospital; it indicates proximity to both inpatient and outpatient care. CA/NPA refers to the area beyond 20 but within 40 miles of a military hospital; it indicates proximity to inpatient care only. NCA/PA refers to the area within 20 miles of a freestanding military clinic (no military hospital nearby); it indicates proximity to outpatient care only. NCA/NPA refers to the area beyond 20 miles of a freestanding military clinic; it indicates lack of proximity to either inpatient or outpatient MTF-based care.

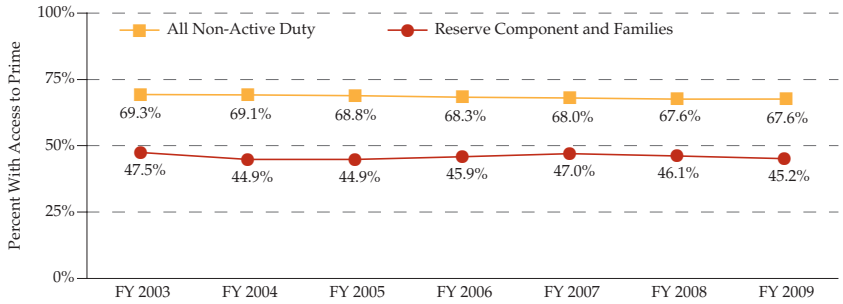
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Beneficiary Access to Prime

Non-Active Duty beneficiaries living in neither a catchment nor a PRISM area have limited or no access to MTF-based Prime.

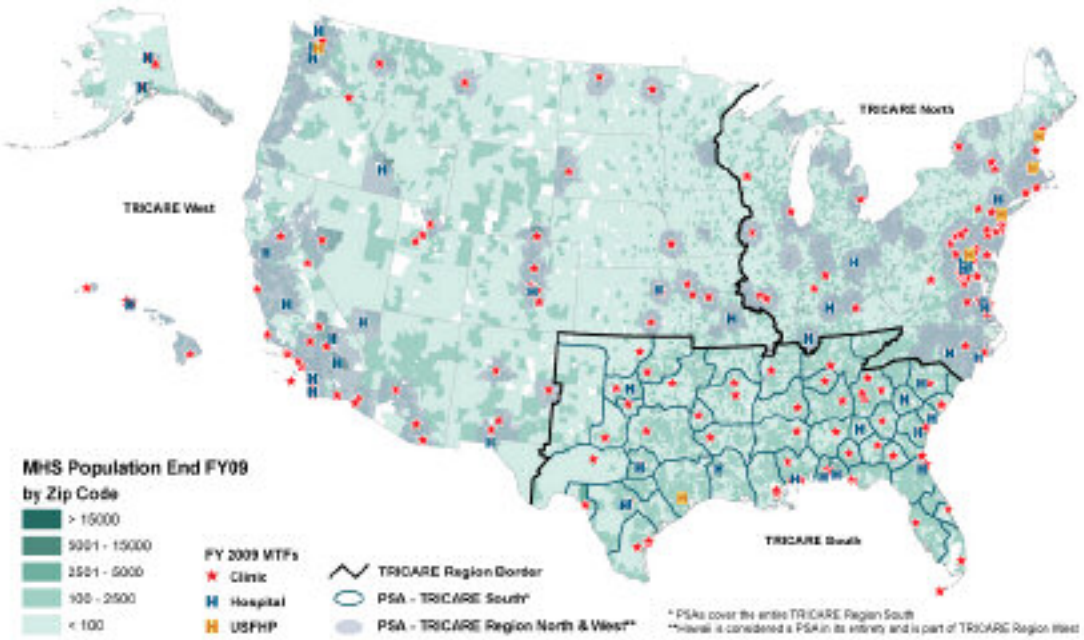
- The number of beneficiaries with access to MTF-based Prime (i.e., those living in a catchment or PRISM area) declined from 69.3 percent of the eligible non-Active Duty population (ADFMs and retirees and family members under age 65) in FY 2003 to 67.6 percent in FY 2009. The decline is largely due to the closings of military hospitals and clinics over that time period. Reserve Component (RC) members with access to MTF-based Prime declined from 47.5 to 45.2 percent over the same period.

TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME



Source: DEERS, 12/4/2009

- Prime Service Areas (PSAs) are those geographic areas where the TRICARE Managed Care Support Contractors (MCSCs) offer the TRICARE Prime benefit through established networks of providers. TRICARE Prime is available at MTFs, in areas around most MTFs ("MTF PSAs"), in a number of areas where an MTF was eliminated in the BRAC process ("BRAC PSAs"), and in some other areas where the MCSCs proposed in their contract bids to offer the benefit ("non-catchment PSAs").
- The map below shows the MTF, BRAC, and noncatchment PSAs, to present an overall picture of the geography of provider networks developed to support TRICARE Prime. Note that in the TRICARE South Region, the MCSC has identified as a noncatchment PSA all portions of the region that lie outside MTF and BRAC PSAs.



Source: TRICARE Regional Offices for PSA zip codes, MTF information from TMA Portfolio Planning Management Division, and residential population and GIS information from TMA/HPA&E and DEERS, 12/18/2009

Note: See previous page: the distance-based catchment and PRISM area concepts have been superseded within the MHS by a time-based geographic concept referred to as an MTF Enrollment Area.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

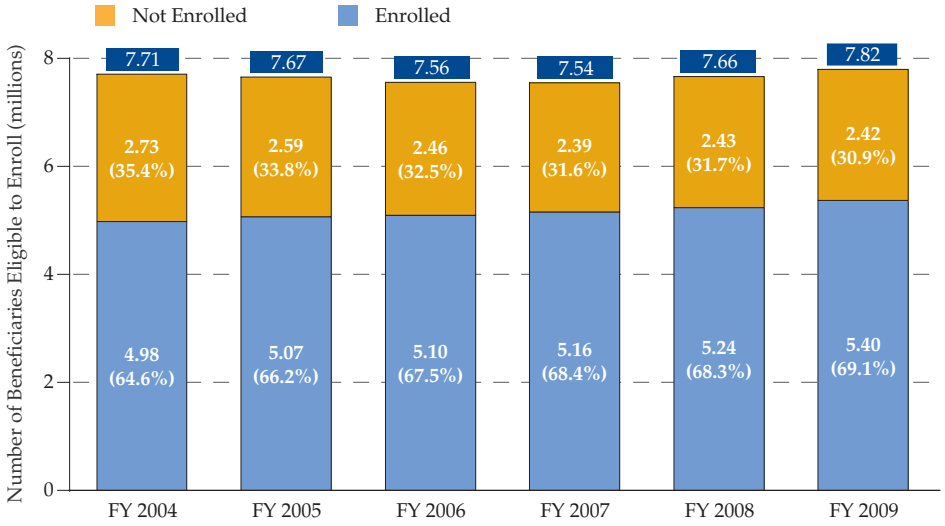
Eligibility and Enrollment in TRICARE Prime

Eligibility for and enrollment in TRICARE Prime was determined from Defense Enrollment Eligibility Reporting System (DEERS). For the purpose of this Report, all Active Duty personnel are considered to be enrolled. The eligibility counts exclude most beneficiaries age 65 and older but include beneficiaries living in remote areas where Prime may not be available. The enrollment rates displayed below may therefore be somewhat understated.

Beneficiaries enrolled in TPR (including Global Remote) and the USFHP are included in the enrollment counts below. Beneficiaries enrolled in TRICARE Plus (a primary care enrollment program offered at selected MTFs) and TRS are excluded from the enrollment counts below; they are included in the non-enrolled counts.

- In terms of total numbers, and as a percentage of those eligible to enroll, TRICARE enrollment has steadily increased since FY 2004.
- After peaking in FY 2005, the number of TRICARE Plus enrollees declined slightly in FY 2006 and again in FY 2007 (not shown). Enrollment has remained flat since then. The trend is likely due to reduced capacity for TRICARE Plus enrollment at many MTFs.
- By the end of FY 2009, 69 percent of all eligible beneficiaries were enrolled (5.40 million enrolled of the 7.82 million eligible to enroll).

HISTORICAL END-OF-YEAR ENROLLMENT NUMBERS



Source: DEERS, 12/4/2009

Note: Numbers may not sum to bar totals due to rounding. Detailed MHS enrollment data by state can be found in the Appendix, page 92.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

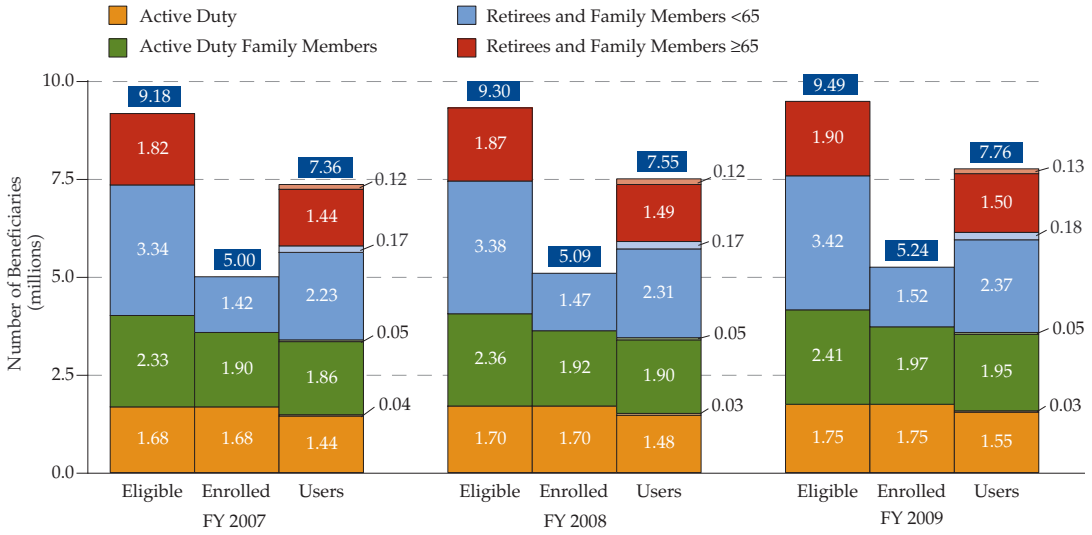
Recent Three-year Trend in Eligibles, Enrollees, Users

When calculating the number of beneficiaries eligible to use MHS services, average beneficiary counts are more relevant than end-year counts because total utilization is generated by beneficiaries eligible for any part of the year. The average numbers of eligibles and TRICARE Prime enrollees by beneficiary category from FY 2007 to FY 2009 were determined from 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 and Reserve Select 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.

- The number of eligibles increased for each beneficiary group between FY 2007 and FY 2009. Retirees and family members age 65 and older continue to increase at the fastest rate of any beneficiary group (4.4 percent).
- The percentage of retirees and family members under age 65 enrolled in TRICARE Prime increased from 42 percent in FY 2007 to 44 percent in FY 2009. The increase is due primarily to formerly non-MHS-reliant retirees dropping their private health insurance because of rising premiums.
- The overall user rate grew from 80.2 percent in FY 2007 to 81.7 percent in FY 2009. The user rate increased slightly for all beneficiary groups except for retirees and family members age 65 and older.
- Retirees and family members under age 65 have the greatest number of users of the MHS but the lowest user rate. Their MHS utilization rate is lower because many of them have Other Health Insurance (OHI).

AVERAGE NUMBER OF FY 2007 TO FY 2009 ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY

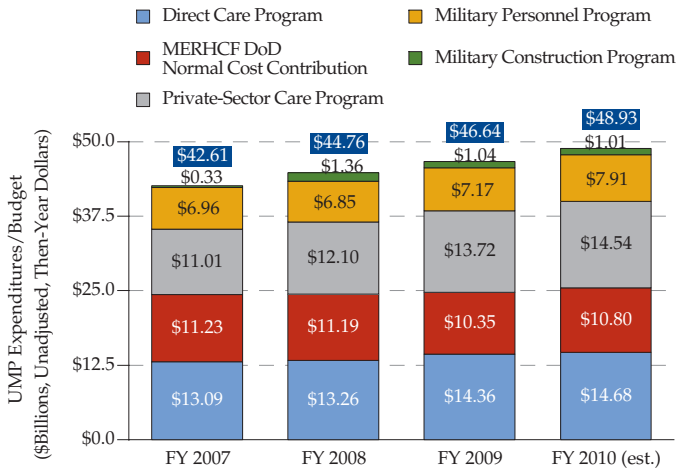


Sources: DEERS and MHS administrative data, 12/4/2009

Note: Numbers may not sum to bar totals due to rounding. The bar totals reflect the average number of eligibles and enrollees, not the end-year numbers displayed in previous charts to account for beneficiaries who were not eligible or enrolled the entire year.

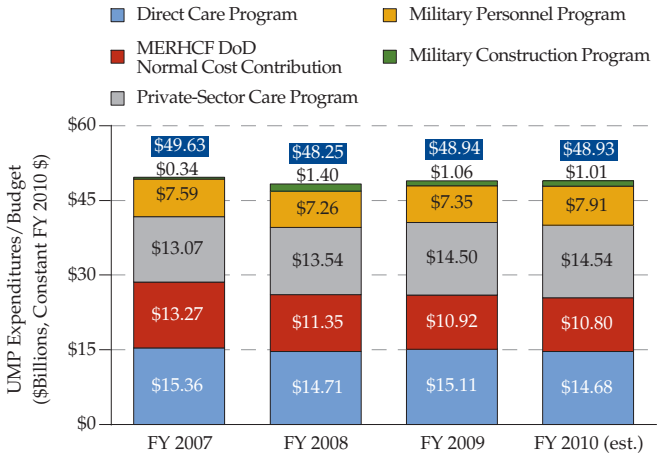
UNIFIED MEDICAL PROGRAM FUNDING

FY 2007 TO FY 2010 (EST.) UNIFIED MEDICAL PROGRAM ($ BILLIONS) (UNADJUSTED, THEN-YEAR DOLLARS)



As shown in the first chart to the left, in terms of unadjusted expenditures (i.e., "then-year" dollars, unadjusted for inflation), the Unified Medical Program (UMP) increased 9.5 percent from almost $43 billion in FY 2007 to almost $47 billion in FY 2009, and is currently programmed for almost $49 billion (estimated) in FY 2010 (as reflected in the President's Budget Estimates). Over half of the $6 billion growth in total expenditures from FY 2007 to the projected FY 2010 budget is in the private sector, purchased care component of the UMP. The FY 2007 to FY 2010 funding and programmed budget shown includes the normal DoD cost contribution to the Medicare-Eligible Retiree Health Care Fund (MERHCF) (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 retail pharmacy network, which began in April 2001, and the TFL benefit, which began in October 2001.

FY 2007 TO FY 2010 (EST.) UNIFIED MEDICAL PROGRAM ($ BILLIONS) IN CONSTANT FY 2010 DOLLARS



In constant-year FY 2010 dollar funding, when actual expenditures or projected funding are adjusted for inflation, the FY 2010 purchasing value ($48.9 billion) is currently programmed to be over 1 percent less than the FY 2007 purchasing value of $49.6 billion.

Source: Cost and Budget Estimates OASD(HA)/OCFO as of 1/22/2010

Note: For both charts above and the "UMP Expenditures" chart on the next page:

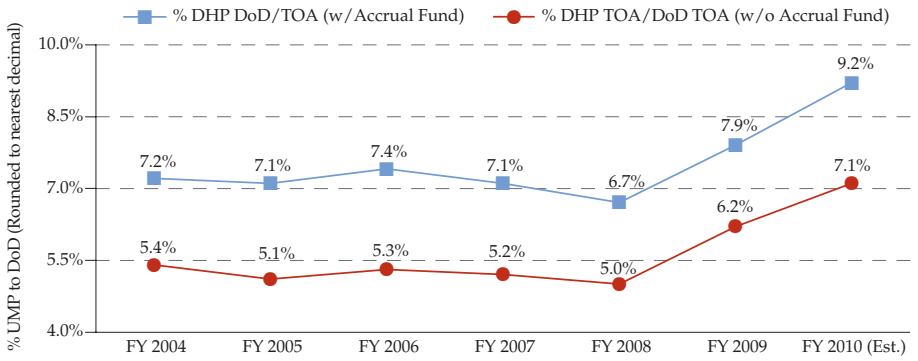
1. FYs 2000–2007 reflect Comptroller Information System Actual execution.
2. FYs 2008–2015 reflect the FY 2009 DHP POM submission.
3. Source of data for deflators (MILPERS, DHP, Procurement, RDT&E and MILCON) is Tables 5–4/5–5, DoD Deflators--TOA, National Defense Budget Estimates for FY 2009 (Green Book).
4. Deflators for constant–year dollars are based on FY 2010 dollars, so FY 2010 is 1.000.
5. Medicare Eligible Retiree Healthcare Fund Deflator computed using a combination of MILPERS and DHP factors.
6. TRICARE for Life and other NDAA enhancements commenced in FY 2002, resulting in an approximate $4B increase.
7. TRICARE for Life reached maturation in FY 2003.
8. While not shown in the charts above, FY 2004 budget includes $658.4 M for Overseas Contingency Operations (OCO); FY 2004/FY 2005 Title IX Funding of $683M (executed in FY 2005); $400M for NDAA Reserve Health Care Benefit.
9. While not shown in the charts above, FY 2005 budget includes the FY04/FY05 Title IX Funding of $683M (executed in FY05); $210.6M in OCO supplemental; $20.5M for Hurricane/Tsunami Supplement.
10. While not shown in the charts above, FY 2006 actuals include supplementals supporting OCO ($1,110.8M), Hurricane Relief ($208.1M), Avian Flu ($120M), and Army Modularity ($42.8M).
11. FY 2007 actuals include supplementals ($2,528M) supporting OCO and other programs such as TBI/PH, Wounded Warrior and Pandemic Influenza.
12. FY 2008 actuals include $1.461B O&M supplemental funding in support of Operation Noble Eagle.
13. FY 2009 actuals include OCO, referred to in previous reports as OCO supporting the conflicts in Afghanistan and Iraq).
14. FY 2010 estimates a $372M increase to RDT&E for eye, hearing, TBI, PH, prosthetic, and other battlefield-related injuries.
15. FY 2010 current estimate includes Operation and Maintenance funding of $1,256.7 million from Public Law 111-118, Department of Defense Appropriations Act for FY 2010; and includes $140.0 million ($132.0 million for Operation and Maintenance and includes $8.0 million for Research, Development, Test and Evaluation) transferred from the Department of Health and Human Services for Pandemic Influenza Preparedness and Response appropriated under Public Law 111-32, Supplemental Appropriations Act of 2009, Title VIII.

UNIFIED MEDICAL PROGRAM FUNDING *(CONT'D)*

UMP Share of Defense Budget

UMP expenditures are expected to increase from 7.2 percent of DoD Total Obligational Authority (TOA) in FY 2004 to 9.2 percent estimated for FY 2010, including the Accrual Fund (as currently reflected in the FYs 2008–2015 President's Budget Request). When the Accrual Fund is excluded, the UMP's share is expected to increase from 5.4 percent in FY 2004 to 7.1 percent in FY 2010.

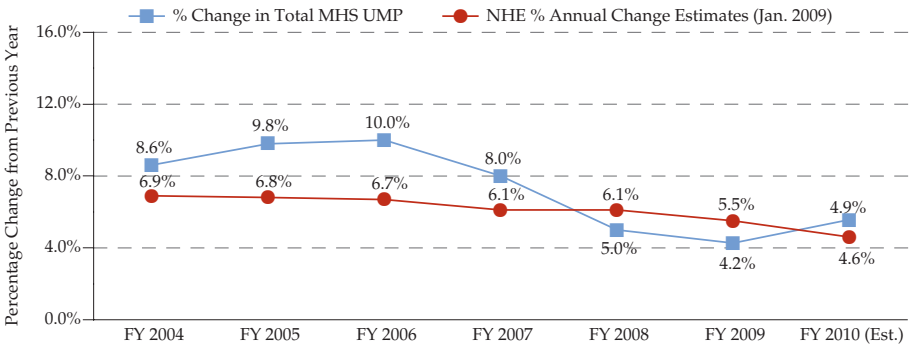
UMP EXPENDITURES AS A PERCENTAGE OF DEFENSE BUDGET: FY 2004 TO FY 2010 (EST.)



Comparison of Unified Medical Program and National Health Expenditures Over Time

The U.S. Department of Health and Human Services (HHS) estimates that, while National Health Expenditures (NHE) will continue to increase over time, the projected rate of growth will decline by about 2 percentage points from FY 2004 to FY 2010. The annual rate of growth in the UMP increased from FY 2004 to FY 2006, and reaching a peak of 10 percent growth in FY 2006, declined through FY 2009. During that period, the UMP rate of growth first exceeded the NHE estimate growth from FY 2004 through FY 2007, but was lower in FY 2008 and FY 2009. The UMP and NHE estimates are both projected to be comparable at under 5 percent in FY 2010.

COMPARISON OF CHANGE IN ANNUAL UMP AND NHE OVER TIME: FY 2004 TO FY 2010 (EST.)



Sources:

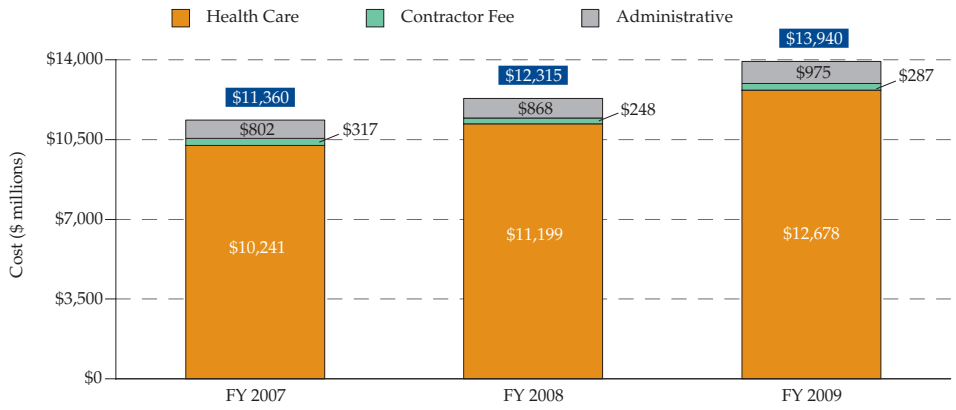
1. NHE based on Department of Health and Human Services: *http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf.* NHE Amounts by Type of Expenditure and Source of Funds: Calendar Years 1965–2018 in PROJECTIONS format Table. The health spending projections were based on the 2007 version of the NHE released in January 2009.
2. DHP: Cost and Budget Estimates OASD(HA)/OCFO, 1/22/2010

PRIVATE SECTOR CARE ADMINISTRATIVE COSTS

The private sector care budget activity group includes underwritten health care, pharmacy, Active Duty supplemental care, dental care, overseas care, the health care portion of USFHP capitation, funds received and executed for the Overseas Contingency Operations (OCO), funds authorized and executed under the DHP carry-over authority, and other miscellaneous expenses. It excludes costs for non-DoD beneficiaries and MERHCF expenses.

- Total private sector care costs grew from $11,360 million in FY 2007 to $13,940 million in FY 2009, an increase of 23 percent.
- Excluding contractor fee, administrative expenses declined from 7.3 percent of total private sector care costs in FY 2007 to 7.1 percent in FY 2009. Including contractor fee, administrative expenses declined from 9.9 percent to 9.1 percent of total private sector care costs.

TREND IN PRIVATE SECTOR CARE COSTS



Source: TRICARE Management Activity, Office of the Chief Financial Officer, Private Sector Care Requirements Office budget data execution and methodology, 11/5/2009

Note: The FY 2007, FY 2008 and FY 2009 totals in the chart above are greater than the Private Sector Care Program costs because the former include carry-over funding. TMA has congressional authority to carry over a certain percentage of funding into the following year. The FY 2007, FY 2008, and FY 2009 amounts carried forward from the prior year appropriation were $352M, $212M, and $226M, respectively. The amount authorized to be carried over from year to year historically has been 2 percent but in FY 2008 the authority was reduced to 1 percent of the Operations and Maintenance account.

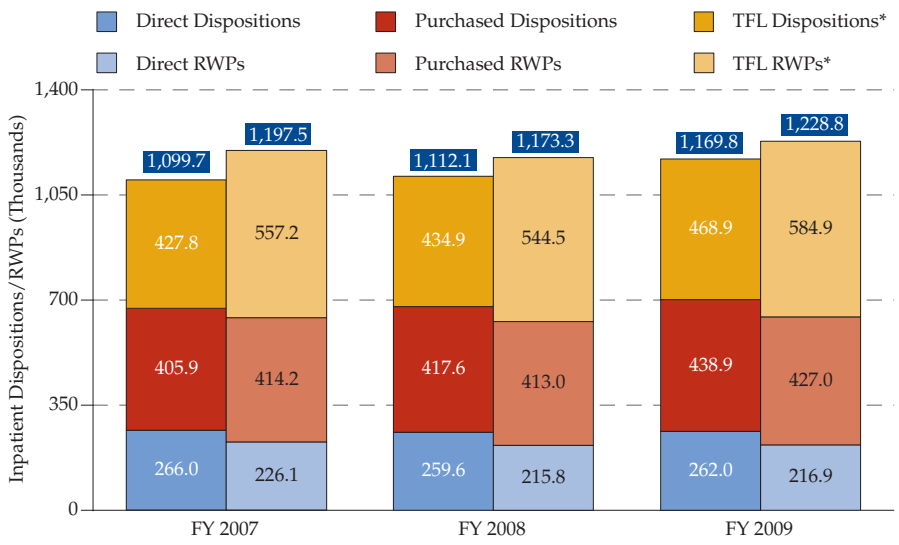
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE)

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, relevant only for acute care hospitals, reflects the relative resources consumed by a hospitalization as compared with 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 2007 and FY 2009 (dispositions increased by 4 percent and RWPs by 1 percent), excluding the effect of TFL.

- Direct care inpatient dispositions declined by 2 percent and RWPs declined by 4 percent over the past three years. This can be partially attributed to a decline in the number of MTFs performing inpatient workload over this period.
- Excluding TFL workload, purchased care inpatient dispositions increased by 8 percent and RWPs increased by 3 percent between FY 2007 and FY 2009.
- Including TFL workload, purchased care dispositions increased by 9 percent and RWPs increased by 4 percent between FY 2007 and FY 2009.
- While not shown, about 10 percent of direct care inpatient dispositions and 9 percent of RWPs were performed abroad in FY 2009. 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, 2/5/2010

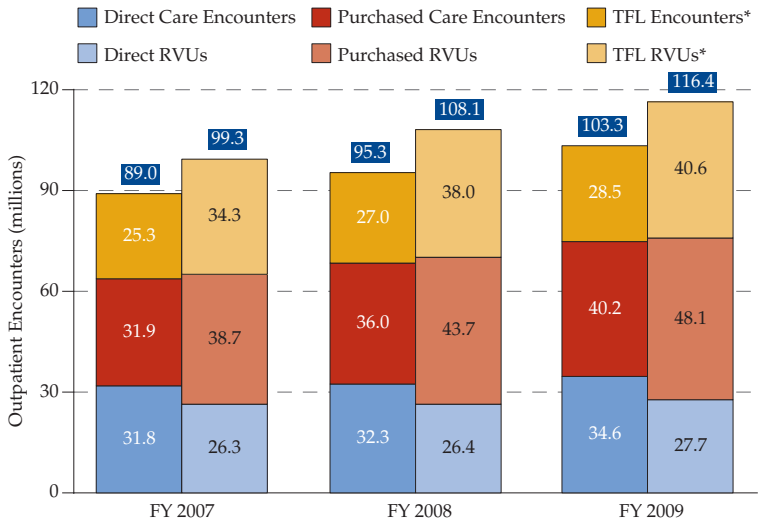
* Purchased care only

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(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 with the average of all encounters. Total outpatient workload (direct and purchased care combined) increased between FY 2007 and FY 2009 (both encounters and RVUs increased by 17 percent), excluding the effect of TFL.

TRENDS IN MHS OUTPATIENT WORKLOAD



Source: MHS administrative data, 2/5/2010

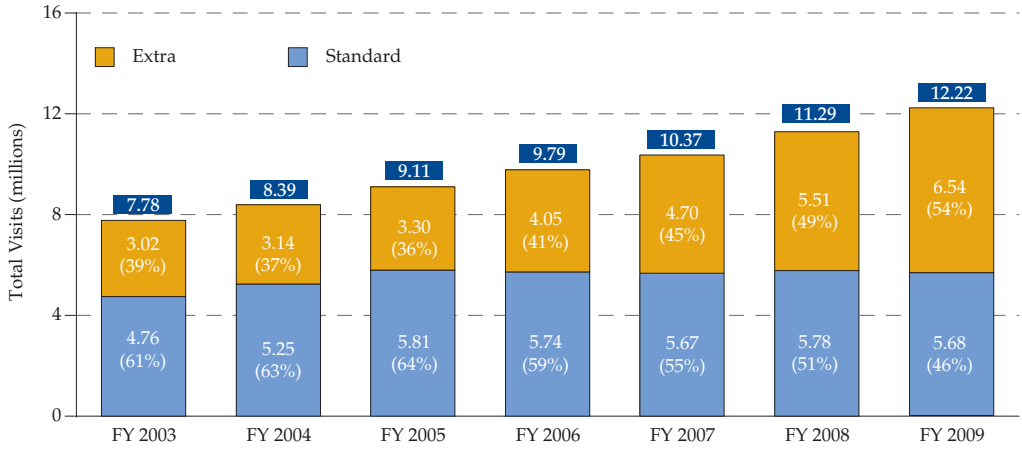
* Purchased care only.

- Direct care outpatient encounters increased by 9 percent and RVUs by 5 percent over the past three years, despite a slight decrease in the number of MTFs performing outpatient workload.
- Excluding TFL workload, purchased care outpatient encounters increased by 26 percent and RVUs by 25 percent. Including TFL workload, encounters increased by 20 percent and RVUs by 22 percent.
- While not shown, about 13 percent of direct care outpatient workload (both encounters and RVUs) was performed abroad. Purchased care and TFL outpatient workload performed abroad accounted for only about 1 percent of the worldwide total.

Extra vs. Standard Non-Prime Visits

For beneficiaries not enrolled in Prime, the ratio of Extra to Standard visits has been steadily increasing with time. In FY 2003, Extra visits accounted for only 39 percent of all non-Prime visits. In FY 2008, that percentage had increased to 49 percent and, for the first time in FY 2009, the number of Extra visits exceeded the number of Standard visits (54 percent).

TRENDS IN EXTRA VS. STANDARD VISITS



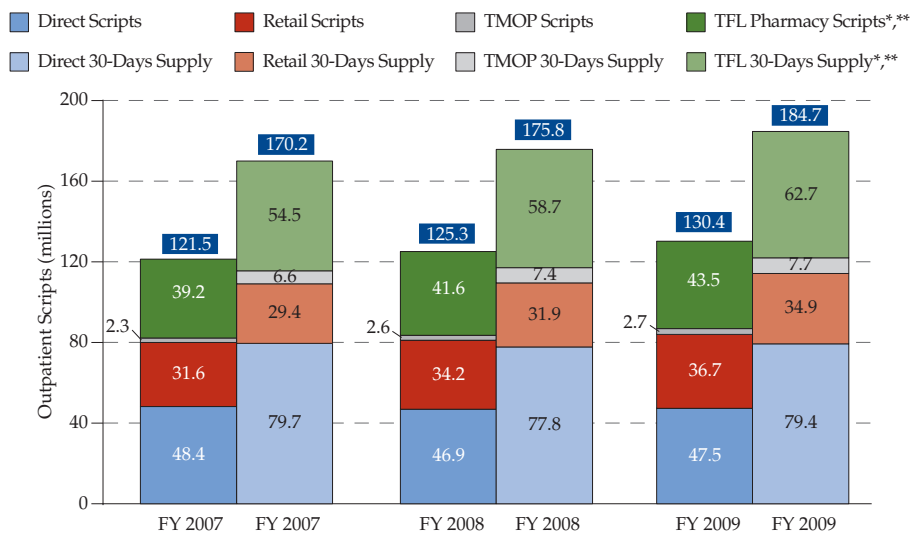
Source: MHS administrative data, 2/5/2010

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT'D)*

MHS Prescription Drug Workload

Total MHS outpatient prescription workload is measured two ways: as the number of prescriptions and as the number of days supply (in 30-day increments). Total prescription drug workload (direct and purchased care combined) increased between FY 2007 and FY 2009 (both prescriptions and days supply increased by 5 percent), excluding the effect of TFL pharmacy purchased care usage (TFL beneficiaries may fill prescription medications at MTF pharmacies; through the TRICARE Mail Order Pharmacy (TMOP); at TRICARE retail network pharmacies; and at non-network pharmacies).

TRENDS IN MHS PRESCRIPTION WORKLOAD



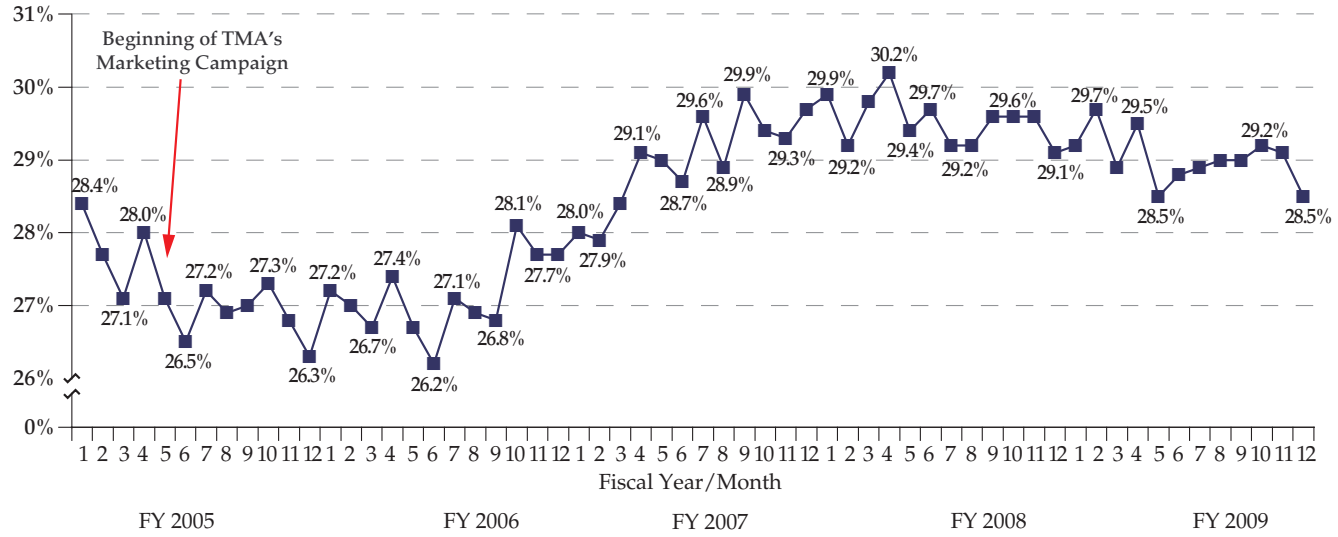
Source: MHS administrative data, 2/5/2010

* TMOP workload for TFL-eligible beneficiaries is included in the TFL total.
** Purchased care only.

- Direct care scripts fell by 2 percent and days supply remained unchanged between FY 2007 and FY 2009.
- Purchased care scripts increased by 16 percent and days supply by 18 percent from FY 2007 to FY 2009, excluding the impact of the TFL pharmacy usage. Including the impact of TFL pharmacy usage, purchased scripts increased by 13 percent and days supply by 16 percent.
- While not shown, almost 7 percent of direct care prescriptions were issued abroad. Purchased care prescriptions issued abroad accounted for less than 2 percent of the worldwide total.

Although the TMOP and its predecessor, the National Mail Order Pharmacy, have been available to DoD beneficiaries since the late 1990s, they have never been heavily used. TMOP offers benefits to both DoD and its beneficiaries since DoD negotiates prices that are considerably lower than those for retail drugs, and the beneficiary receives up to a 90-day supply for the same copay as a 30-day supply at a retail pharmacy. Concerned that beneficiaries were not taking advantage of a good benefit, DoD launched a marketing campaign in February 2006 to increase beneficiary awareness of the benefits offered by the TMOP.

TREND IN TMOP UTILIZATION (DAYS SUPPLY) AS A SHARE OF TOTAL PURCHASED CARE UTILIZATION



Source: MHS administrative data, 2/5/2010

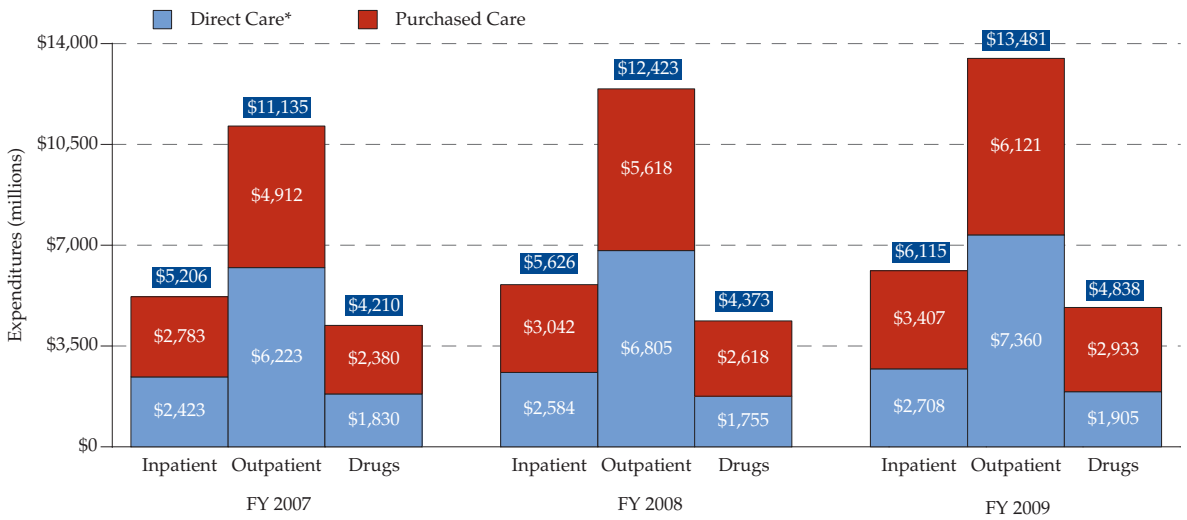
The TMOP share of total purchased care utilization had been steadily increasing from the inception of the TMA marketing campaign until January 2008, when it reached its peak. However, the TMOP share has been gradually declining since January 2008.

MHS COST TRENDS

Total MHS costs (net of TFL) increased between FY 2007 and FY 2009 for all three major components of health care services: inpatient, outpatient, and prescription drugs. The proportion of total MHS costs accounted for by each health care service type remained about the same. Overall, direct care costs increased by 14 percent and purchased care costs increased by 24 percent.

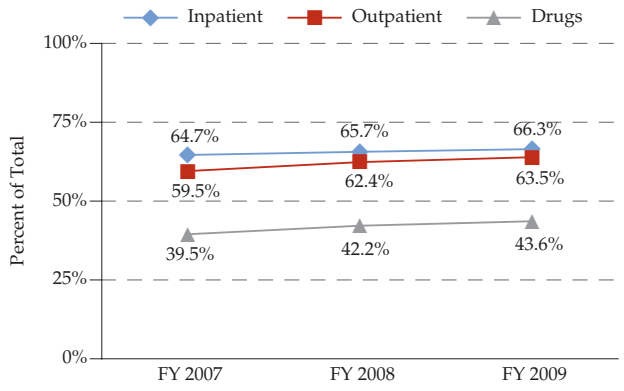
- The share of DoD expenditures on outpatient care relative to total expenditures on inpatient and outpatient care remained at about 68–69 percent from FY 2007 to FY 2009. For example, in FY 2009, DoD expenses for inpatient and outpatient care totaled $19,596 million, of which $13,481 million was for outpatient care for a ratio of $13,481/$19,596 = 69 percent.
- In FY 2009, DoD spent $2.20 on outpatient care for every $1 spent on inpatient care.
- The proportion of total expenses for care provided in DoD facilities fell from 51 percent in FY 2007 to 49 percent in FY 2009.

TREND IN DoD EXPENDITURES FOR HEALTH CARE (NET OF TFL)

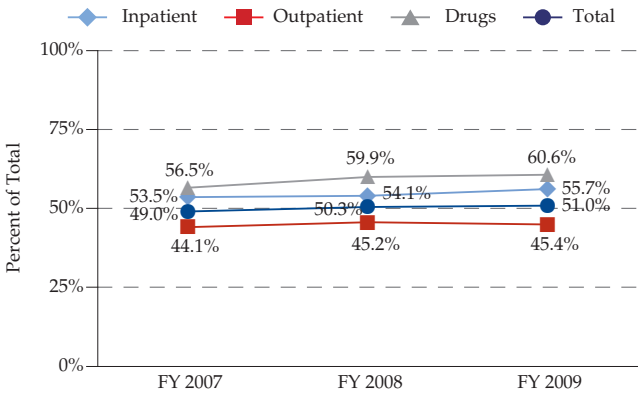


Source: MHS administrative data, 2/5/2010
* Direct care prescription costs include an MHS-derived dispensing fee.

TRENDS IN PURCHASED CARE UTILIZATION AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE



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



Source: MHS administrative data, 2/5/2010
Note: TFL purchased care costs are excluded from the above calculations.

- The purchased care share of total inpatient utilization increased slightly from 65 percent in FY 2007 to 66 percent in FY 2009. The purchased care share of total outpatient utilization increased from 60 to 64 percent and the purchased care share of total prescription utilization increased from 40 to 44 percent.
- The purchased care share of total MHS inpatient costs increased from 54 percent in FY 2007 to 56 percent in FY 2009. For outpatient costs, the purchased care share increased from 44 to 45 percent. Of all the medical services, prescription drugs exhibited the steepest increase in the purchased care share, from 57 to 61 percent.

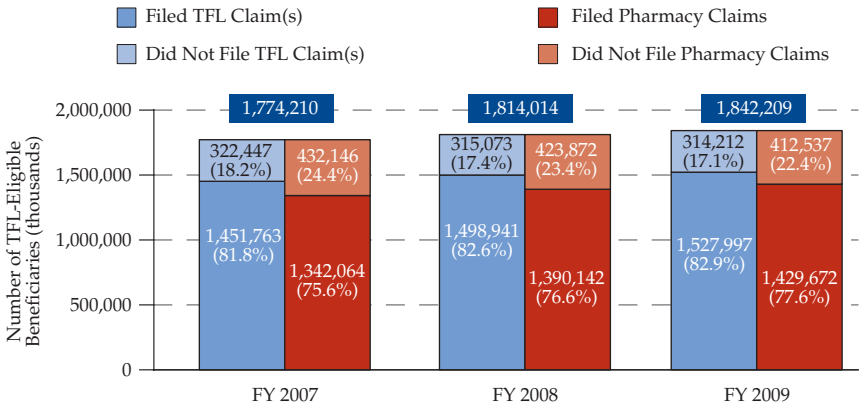
IMPACT OF TRICARE FOR LIFE (TFL) IN FYs 2007–2009

The TFL program began October 1, 2001, in accordance with the Floyd D. Spence NDAA 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.

TFL Beneficiaries Filing Claims

- The number of Medicare-eligible beneficiaries age 65 and older grew from 1.83 million at the end of FY 2007 to 1.91 million at the end of FY 2009.
  - The percentage eligible for TFL remained about the same from FY 2007 to FY 2009. At the end of FY 2009, about 96 percent (1.84 million) were eligible for the TFL benefit (including pharmacy), whereas the remainder were ineligible for TFL because they did not have Medicare Part B coverage (either by choice or ineligibility).

TFL-ELIGIBLE BENEFICIARIES FILING TFL HEALTH CARE AND PHARMACY CLAIMS IN FY 2007 TO FY 2009



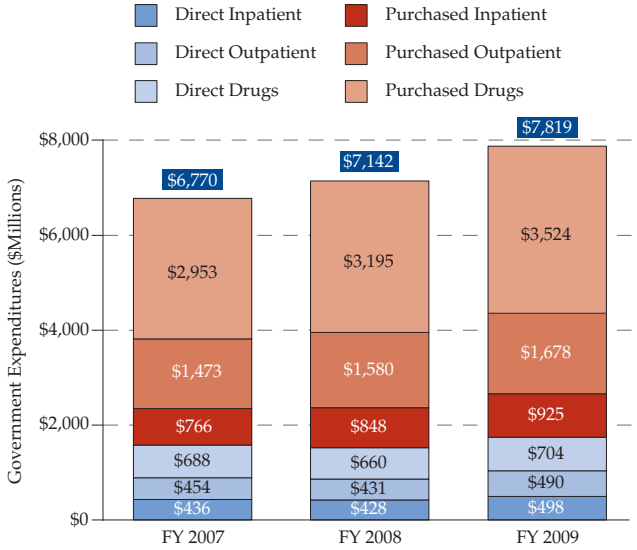
Source: MHS administrative data, 2/5/2010

- The percentage of TFL-eligible beneficiaries who filed at least one claim remained at about 83 percent between FY 2007 and FY 2009.
  - The reasons some beneficiaries do not file claims are varied, including retaining an employer-sponsored insurance policy (some senior beneficiaries with a spouse under age 65 will retain employer-sponsored coverage to keep their spouse insured) and not receiving any care at all.
- The percentage of TFL-eligible beneficiaries who filed at least one pharmacy claim increased from 76 percent in FY 2007 to 78 percent in FY 2009.

MERHCF Expenditures for Medicare-Eligible Beneficiaries

The MERHCF covers Medicare-eligible retirees, retiree family members, and survivors only, regardless of age or Part B enrollment status. The MERHCF is not identical to TFL, which covers Medicare-eligible non-Active Duty beneficiaries age 65 and above enrolled in Part B. For example, the MERHCF covers MTF care and USFHP costs, whereas TFL does not. Total MERHCF expenditures increased from $6,770 million in FY 2007 to $7,818 million in FY 2009 (15 percent).

MERHCF EXPENDITURES FROM FY 2007 TO FY 2009 BY TYPE OF SERVICE



Source: MHS administrative data, 2/5/2010
* Direct care prescription costs include an MHS-derived dispensing fee.

- After declining in FY 2008, total DoD direct care expenses for MERHCF-eligible beneficiaries increased by 7 percent in FY 2009. The most notable increase was in direct inpatient expenses (14 percent).
  - From FY 2007 to FY 2009, TRICARE Plus enrollees accounted for 67–68 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries.
  - Including prescription drugs, TRICARE Plus enrollees accounted for 50–51 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FYs 2007–2009.
- Purchased care MERHCF expenditures increased substantially from FY 2007 to FY 2009 for inpatient, outpatient, and prescription drugs. Inpatient expenditures increased by 21 percent, outpatient expenditures by 14 percent, and prescription drug expenditures by 19 percent.

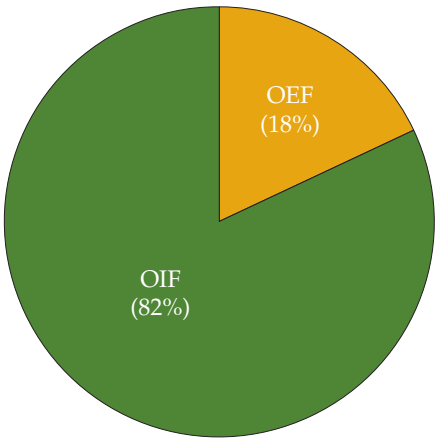
DEPLOYABLE MEDICAL CAPABILITY: PATIENT MOVEMENT OUTSIDE JOINT OPERATIONAL AREA

To meet the needs of operational commanders, our deployable medical capability must be able to deploy anytime, anywhere, with flexibility, interoperability, and agility. This capability is dependent on globally accessible health information and rapid development and deployment of innovative medical services and products. Since we support the full range of military operations, we must be ready to assist in civil support and homeland defense operations such as disaster relief and management of pandemic flu.

An important component of the deployable medical capability is Patient Movement Outside of a Joint Operational Area (JOA). This is the ability to conduct effective coordination and movement from a JOA to an appropriate care facility with en route care provided. Critical patients must be rapidly identified for replacement in the JOA. These processes allow commanders to project forces more accurately and maintain maximum troop strength where needed.

- Rapid evacuation by air has been an important factor in increasing survivability. Additional factors include: Body Armor; Far forward Resuscitative Surgical Care; Enhanced Trauma skills of the 91W Combat Medic; Combat Life Savers; Tourniquets; Quick Clot Bandages; Combat Medical Simulation Centers; and the Deployable Medical Systems.
- Patients were transported via aeromedical evacuation out of the following operational theaters. As shown in the pie chart below, those transported out of the Operation Iraqi Freedom represent the majority of patient movement:
  - Operation Enduring Freedom (OEF)
    - Afghanistan
    - Philippines
    - Horn of Africa
    - Trans Sahara
    - Pankisi Gorge (Rep. of Georgia)
  - Operation Iraqi Freedom (OIF)
    - Includes some areas outside Iraq, such as Kuwait

MEDICAL AIR TRANSPORTS (MAT), BY THEATER OF OPERATION

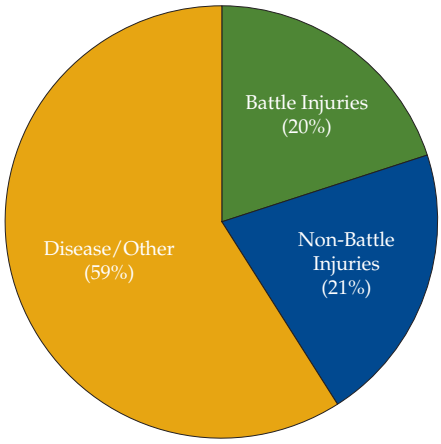


Source: U.S. Transportation Command Regulating And Command & Control Evacuation System (TRAC2ES) as of 10/6/2009

DEPLOYABLE MEDICAL CAPABILITY: PATIENT MOVEMENT OUTSIDE JOINT OPERATIONAL AREA *(CONT'D)*

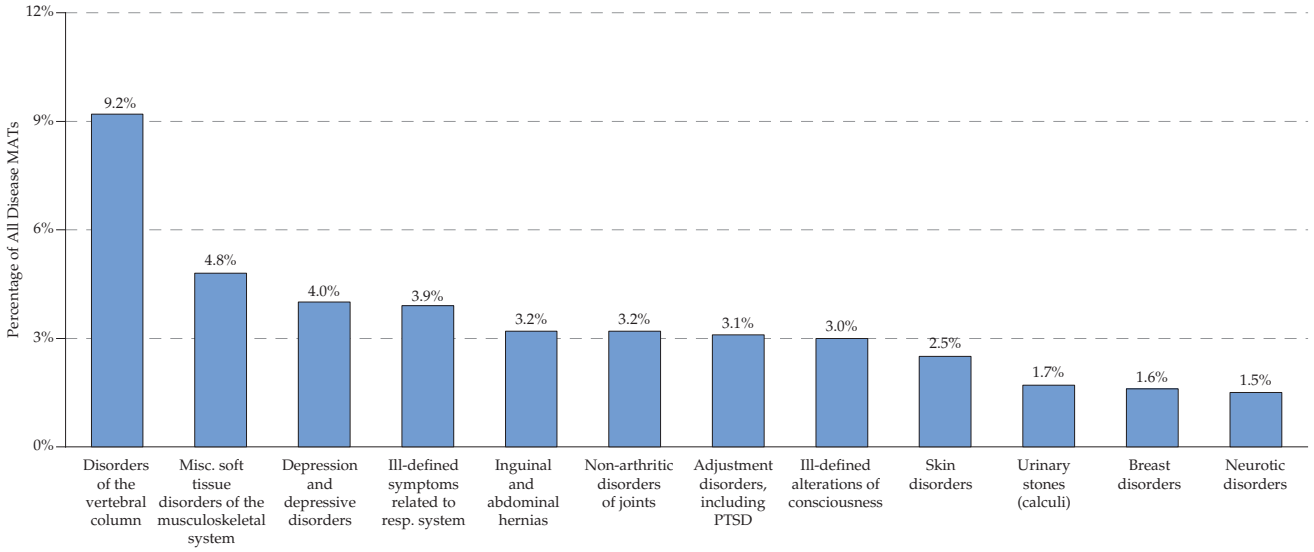
- Since October 2001, a total of 59,358 medical air transports have been provided, with disease and other conditions representing almost 60 percent of the movement, and the rest equally split between battle injuries and nonbattle injuries (each about one-fifth of total air transport movement).
- These cases cover a wide range of conditions and severity: Back problems; chest symptoms; mental health concerns; kidney stones; hernias; etc. The chart at the bottom of the page shows the 12 most common diseases resulting in medical air transport (MAT).

REASON FOR MEDICAL AIR TRANSPORTS (MAT)



Source : U.S. Transportation Command Regulating And Command & Control Evacuation System (TRAC2ES) as of 10/6/2009

12 MOST COMMON TYPES OF DISEASE RESULTING IN MAT, MILITARY PERSONNEL ONLY



Source: U.S. Transportation Command Regulating And Command & Control Evacuation System (TRAC2ES) as of 10/6/2009

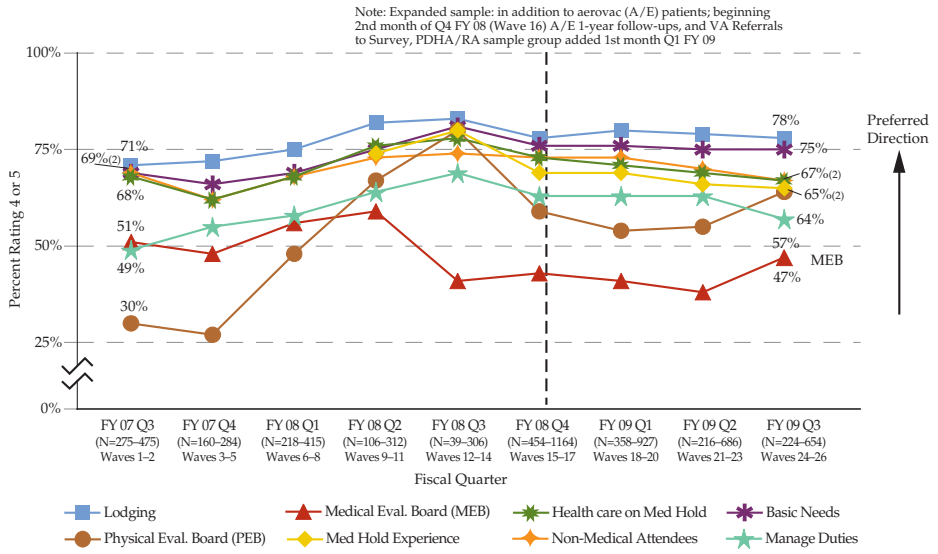
SURVEY OF WOUNDED, ILL, OR INJURED SERVICE MEMBERS POST-OPERATIONAL DEPLOYMENT

Beginning in May 2007, the DoD began the monthly Telephone Survey of Ill or Injured service members Post-Operational Deployment. This survey was fielded as one of several responses to a Secretary of Defense tasking to establish a mechanism to identify and provide actionable information to the Services to resolve shortcomings related to service members recuperating from illness or injury following return from operational deployment. Developed by the Tri-Service Military Health Services Survey Work Group, chaired by OASD(HA)/TMA Health Program Analysis and Evaluation, this survey initially focused on service members returning from operational deployment overseas via aeromedical evacuation. It was expanded to sample from all service members who had returned from operational deployment and had the opportunity to use the MHS during the previous year, including those referred to the VA for care and those completing a Post Deployment Health Reassessment (PDHRA).

Over the past two years (26 consecutive survey months), most responding service members rate favorably most aspects of medical hold, outpatient health care, support services, including transition to VA care, as well as their general medical and mental health status. Most ratings over the past two years are stable with some measures improving, either in increasing favorable or decreasing unfavorable ratings. However, a few key measures continue to challenge the MHS:

- **Medical Hold:** Favorable ratings of the Medical Evaluation Board (MEB) experience remain lower than desired, with under 50 percent rating a "4" or "5" on a 5-point scale (where 1=poor and 5=outstanding) of those in Medical Hold/Warrior Transition Units. The rating for the overall medical hold experience is still relatively high but edging in the wrong direction. Both show concurrent increases in unfavorable ratings (not shown). We include the MEB ratings in our strategic metrics targeted for improvement and monitored each quarter.
- **Health Status:** In the fourth quarter of FY 2009, the survey was extended to cover more service members, by including those who have been back from deployment a year or more. Responding service members reported that their physical and mental health, while worse than it was before deployment, is better than that of those reporting 1–2 years ago.
- **Transition to VA Health System ratings remain steady:** favorable (about 66 percent), unfavorable (15 percent) and records availability (65 percent) (not shown).

MEDICAL HOLD/HOLDOVER: PERCENTAGE OF TOP 2 RATINGS OVER TIME
(PERCENTAGE RATING "4" OR "5" ON 5-POINT SCALE)*

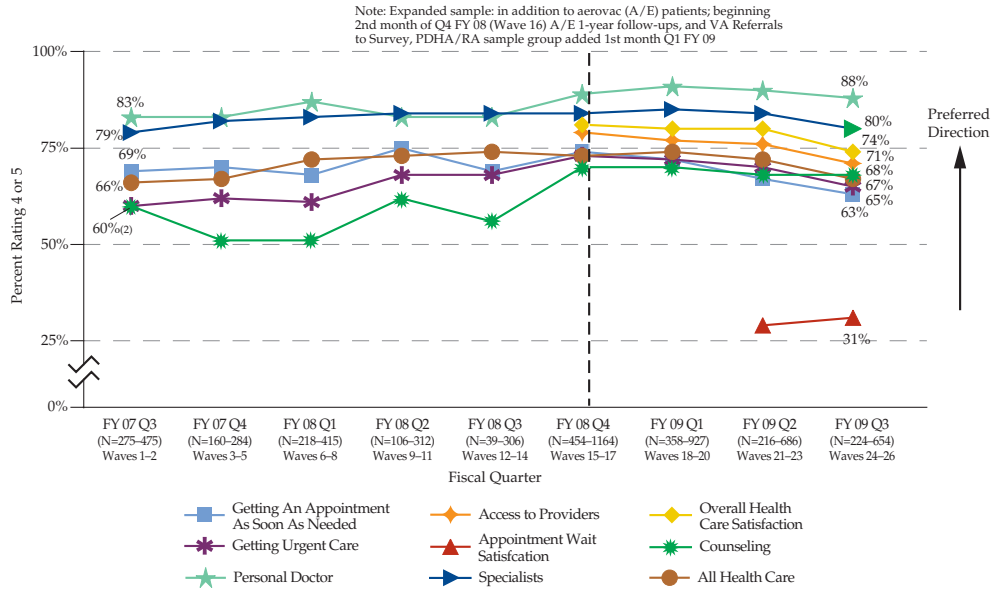


Source: OASD(HA)/TMA-HPA7E monthly Survey of Ill or Injured service members Post Operational Deployment, 11/6/2009

* The survey began in February 2007, sampling service members who were aeromedically evacuated from operational theaters (Iraq, Afghanistan) since December 2006. The survey was expanded in the second month of Q4 FY 2008 to include a one-year follow-up of aeromedically evacuated patients and DoD referrals to Veterans Affairs facilities. It was expanded further beginning the first month of Q1 FY 2009 to include service members completing a Post Deployment Health Assessment (PDHA) or Reassessment (PDHRA).

SURVEY OF WOUNDED, ILL, OR INJURED SERVICE MEMBERS POST-OPERATIONAL DEPLOYMENT *(CONT'D)*

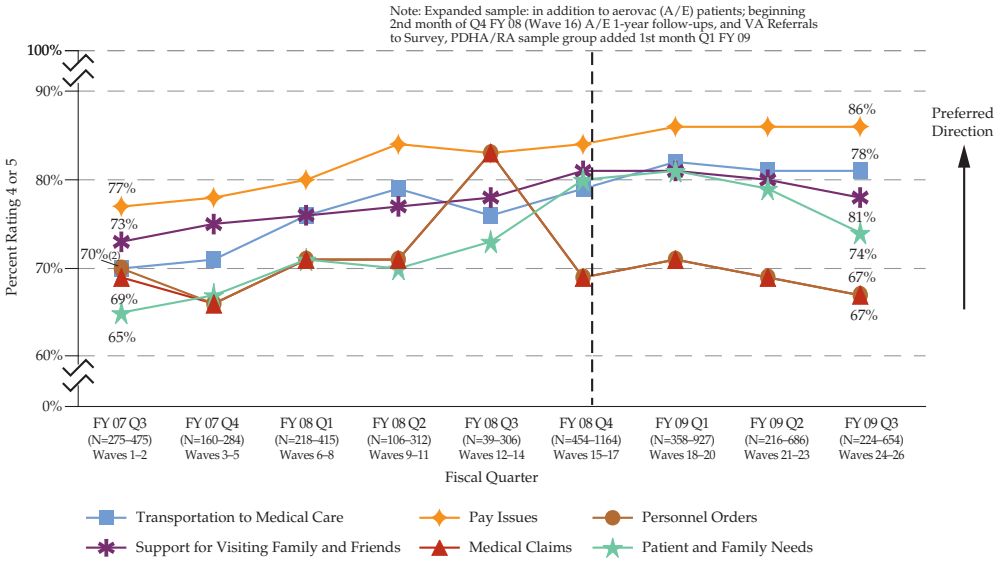
AMBULATORY HEALTH CARE: PERCENTAGE OF TOP 2 RATINGS OVER TIME (PERCENTAGE RATING "4" OR "5" ON 5-POINT SCALE)*



Source: OASD(HA)/TMA-HPA&E Monthly Survey of Ill or Injured service members Post Operational Deployment, 11/29/2009

- **Outpatient (Ambulatory) Care:** Favorable ratings have declined somewhat for three measures: "ability to get appointment," "ability to see providers when needed," and "overall satisfaction with health care."

SUPPORT SERVICES: PERCENTAGE OF TOP 2 RATINGS OVER TIME (PERCENTAGE RATING "4" OR "5" ON 5-POINT SCALE)*



Source: OASD(HA)/TMA-HPA&E Monthly Survey of Ill or Injured service members Post Operational Deployment, 11/2/2009

- All six Support Services measures are highly favorable (67–86 percent favorable ratings); 5 of 6 measures show increasingly favorable ratings over the entire 26 months of surveying (e.g., "transportation," "support to visitors," "pay issues," "personnel orders," "meeting attendee and patient needs)." Unfavorable ratings for these same areas have also significantly decreased over time.

SHARING OF DoD INFORMATION WITH OTHER FEDERAL AGENCIES: DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE JOINT STRATEGIC EFFORTS

The Mission of the VA and DoD Joint Strategic Plan is: To improve the quality, efficiency, and effectiveness of the delivery of benefits and services to veterans, service members, military retirees, and their families through an enhanced VA and DoD partnership.

The Vision Statement for this effort is: A world-class partnership that delivers seamless, cost-effective, quality services to beneficiaries and value to our nation.

The Guiding Principles for this strategic effort are:

- **Collaboration:** To achieve shared goals through mutual support of both our common and unique mission requirements.
- **Stewardship:** To provide the best value for our beneficiaries and the taxpayer.
- **Leadership:** To establish clear policies and guidelines for VA/DoD partnership, promote active decision-making, and ensure accountability for results.

Sharing of Information:

In support of this mission, the Health Executive Council (HEC), was formed in 1997 to establish a high-level program of VA/DoD cooperation and coordination in a joint effort to reduce costs and improve health care for VA and DoD beneficiaries. The emphasis of the strategic plan is on working together to store, manage and share data. The HEC is providing ongoing oversight of the following projects:

- **Federal Health Information Exchange (FHIE):** FHIE supports the transfer of electronic health information from DoD to VA at the time of a Service member's separation. DoD transmits to VA on a monthly basis: inpatient and outpatient laboratory and radiology results, outpatient pharmacy data, allergy information, consult reports, admission, disposition and transfer information, elements of the standard ambulatory data records, and demographic data on separated service members.
- **Deployment Health Assessments:** Deployment Health Assessments are conducted on service members and demobilized Reserve and National Guard members as they leave and return from duty in a theater of operations. Post-Deployment Health Re-Assessments are completed by the same service members between three and six months following departure from operational theaters.The information is used to monitor the overall health condition of deployed troops, inform them of potential health risks, as well as maintain and improve the health of service members and veterans.
- **Bidirectional Health Information Exchange (BHIE):** BHIE leveraged already developed joint VA/DoD infrastructure, IT investments, VA/DoD test facilities, and existing personnel resources to create a real-time, bidirectional interface. BHIE functionality enables the real-time sharing of allergy information; outpatient pharmacy; demographic data; inpatient and outpatient laboratory and radiology results; ambulatory encounters/clinical notes; procedures and problem lists; theater clinical data, including inpatient notes, outpatient encounters, and ancillary clinical data, such as pharmacy data, allergies, laboratory results, radiology reports, and vital signs.
- **Laboratory Data Sharing Initiative (LDSI):** LDSI supports the electronic sharing of order entry and results, retrieval of chemistry, hematology, anatomic pathology, and microbiology laboratory tests between the DoD and VA. LDSI is actively being used on a daily basis between DoD and VA at several sites where one Department uses the other as a reference lab.
- **Clinical Data Repository/Health Data Repository (CHDR):** CHDR establishes interoperability between the Clinical Data Repository (CDR) of Armed Forces Longitudinal Technology Application (AHLTA), DoD's electronic health record, and VA's Health Data Repository (HDR) enabling the exchange of computable outpatient pharmacy and medication allergy data into each agency's electronic health record. Patient safety is now enhanced through medication and allergy data from the other Department being used in drug-drug interaction and drug-allergy checking.
- **AHLTA:** AHLTA is the military's Electronic Health Record (EHR). AHLTA generates, maintains and provides worldwide secure online access to comprehensive patient medical records.
- **VA/DoD Wounded Warrior:** The VA and the DoD are working together to support our most severely wounded and injured service members transferring to VA Polytrauma Centers for care.
  - **Radiology Image Sharing Initiative:** DoD electronically sends digital radiology images from Walter Reed Army Medical Center (WRAMC), National Naval Medical Center (NNMC), Bethesda, and Brooke Army Medical Center (BAMC) to the VA Polytrauma Centers in Tampa, Richmond, Palo Alto, and Minneapolis.
  - **Scanned/ Electronic Document Sharing Initiative:** WRAMC, NNMC, and BAMC scan the patient's entire paper medical record into portable document format (PDF) for electronic transmission to the VA Polytrauma Centers in Tampa, Richmond, Palo Alto, and Minneapolis. The PDF document contains records from the entire inpatient stay as well as all available records of treatment provided in Theater medical facilities, care during transport, and care rendered at Landstuhl Regional Medical Center.

SHARING OF DoD INFORMATION WITH OTHER FEDERAL AGENCIES: DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE JOINT STRATEGIC EFFORTS *(CONT'D)*

The table below reflects selected measures of the progress made in increasing the sharing of health care data between the DoD and the VA in support of the VA/DoD Joint Strategic Plan.

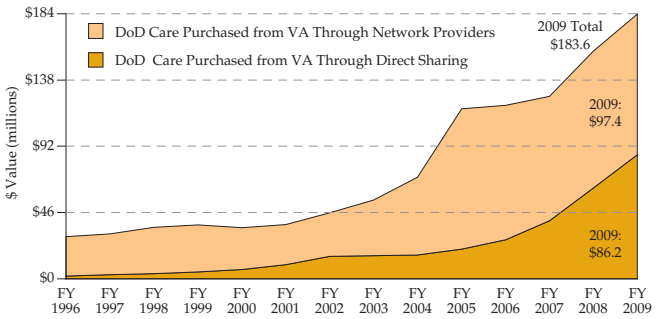
DoD/VA SHARING IT METRICS (CUMULATIVE)

	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Millions of unique patients for which DoD has transferred data to the Federal Health Information Exchange (FHIE) repository	3.1	3.6	4.0	4.5	5.0
Number of Pre- and Post-Deployment Health Assessments forms sent electronically to VA	0.5	1.4	1.9	2.4	2.7
FHIE transfer includes the following:					
Millions of laboratory results sent to VA	42.3	49.5	55.2	67.1	75.6
Millions of radiology reports sent to VA	6.8	8.2	9.1	11.0	12.3
Millions of pharmacy records sent to VA	42.6	49.7	55.7	69.1	78.0
Millions of standard ambulatory data records sent to VA	40.3	48.9	62.0	68.2	85.7
Millions of consultation reports sent to VA	1.0	1.4	1.8	2.8	3.5

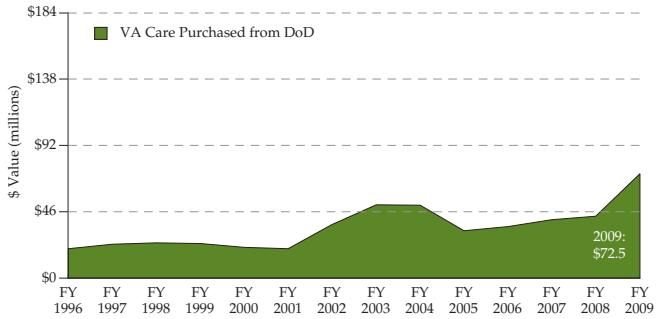
Source: OCIO/ERM Received 12/1/2009

The charts below show the total extent of health care services sharing over the past 14 years, and the dramatic rise over the past five years. The DoD has always purchased more care from the VA than vice-versa (on average, between 1996 and 2003, the DoD purchased $1.45 from the VA for every $1.00 provided to the VA), but over the last five years the DoD has purchased $3.27 for every $1.00 provided to the VA.

DoD/VA SHARING: HEALTH CARE SERVICE PROVIDED BY VA TO DoD ($ MILLIONS)



DoD/VA SHARING: HEALTH CARE SERVICES PROVIDED BY DoD TO VA ($ MILLIONS)



Source: VA DoD quarterly report prepared by OASD HA/HB & FP. Received 12/1/2009

HEALTHY, FIT, AND PROTECTED FORCE

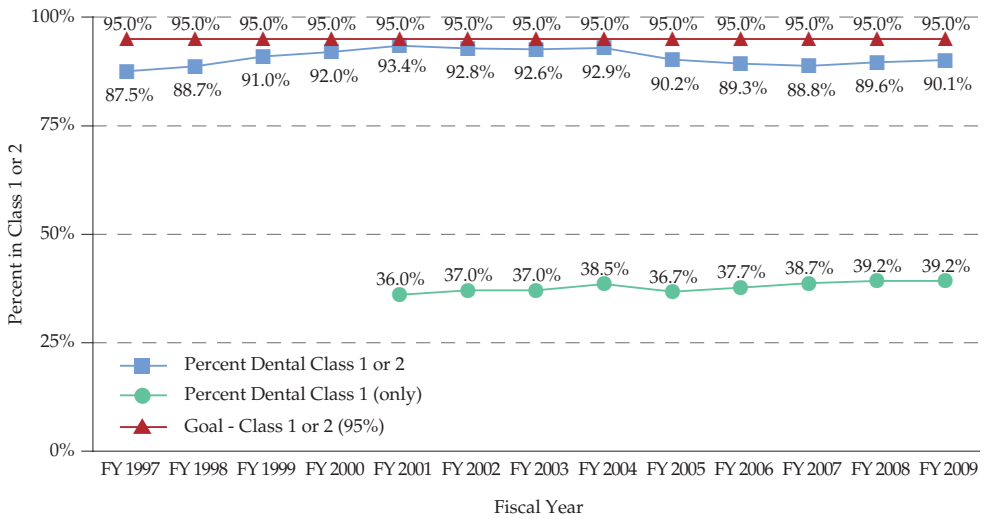
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we: (1) maintain the worldwide deployment capability of our service members, as in dental readiness and immunization rates, and (2) measure the success of benefits programs designed to support the RC forces and their families, such as in TRS.

DENTAL READINESS

The MHS Dental Corps Chiefs established in 1996 the goal of maintaining at least 95 percent of all Active Duty personnel in Dental Class 1 or 2. Patients in Dental Class 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). This goal also provides a measure of Active Duty access to necessary dental services. Overall, the percentage of patients in Dental Class 1 or 2 has been stable over the past 12 years, from FY 1997 to FY 2009 as shown below:

- Overall MHS dental readiness in the combined Classes 1 and 2 remains high. However, while the 95 percent target rate for dental readiness in Classes 1 and 2 was almost achieved in FY 2001, it remains elusive. FY 2009 rate of 90.1 percent reflects a slight increase from FY 2008.
- The rate for Active Duty personnel in Dental Class 1 remained steady at 39.2 percent in FY 2009.

ACTIVE DUTY DENTAL READINESS: PERCENT CLASS 1 OR 2



Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 11/6/2009

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

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

TRICARE RESERVE SELECT—PROGRAM ENROLLMENT

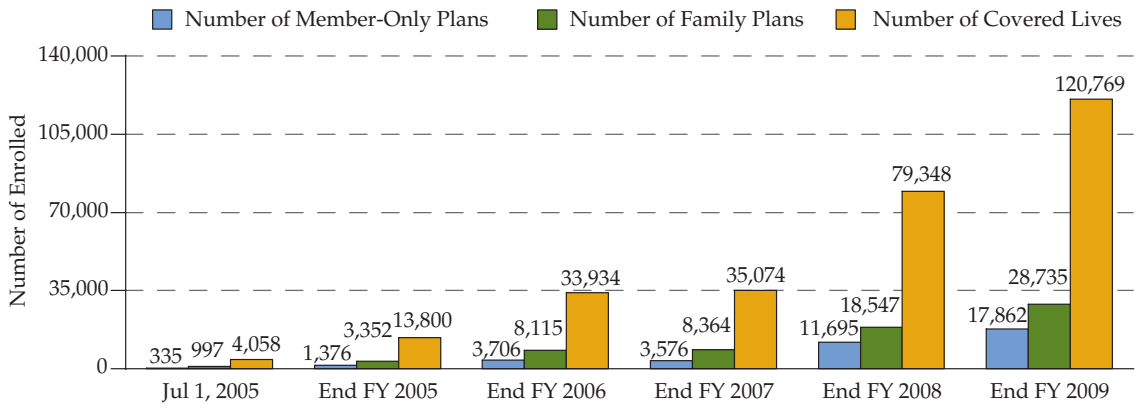
TRS was established by the 2005 NDAA to offer TRICARE Standard and Extra health coverage to qualified members of the Selected Reserve and their immediate family members (*Federal Register*, June 21, 2006). TRS is the premium-based TRICARE health plan offered for purchase by certain members and former members of the RC and their families. TRS coverage must be purchased, with TRS members paying a monthly premium for health care coverage (for self only or for self and family). Originally, Reserve members were 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 respective Reserve units had to agree for the member to stay in the Select Reserve one or more years to qualify. The NDAA for FY 2006 expanded eligibility and added two more premium tiers. The NDAA for FY 2007 restructured the program to a simpler, single tier plan, expanded eligibility, and eliminated the service agreement requirements. Currently, all Selected Reserves are eligible, unless they are able to obtain health insurance through the Federal Employees Health Benefits Program.

The 2009 NDAA required TRICARE to analyze costs and set new rates for 2009. Effective January 1, 2009, monthly premiums for single coverage dropped 44 percent and premiums for family coverage dropped 29 percent.

The program offers comprehensive health care coverage similar to TRICARE Standard and TRICARE Extra.

Since the revised benefit became available on October 1, 2007, TRS enrollment has more than doubled. As of the end of FY 2009, there are more than 120,000 covered lives in over 17,000 member-only plans and over 28,000 family plans.

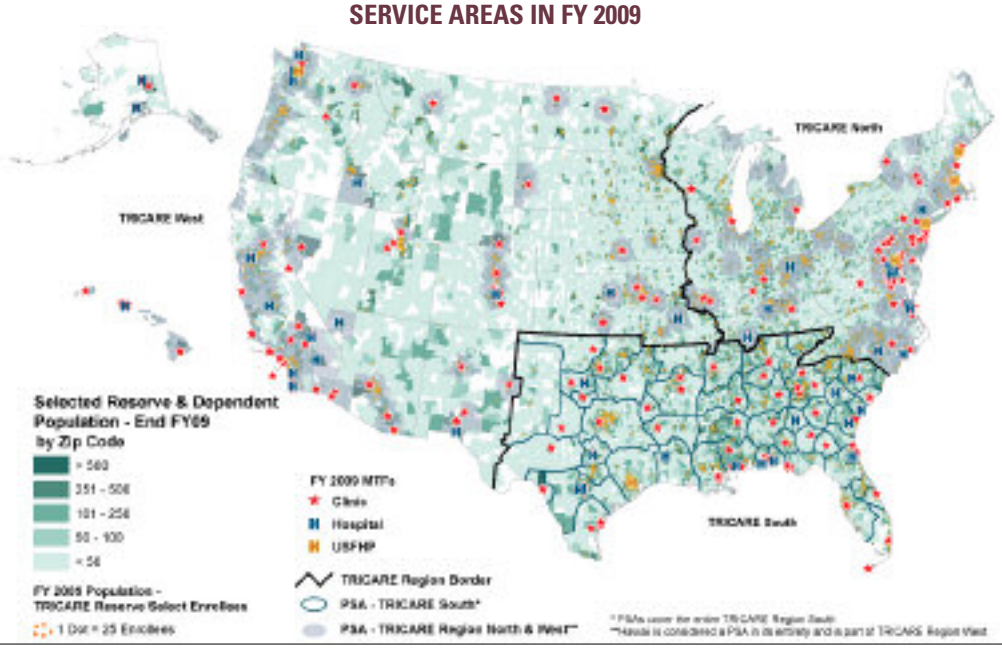
TREND IN ENROLLMENT IN TRICARE RESERVE SELECT SINCE INCEPTION (JULY 2005 TO SEPTEMBER 2009)



Source: HA/TMA–TRICARE Operations, 10/28/2009

- As of December 31, 2009, there were nearly 2 million Selected Reserve Service members and their families (855,591 Service members and 1,069,815 family members), provided by OSD(RA).
- The map to the right depicts where the Reservists and their family members reside in the United States (U.S.), relative to the direct care MTFs.

SELECTED RESERVE POPULATION IN THE U.S. RELATIVE TO MTF, PRIME, AND NON-PRIME SERVICE AREAS IN FY 2009



Source: Selected Reserve and Guard residential population data from DEERS, MTF information from TMA, Portfolio Planning Management Division, and geospatial representation by TMA/HPA&E, 12/23/2009

HEALTHY AND RESILIENT INDIVIDUALS, FAMILIES, AND COMMUNITIES

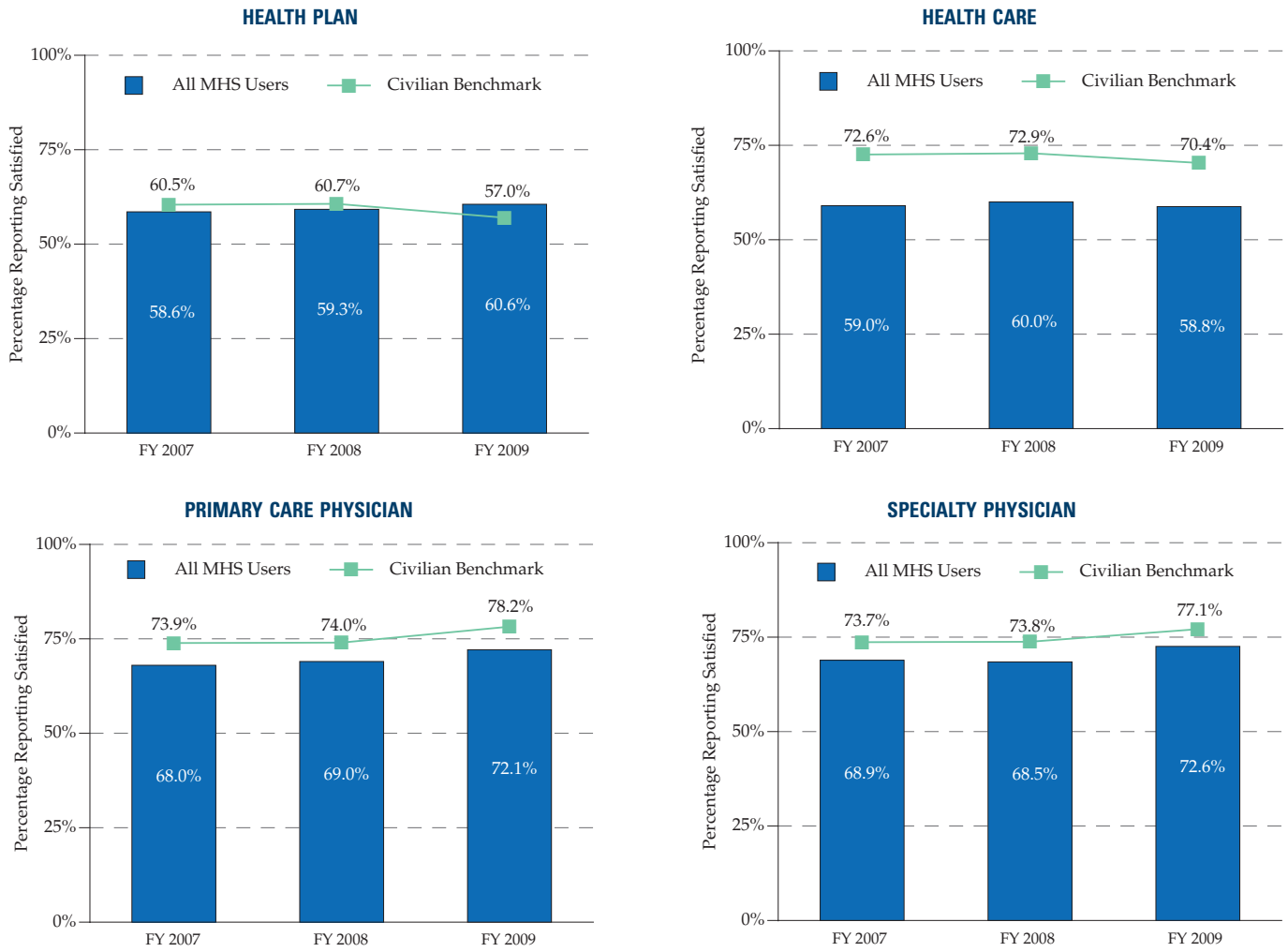
This section focuses on scanning the health care environment for relevant benchmarks, applying their metrics, and striving to meet or exceed those standards. The metrics presented here focus on customer satisfaction and health promotion activities through Building Healthy Communities.

CUSTOMER REPORTED EXPERIENCE AND 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 U.S. 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 Healthcare Providers and Systems (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 improved between FY 2007 and FY 2009. Satisfaction with health care remained stable during this three-year period, while satisfaction with one's personal or specialty physician improved.
- MHS satisfaction rates continued to lag civilian benchmarks, with the exception of Health Plan.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS



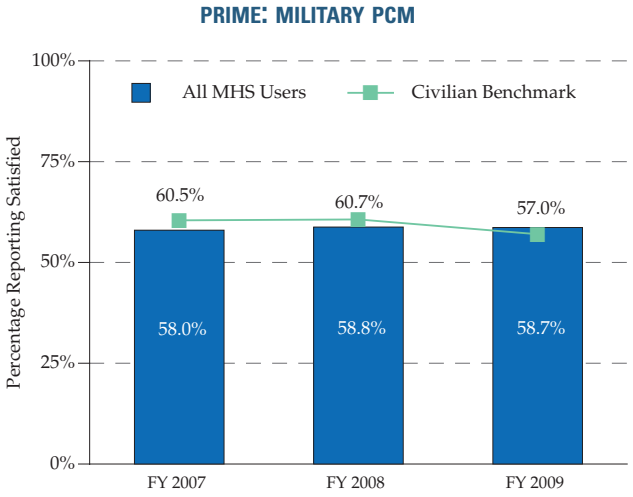
Note: DoD data were derived from the FYs 2007–2009 HCSDB, as of 12/11/2009, and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. FY 2007 and FY 2008 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 National CAHPS Benchmarking Database (NCDB), whereas FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared to the 2008 NCBD, the latest benchmark data available.

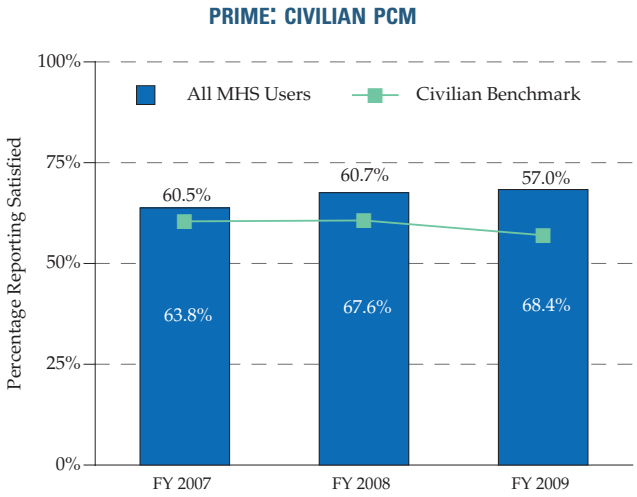
SATISFACTION WITH THE HEALTH PLAN BASED ON ENROLLMENT STATUS

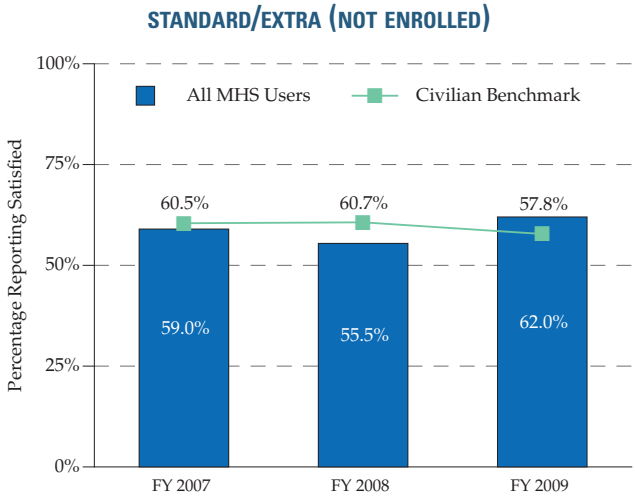
DoD health care beneficiaries can participate in TRICARE in several ways: By enrolling in the Prime option or by not enrolling and using the traditional indemnity option for seeing participating providers (Standard) or network providers (Extra). Satisfaction levels with one's health plan across the TRICARE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

- Satisfaction during FY 2007 to FY 2009 remained stable for Prime enrollees with military PCMs and increased slightly for Prime enrollees with civilian PCMs. Satisfaction of non-enrollees increased between FY 2007 and FY 2009.
- During each of the past three years (FY 2007 to FY 2009), MHS beneficiaries enrolled with civilian network providers reported higher levels of satisfaction than their civilian counterparts.
- MHS beneficiaries enrolled with military PCMs and non-enrollees reported lower levels of satisfaction than their civilian plan counterparts in FY 2007 and FY 2008, but higher levels of satisfaction in FY 2009.

TRENDS IN SATISFACTION WITH HEALTH PLAN BY ENROLLMENT STATUS







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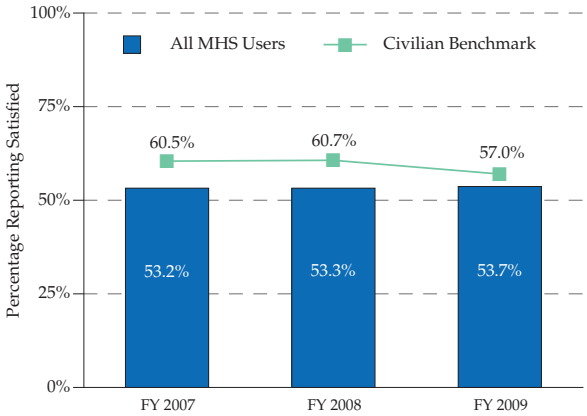
SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY

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

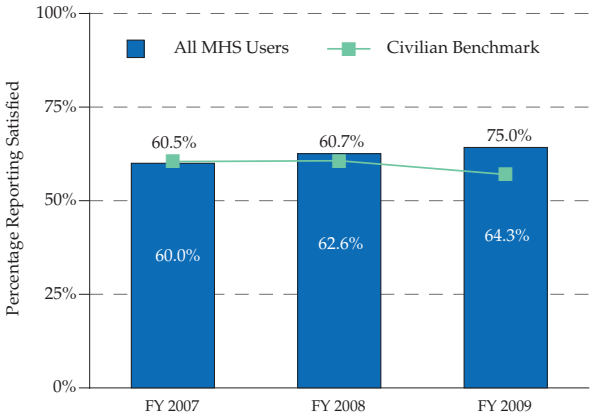
- Satisfaction with the TRICARE health plan improved for ADFM and retirees and families between FY 2007 and FY 2009. Satisfaction of Active Duty beneficiaries remained stable between FY 2007 and FY 2009, but lagged the civilian benchmark.
- ADFM and Retired and Family Member satisfaction ratings were statistically comparable to the civilian benchmark in FY 2007 and exceeded the benchmark in FY 2008 and FY 2009.

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY

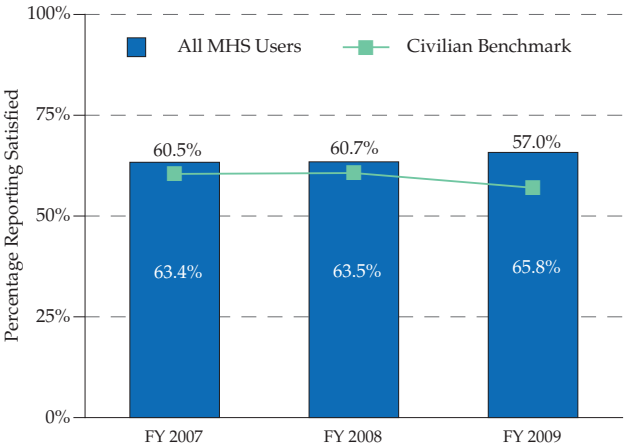
ACTIVE DUTY



ACTIVE DUTY FAMILY MEMBERS



RETIRED AND FAMILY MEMBERS



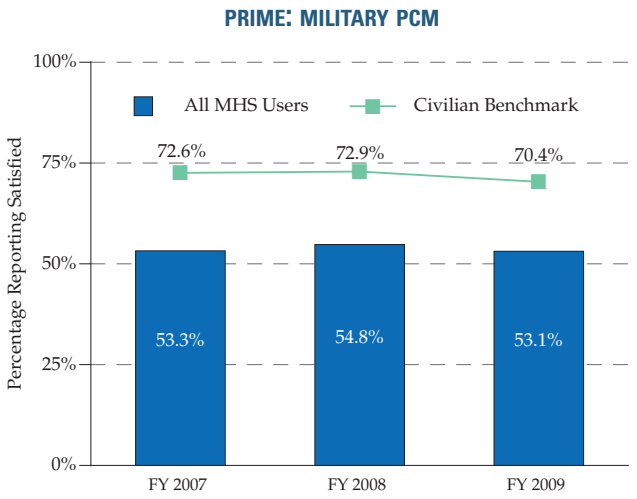
Note: DoD data were derived from the FYs 2007–2009 HCSDB, as of 12/11/2009, and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. FY 2007 and FY 2008 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 National CAHPS Benchmarking Database (NCDB), whereas FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared to the 2008 NCBD, the latest benchmark data available.

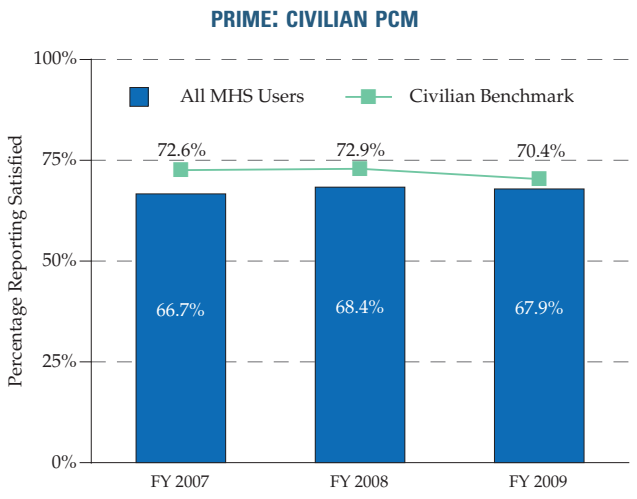
SATISFACTION WITH THE HEALTH CARE BASED ON ENROLLMENT STATUS

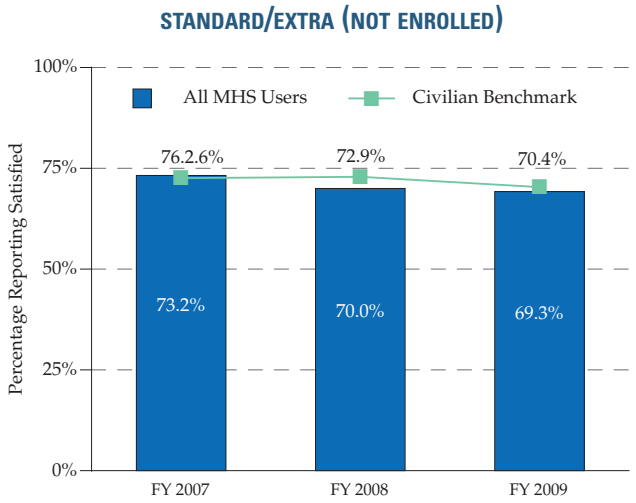
Similar to satisfaction with the TRICARE health plan, satisfaction levels with the health care received differ by enrollment status:

- Non-enrollee satisfaction was comparable to the civilian benchmark during FY 2007 (bottom chart), but declined in FY 2008 and FY 2009.
- Between FY 2007 and FY 2009, MHS Prime enrollee satisfaction with their health care remained unchanged (no statistically significant change), and continued to lag the civilian benchmark.

TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BASED ON ENROLLMENT STATUS







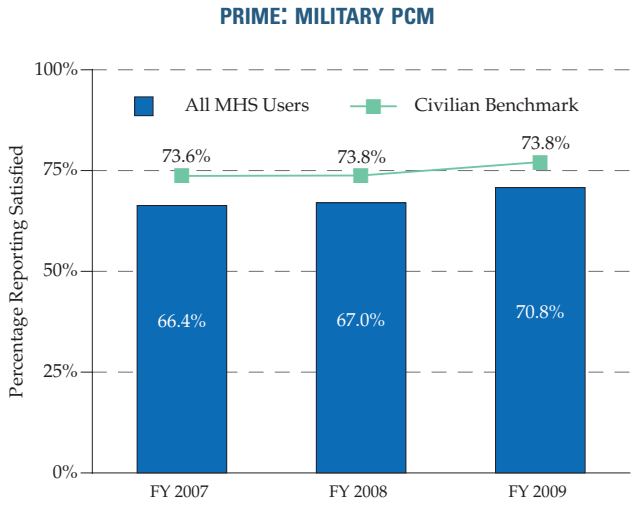
Note: DoD data were derived from the FYs 2007–2009 HCSDB, as of 12/11/2009, and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. FY 2007 and FY 2008 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 National CAHPS Benchmarking Database (NCDB), whereas FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared to the 2008 NCBD, the latest benchmark data available.

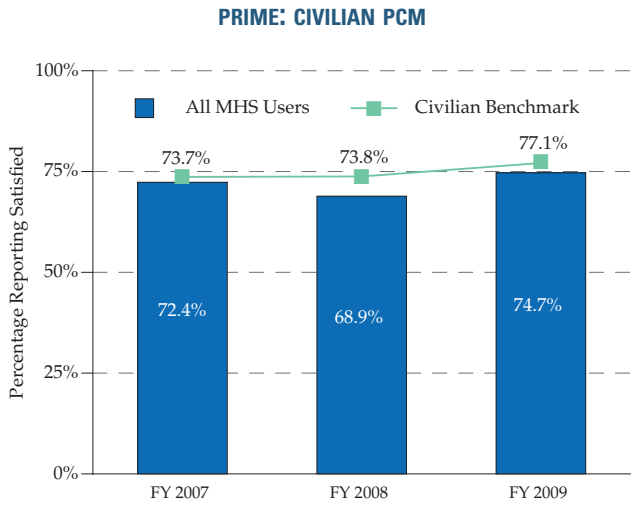
SATISFACTION WITH ONE'S SPECIALTY PROVIDER BASED ON ENROLLMENT STATUS *(CONT'D)*

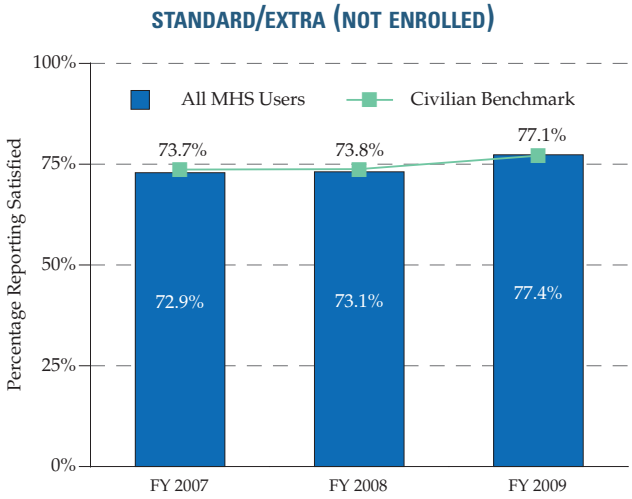
MHS user satisfaction with their specialty providers differs by enrollment status.

- Satisfaction levels of Prime enrollees with military PCMs continue to lag the civilian benchmark, but increased between FY 2007 and FY 2009. Non-enrollees report satisfaction levels comparable to the civilian benchmark and increased in FY 2009. Prime enrollees with civilian PCMs satisfaction levels were comparable to the civilian benchmark in FY 2007, dropped below the benchmark in FY 2008, but increased in FY 2009.

TRENDS IN SATISFACTION WITH ONE'S SPECIALTY PROVIDER BY ENROLLMENT STATUS







Note: DoD data were derived from the FYs 2007–2009 HCSDB, as of 12/11/2009, and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. "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. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. FY 2007 and FY 2008 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 National CAHPS Benchmarking Database (NCDB), whereas FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared to the 2008 NCBD, the latest benchmark data available..

ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS

Sustaining the benefit is anchored on a number of supporting factors, including access to, and promptness of, health care services, customer services, and communication with health care providers. This section enumerates several areas routinely monitored by the MHS leadership addressing patient access and clinical quality processes and outcomes, including: (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, timeliness of care, and communication with health care providers); (3) responsiveness of customer service, quality, and timely claims processing (both patient reported as well as tracking through administrative systems); (4) Joint Commission quality metrics in MTFs compared with Commission findings nationwide; and (5) access to and satisfaction with MTF care.

ACCESS TO MHS CARE

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

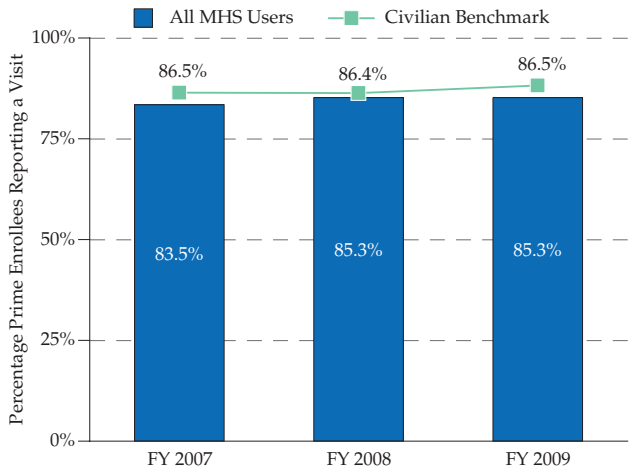
- Access based on reported use of the health care system in general.
- Availability and ease of obtaining care, and communicating with providers.
- Responsive customer service.
- Quality and timeliness of claims processing.

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 were 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 FY 2009.
- The MHS Prime enrollee rate continues to lag the civilian benchmark each year (statistically significantly different each year).

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



Note: DoD data were derived from the FYs 2007–2009 HCSDB, as of 12/11/2009, and adjusted for age and health status. "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. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. FY 2007 and FY 2008 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared to the 2006 National CAHPS Benchmarking Database (NCDB), while FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared to the 2008 NCDB, the latest benchmark available.

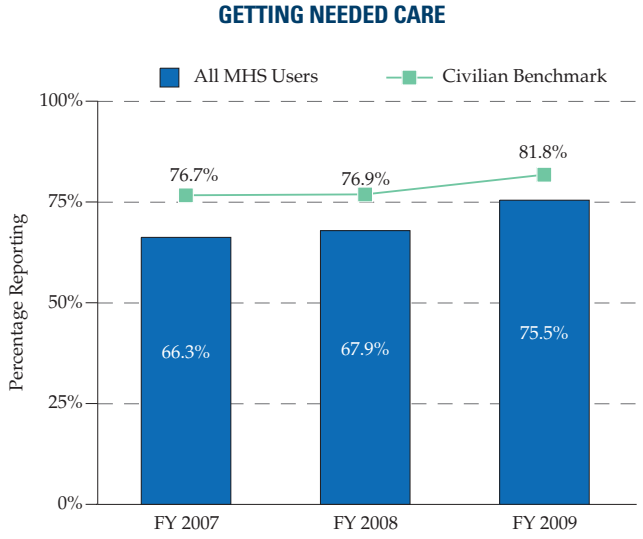
ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS *(CONT'D)*

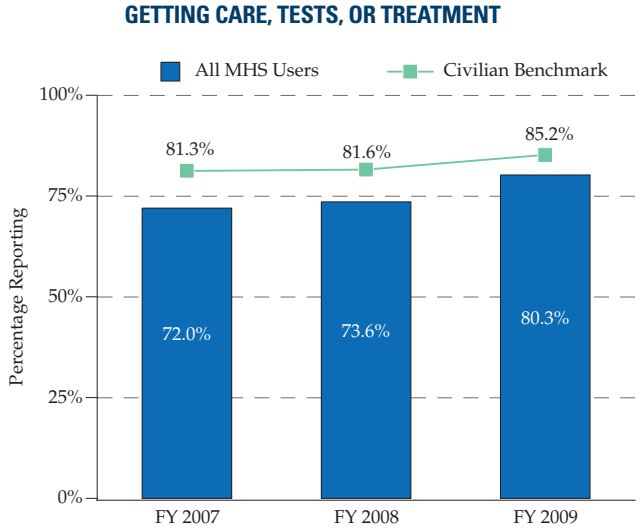
AVAILABILITY AND EASE OF OBTAINING CARE

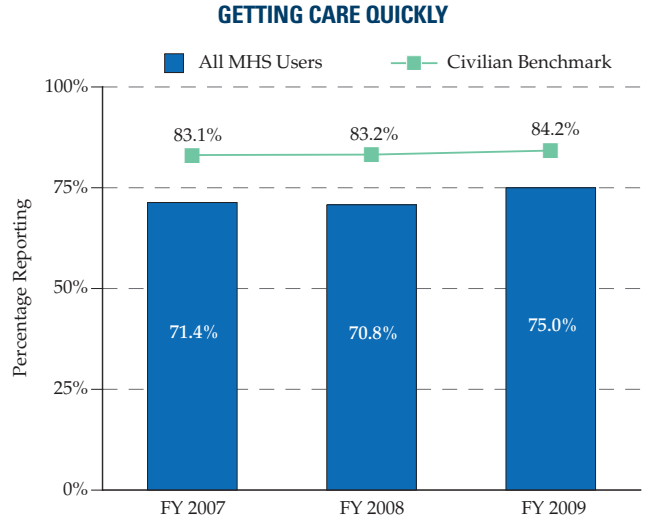
Availability and ease of obtaining care can be characterized by the ability of beneficiaries to obtain the care they need when they need it. Two major measures of access within the CAHPS survey—getting needed care and getting care quickly—address these issues. Getting needed care has two submeasures: easy to get appointment with specialists and easy to get care, tests or treatment. Getting care quickly also has two submeasures: getting care as soon as needed and waiting for a routine visit.

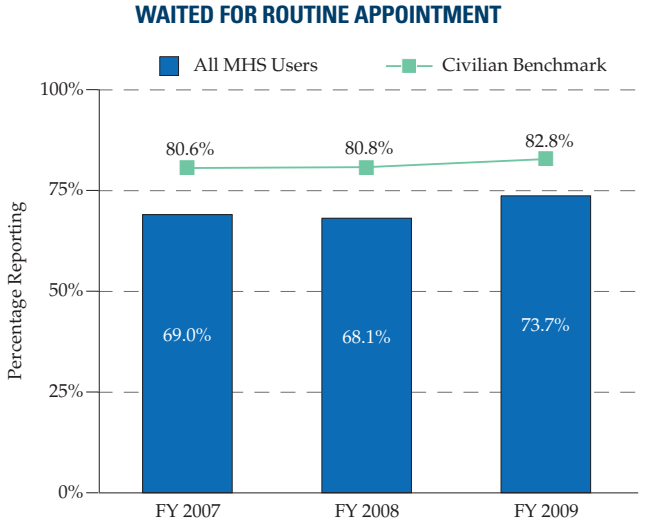
- MHS beneficiary ratings for getting needed care and getting care, tests, or treatment improved between FY 2007 and FY 2009, but continued to lag the civilian benchmark, which also improved during this period.
- MHS beneficiary ratings for getting care quickly and waiting for a routine visit improved as well. Although the ratings continue to lag the civilian benchmark, the gap narrowed between FY 2007 and FY 2009.

TRENDS IN MEASURES OF ACCESS FOR ALL MHS BENEFICIARIES (ALL SOURCES OF CARE)









Note: DoD data were derived from the FYs 2007–2009 HCSDB, as of 12/11/2009, and adjusted for age and health status. "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. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. FY 2007 and FY 2008 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared to the 2006 National CAHPS Benchmarking Database (NCDB), while FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared to the 2008 NCDB, the latest benchmark available.

ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS *(CONT'D)*

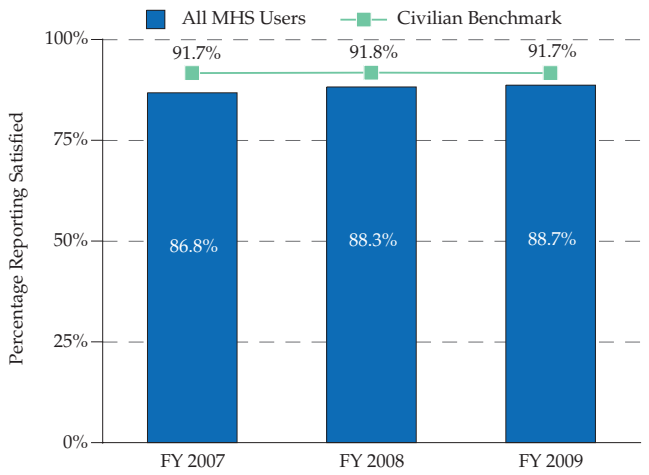
SATISFACTION WITH DOCTORS' COMMUNICATION

Communication between doctors and patients is an important factor in beneficiaries' satisfaction and their ability to obtain appropriate care. The following charts present beneficiary reported perceptions of how well their doctor communicates with them, by enrollment status.

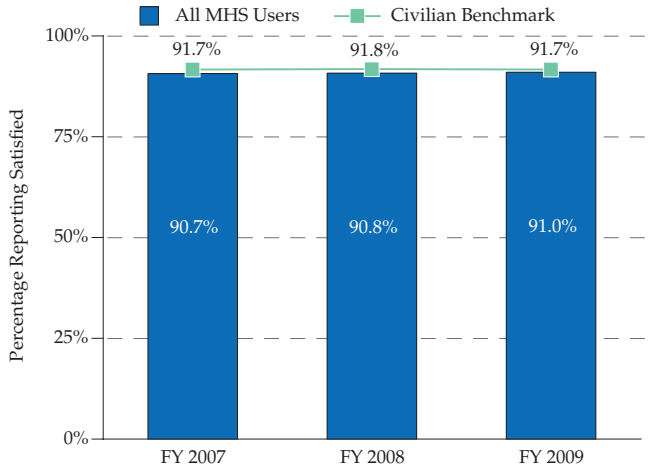
- Satisfaction levels with doctors' communication for Prime enrollees with military PCMs increased slightly between FY 2007 and FY 2009, but lagged the civilian benchmark, which was stable during this period.
- Satisfaction levels of Prime enrollees with civilian PCMs and non-enrollees with their providers equaled the civilian benchmarks (no statistically significant difference). MHS satisfaction levels and the civilian benchmark remained stable between FY 2007 and FY 2009.

TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION

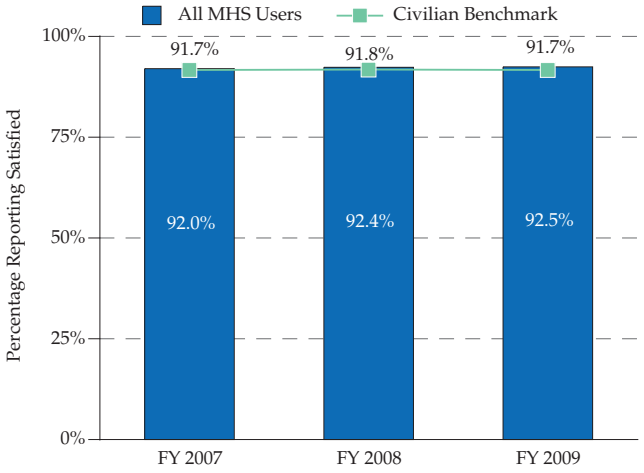
PRIME–MILITARY PCM



PRIME–CIVILIAN PCM



STANDARD/EXTRA (NOT ENROLLED)



Note: DoD data were derived from the FYs 2007–2009 HCSDB, as of 12/11/2009, and adjusted for age and health status. Ratings are based on the percentage reporting "usually" or "always." "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. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. FY 2007 and FY 2008 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 National CAHPS Benchmarking Database (NCDB), whereas FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared to the 2008 NCBD, the latest benchmark data available.

BRAC BASELINE SURVEY OF BENEFICIARY ACCESS AND SATISFACTION

The 2005 BRAC represented the fourth and largest round of closures and realignments, with more than 812 recommended actions that included closure of 22 military installations and major realignment of 29 military installations. Besides reducing excess capacity, the 2005 BRAC was intended to transform the military and increase joint operations. The BRAC Commission's recommendations had a direct impact on 26 MTFs, including the closure of 6 military installations and major realignment of 5 military installations.[1]

A primary goal of the BRAC recommendations was to "[maintain or improve] access to care for all beneficiaries, including retirees, using combinations of the Direct Care and TRICARE systems." As a result, many of the 2005 BRAC recommendations involved eliminating duplicate services and consolidating direct care at MTFs in multiple service market areas, with the goal of preserving options for direct care. In addition, in recent years TRICARE has added options to help reduce problems with access to care. For example, TRICARE has been increasing its network of civilian providers, offering more provider options for retirees under age 65 and for ADFMs. Initiated in 2001, TFL also provided supplemental insurance for retirees age 65 and over with Medicare. This program further enhances access to prescription drugs through a network of retail pharmacies.

This section presents the results of a preliminary and baseline assessment of the impact of the 2005 BRAC on beneficiary satisfaction and access to health care services. This survey contained questions directly related to BRAC as well as questions on perceptions of care from the quarterly population-based Health Care Survey of DoD Beneficiaries (HCSDB).

The target population for this study was adult MHS beneficiaries most likely to be affected by BRAC. This group was likely to include beneficiaries who were relying on a BRAC-affected MTF to provide medical services during retirement—particularly Active Duty beneficiaries close to retirement—as well as their family members and retired beneficiaries enrolled in TRICARE Prime.

The purpose of this 2008 special survey was to (1) determine whether beneficiaries' satisfaction and perceived access at locations targeted by BRAC differ from other beneficiaries' satisfaction and perceived access in non-BRAC locations; and (2) provide an initial assessment of beneficiary current level of satisfaction with health care services at locations where BRAC 2005 will either eliminate or alter the availability of medical services, for follow-up evaluation in subsequent years after the BRAC closures or consolidations have occurred.

SUMMARY OF FINDINGS

- The majority of TRICARE beneficiaries in BRAC-affected areas have positive perceptions of their health care experiences.
  - Beneficiaries' reported satisfaction levels are either similar to or higher than those reported by beneficiaries in non-BRAC sites (table below, column labeled "All").
- Beneficiaries in BRAC clinic areas (within the 20-mile radius of an MTF clinic, or PRISM area), where access to MTFs has been or will be limited, appear more satisfied than those in non-BRAC clinic areas (table below, column labeled "Clinic PRISM area"). Beneficiaries in hospital catchment areas (the 40-mile radius around MTF hospitals) rate their access to and satisfaction with health care services similar to those in non-BRAC areas, except more favorably for doctors communications and less favorably for getting needed care.
- Beneficiaries' satisfaction with their health plans increased between 2005 and 2008 in BRAC and non-BRAC sites.

Care Experiences	2008 BRAC vs. non-BRAC		
	All	Clinic PRISM area	Hospital Catchment area
Getting needed care	no diff.	+	—
Getting care quickly	no diff.	+	no diff.
Doctors and medical care			
Doctors communicate well	+	+	+
Rating of 8+ for personal doctor	no diff.	no diff.	no diff.
Rating of 8+ for health care	no diff.	no diff.	no diff.
Courteous and helpful office staff	no diff.	no diff.	no diff.
Rating of 8+ for health plan	no diff.	no diff.	no diff.

— = Beneficiaries in BRAC sites have LOWER scores than beneficiaries in non-BRAC sites
+ = Benefeciaries in BRAC sites have HIGHER scores than beneficiaries in non-BRAC sites
no diff. = Beneficiaries in BRAC sites have STATISTICALLY SIMILAR scores to beneficiaries in non-BRAC sites

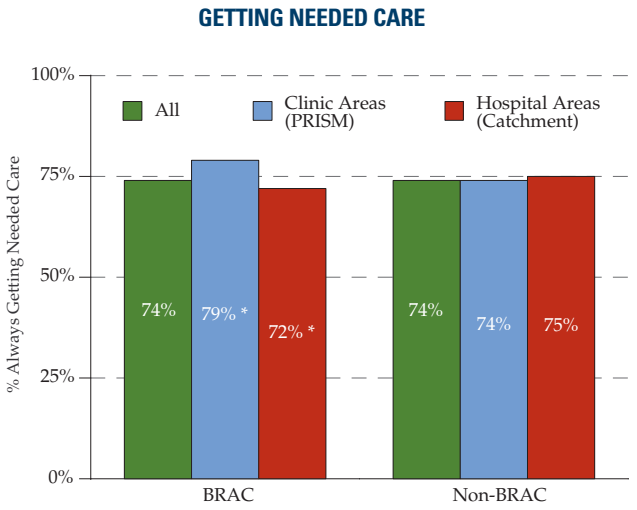
[1] The BRAC medical sites were AHC Ft. McPherson, GA; Air Force Academy, Colorado Springs, CO; Andrews AFB, MD; Bethesda Naval National Medical Center, MD; BMC, Athens, GA; BMC, Barstow, CA; BMC, Ingleside, TX; BMC NAS Brunswick, ME; BMC NSA New Orleans, LA; BMC Willow Grove, Hatboro, PA; Brooke Army Medical Center, Fort Sam Houston, TX; Brooks City Base, San Antonio, TX; Cherry Point, NC; DeWitt Army Hospital, NCA; Fort Eustis, VA; Great Lakes, IL; Keesler Medical Center, Biloxi, MS; MacDill, FL; Marietta, GA; Monroe AHC, Ft. Monroe, VA; NBHC, Pascagoula, MS; Patterson AHC, Ft. Monmouth, NJ; Scott AFB, IL; Selfridge AHC, MI; Walter Reed Medical Center, Washington, DC; and Wilford Hall Medical Center, TX.

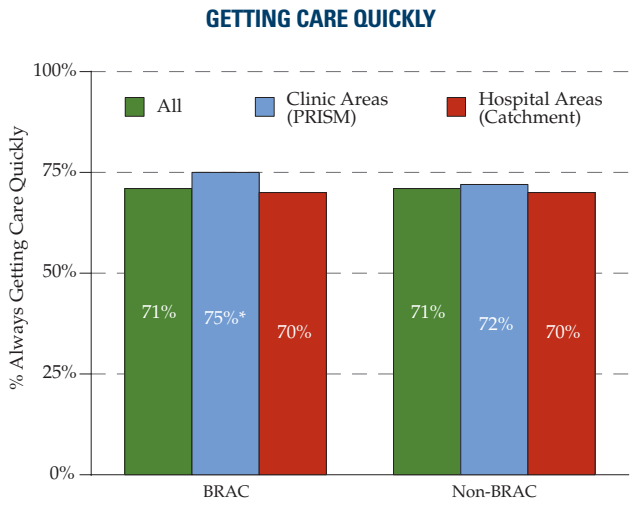
BRAC BASELINE SURVEY OF BENEFICIARY ACCESS AND SATISFACTION *(CONT'D)*

The chart below provides an example of two measures of access (Getting Needed Care and Getting Care Quickly) reflected in the table on the previous page.

- As shown in the chart on the left, always getting needed care is more common in BRAC clinic (PRISM) areas and less common in BRAC hospital (catchment) areas.
- As shown in the chart on the right, beneficiaries in BRAC clinic (PRISM) areas are more likely to report always getting care quickly.

TRENDS IN SATISFACTION WITH ABILITY TO OBTAIN CARE (ALL SOURCES OF CARE)





* Significant difference between BRAC & non-BRAC at $p < 0.05$
Source: 2008 BRAC data are from the 2008 BRAC Survey, 2008 non-BRAC data are from the 2008 Q1Q2 HCSDB

FINDINGS ON DIFFERENCES BETWEEN BRAC AND NON-BRAC SITES, BY BENEFICIARY CATEGORY (NOT SHOWN IN CHARTS)

- ADFMs in BRAC sites—particularly PRISMSs—appear more satisfied than their counterparts in non-BRAC sites.
- There was no difference in satisfaction between BRAC and non-BRAC sites for Active Duty personnel or for ADFMs not enrolled in Prime.

METHODOLOGY

- Randomly surveyed 24,290 beneficiaries in BRAC sites, with an oversample of retirees and Active Duty near retirement age.
- Used a common methodology and instrument-abbreviated version of HCSDB with BRAC-specific questions.
- Retirees and family members 65+:
  - Access and satisfaction adjusted by age, health status, education, and sex
  - Reported results are significant at $p<0.05$.

COMPARISON GROUPS, ALL AGE 18+

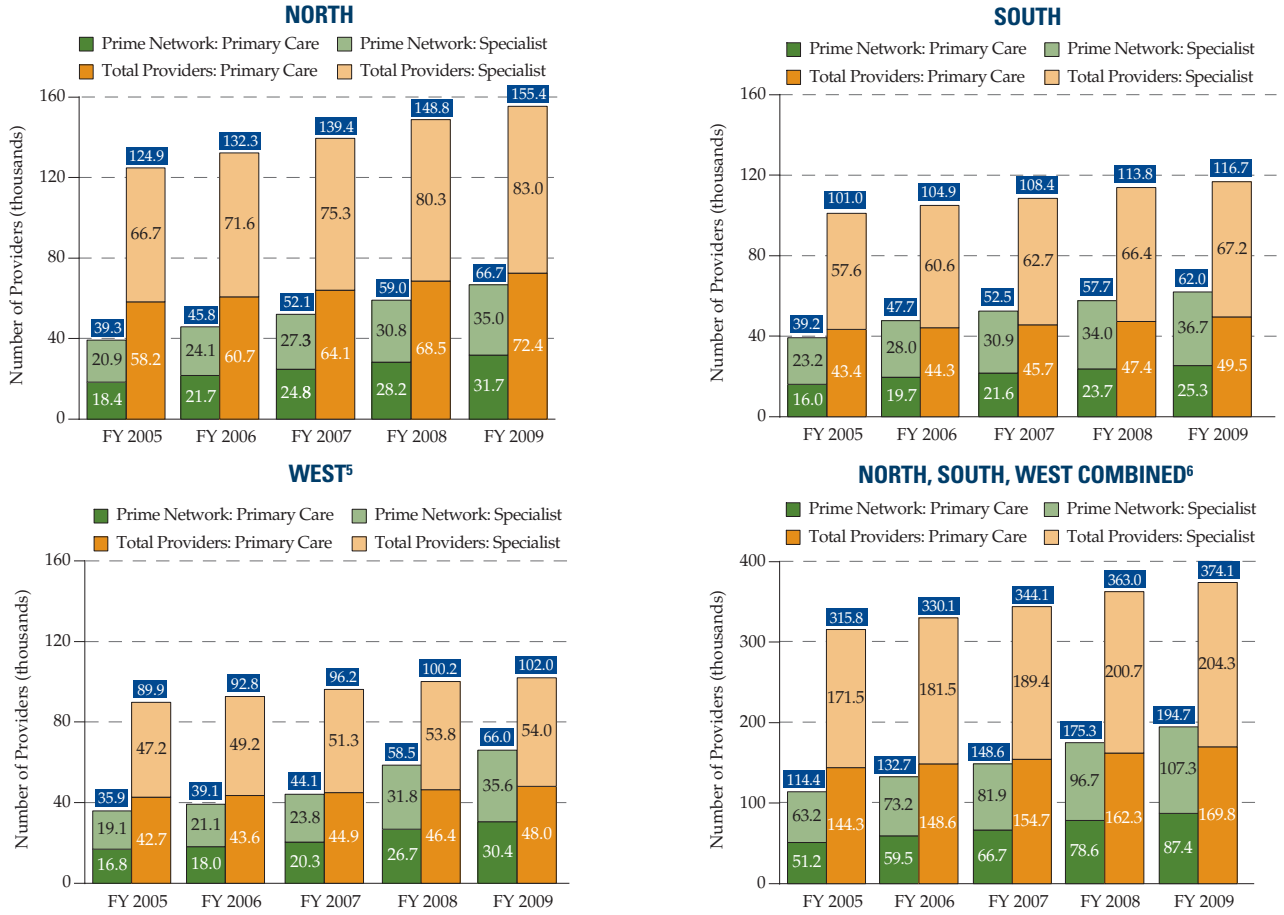
- Beneficiaries in all BRAC sites versus all non-BRAC sites
- Beneficiaries in BRAC catchments versus non-BRAC catchments
- Beneficiaries in BRAC PRISMs versus non-BRAC PRISMs

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 was determined by the number of unique providers filing TRICARE (excluding TFL) claims.[1] The number of providers had been rising steadily since FY 2005 but began to level off in FY 2008. The trend has been evident for both Prime and Standard/Extra providers. Furthermore, as evidenced by the claims data, the number of specialists has increased at a somewhat greater rate than primary care providers.[2]

- Between FY 2005 and FY 2009, the North Region saw the largest increase in the total number of TRICARE providers (25 percent), followed by the South Region (16 percent) and the West Region (13 percent).
- The West Region saw the largest increase in the number of Prime network providers (84 percent), followed by the North Region (70 percent) and the South Region (58 percent).
- The total number of TRICARE providers decreased by 10 percent in catchment areas and increased by 27 percent in noncatchment areas (not shown).[3]
- The number of Prime network providers increased by 24 percent in catchment areas and by 89 percent in noncatchment areas (not shown).

TRENDS IN PRIME NETWORK AND TOTAL PARTICIPATING PROVIDERS[4]



Source: MHS administrative data, 1/26/2010

[1] Providers include physicians, physician assistants, nurse practitioners, and select other health professionals. Providers of support services (e.g., nurses, laboratory technicians) were not counted. Additionally, providers were counted in terms of full-time equivalent units (FTE) (1/12 of a provider for each month the provider saw at least one MHS beneficiary) and, based on data from TMA–Aurora, a downward adjustment was made to account for the fact that some providers have multiple identifiers.

[2] 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.

[3] As noted on page 22, the catchment area concept is being replaced within the MHS by MTF Enrollment Areas.

[4] Network providers are TRICARE-authorized providers who have a signed agreement with the regional contractors to provide care at a negotiated rate. Participating providers include network providers and those non-network providers who have agreed to file claims for beneficiaries, to accept payment directly from TRICARE and to accept the TRICARE allowable charge, less any applicable cost shares paid by beneficiaries, as payment in full for their services.

[5] Includes Alaska.

[6] 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 or she was listed as a TRICARE participating provider. From FY 2005 forward, the claims explicitly identify network providers.

SURVEYS OF MHS BENEFICIARIES AND CIVILIAN PROVIDERS TO DETERMINE ACCEPTANCE OF TRICARE STANDARD AND EXTRA PATIENTS

Purpose of Study

The Department has completed the final year of four planned annual surveys to determine civilian physician acceptance of new TRICARE Standard patients. The DoD is responding to the requirements of Section 711, NDAA for FY 2008, Public Law 110-181, with an Office of Management and Budget (OMB)-approved four-year survey strategy designed to determine MHS beneficiary access to, and civilian provider acceptance of, the TRICARE Standard benefit option.

- Section 711, NDAA for FY 2008, directed DoD to annually conduct two surveys—one survey of civilian medical and mental health providers and one survey of TRICARE beneficiaries—in 20 U.S. locations in which TRICARE Prime is offered and 20 locations in which it is not. Surveys are to be accomplished from 2008 to 2011.
- **Background:** The 2008 congressional requirement succeeds an NDAA 2004 Section 723 requirement that was fulfilled by completing an OMB-approved three-year survey of civilian physicians annually in 2005, 2006 and 2007. This three-year survey effort revealed that just under nine of 10 physicians (87%) reported awareness of the TRICARE program in general, and about eight of 10 physicians (81%) accepted new TRICARE Standard patients, if they accepted any patients at all.

RESULTS OF 2008 SURVEYS

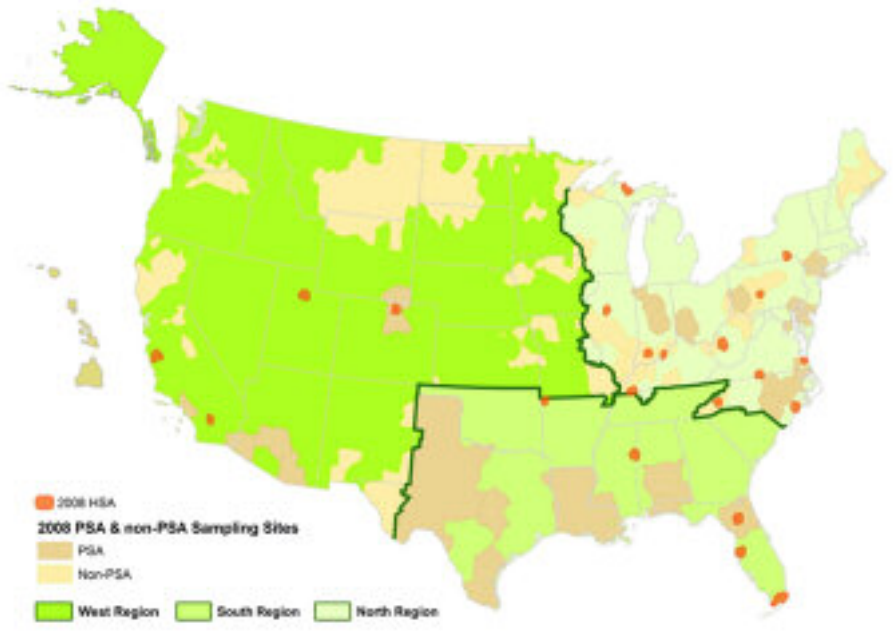
Beneficiary Survey:

- Beneficiary ratings were comparable, irrespective of location of residence. That is, when comparing TRICARE Standard and Extra users by location of residence, most ratings of access, satisfaction or use of preventive services between the two user types residing in the 20 PSAs and those residing outside prime service areas were similar.
  - One key exception: Standard/Extra users residing outside PSAs reported a statistically higher level of getting care quickly (83%) than those in PSAs (79%).
  - The MHS beneficiary survey results were benchmarked and compared with national civilian health plan results using the industry-accepted CAHPS survey questions sponsored by the Agency for Healthcare Research and Quality (AHRQ).
  - There is variation within groups both within and outside PSAs.

Provider Survey:

- ***Results compared to benchmarks:*** Physician-reported awareness of the TRICARE program in general is similar to findings in a previous three-year physician-only study used as benchmark (84 percent vs. 87 percent, respectively), but is lower for accepting new TRICARE Standard or Extra patients than reported by physicians in the benchmark study (66 percent vs. 81 percent).
- Psychiatrists and nonphysician behavioral health providers reported lower levels of awareness (about one-half) and acceptance (about one-third) of TRICARE Standard/Extra than other physician specialty types, along with lower levels of acceptance of new Medicare patients.
- ***PSA vs. non-PSA results:*** The average rates of awareness of the TRICARE program and acceptance of new TRICARE Standard/Extra patients are higher outside PSA locations than in PSA locations.

LOCATIONS OF DoD SURVEYS OF MHS BENEFICIARIES AND CIVILIAN PROVIDER ACCEPTANCE OF NEW TRICARE STANDARD PATIENTS



Source: OASD(HA)/TMA-HPA&E and administrative data, 12/30/2009

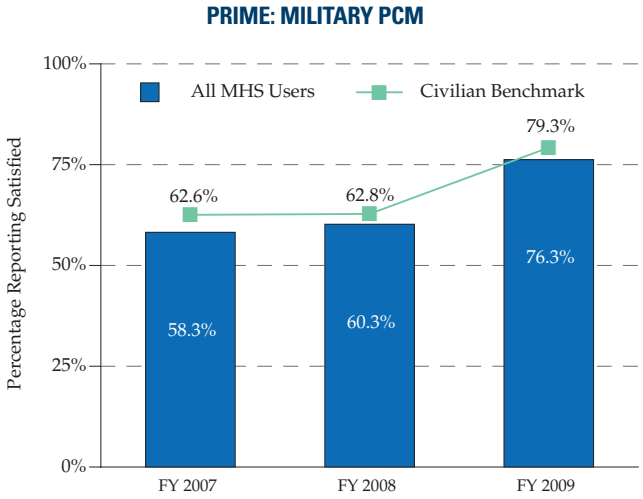
CUSTOMER SERVICE

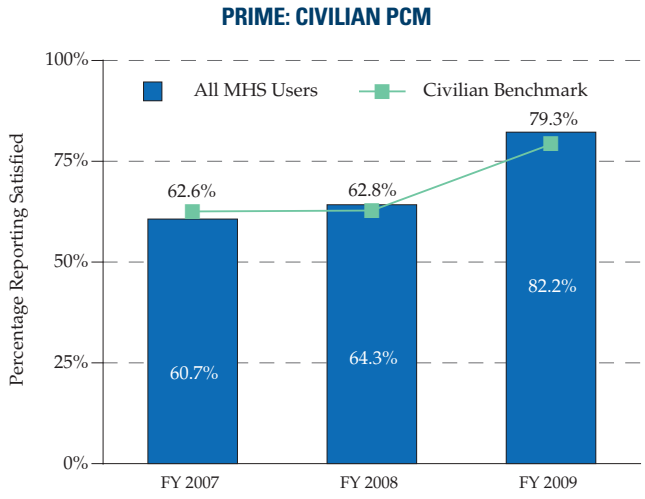
SATISFACTION WITH CUSTOMER SERVICE

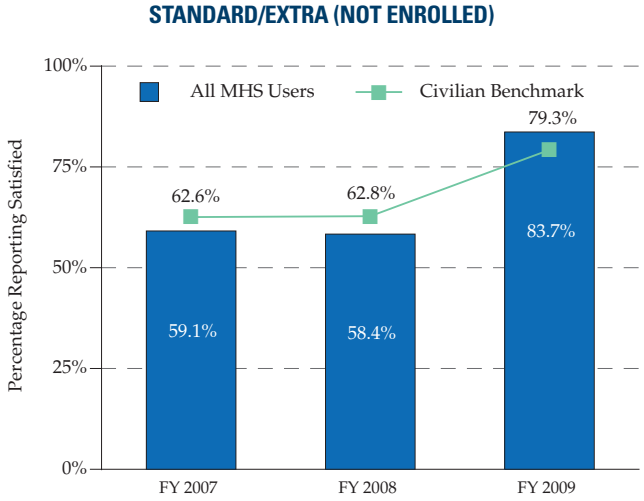
Access to and understanding written materials about one's health plan are important determinants of overall satisfaction with the plan.

- MHS beneficiaries' reported satisfaction with customer service, in terms of understanding written materials, getting customer assistance, and dealing with paperwork, increased between FY 2007 and FY 2009.
- MHS enrollees with civilian PCMs reported levels of satisfaction comparable to the civilian benchmark in FY 2007 and FY 2008, and exceeded it in FY 2009 (top right chart below).
- MHS MTF enrollee and non-enrollee (users of Standard or Extra) satisfaction improved between FY 2007 and FY 2009. Non-enrollee satisfaction exceeded the civilian benchmark in FY 2009, while MTF enrollee satisfaction continued to lag.

TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE OF FINDING AND UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK







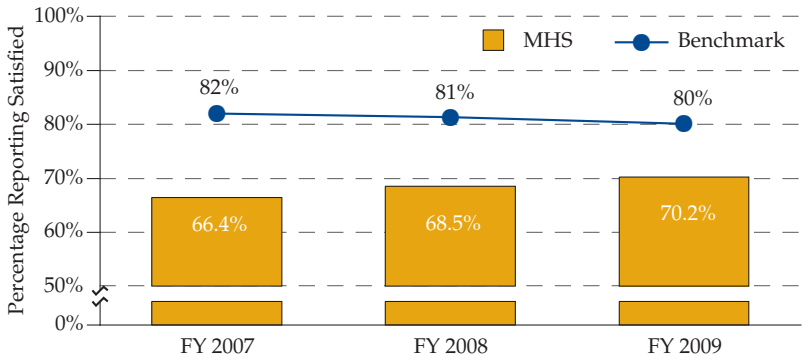
Note: DoD data were derived from the FYs 2007–2009 HCSDB, as of 12/11/2009, and adjusted for age and health status. Satisfaction ratings are based on the percentage rating "not a problem." "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. FY 2007 and FY 2008 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 National CAHPS Benchmarking Database (NCDB), whereas FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared to the 2008 NCBD, the latest benchmark data available.

SURVEYS OF MHS BENEFICIARY ACCESS TO AND EXPERIENCE WITH HEALTH CARE SERVICES FOLLOWING TREATMENT

TRICARE OUTPATIENT SATISFACTION SURVEY (TROSS)

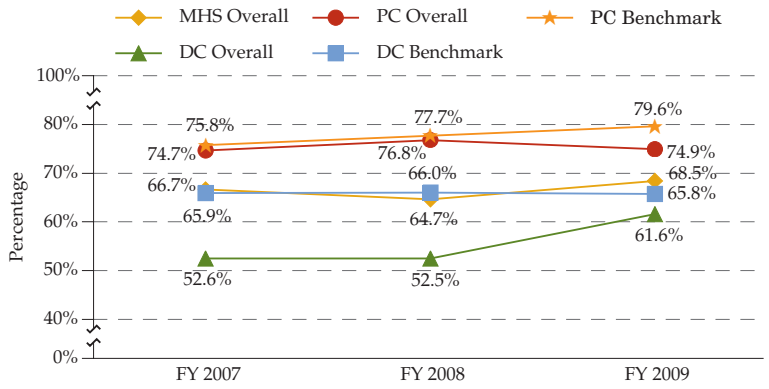
The goal of the OASD(HA)/TMA TRICARE Outpatient Satisfaction Survey (TROSS) is to monitor and report on the experience and satisfaction of MHS beneficiaries who have received outpatient care in an MTF or civilian outpatient setting. The TROSS is based on the Agency for Healthcare Research and Quality's (AHRQ) CAHPS, which allows for comparison with civilian outpatient services. The TROSS was first fielded in January 2007, succeeding its predecessor, the Customer Satisfaction Survey (CSS) used in previous Evaluation reports.

TROSS: EASE OF MAKING APPOINTMENT THROUGH PHONE, MHS ONLY

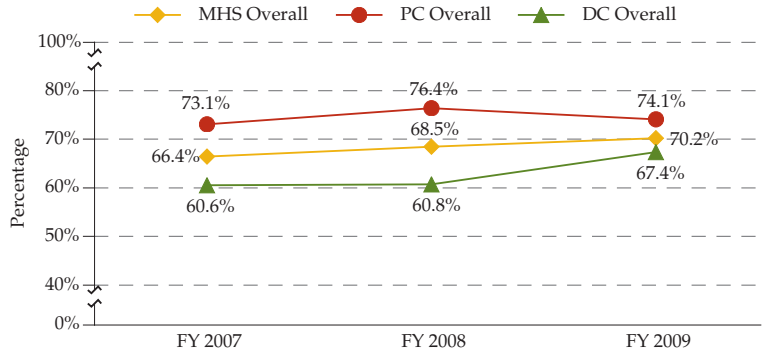


Source: OASD(HA)/TMA-HPA&E TROSS—FYs 2007, 2008 and 2009 (through May 2009). Ratings are on a 5 point scale with "Satisfied" defined as a rating of 4 or 5. Data are as of 1/4/2010.

OVERALL RATING OF HEALTH CARE (0–10 SCALE)



OVERALL RATING OF HEALTH PLAN (0–10 SCALE)



Source: OASD(HA)/TMA-HPA&E TROSS—FY 2007, 2008 and 2009 (through May 2009). Ratings are on a 10 point scale with "Satisfied" defined as a rating of 8, 9, or 10. Data are as of 1/4/2010.

Note: Terms above include direct care (i.e., MTF-based care) and purchased care (i.e., care provided in the private sector, through claims-based reimbursement). "MHS" overall refers to the combination of responses from users of the direct and purchased care components.

- The MHS is concerned about beneficiary satisfaction with telephone access to the direct care system, in addition to the satisfaction metrics previously presented.
  - The reported ease of making appointments by telephone increased from 66 percent in FY 2007 to 70 percent in FY 2009.
- The MHS is also concerned about beneficiary satisfaction with health care received, their overall health plan, and their health care provider.
  - Beneficiary ratings of the overall health care experience after receiving outpatient health care services increased from almost 67 percent in FY 2007 to over 68 percent in FY 2009, with the MTF-based direct care ratings increasing the most, and the claims-based purchased care ratings remaining the same during that time.
  - While the MHS combined direct and purchased care rating for overall satisfaction with care has improved over the past three years, it has lagged similar improvement in the civilian benchmark.
  - TRICARE Prime enrollee ratings of the health plan improved for all MHS enrollees, from 66 percent in FY 2007 to 70 percent in FY 2009. Although enrollees with civilian providers tend to rate their overall plan higher than enrollees with military providers, the greatest increase in plan ratings over the past three years has been by those beneficiaries enrolled to MTFs.

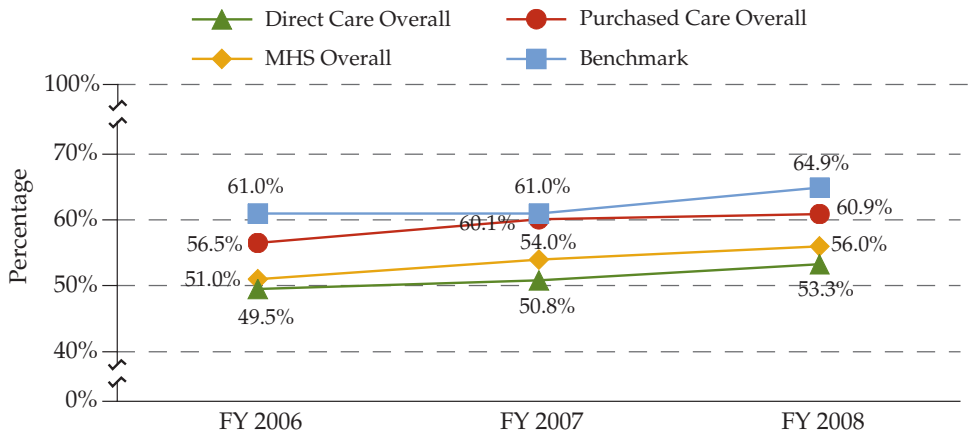
SURVEYS OF MHS BENEFICIARY ACCESS TO AND EXPERIENCE WITH HEALTH CARE SERVICES FOLLOWING TREATMENT *(CONT'D)*

TRICARE INPATIENTT SATISFACTION SURVEY (TRISS)

The purpose of the OASD(HA)/TMA TRICARE Inpatient Satisfaction Survey (TRISS) is to monitor and report on the experience and satisfaction of MHS beneficiaries who have been admitted to MTF and civilian hospitals. As with the TROSS, the TRISS is designed to compare across all Services, and across venues (i.e., direct care versus purchased care). Separate but comparable surveys are used for inpatient surgical, medical, and obstetrical care. Similar to the TROSS and HCSDB, the TRISS is based on the AHRQ's CAHPS surveys. Specifically, the TRISS is based on the Hospital-CAHPS (H-CAHPS) survey instrument, so that MHS results may be benchmarked to civilian hospitals reporting similar measures, and trended over time. The TRISS includes 22 questions from H-CAHPS, while 60 questions are DoD-specific. The survey covers a number of domains, including:

- Overall satisfaction, and recommendation to others
- Nursing care (care, respect, listening, and explanations)
- Physician care (care, respect, listening, and explanations)
- Communication (with nurses, doctors, and regarding medications)
- Responsiveness of staff
- Pain control
- Hospital environment (cleanliness and quietness)
- Post discharge such as written directions for post-discharge care

TRISS: RATING OF HOSPITAL, OVERALL

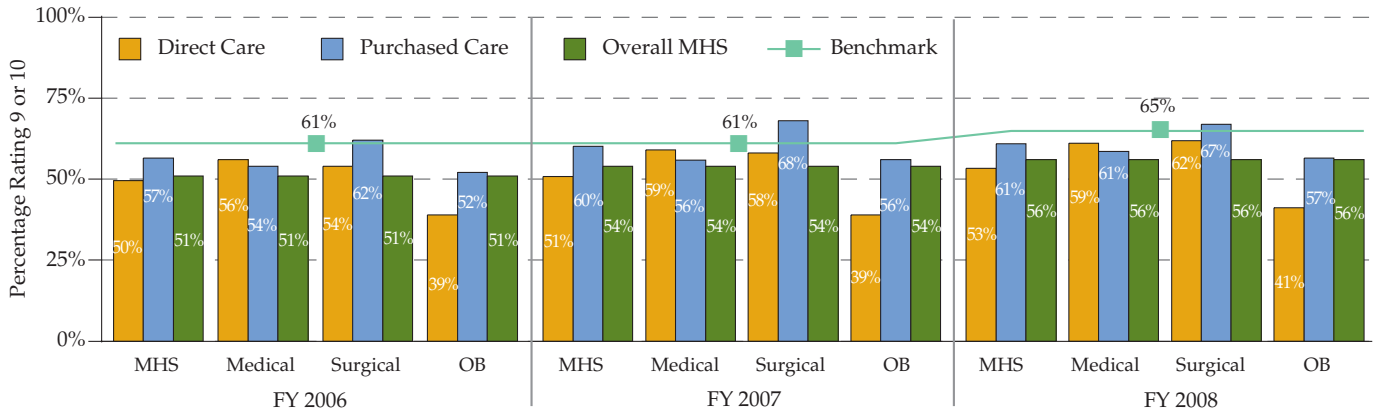


Source: TRISS as of 11/11/2009. Data are adjusted to account for the sampling design and nonresponse. Ratings are on a 0–10 point scale with "Satisfied" defined as a rating of 9 or better.

Note: Terms above include direct care (i.e., MTF-based care) and purchased care (i.e., care provided in the private sector, through claims-based reimbursement). "MHS" overall refers to the combination of responses from users of the direct and purchased care components.

- The MHS overall, and within its direct care (i.e., MTF) as well as purchased care (i.e., private sector through paid claims) components, has steadily increased over all three years, from 51 percent in FY 2006 to 56 percent in FY 2008.
- Surgical purchased care ratings of the hospital met or exceeded the benchmark each year from FY 2006 to FY 2008. MHS beneficiaries who were discharged from either surgical or obstetrical purchased care services rated their hospital higher than beneficiaries discharged from counterpart services in direct care hospitals each year.

TRISS: RATING OF HOSPITAL: OVERALL (0–10 SCALE)



Source: TRISS as of 11/11/2009. Data are adjusted to account for the sampling design and non-response. Ratings are on a 0–10 point scale with "Satisfied" defined as a rating of 9 or better.

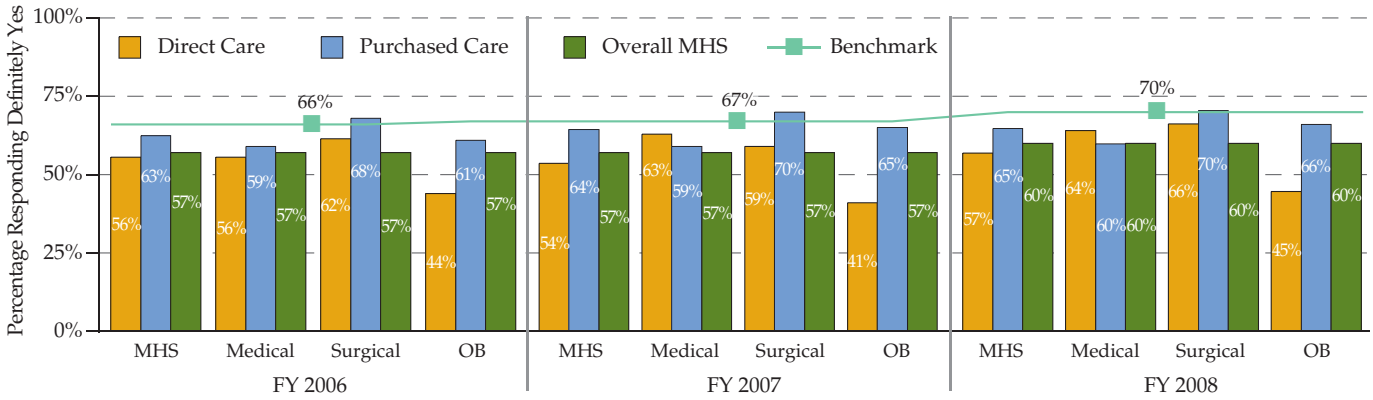
Note: Terms above include the direct care (i.e., MTF-based care) and purchased care (i.e., care provided in the private sector, through claims-based reimbursement). "MHS" overall refers to the combination of responses from users of the direct and purchased care components.

SURVEYS OF MHS BENEFICIARY ACCESS TO AND EXPERIENCE WITH HEALTH CARE SERVICES FOLLOWING TREATMENT *(CONT'D)*

TRICARE INPATIENTT SATISFACTION SURVEY (TRISS) *(CONT'D)*

- Overall MHS "willingness to recommend" ratings increased between FY 2006 and FY 2008.
- Direct care ratings by beneficiaries using medical and obstetrical services decreased slightly from FY 2006 to FY 2007, but rebounded in FY 2008 to levels equal to or higher than FY 2006.
- Surgical purchased care ratings met or exceeded the civilian benchmark each year.
- Purchased care ratings increased each year for all survey product lines.

TRISS: WILLINGNESS TO RECOMMEND HOSPITAL



Source: TRISS as of 11/11/2009. Data are adjusted to account for the sampling design and non-response. Ratings represent responses of "Definitely Yes".

Note: Terms above include direct care (i.e., MTF-based care) and purchased care (i.e., care provided in the private sector, through claims-based reimbursement). "MHS" overall refers to the combination of responses from users of the direct and purchased care components.

DRIVERS OF INPATIENT AND OUTPATIENT SATISFACTION

Results of customer surveys have become increasingly important in measuring health plan performance, and in directing action to improve the beneficiary experience and quality of services provided. Customer satisfaction is related to trust in doctors and the intention to switch doctor and health plan. In addition, patients with more positive reports about their care experiences had better health outcomes.

- Three key beneficiary surveys measure self-reported access and satisfaction with the MHS direct and purchased care experience:
  - HCSDB—population based;
  - TRISS—event-based after a discharge from a hospital;
  - TROSS—event-based following an outpatient visit.

OASD(HA)/TMA-HPA&E, supported by Altarum Institute, analyzed the results of the three key beneficiary surveys to determine the drivers of satisfaction. Drivers of satisfaction for all surveys were determined by examining the effects of composite scores on outcome models. The models controlled for all composites and demographic variables, including age, gender, service, health status, and region.

The statistical significance and effect size of odds ratios were used to rank-order drivers of satisfaction.

- As shown in the table below, MHS satisfaction with health care is driven by the following factors for direct care services: communication between patients and doctors, nurses and staff; respect for family and friends; and respondent perception of MHS.
- These results suggest that improving communication has the potential to influence a patient's satisfaction with their health care, health plan, and their hospital.

TOP THREE DRIVERS OF SATISFACTION BY SURVEY: DIRECT CARE

	TRISS 2008 Direct Care MHS - Medical Rating of Hospital	TROSS 2009 Direct Care MHS Rating of Health Care
#1	Respect for Family & Friends	Perception of MHS
#2	Nurse Communication	Doctor Communication
#3	Doctor Communication	Office Staff

Sources: OASD(HA)/TMA-HPA&E TRICARE Inpatient Satisfaction TRICARE Outpatient Satisfaction Survey, Calendar Years 2007, 2008, and 2009 (through May 2009). Surveys as of 11/11/2009

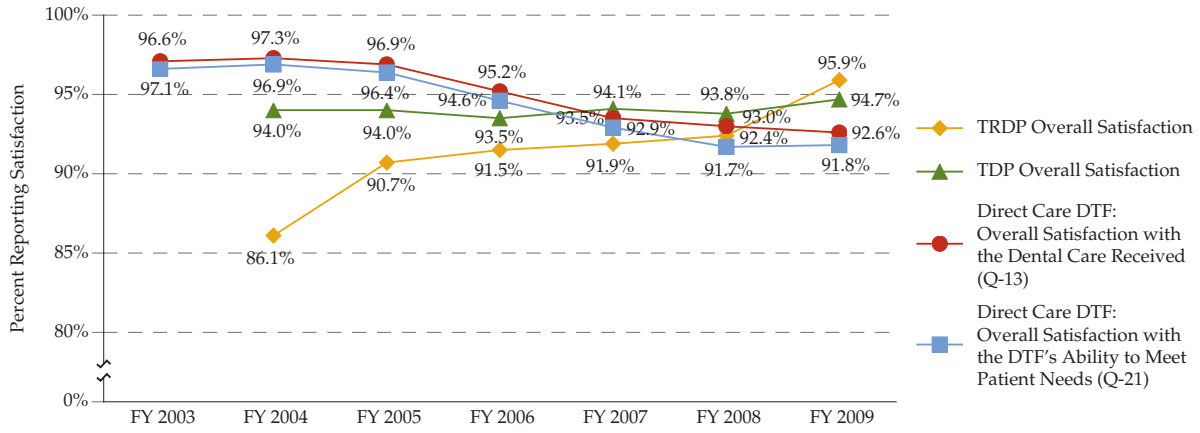
TRICARE DENTAL PROGRAMS CUSTOMER SATISFACTION

DENTAL CUSTOMER SATISFACTION

The overall TRICARE dental benefit is composed of several delivery programs serving the MHS beneficiary population. Consistent with other benefit programs, beneficiary satisfaction is routinely measured for each of these important dental programs.

- Satisfaction with dental care reported by patients receiving dental care in military DTFs was 92.6 percent in FY 2009, compared with 93.0 percent in FY 2008. DTFs are responsible for the dental care of about 1.8 million ADSMs, as well as eligible Outside Continental U.S. family members. During FY 2009, the Tri-Service Center for Oral Health Studies collected 219,634 DoD Dental Patient Satisfaction Surveys from patients who received dental care at the Services' DTFs, a decrease of almost 7,000 from that of FY 2008. The overall DoD dental patient satisfaction with the ability of the DTFs to meet their dental needs remained steady at 91.8 percent in FY 2009.
- **The TRICARE Dental Program:** FY 2009 composite average enrollee satisfaction increased nearly one percent, to 94.7 percent in FY 2009. The TRICARE Dental Program (TDP) is a voluntary, premium-sharing dental insurance program that is available to eligible ADFMs, Selected Reserve and Individual Ready Reserve members, and their family members. As of September 30, 2009, the TDP serviced 798,282 contracts, covering 1,907,331 lives. Although not shown, this measure includes satisfaction ratings for network access (95.0 percent), provider network size and quality (93.0 percent), claims processing (95.7 percent), enrollment processing (96.0 percent), and written and telephonic inquiries (95.0 percent). The TDP network has 65,099 dentists, comprised of 52,711 general and 12,388 specialty dentists.
- The **TRICARE Retiree Dental Program** overall retired enrollee satisfaction rate increased nearly four percent, from 92.4 percent in FY 2008 to 95.9 percent in FY 2009. The TRICARE Retiree Dental Program (TRDP) is a full premium insurance program open to retired Uniformed service members and their families. It had an 8.9 percent increase in enrollees from FY 2008 to FY 2009, ending the year with 574,594 contracts covering 1,185,663 lives. The TRDP network has 136,841 provider locations, including both general and specialty dentists.

SATISFACTION WITH TRICARE DENTAL CARE: MILITARY AND CONTRACT SOURCES



Source: Tri-Service Center for Oral Health Studies, DoD Dental Patient Satisfaction reporting Web site (Trending Reports) and TRICARE Operations Division, 11/06/2009

Note: The three dental satisfaction surveys (Direct Care, TDP, and TRDP) are displayed above for ease of reference, but are not directly comparable because they are based on different survey instruments and methodologies.

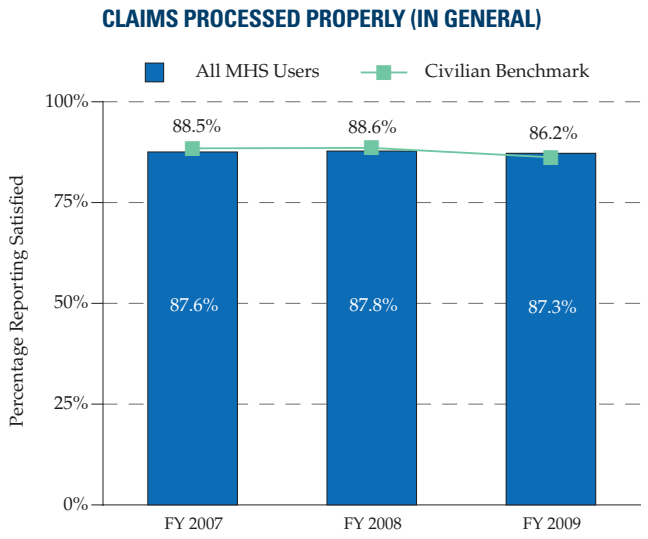
CLAIMS PROCESSING

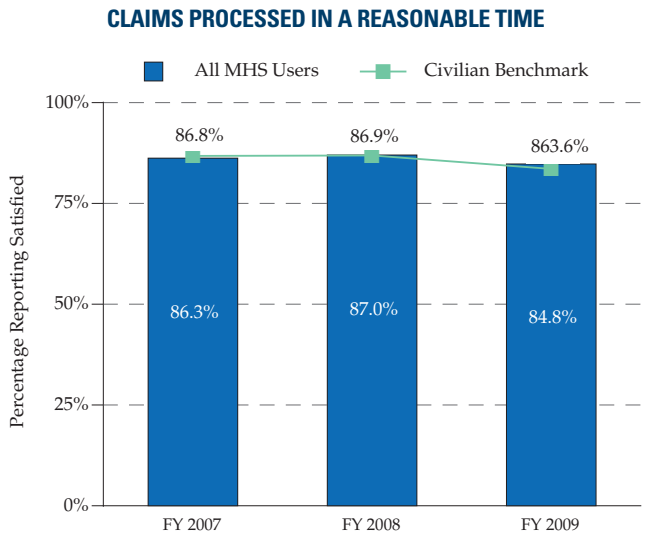
Claims processing is often cited as a "hot button" issue for beneficiaries as well as their providers. This is usually the case for the promptness of processing, as well as the accuracy of claims and payment. The MHS monitors the performance of TRICARE claims processing through two means—surveys of beneficiary 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

- Satisfaction with claims being processed accurately remained stable from FY 2007 to FY 2009. Satisfaction with processing in a reasonable period of time decreased slightly in FY 2009.
- MHS satisfaction levels for both measures were comparable (i.e., not statistically significantly different) to the civilian benchmark in FY 2007 and FY 2008, and exceeded the benchmark in FY 2009.
- While not shown, 99.87 percent of retained claims were processed within the 30 day TRICARE performance standard, as they have for the past eight years.

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





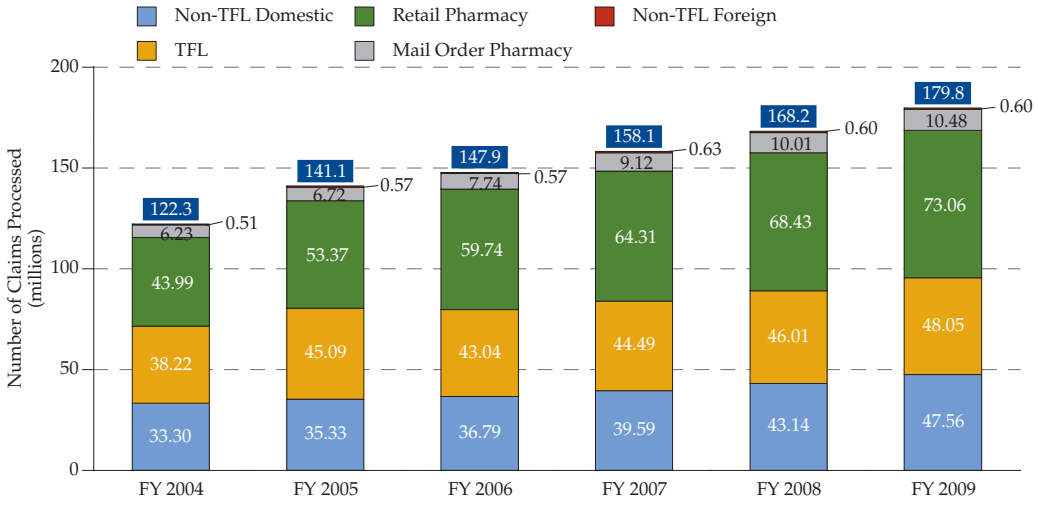
Note: DoD data were derived from the FYs 2007–2009 HCSDB, as of 12/11/2009, and adjusted for age and health status. Satisfaction ratings are based on the percentage rating "usually" or "always." "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. FY 2007 and FY 2008 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 NCDB, whereas FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared to the 2008 NCBD, the latest benchmark data available.

CLAIMS PROCESSING *(CONT'D)*

ADMINISTRATIVELY REPORTED CLAIMS FILING BY CONUS/TFL/OCONUS

The number of claims processed continues to increase, due to increases in purchased care workload, including claims from seniors for TFL, pharmacy, and TRICARE dual-eligible beneficiaries. Claims processing volume increased by almost one-half (47 percent) between FY 2004 and FY 2009, and almost 7 percent just between FY 2008 and FY 2009. This increase is due to a combination of an increase in the overall volume of claims as well as a change in how pharmacy claims are reported. Prior to FY 2005, a pharmacy claim could include multiple prescriptions, whereas beginning in FY 2005 individual pharmacy prescriptions were reported separately. Retail and mail order prescriptions alike increased the fastest between FY 2004 and FY 2009 (66 percent and 68 percent, respectively).

TREND IN THE NUMBER OF TRICARE CLAIMS PROCESSED, FY 2004 TO FY 2009



Source: MHS Administrative data, 11/18/2009

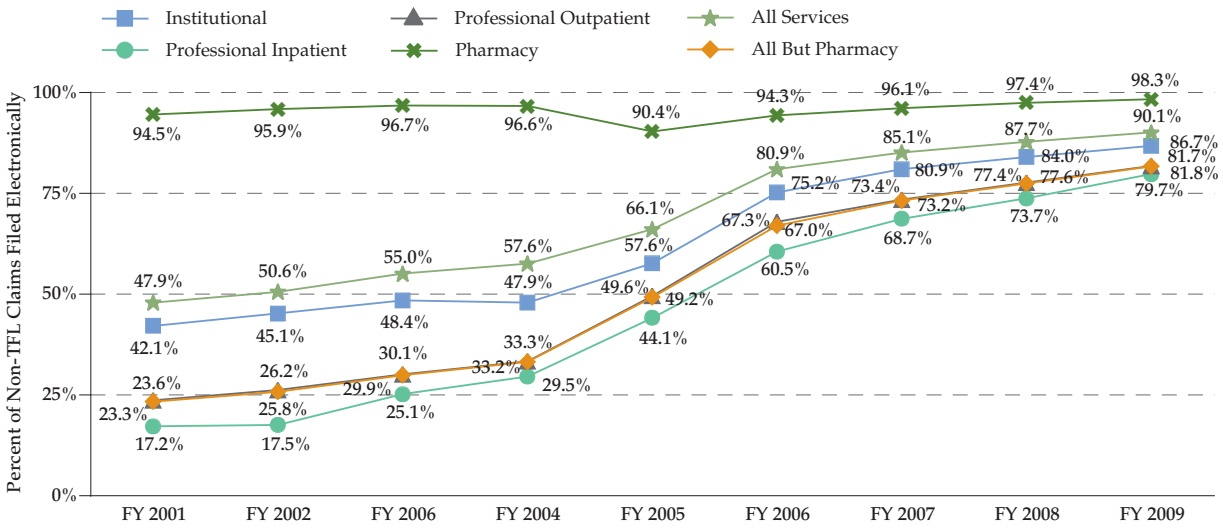
ELECTRONIC CLAIMS PROCESSING

TRENDS IN ELECTRONIC CLAIMS FILING

TRICARE continues to work with providers and claims processing contractors to increase processing of claims electronically, rather than in mailed, paper form. 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 prompter payment to the provider. The TROs have been actively collaborating with the health care support contractors to improve the use of electronic claims processing.

- The percentage of non-TFL claims processed electronically for all services increased to more than 90 percent in FY 2009, up more than two percentage points from the previous year, and more than 42 percentage points since FY 2004. These data focus on non-TFL claims because TRICARE is a second payer to Medicare providers, which have, historically, reflected a higher percentage of electronic claims because of their program requirements and the size of their program.
- While pharmacy claims continue to be predominantly electronic, hovering between 95–97 percent, the real growth in electronic claims has been in the other categories reflected individually below, as well as in the "All but Pharmacy" trend line, reaching almost 82 percent in 2009 (the individual categories below are institutional and professional inpatient and outpatient services).

EFFICIENCY OF PROCESSING TRICARE CLAIMS: PERCENTAGE OF NON-TFL CLAIMS FILED ELECTRONICALLY



Source: MHS administrative claims data, 11/18/2009

Foreign claims are excluded.

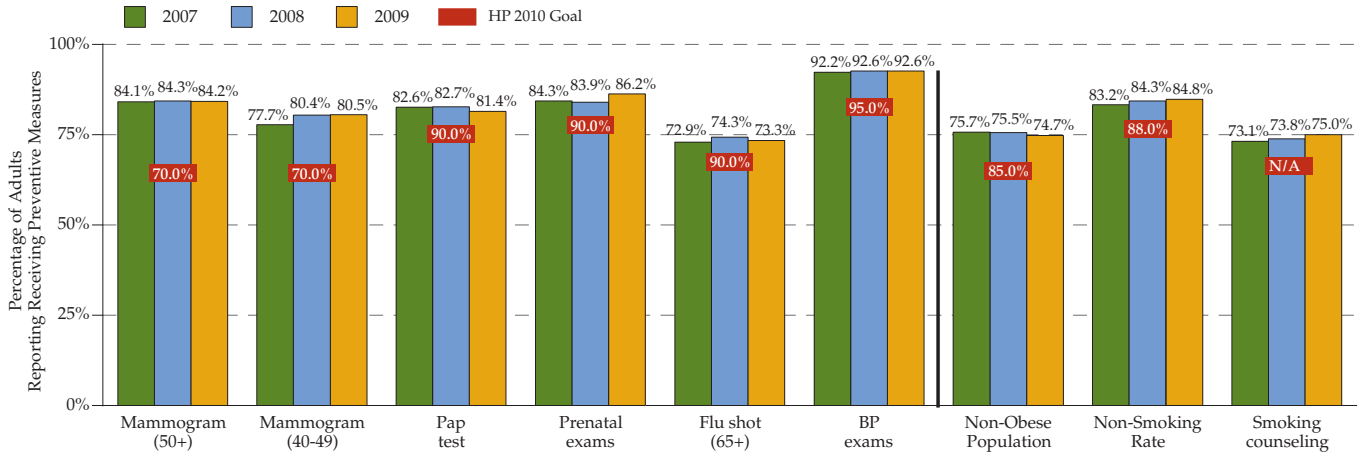
Note: Efforts to increase pharmacy access through the mail order program beginning in mid–FY 2007 is reflected in the overall percentage of claims processed electronically. This is because mail order scripts cover longer periods of time (90 days for mail order instead of 30 days at retail pharmacies), which will be reflected in fewer refill scripts per person, all other factors being equal. As such, the mix of pharmacy vs. other claims will also likely change which will skew the composite numbers in the future.

BUILDING HEALTHY COMMUNITIES: HEALTHY PEOPLE 2010

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.

- The MHS has set as goals a subset of the health-promotion and disease-prevention objectives specified by DHHS in HP 2010. Over the past three years, the MHS has met or exceeded targeted HP 2010 goals in providing mammograms (for ages 40–49 years as well as 50+ categories).
- Efforts continue toward achieving HP 2010 standards for Pap smears, prenatal exams, flu shots (for people age 65 and older), and blood pressure screenings.
- **Tobacco Use:** The overall self-reported nonsmoking rate among all MHS beneficiaries increased slightly from FY 2007 through FY 2009 to nearly 85 percent. While the proportion of nonsmoking MHS beneficiaries appears higher than the overall U.S. population (not shown), it continued 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).
- **Obesity:** The metric of "non-obese" has been established to indicate a general sense of the population likely not excessively overweight and at health risk due to obesity. The overall proportion of all MHS beneficiaries identified as non-obese has remained relatively constant from FY 2007 to FY 2009. The MHS rate of 75 percent non-obese in FY 2009, using self-reported data, did not reached the HP 2010 goal of 85 percent, but did exceed the most recently identified U.S. population average of 69 percent (not shown).
- Still other areas continue to be monitored in the absence of specified HP standards, such as smoking-cessation counseling, which appears to be heading in the right direction, reaching 75 percent in FY 2009.

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FY 2007 TO FY 2009



Source: Health Care Survey of DoD Beneficiaries and the NCBD as of 12/11/2009

MHS-TARGETED PREVENTIVE CARE OBJECTIVES

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

Non-Obese: 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 times 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 be used in conjunction with other assessments of overall health and body fat.

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

DoD SURVEY OF HEALTH RELATED BEHAVIORS AMONG MILITARY PERSONNEL

The findings from the most recent Survey of Health Related Behaviors (HRB) related to substance abuse among Active Duty military personnel throughout the world are presented below. Completed in 2008, this is the 10th in a series of surveys of Active Duty military personnel since 1980. The HRB is the largest on-site anonymous population-based health behavior survey of Active Duty personnel. In 2008, the results were based on 28,546 usable responses for an overall 70.6 percent response rate (compared with 51.8 percent in the 2005 Survey). These surveys have investigated the prevalence of alcohol, illicit drug, and tobacco use, along with the negative consequences associated with these practices. The survey has evolved over time, with revisions and additions to accommodate new areas of concern (e.g., mental health of the force, oral health, abusive use of legal drugs, and gambling behaviors), as well as the inclusion of HP 2010 objectives. Key findings of Active Duty military personnel were presented in the FY 2007 Evaluation of the TRICARE Program (p. 29), and results of a comparable survey of RC personnel were presented in the FY 2008 report (p. 61).

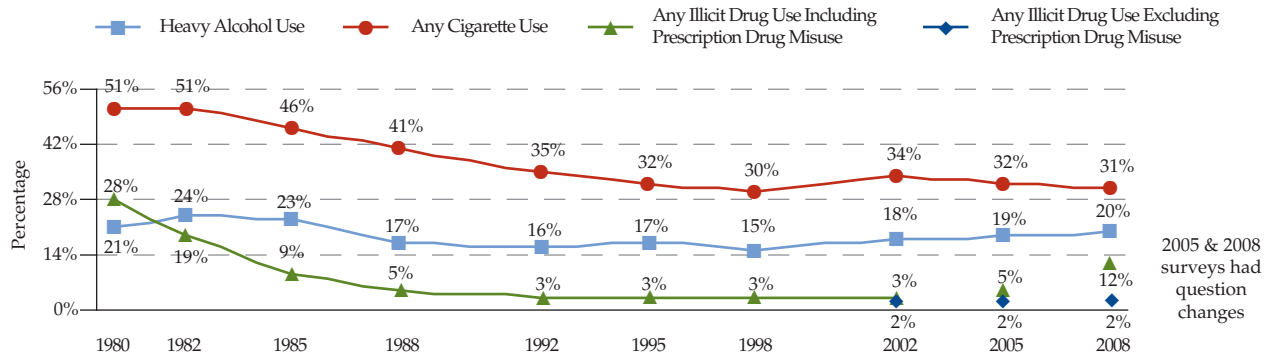
The HRB became a component of the DoD Lifestyle Assessment Program (DLAP) which was initiated in 2005 to build on the health behavior surveys of Active Duty military personnel conducted since 1980. The purpose of this program is to:

- Assess lifestyle factors affecting health and readiness.
- Identify/track health-related trends and high-risk groups.
- Target groups and/or lifestyle factors for intervention.
- Help identify future directions for additional studies, DoD programs and policies.

REPORTED SUBSTANCE USE BY DoD PERSONNEL

The chart below presents the trends, over the nine DoD surveys, of the percentages of the total active force during the past 30 days who engaged in heavy alcohol, any illicit drug, and any cigarette use.

TRENDS IN SUBSTANCE USE FOR DoD ACTIVE DUTY IN THE PAST 30 DAYS, 1980–2008



Source: DoD Survey of HRB among Active Duty Military Personnel, prepared by RTI International, March 2009, page 43, provided 11/10/2009

DEFINITIONS

Heavy Alcohol Use: Five or more drinks on the same occasion at least once a week in the the past 30 days.

Any Illicit Drug Use Including Prescription Drug Misuse: Use of marijuana, cocaine (including crack), hallucinogens (PCP, MDA, MDMA, and other hallucinogens), heroin, methamphetamine, inhalants, GHB/GBL, or nonmedical use of prescription-type amphetamines/stimulants, tranquilizers/muscle relaxers, barbiturates/sedatives, or pain relievers.

Any Illicit Drug Use Excluding Prescription Drug Misuse: Use of marijuana, cocaine (including crack), hallucinogens (PCP, MDA, MDMA, and other hallucinogens), heroin, inhalants, etc.

OVERVIEW OF KEY TRENDS IN SUBSTANCE USE:

- For the DoD services, the percentage of military personnel who smoked cigarettes in the past 30 days fell significantly between 1980 (51 percent) and 1998 (30 percent). This rate had increased significantly between 1998 and 2002 (34 percent), but has been slowly trending downward since that time, to 31 percent in 2008.
- Personnel engaged in heavy alcohol use rose in the 10 years from 1998 to 2008 (15 percent to 20 percent). Yet the heavy drinking rate for 2008 (20 percent) was not significantly different from when the survey series began in 1980 (21 percent).
- Illicit drug use (including prescription drug misuse) during the past 30 days fell sharply, from 28 percent in 1980 to 3 percent in 2002, but rose to 5 percent in 2005 and 12 percent in 2008. Improved question wording in 2005 and 2008 may partially account for the higher observed rates, which are largely attributable to reported increases in misuse of prescription pain medications. Because of these changes, data from 2005 and 2008 are not comparable to data from prior surveys and are not included as part of the trend line. An additional line from 2002 to 2008 shows estimates of illicit drug use, excluding prescription drug misuse. As shown, those rates were very low (2 percent in 2008) and did not change across these three iterations of the survey.

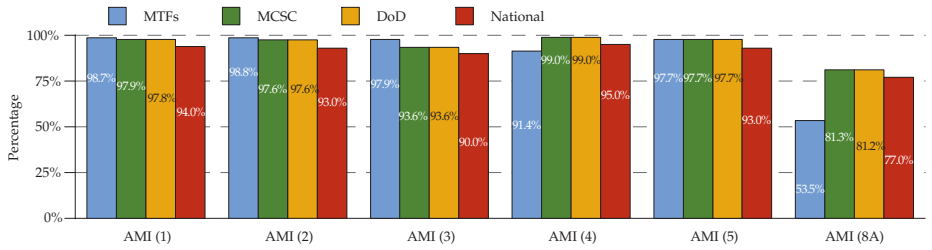
NATIONAL HOSPITAL QUALITY MEASURES—MILITARY HEALTH SYSTEM HOSPITALS PERFORMANCE

Quality measures assist MHS beneficiaries in comparing the quality of care provided in medical facilities, and in making informed decisions about the quality of health services available to them and their families. Additionally, standardized and consensus-based metrics are integral for leaders and stakeholders who are focused on evaluating and improving the quality of health care delivered in the direct care MTFs and purchased care facilities of the MHS.

Through the coordination of the Hospital Quality Alliance, health care leaders from key organizations collaborate to align measures across the health care industry. Proposed measures are analyzed and, if approved, are formally endorsed by the National Quality Forum (NQF), a multi-stakeholder organization consisting of more than 350 organizations representing consumers, purchasers, health care professionals, providers, health systems, insurers, state governments, and federal agencies. The hospital-focused measures endorsed by the NQF have been designed to permit more rigorous comparisons, using standardized, evidence-based measures and data gathering procedures. The Joint Commission and the U.S. HHS Centers for Medicare and Medicaid Services (CMS) utilizes these nationally recognized hospital quality measures to evaluate care provided in hospitals across the nation. The MHS utilizes national consensus hospital measures for analyzing the quality of care provided to military beneficiaries.

The performance of hospitals in the MHS is evaluated through measure sets for the following conditions: AMI; heart failure (HF); pneumonia (PN); children's asthma care (CAC); and surgical care improvement project (SCIP). In the direct care facilities, the data for the hospital quality measures are abstracted by trained specialists and reported to facility leadership for analysis and identification of improvement opportunities. Data on the measure sets for hospitals enrolled to a MCSC network are obtained from the files posted by CMS on the Hospital Compare Web site: *http://www.hospitalcompare.hhs.gov*. The data table below provides a view of the performance of the direct care and purchased care systems compared with the national average.

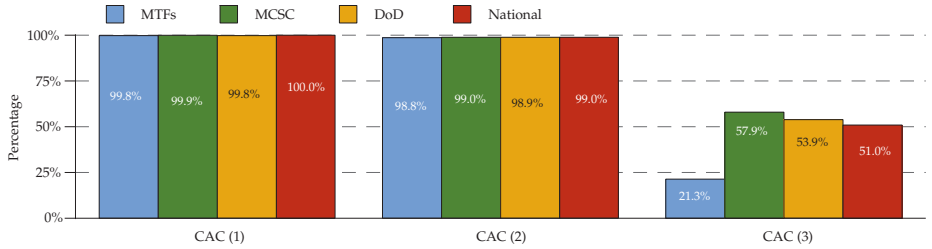
ACUTE MYOCARDIAL INFARCTION JANUARY–DECEMBER, 2008



Acute Myocardial Infarction

AMI (1) – Aspirin on Arrival
AMI (2) – Aspirin Prescribed at Discharge
AMI (3) – ACE (angiotensin converting enzyme) inhibitors and ARBs (angiotensin receptor blockers) for Left Ventricular Systolic Dysfunction (LVSD)
AMI (4) – Adult Smoking Cessation Advice/Counseling
AMI (5) – Beta Blocker at Discharge
AMI (8A) – PCI within 90 minutes of Arrival

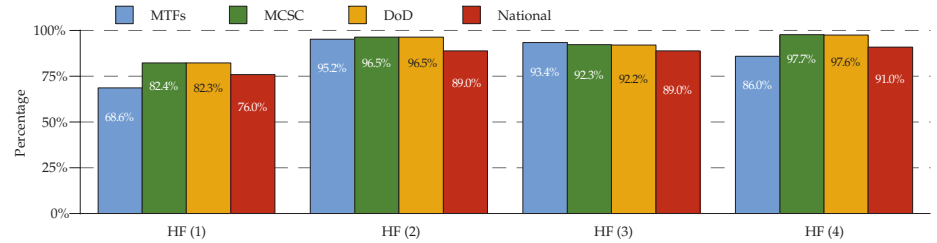
CHILDREN'S ASTHMA CARE JANUARY–DECEMBER, 2008



Children's Asthma Care

CAC (1) – Reliever Prescribed for Inpatient Asthma
CAC (2) – Systematic Corticosteroids for Inpatient Asthma
CAC (3) – Home Management Plan Documented

HEART FAILURE JANUARY–DECEMBER, 2008



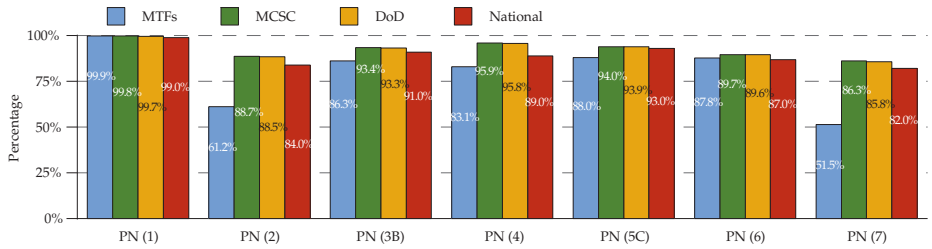
Heart Failure

HF (1) – Discharge Instructions
HF (2) – Evaluation of Left Ventricular Systolic Assessment
HF (3) – ACE (angiotensin converting enzyme) inhibitors and ARBs (angiotensin receptor blockers) for Left Ventricular Systolic Dysfunction (LVSD)
HF (4) – Adult Smoking Cessation Advice/Counseling

Source: OASD(HA), Office of the Chief Medical Officer, 12/18/2010

NATIONAL HOSPITAL QUALITY MEASURES— MILITARY HEALTH SYSTEM HOSPITALS PERFORMANCE *(CONT'D)*

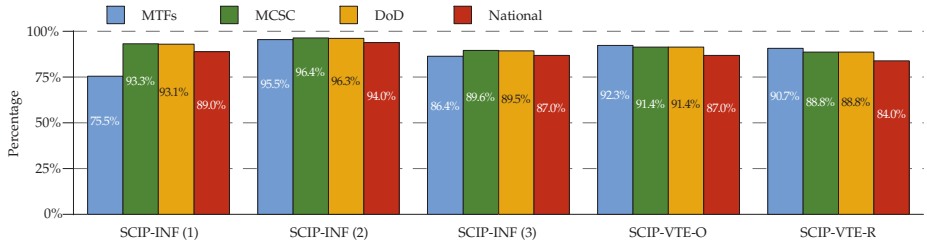
PNEUMONIA JANUARY–DECEMBER, 2008



Pneumonia

PN (1) – Oxygenation Assessment
PN (2) – Pneumococcal Vaccination
PN (3B) – Blood Cultures in Emergency Department Prior to Antibiotics
PN (4) – Adult Smoking Cessation Advice/Counseling
PN (5C) – Initial Antibiotic Received within six Hours of Hospital Arrival
PN (6) – Most Appropriate Initial Antibiotic(s)
PN (7) – Influenza Vaccination

SURGICAL CARE IMPROVEMENT PROJECT JANUARY–DECEMBER, 2008



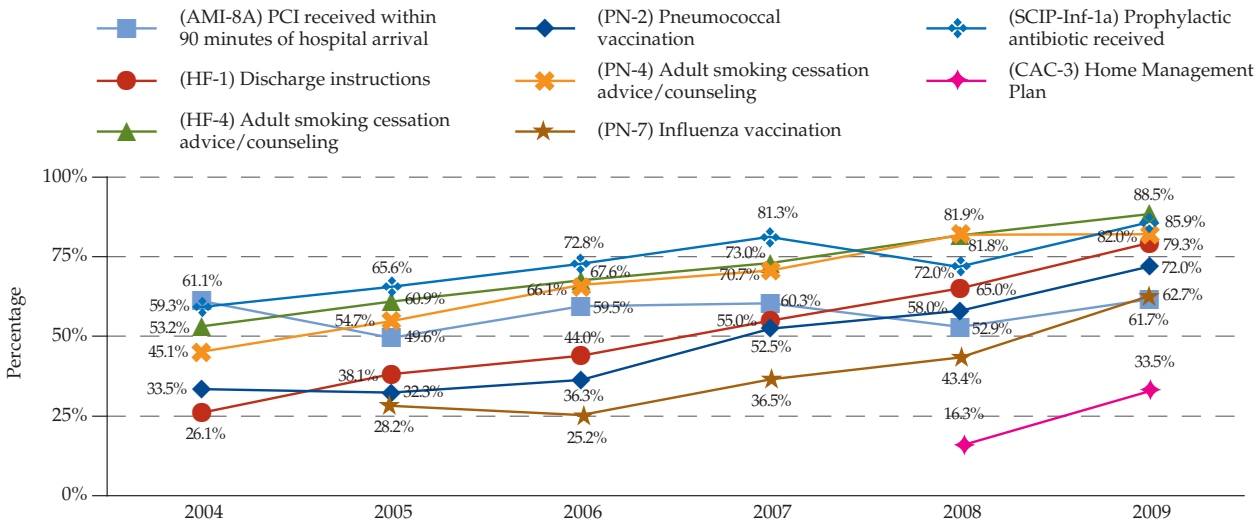
Surgical Care Improvement Project

SCIP-INF (1) – Preventive Antibiotic Received within One Hour of Incision
SCIP-INF (2) – Preventative Antibiotic Selection Appropriate
SCIP-INF (3) – Preventative Antibiotic Discontinues with 24 hours of Surgery
SCIP-VTE-O – Recommended Venous Thromboembolism (VTE) Prophylaxis Ordered
SCIP-VTE-R – Recommended Venous Thromboembolism (VTE) Prophylaxis Received

Source: OASD(HA), Office of the Chief Medical Officer, 12/18/2010

The charts reveal that the hospitals included in the purchased care networks perform as good as or better than the national average on all 25 measures. The direct care facilities perform as good as or better than the national rate on 76 percent of the measures. As shown on the chart below, MHS MTFs improved between FY 2004 and FY 2009 on the measures that lagged behind the national average, as reported on Hospital Compare, by Health and Human Services.

HOSPITAL QUALITY MEASURES: MILITARY TREATMENT FACILITIES



Source: OASD(HA), Office of the Chief Medical Officer, 12/18/2010

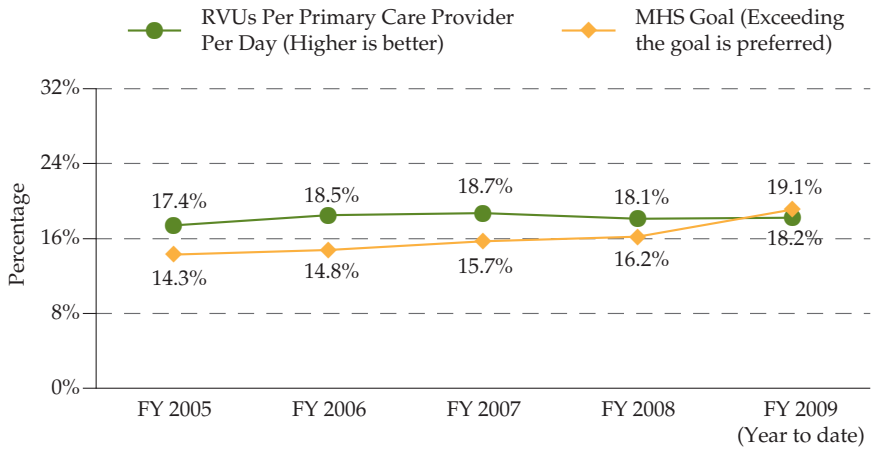
SYSTEM PRODUCTIVITY: RVU PER FULL-TIME EQUIVALENT PRIMARY CARE PROVIDER

This chart reflects the availability of a specific provider for patient care and the intensity of the associated work. 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.

MHS productivity improved over time, from FY 2005 to FY 2009 (through March), although it lagged the civilian average productivity of 21.8 RVUs per primary care provider (not shown). Trending adjustments have been made to account for changes to CMS weights. However, missing MTF data at the time of writing may have resulted in overstating MHS-wide performance.

No adjustments in actual productivity have been made to account for the effects of deploying military providers and support staff, or for the influx of mobilized National Guard and Reservists and their family members.

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

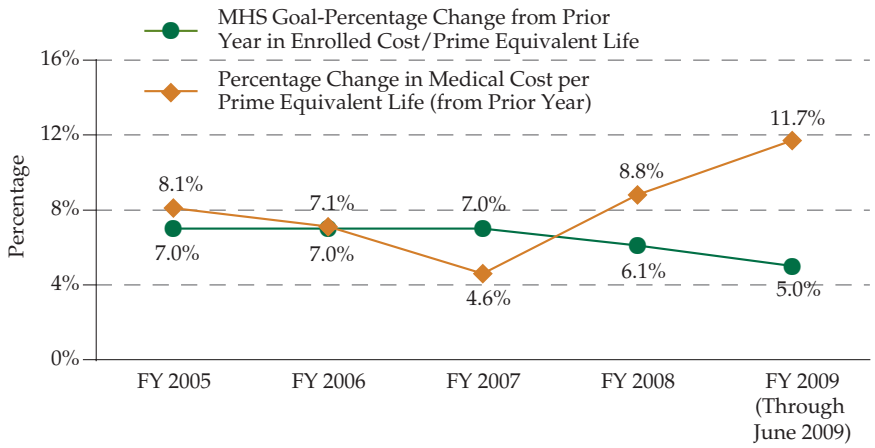


Source: OASD(HA)/Office of the Chief Financial Officer, MHS Administrative data sources (M2), 11/30/2009. This measure reflects the sum of the RVUs for all visits of a provider for a specific period attributed to a specific clinical site clinic divided by the availability of that provider in that clinic computed on a daily basis. The measure is defined as the number of RVUs per FTE provider per 8-hour day in U.S. military clinics. Data are missing for 13 MTFs, representing approximately 11.6 percent of total RVUs and 12.4 percent of the FTEs.

MEDICAL COST PER PRIME ENROLLEE

The goal of this financial and productivity metric in FY 2009 is to stay below a 5 percent annual rate of increase (revised downward from previous year goals), based on the projected rise in private health insurance premiums. Following a decline from FY 2005 to FY 2007, the annual rate of increase in average medical costs per TRICARE Prime enrollee increased from a low of 4.6 percent in FY 2007 to 8.8 percent in FY 2008, and, with incomplete data for the fiscal year, may reach 12 percent in FY 2009.

PERCENTAGE CHANGE IN MEDICAL COST PER PRIME EQUIVALENT LIFE (FROM PRIOR YEAR)



Source: OASD(HA)/Office of the Chief Financial Officer, MHS Administrative data sources (M2), 11/30/2009. Enrollees are adjusted for age, gender, and beneficiary category. FY 2009 data are current as of October 2009, with measure reported through June 2009 (with portions of value projected due to missing expense data from MTFs).

INPATIENT UTILIZATION RATES AND COSTS

TRICARE Prime Inpatient Utilization Rates Compared with Civilian Benchmarks

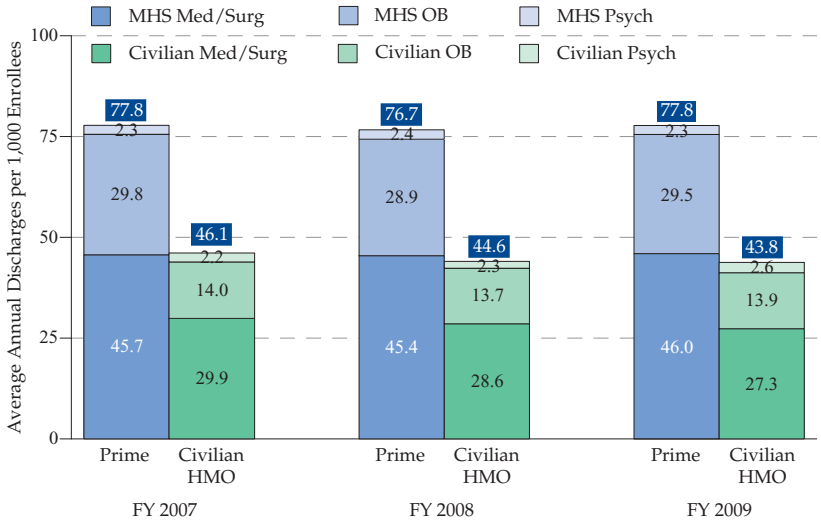
TRICARE Prime Enrollees

This section compares the inpatient utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored HMO plans. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and purchased care dispositions), because RWPs are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—Obstetrician/Gynecologist (OB/GYN), mental health (PSYCH), and other Medical/Surgical (MED/SURG)—and compared for *acute care facilities only*. The comparisons exclude beneficiaries age 65 and older because very few are covered by employer-sponsored plans. The MHS data further exclude beneficiaries enrolled in the USFHP and TRICARE Plus.

- The TRICARE Prime inpatient utilization rate (direct and purchased care combined) was 77 percent higher than the civilian HMO utilization rate in FY 2009 (77.8 discharges per thousand Prime enrollees compared with 43.8 per 1,000 civilian HMO enrollees). That is up from 69 percent higher in FY 2007.
- In FY 2009, the TRICARE Prime inpatient utilization rate was 69 percent higher than the civilian HMO rate for MED/SURG procedures, 111 percent higher for OB/GYN procedures, and 11 percent lower for PSYCH procedures.

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data, 2/5/2010, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/12/2010

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population.
FY 2009 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

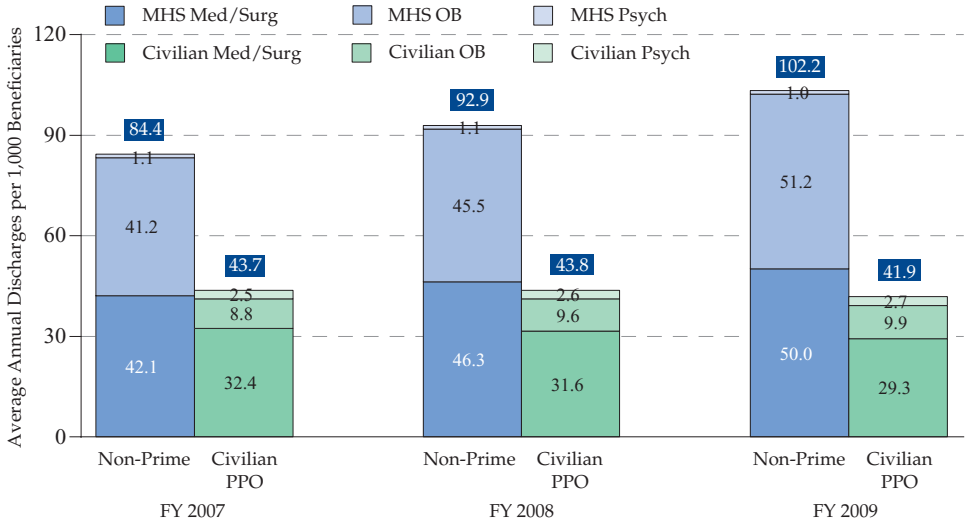
Non-Enrolled Beneficiaries

This section compares the inpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored preferred provider organization (PPO) plans. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and purchased care dispositions) because RWPs are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG procedures—and compared for acute care facilities only. The comparisons exclude beneficiaries age 65 and older because very few are covered by employer-sponsored 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. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate between 10 and 14 percent (depending on the year) do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable with the civilian rates, which also include them.

- The inpatient utilization rate (direct and purchased care combined) for non-enrolled beneficiaries was more than double the rate for civilian PPO participants. From FY 2007 to FY 2009, the inpatient utilization rate for non-enrolled beneficiaries increased substantially while it remained essentially constant in the civilian sector.
- By far the largest discrepancy in utilization rates between the MHS and private sector is for OB/GYN procedures. From FY 2007 to FY 2009, the MHS OB disposition rate increased by 24 percent, whereas it increased by only 13 percent in the civilian sector. In FY 2009, the MHS OB disposition rate was more than five times higher than the corresponding civilian rate.

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



Sources: MHS administrative data, 2/5/2010, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/12/2010

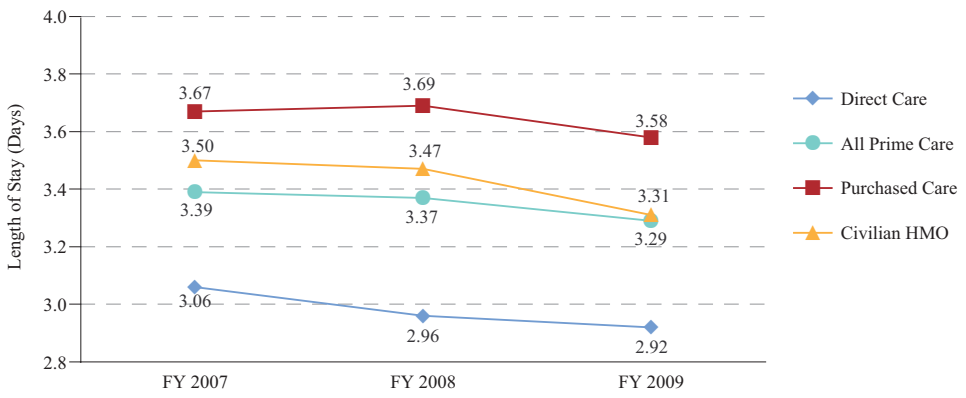
Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population.
FY 2009 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

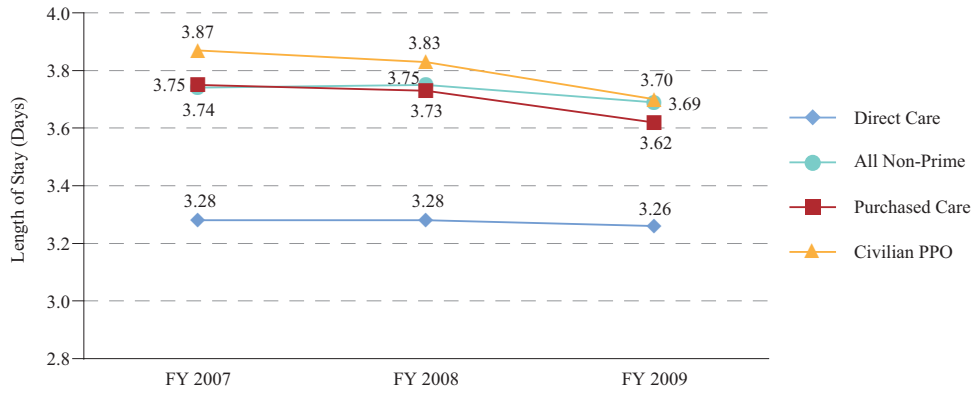
Average Length of Stay (LOS) in Acute Care Hospitals

- Average LOS for Prime enrollees in DoD facilities (direct care) declined by 5 percent between FY 2007 and FY 2009. Average LOS for space-available care declined by less than 1 percent over that period. Purchased care LOS declined by 2 percent for enrolled beneficiaries and by 4 percent for non-enrolled beneficiaries.
- Average LOS in TRICARE purchased acute care facilities is 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).
- The average LOS for MHS-wide Prime care declined by 3 percent between FY 2007 and FY 2009, whereas the average LOS for civilian HMOs declined by 5 percent. The average LOS for MHS-wide non-Prime care (space-available and Standard/Extra) declined by 1 percent, whereas the average LOS for civilian PPOs declined by 4 percent.
- In FY 2009, average LOS for MHS-wide Prime care was 1 percent lower than in civilian HMOs. The average LOS for non-Prime care was 2 percent higher than in civilian PPOs.

INPATIENT AVERAGE LOS: TRICARE PRIME vs. CIVILIAN HMO



INPATIENT AVERAGE LOS: TRICARE NON-PRIME vs. CIVILIAN PPO



Sources: MHS administrative data, 2/5/2010, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/12/2010

Note: Beneficiaries age 65 and older 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 (civilian HMO data were adjusted by Prime dispositions and civilian PPO data were adjusted by Standard/Extra dispositions). FY 2009 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

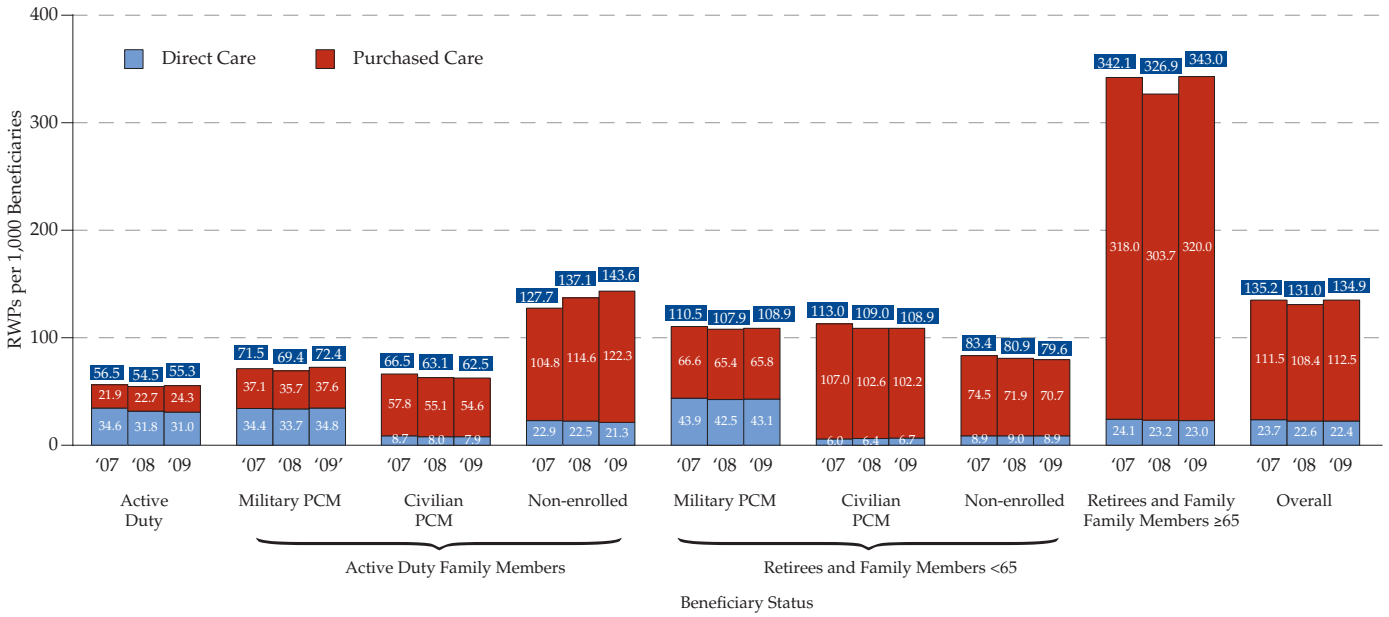
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Inpatient Utilization Rates by Beneficiary Status

When breaking out inpatient utilization by beneficiary group, RWPs per capita more accurately reflect differences across beneficiary groups than discharges per capita. However, RWPs are relevant only for acute care hospitals.

- The direct care inpatient utilization rate (RWPs per 1,000 beneficiaries) decreased the most (10 percent) for ADSMs and increased the most (12 percent) for retirees and family members with a civilian PCM. Most other beneficiary groups experienced a decline in direct inpatient utilization.
- Purchased acute care inpatient utilization rates increased substantially for Active Duty members and for non-enrolled ADFMs. ADFMs with a military PCM saw a slight increase in utilization while the remaining beneficiary groups saw no change or a decline in utilization.
- The acute care inpatient utilization rate for seniors declined by 5 percent between FY 2007 and FY 2009.*
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE is second payer), the percentage of total inpatient workload performed in purchased care facilities increased from 71 percent in FY 2007 to 73 percent in FY 2009.
- From FY 2007 to FY 2009, 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 50 percent in FY 2007 to 52 percent in FY 2009.

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



Source: MHS administrative data, 2/5/2010

* 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 who are not.

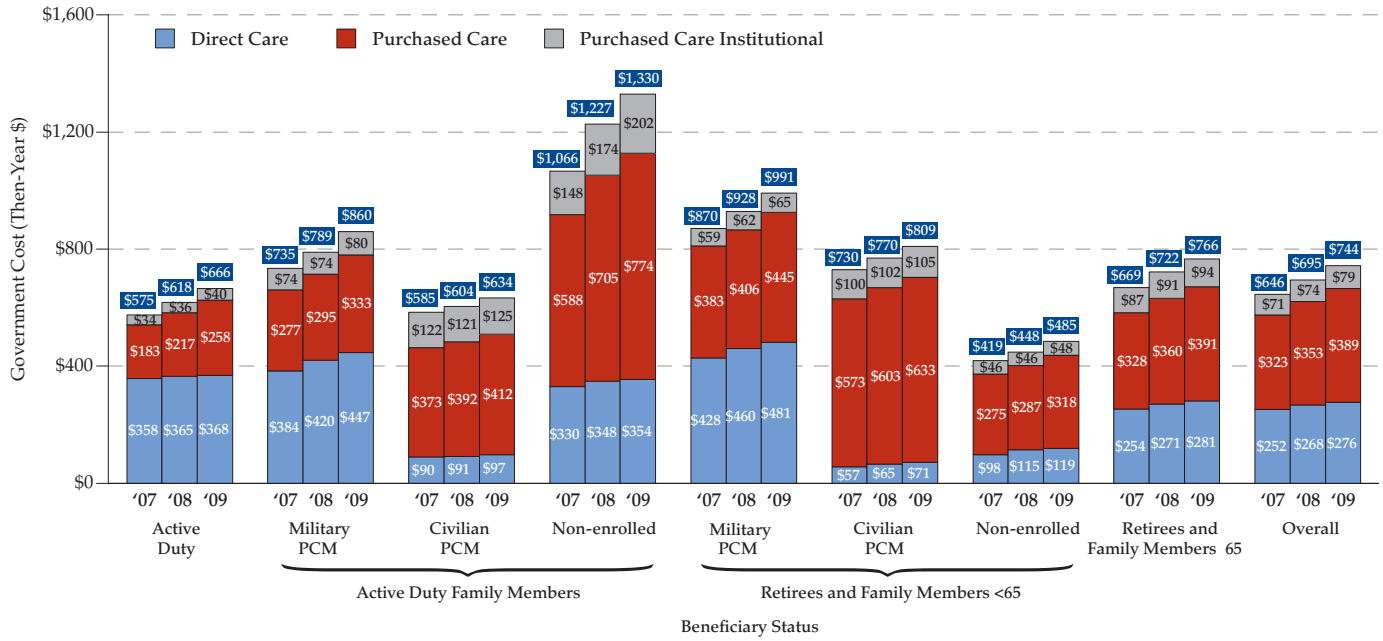
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Inpatient Cost by Beneficiary Status

MHS costs for inpatient care include costs incurred in both acute and non-acute care facilities. They also include the cost of inpatient professional services, i.e., noninstitutional charges (e.g., physician, lab, anesthesia) associated with a hospital stay. Overall MHS inpatient costs (in then-year dollars) per beneficiary (far right columns below) increased by 15 percent from FY 2007 to FY 2009. The increases were due largely to higher purchased care costs.

- The direct care cost per RWP increased from $10,667 in FY 2007 to $12,330 in FY 2009 (16 percent).
- Exclusive of TFL, the total purchased care cost (institutional plus noninstitutional) per RWP increased from $6,581 in FY 2007 to $7,845 in FY 2009 (19 percent).
- The purchased care 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 FY)



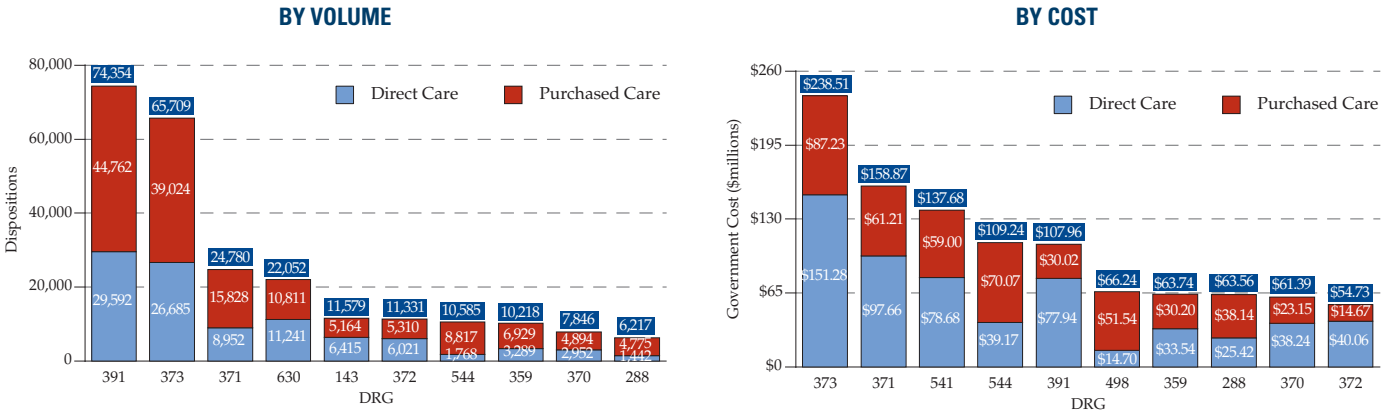
Source: MHS administrative data, 2/5/2010

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

Leading Inpatient Diagnoses by Volume

The top 10 diagnosis-related groups (DRGs) in FY 2009 accounted for 40 percent of all inpatient admissions (direct care and purchased care combined) in acute care hospitals. The leading diagnoses in terms of cost in FY 2009 were determined from institutional claims only; i.e., they include hospital charges but not attendant physician, laboratory, drug, or ancillary service charges. The top 10 DRGs in terms of cost in FY 2009 accounted for 23 percent of total inpatient costs (direct and purchased care combined) in acute care hospitals. TFL admissions are excluded from the calculations for both volume and cost.

TOP 10 DRGs IN FY 2009 (ACUTE CARE HOSPITALS ONLY)



Source: MHS administrative data, 2/5/2010

DRGs

143 Chest pain
288 Operating room procedures for obesity
359 Uterine and adnexa procedures for non-malignancy without complicating conditions
370 Cesarean section with complicating conditions
371 Cesarean section without complicating conditions
372 Vaginal delivery with complicating diagnoses
373 Vaginal delivery without complicating diagnoses
391 Normal newborn
498 Spinal fusion except cervical without complicating conditions
541 Extracorporeal membrane oxygenation or tracheotomy with mechanical ventilation 96+ hours or principal diagnosis except face, mouth, and neck with major operating room
544 Major joint replacement or reattachment of lower extremity
630 Neonate, birthweight >2499 grams, without significant operating room procedure, with other problems

- The top four procedures by volume are all related to childbirth.
- Procedures performed in private sector acute care hospitals account for 60 percent of the total volume of the top 10 diagnoses but only 44 percent of the total cost.
- Expenditures in direct care facilities exceed those in purchased care facilities for seven of the 10 top diagnoses. However, admissions in direct care facilities exceed those in purchased care facilities for only three of the top 10 diagnoses.
- Although much lower in volume than the top four procedures, surgical procedures for obesity continue to be one of the top 10 diagnoses. Admissions are almost evenly divided between ADFMs and retiree family members (not shown). Thus the obesity epidemic in the civilian sector appears to be mirrored to an extent in the DoD population as well.

OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks

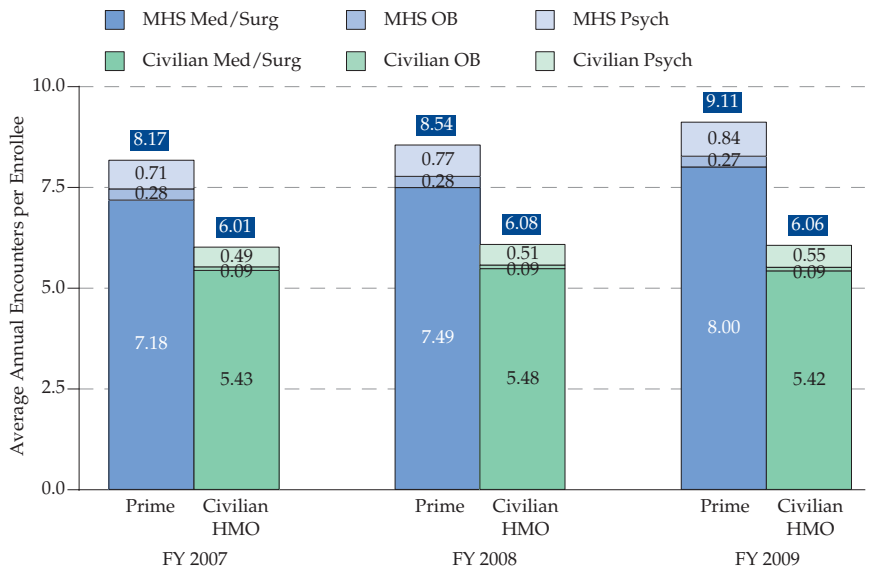
TRICARE Prime Enrollees

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

Encounters are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG procedures. The comparisons are made for beneficiaries under age 65 only. The MHS data exclude beneficiaries enrolled in the USFHP and TRICARE Plus. Because telephone consults are routinely recorded in direct care data, but appear very infrequently in private-sector claims, they are also excluded from the direct care utilization computations.

- The overall TRICARE Prime outpatient utilization rate (direct and purchased care utilization) rose by 12 percent between FY 2007 and FY 2009. The civilian HMO outpatient utilization rate rose by only 1 percent over the same period.
- In FY 2009, the overall Prime outpatient utilization rate was 51 percent higher than the civilian HMO rate.
- In FY 2009, the Prime outpatient utilization rate for MED/SURG procedures was 48 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures was more than triple the corresponding rate for civilian HMOs in FYs 2007 to 2009, but that is due in part to how the direct care system records bundled services.*
- The Prime outpatient utilization rate for PSYCH procedures was 49 percent higher than the corresponding rate for civilian HMOs in FYs 2007 to 2009. This disparity, though based on relatively low MHS and civilian mental health utilization rates, may reflect the more stressful environment that many ADSMs and their families endure.

OUTPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data, 2/5/2010, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/12/2010

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2009 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

* Outpatient encounters are not precisely comparable between the direct and private care sectors (including purchased care). In particular, services that are bundled in the private sector (such as newborn delivery, including pre-natal and post-natal care) will not generate any outpatient encounters but will generate a record for each encounter in the direct care system. Because maternity care is a high-volume procedure, the disparity in utilization rates between the direct care and civilian systems will be exacerbated.

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

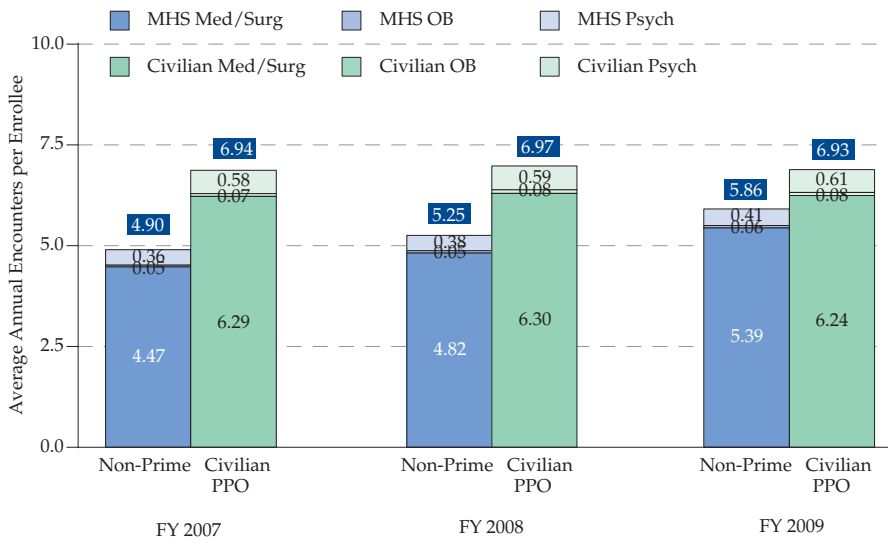
Non-Enrolled Beneficiaries

This section compares the outpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. Outpatient utilization is measured as the number of encounters because the civilian-sector data do not contain a measure of RVUs.

Encounters are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG. The comparisons are made for beneficiaries under age 65 only. 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. Because telephone consults are routinely recorded in direct care data, but appear very infrequently in private-sector claims, they are also excluded from the direct care utilization computations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate between 10 and 14 percent (depending on the year) do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include them.

- The overall TRICARE outpatient utilization rate (direct and purchased care utilization combined) for non-enrolled beneficiaries increased by 20 percent from 4.9 encounters per participant in FY 2007 to 5.9 in FY 2009. The civilian PPO outpatient utilization rate remained unchanged at 7 encounters over this period.
- The overall TRICARE non-Prime (space-available and Standard/Extra) outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2009, TRICARE non-Prime outpatient utilization was 16 percent lower than in civilian PPOs.
- In FY 2009, the non-Prime outpatient utilization rate for MED/SURG procedures was 14 percent lower than the civilian PPO rate. Medical/surgical procedures account for about 90 percent of total outpatient utilization in both the military and private sectors.
- The non-Prime outpatient utilization rate for OB/GYN procedures held steady between FY 2007 and FY 2009 at a level about 30 percent lower than that for civilian PPO participants.
- The PSYCH outpatient utilization rate of non-enrolled MHS beneficiaries increased by 15 percent from FY 2007 to FY 2009, whereas the rate increased by only 5 percent for civilian PPO participants. Even so, the PSYCH outpatient utilization rate for non-enrolled beneficiaries was 33 percent below that of civilian PPO participants in FY 2009. The latter observation, together with the utilization exhibited by Prime enrollees, suggests that MHS beneficiaries in need of extensive PSYCH counseling are more likely to enroll in Prime.

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



Sources: MHS administrative data, 2/5/2010, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/12/2010

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2009 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

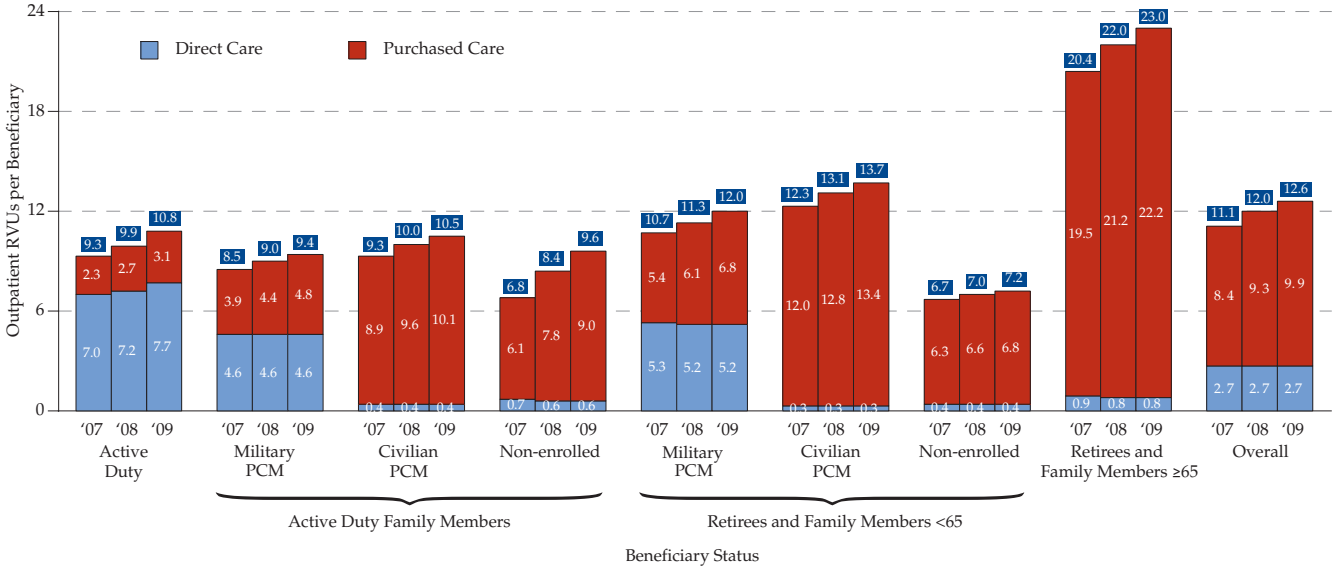
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Outpatient Utilization Rates by Beneficiary Status

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

- The direct care outpatient utilization rate increased by 10 percent from FY 2007 to FY 2009 for Active Duty personnel. Non-enrolled ADFMs experienced a decline of 14 percent and seniors experienced a decline of 6 percent. The rate stayed about the same for all other beneficiary groups.
- From FY 2007 to FY 2009, the purchased care outpatient utilization rate increased for all beneficiary groups. The largest increase (48 percent) was experienced by non-enrolled ADFMs. This continues a pattern for that beneficiary group of shifting direct care utilization to purchased care. Active Duty personnel experienced an increase of 34 percent, continuing a trend of increased purchased care utilization by that group. Unlike non-enrolled ADFMs, however, their increased purchased care utilization was not offset by declining direct care utilization.
- The TFL outpatient utilization rate increased by 8 percent in FY 2008 and by another 5 percent in FY 2009.*

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY (BY FY)



Source: MHS administrative data, 2/5/2010

* 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 who are not.

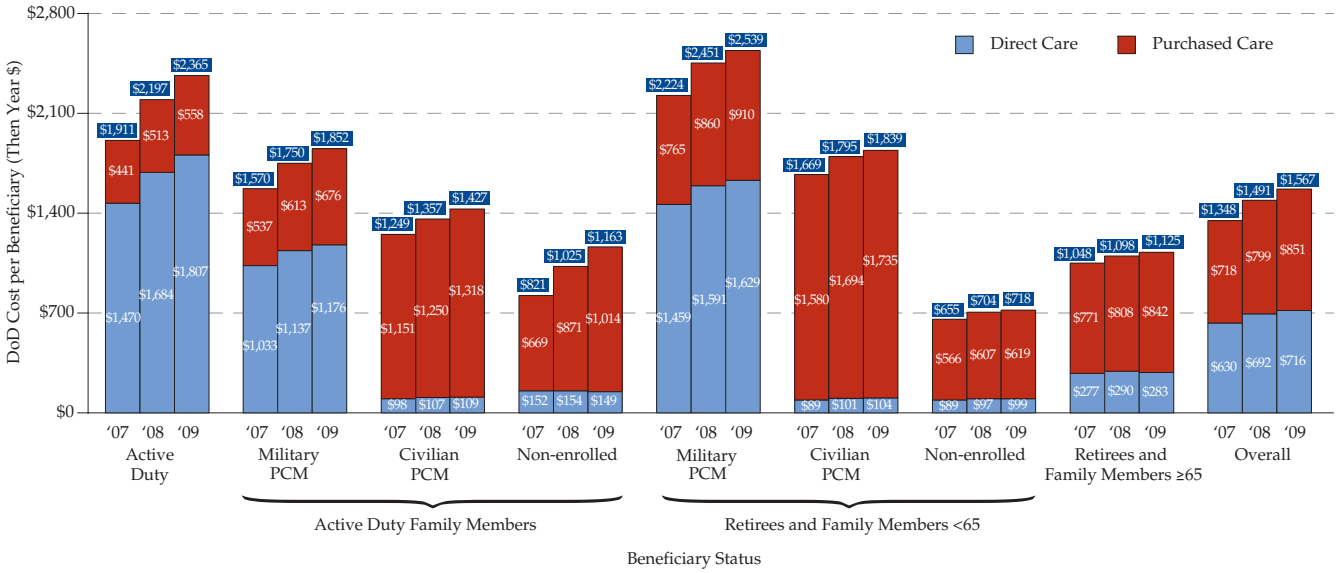
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Outpatient Cost by Beneficiary Status

Corresponding to higher purchased care outpatient utilization rates, DoD medical costs continued to rise. Overall, DoD outpatient costs per beneficiary increased by 16 percent from FY 2007 to FY 2009.

- The direct care cost per beneficiary increased for all beneficiary groups except non-enrolled Active Duty family members. Active Duty members experienced the largest increase (23 percent), followed by enrolled beneficiaries (between 12 and 17 percent, depending on beneficiary group and whether enrolled with a military or civilian PCM).
- Net of TFL, the DoD purchased care outpatient cost per beneficiary increased by 15 percent in FY 2008 and by another 9 percent in FY 2009.
- The TFL purchased care outpatient cost per beneficiary increased by 5 percent in FY 2008 and by another 4 percent in FY 2009.* The direct care outpatient cost per senior increased by 5 percent in FY 2008 but then dropped by 3 percent in FY 2009.

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 2/5/2010

* 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 who are not.

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS

TRICARE 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 dividing the total days supply for each by 30 days.

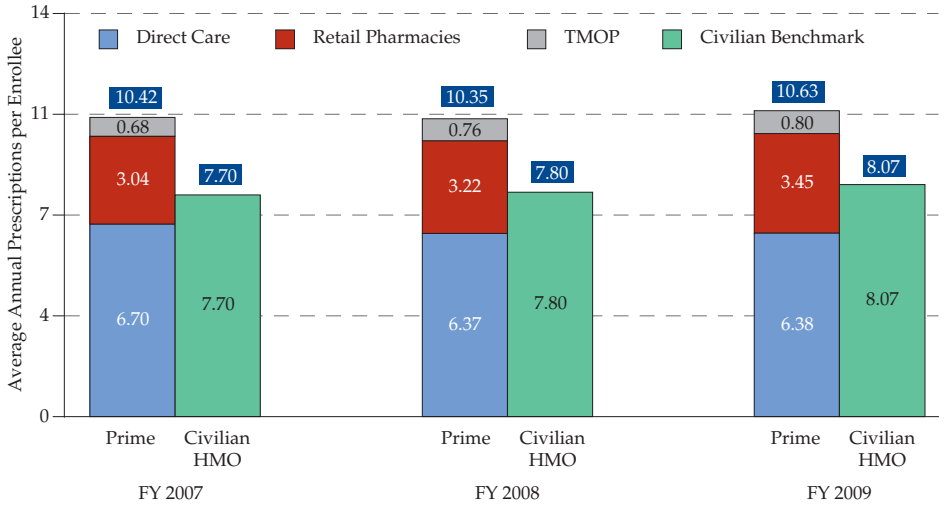
Direct care pharmacy data differ from private sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the DoD Pharmacoeconomic Center.

TRICARE Prime Enrollees

This section compares the prescription drug utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored HMO plans. The comparisons are made for beneficiaries under age 65 only. The MHS data exclude beneficiaries enrolled in the USFHP and TRICARE Plus.

- The overall prescription utilization rate (direct and purchased care combined) for TRICARE Prime enrollees rose by 2 percent between FY 2007 and FY 2009, whereas the civilian HMO benchmark rate rose by 5 percent. The TRICARE Prime prescription utilization rate was 32 percent higher than the civilian HMO rate in FY 2009.
- Prescription utilization rates for Prime enrollees at DoD pharmacies declined by 5 percent, whereas the utilization rate at retail pharmacies increased by 13 percent from FY 2007 to FY 2009.
- Enrollee mail order prescription utilization increased by 17 percent from FY 2007 to FY 2009. Nevertheless, TMOP utilization remains small compared to other sources of prescription services.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE*: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data, 2/5/2010, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/12/2010

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2009 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

* Source of care (direct or purchased) is based solely on where care is received, not where beneficiaries are enrolled.

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

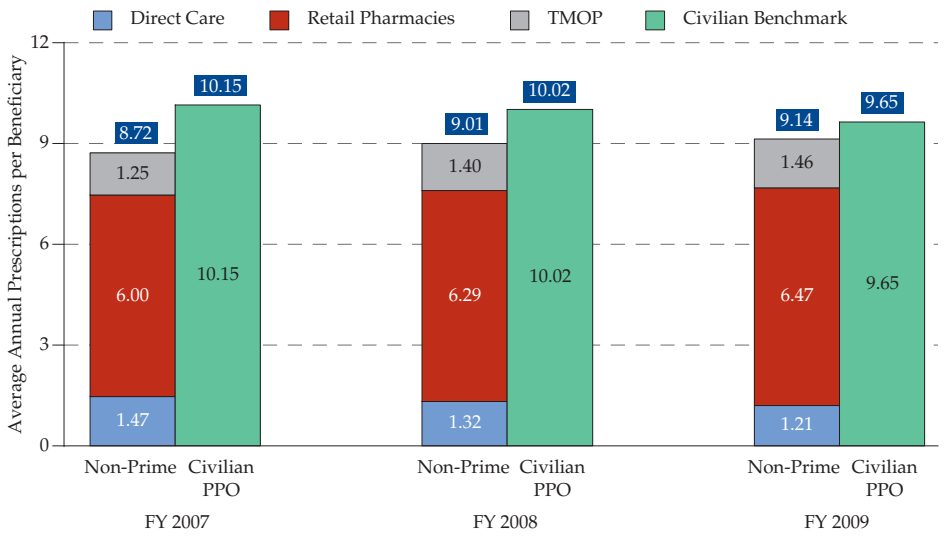
Non-Enrolled Beneficiaries

This section compares the prescription drug utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. The comparisons are made for beneficiaries under age 65 only.

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. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate between 10 and 14 percent (depending on the year) do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include them.

- The overall prescription utilization rate (direct and purchased care combined) for non-enrolled beneficiaries rose by 5 percent between FY 2007 and FY 2009. During the same period, the civilian PPO benchmark rate fell by 5 percent. Although the gap has narrowed, the TRICARE prescription utilization rate is still 5 percent lower than the civilian PPO rate.
- Prescriptions filled for non-enrolled beneficiaries at DoD pharmacies dropped by 17 percent, whereas prescriptions filled at retail pharmacies increased by 8 percent from FY 2007 to FY 2009.
- Non-enrollee mail order prescription utilization increased by 17 percent from FY 2007 to FY 2009. Nevertheless, TMOP utilization remains small compared to other sources of prescription services.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE*: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK



Sources: MHS administrative data, 2/5/2010, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/12/2010

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2009 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

* Source of care (direct or purchased) is based solely on where care is received, not where beneficiaries are enrolled.

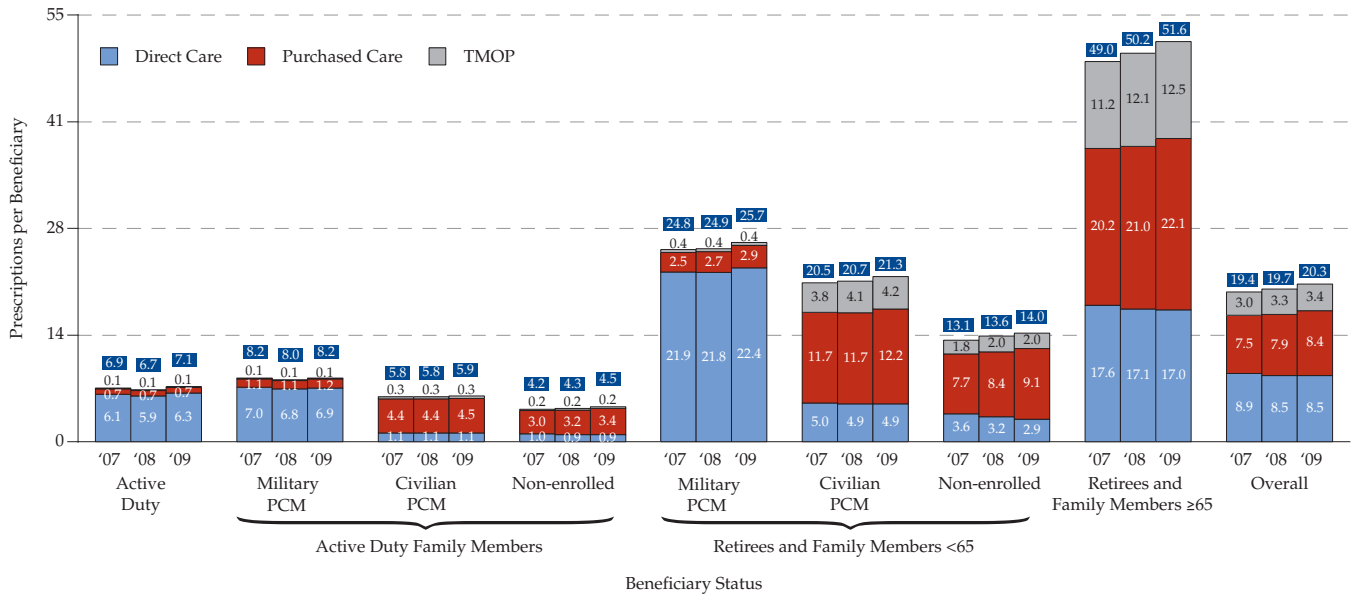
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

TRICARE Prescription Drug Utilization Rates by Beneficiary Status

Prescriptions include all initial and refill prescriptions filled at military pharmacies, retail pharmacies, and the TMOP. Prescription counts from these sources were normalized by dividing the total days supply for each by 30 days.

- The total (direct, retail, and TMOP) number of prescriptions per beneficiary increased by 4 percent from FY 2007 to FY 2009, exclusive of the retail pharamcy benefit. Including TRICARE Senior Pharmacy (TSRx), the total number of prescriptions increased by 5 percent.
- Average direct care prescription utilization declined by 3 percent from FY 2007 to FY 2009. The direct care prescription utilization rate increased for ADSMs (4 percent) and for retirees and family members under age 65 enrolled with a military PCM (2 percent). The rate decreased for all other beneficiary groups, with non-enrolled beneficiaries under age 65 experiencing the largest drop (19 percent).
- Average prescription utilization through nonmilitary pharmacies (civilian retail and mail order) increased for all beneficiary groups, but most notably for non-enrolled retirees and family members under age 65 and for retirees and family members under age 65 with a military PCM (by 17 and 14 percent, respectively).
- TMOP remains a relatively infrequent source of purchased care prescription utilization but its use has been increasing. When normalized by 30 days supply, TMOP utilization as a percentage of total purchased care prescription drug utilization remained constant at 29 percent.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY (BY FY)



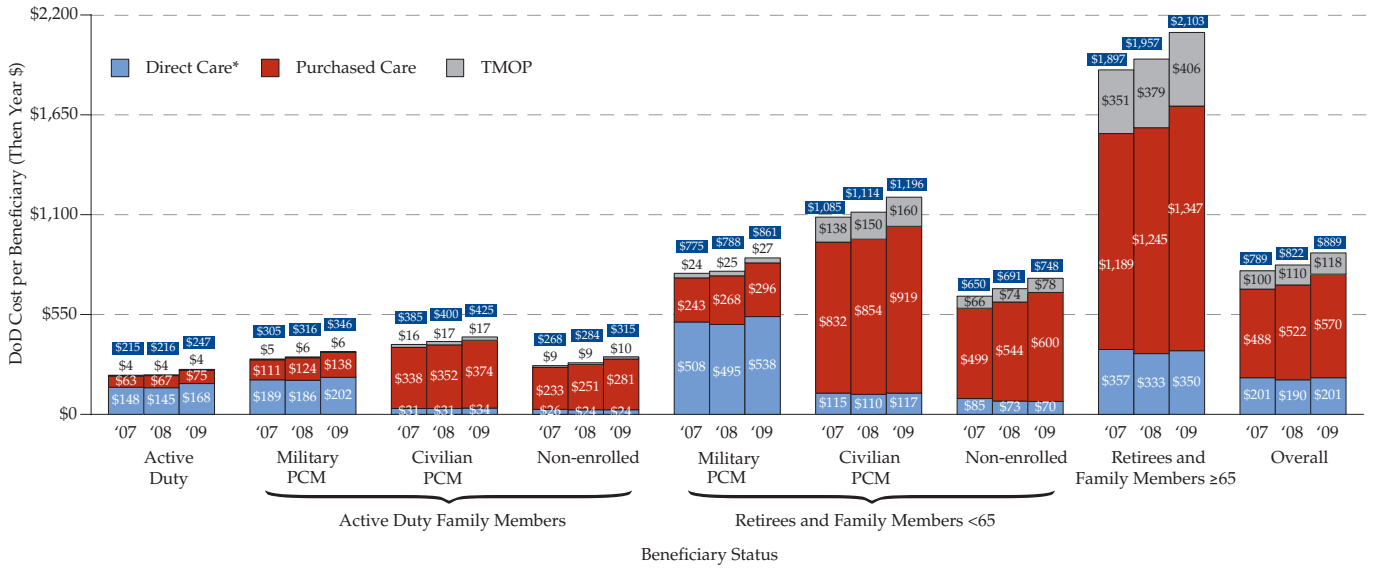
Source: MHS administrative data, 2/5/2010

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

Prescription Drug Cost by Beneficiary Status

- Exclusive of retail pharmacy, prescription drug costs rose by 14 percent between FY 2007 and FY 2009. Including TSRx, prescription drug costs rose by 13 percent. This is lower than the increases in inpatient costs (16 percent) and outpatient costs (19 percent).
- Direct care costs per beneficiary increased by less than 1 percent but retail pharmacy costs rose by 19 percent exclusive of retail pharmacy and by 17 percent including retail pharmacy.
- TMOP costs increased at the same rate as retail pharmacy (17 percent).

AVERAGE ANNUAL PRESCRIPTION COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 2/5/2010

* Direct care prescription costs include an MHS-derived dispensing fee.

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65)

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. Costs are compared with those of civilian counterparts, i.e., civilian families with the same demographics as the typical MHS family. For beneficiaries under age 65, civilian counterparts are assumed to be covered by employer-sponsored health insurance (OHI). Added drug benefits in April 2001 and the TFL Program in FY 2002 sharply reduced Medicare supplemental insurance coverage for MHS seniors. For seniors, costs are compared with those of civilian counterparts having pre-TFL supplemental insurance coverage.

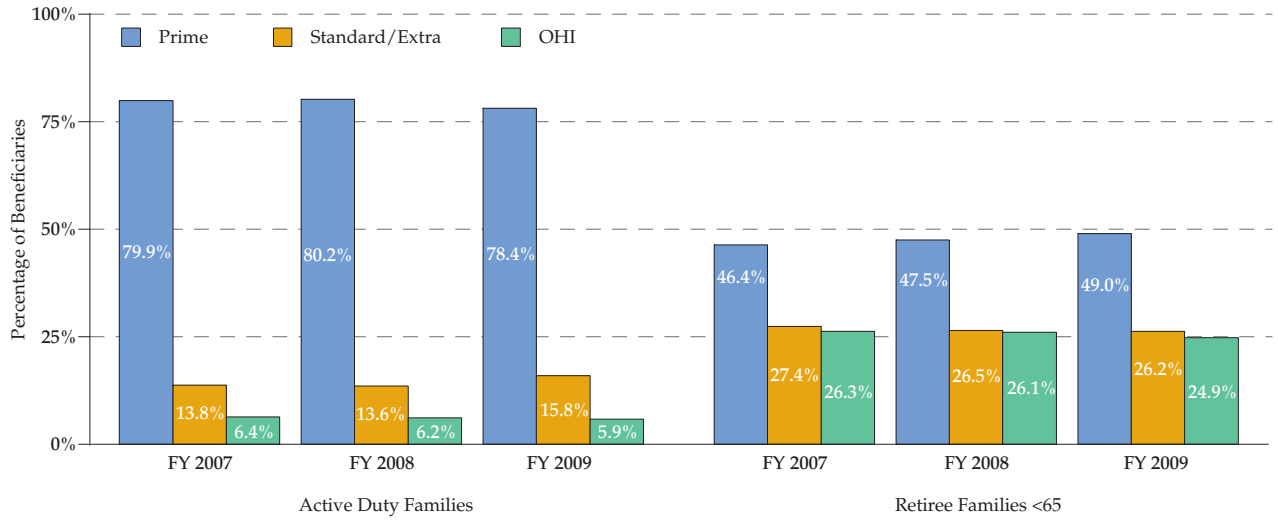
Health Insurance Coverage of MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of: (1) TRICARE Prime, (2) TRICARE Standard/Extra, and (3) OHI. Many 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 (including those enrolled in OHI.) In FY 2009, 78.4 percent of Active Duty families and 49.0 percent of retiree families were in this group.
- TRICARE Standard/Extra: Family not enrolled in TRICARE Prime and no OHI coverage. In FY 2009, 15.8 percent of ADFMs and 26.2 percent of retiree families were in this group.
- OHI: Family covered by OHI. In FY 2009, 5.9 percent of Active Duty families and 24.9 percent of retiree families were in this group.

HEALTH INSURANCE COVERAGE OF BENEFICIARIES UNDER AGE 65



Source: FYs 2007–2009 Healthcare Surveys of DoD Beneficiaries (HCSDB)

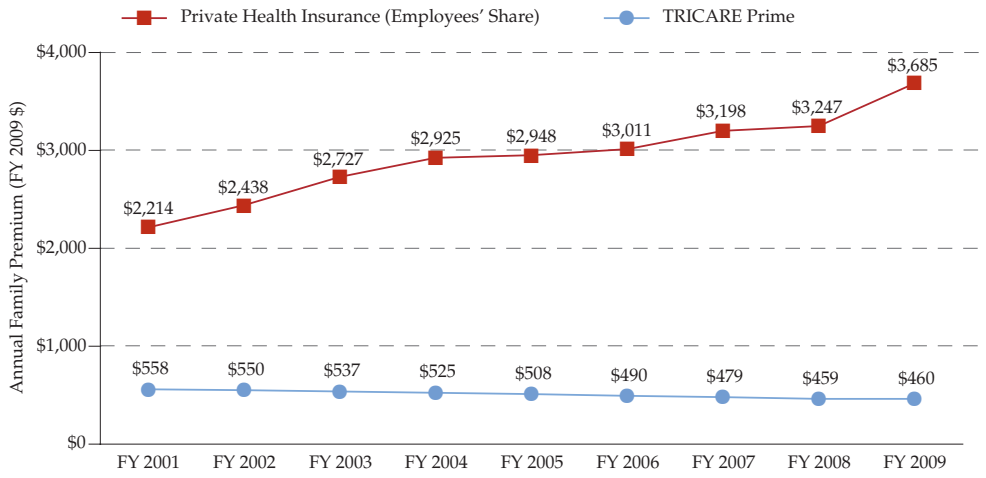
Note: The Prime group includes HCSDB respondents enrolled in Prime based on DEERS. The Standard/Extra group includes HCSDB respondents without OHI who are non-enrollees based on DEERS. The OHI group includes HCSDB respondents with private health insurance. A small percentage of Prime enrollees are also covered by OHI; these beneficiaries are included in the Prime group. Percentages may not add up to 100 percent due to rounding.

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

Retirees and Family Members Under Age 65 Returning to the MHS

Since FY 2001, private health insurance family premiums have been rising, while the TRICARE enrollment fee has remained fixed at $460 per retiree family. In constant FY 2009 dollars, the private health insurance premium increased by $1,471 (66 percent) from FY 2001 to FY 2009, whereas the TRICARE premium declined by $98 (–18 percent) during this period.

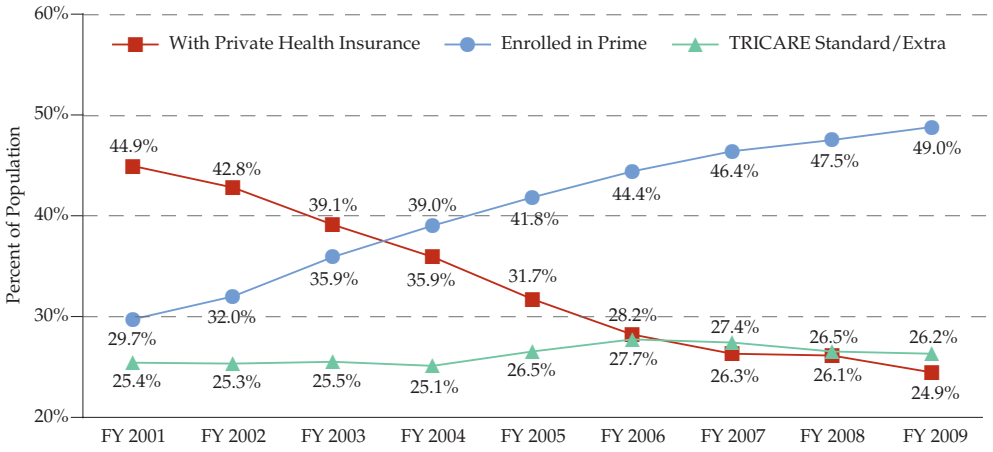
TREND IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT FEE



Sources: Employees' share of insurance premium for typical employer sponsored family health plan: Medical Expenditure Panel Surveys, 2000–2008; forecasted by Institute for Defense Analyses in FY 2009 based on trends in premiums from Kaiser Family Foundation surveys in 2008–2009.

An increasing disparity in premiums (and out-of-pocket expenses) induced 20 percent of retirees to drop their private health insurance and switch to TRICARE between FY 2001 and FY 2009. As a result, an additional 614,000 retirees and family members under age 65 are now relying primarily on TRICARE instead of private health insurance.

TREND IN RETIREE (<65) HEALTH INSURANCE COVERAGE



Sources: DEERS and Health Care Beneficiary Surveys of DoD Beneficiaries, 2001–2009.

Note: The Prime enrollment rates above include those who also have private health insurance (about 4 percent of retirees).

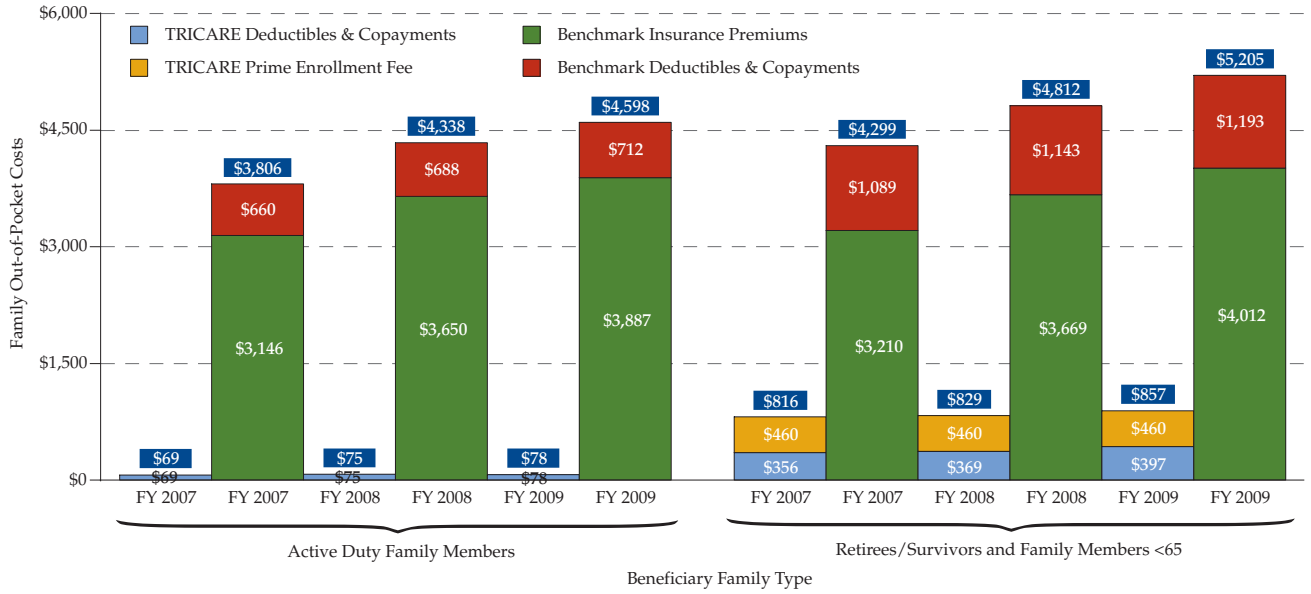
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

In FYs 2007–2009, 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 2009, costs for civilian counterparts were:
  - $4,500 more than those incurred by Active Duty families enrolled in Prime.
  - $4,300 more than those incurred by retiree families enrolled in Prime.

OUT-OF-POCKET COSTS FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, FY 2007–2009; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2006–2009; civilian insurance premiums for FYs 2007–2008 from the 2006–2008 Medical Expenditure Panel Surveys; premiums for FY 2009 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys in 2008–2009. Private health insurance coverage from Health Care Surveys of DoD Beneficiaries, 2006–2009.

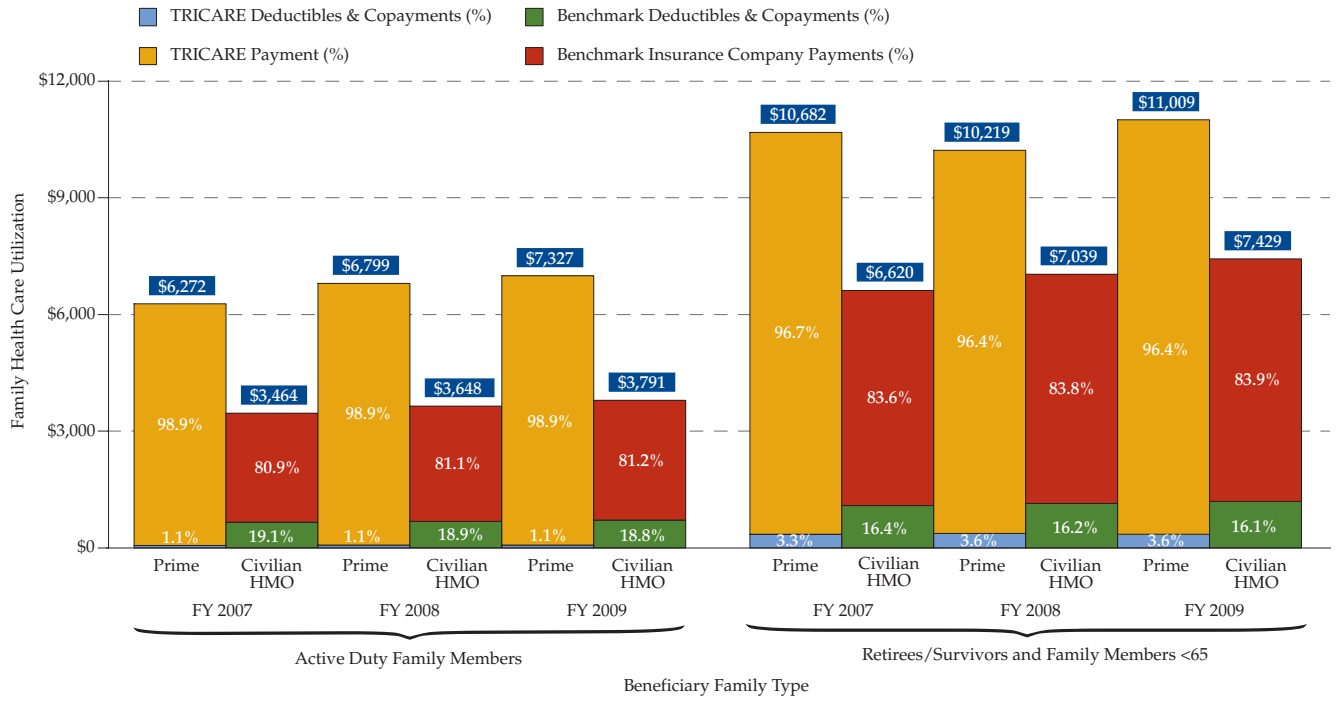
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

Cost Shares and Health Care Utilization for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

Previous private sector studies find that very low coinsurance rates increase health care utilization (dollar value of health care services).* In FYs 2007–2009, TRICARE Prime enrollees had negligible co-insurance rates (deductibles and copayments per dollar of utilization) and, not surprisingly, much higher utilization compared to civilian HMO counterpart families. Differences in coinsurance rates are a major reason for the higher utilization of health care services by Prime enrollees.

- TRICARE Prime enrollees had much lower average co-insurance rates than civilian HMO counterparts.
  - In FY 2009, the co-insurance rate for Active Duty families was 1.1 percent versus 18.8 percent for civilian counterparts.
  - In FY 2009, the co-insurance rate for retiree families was 3.6 percent versus 16.1 percent for civilian counterparts.
- TRICARE Prime enrollees had 49–92 percent higher health care utilization than civilian HMO counterparts.
  - In FY 2009, Active Duty families consumed $7,300 of medical services versus $3,800 by civilian counterparts (92 percent higher).
  - In FY 2009, retiree families consumed $11,000 of medical services versus $7,400 by civilian counterparts (49 percent higher).

COST SHARES AND HEALTH CARE UTILIZATION FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, 2007–2009; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2006–2009.

* Joseph P. Newhouse, Insurance Experiment Group. *Free for All? Lessons from the RAND Health Insurance Experiment*. A RAND Study, Harvard University Press, Cambridge MA, 1993.

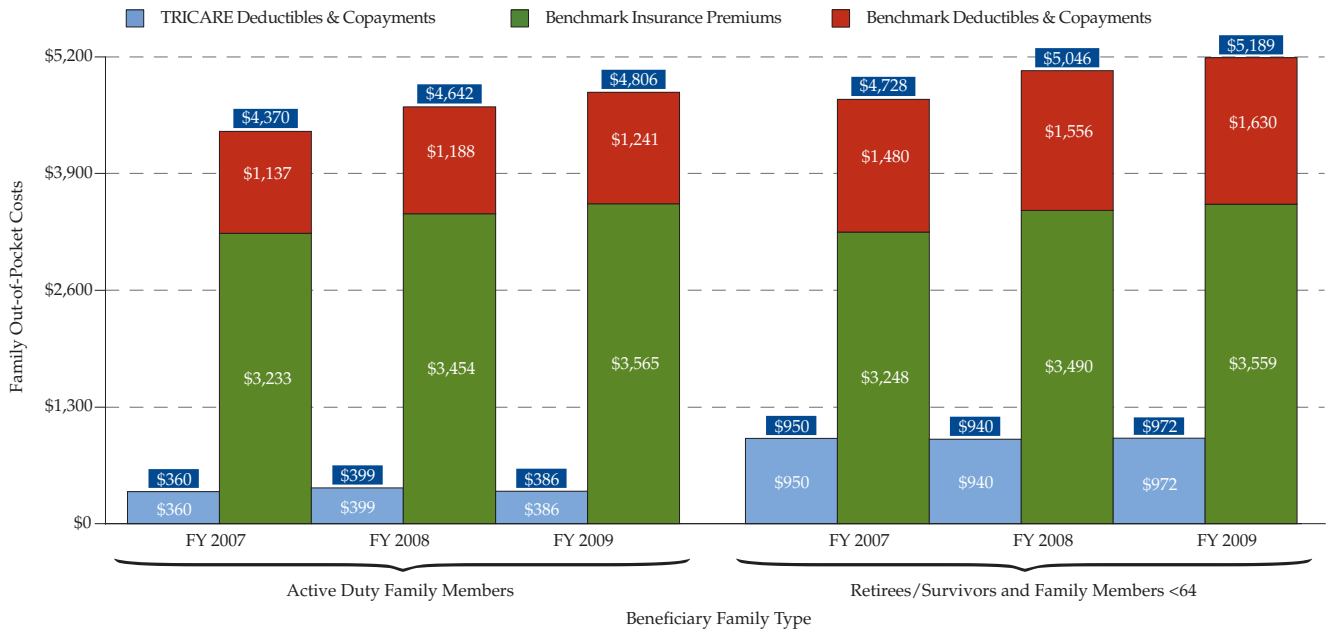
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

Out-of-Pocket Costs for Families who Rely on TRICARE Standard/Extra vs. Civilian PPO Counterparts

In FY 2007 to FY 2009, 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 2009, costs for civilian counterparts were:
  - $4,400 more than those incurred by Active Duty families who relied on Standard/Extra.
  - $4,200 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



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, FY 2007–2009; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2006–2009; civilian insurance premiums for FYs 2007–2008 from the 2006–2008 Medical Expenditure Panel Surveys; premiums for FY 2009 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys in 2008–2009. OHI coverage from Health Care Surveys of DoD Beneficiaries, 2006–2009.

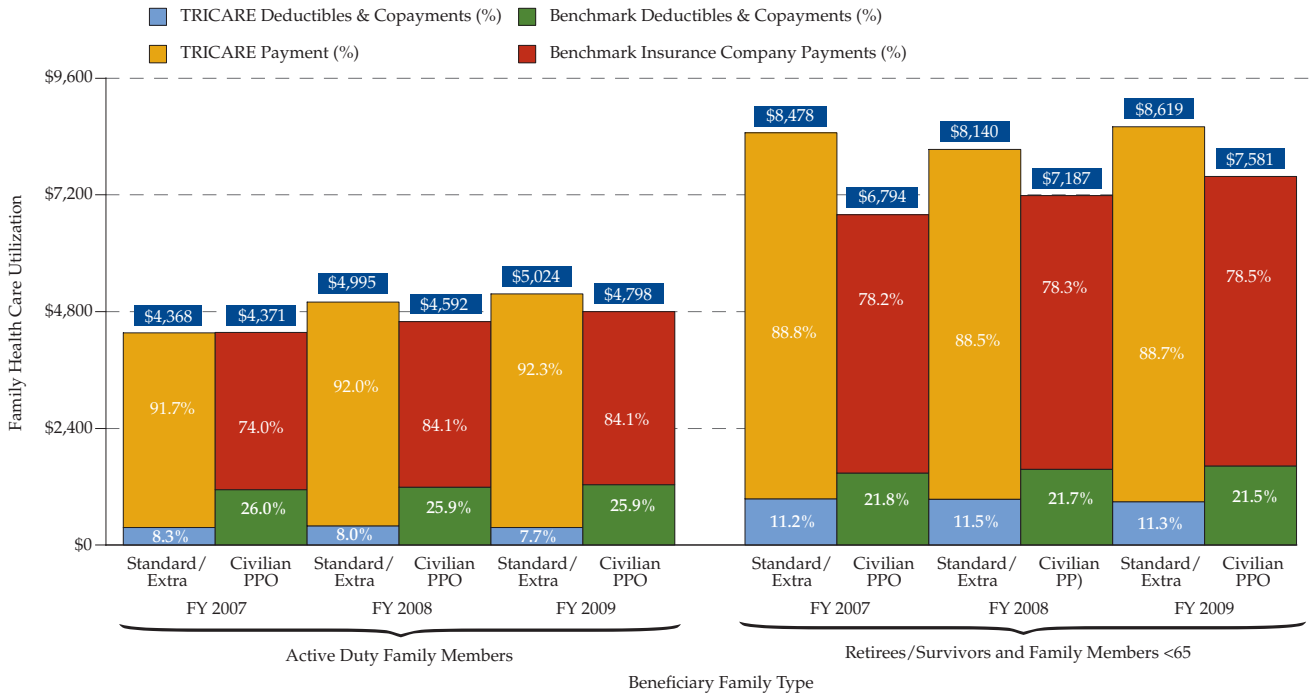
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

Cost Shares and Health Care Utilization for Families who Rely on TRICARE Standard/Extra vs. Civilian PPO Counterparts

In FYs 2007–2009, families who relied on TRICARE Standard/Extra had lower average co-insurance rates (deductibles and copayments per dollar of utilization) than civilian counterparts; however, TRICARE Standard/Extra families still paid a "significant" share of these costs. As a result, utilization (dollar value of health care services consumed) was only slightly higher for TRICARE Standard/Extra families compared to civilian counterparts.

- TRICARE Standard/Extra reliant families had lower average co-insurance rates than civilian PPO counterparts.
  - In FY 2009, the co-insurance rate for Active Duty families was 7.7 percent versus 25.9 percent for civilian counterparts.
  - In FY 2009, the co-insurance rate for retiree families was 11.3 percent versus 21.5 percent for civilian counterparts.
- Health care utilization was 5–14 percent higher for TRICARE Standard/Extra families compared to their civilian PPO counterparts.
  - In FY 2009, Active Duty families consumed $5,000 of medical services versus $4,800 by civilian counterparts (5 percent higher)
  - In FY 2009, retiree families consumed $8,600 of medical services versus $7,600 by civilian counterparts (14 percent higher).

COST SHARES AND HEALTH CARE UTILIZATION FOR FAMILIES WHO RELY ON TRICARE STANDARD/EXTRA VS. CIVILIAN PPO COUNTERPARTS



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, 2007–2009; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, FYs 2006–2009.

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT'D)*

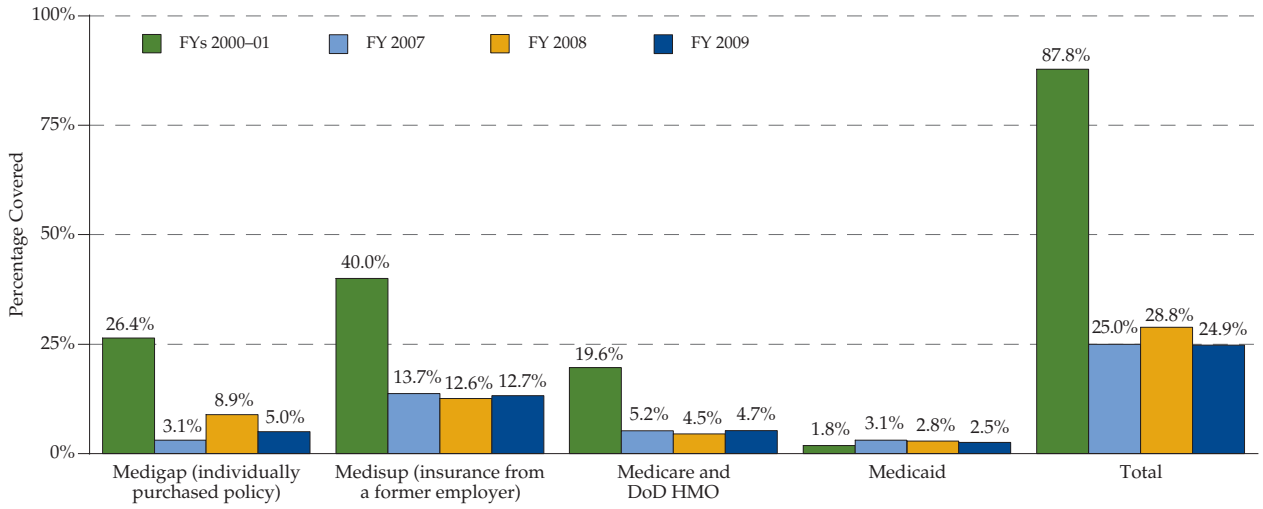
Health Insurance Coverage of MHS Senior Beneficiaries Before and After TFL*

In April 2001, DoD expanded drug benefits for seniors; on October 1, 2001, DoD implemented the TFL program, which provides free Medicare supplemental insurance. This section evaluates the effects of these improved benefits on out-of-pocket costs.

Although Medicare provides coverage for medical services, there are substantial deductibles and copayments. Until FY 2001, most MHS seniors purchased some type of Medicare supplemental insurance. A small number were active employees with employer-sponsored insurance or were covered by Medicaid. Because of the improved drug and TFL benefits, most MHS seniors dropped their supplemental insurance.

- Before TFL (FYs 2000–01), 87.8 percent of MHS seniors had Medicare supplemental insurance or were covered by Medicaid. After TFL, the percentage of MHS seniors with supplemental insurance or Medicaid fell sharply. It was about 25 percent in FYs 2007–09.**
- Why do a quarter of all seniors still retain supplemental insurance when they can use TFL for free? Some possible reasons are:
  - A lack of awareness of the TFL benefit.
  - A desire for dual coverage.
  - Higher family costs if a spouse is not yet Medicare-eligible. Dropping a non-Medicare-eligible spouse from an employer-sponsored plan can result in higher family costs if the spouse must purchase a nonsubsidized individual policy.

MEDICARE SUPPLEMENTAL INSURANCE COVERAGE OF MHS SENIORS



Source: 2000–2001 and 2006–2009 Health Care Surveys of DoD Beneficiaries.

* Insurance coverage for DoD HMOs includes TRICARE Senior Prime (until December 2001) and the Uniformed Services Family Health Plan.
** The higher percentage of seniors with supplemental insurance in FY 2008 is likely due to a change in the format of the HCSDB in that year.

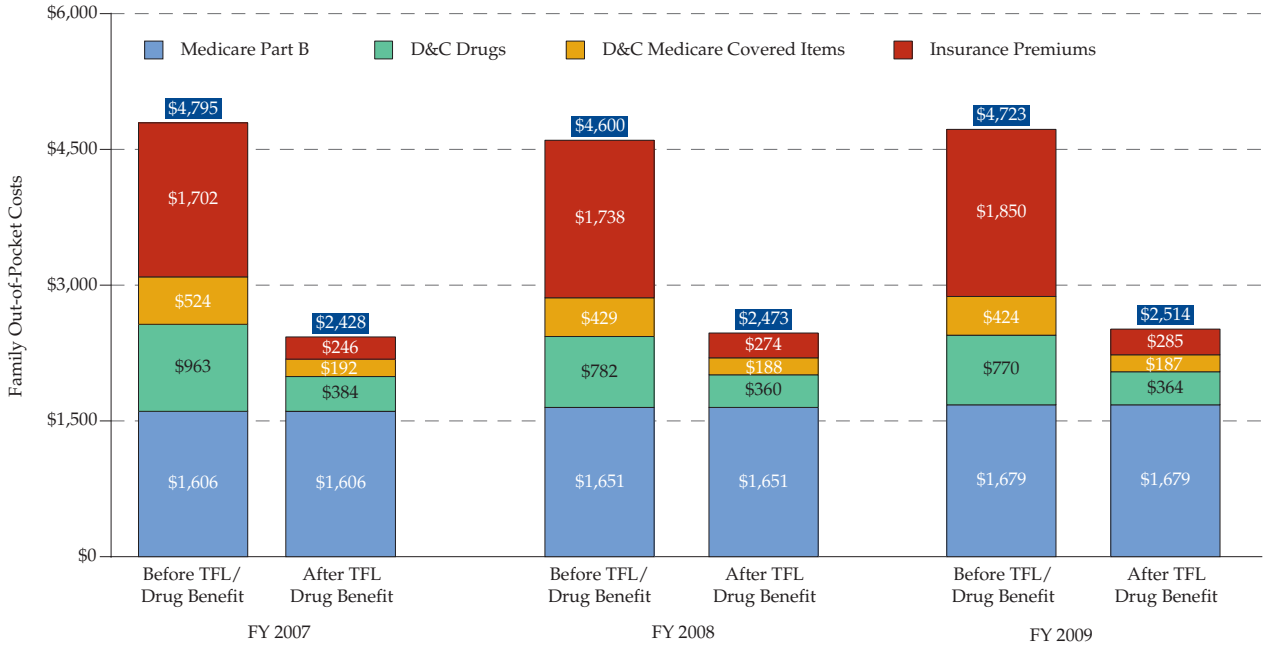
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT'D)*

Out-of-Pockets Costs for MHS Senior Families Before and After TFL

About 87 percent of TRICARE senior families are TFL users, including about half of those with Medicare supplemental insurance. TFL and added drug benefits have enabled MHS seniors to reduce their out-of-pocket costs for deductibles/copayments and supplementary insurance. The costs for a typical TRICARE senior family after TFL are compared with those of civilian counterparts having the supplemental insurance coverage of TRICARE senior families before TFL in FYs 2000–2001.

- In FYs 2007–2009, out-of-pocket costs for MHS senior families were almost 50 percent less than those of "Before TFL" counterparts.
- In FY 2009, MHS senior families saved $2,200 as a result of TFL and added drug benefits.

OUT-OF-POCKET COSTS OF MHS SENIOR FAMILIES AFTER TFL VS. CIVILIAN COUNTERPARTS



Sources: DoD beneficiary expenditures for TFL users from MHS administrative data, FYs 2007–2009; expenditures for TFL non-users and civilian counterparts from Medical Expenditure Panel Surveys and projections, 2006–2009; Medicare and Medicare HMO premiums from Centers for Medicare and Medicaid Services; Medigap premiums from *TheStreet.com* Ratings; Medisup premiums from Tower Perrin Health Care Cost Surveys 2006–2009; Medicare supplemental insurance coverage, before and after TFL, from Health Care Surveys of DoD Beneficiaries, 2000–2001 and 2006–2009.

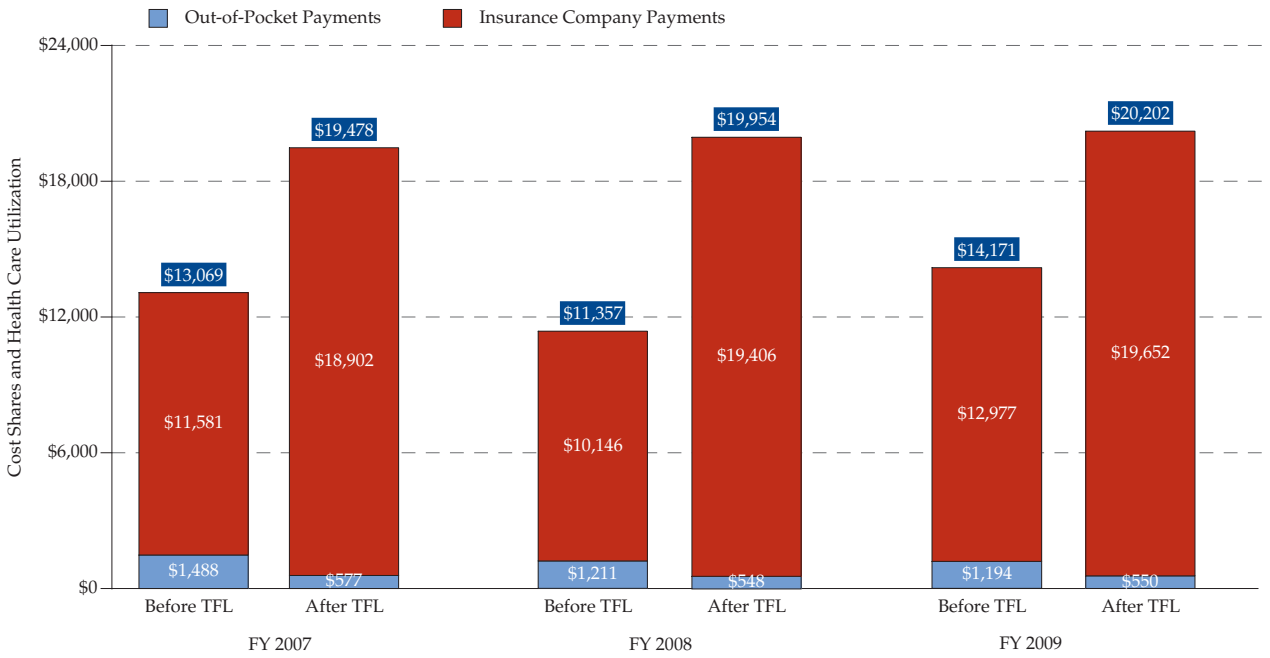
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT'D)*

Cost Shares and Health Care Utilization for MHS Senior Families Before and After TFL

Medicare supplemental insurance lowers the co-insurance rate (deductibles and copayments per dollar of utilization), and previous studies find that this leads to higher utilization (dollar value of health care services consumed).* TFL and added drug benefits substantially lowered co-insurance rates, and, not surprisingly, utilization is higher for MHS seniors compared to civilian counterparts.

- TRICARE senior families have relatively low co-insurance rates.
  - In FY 2009, the co-insurance rate for MHS seniors was 2.7 percent; it was 8.4 percent for civilian counterparts.
- TRICARE senior families have relatively high health care utilization.
  - In FY 2009, MHS families consumed $20,200 of medical services compared to only $14,200 for civilian counterparts (43 percent increase).

COST SHARES AND HEALTH CARE UTILIZATION FOR MHS SENIOR FAMILIES AFTER TFL VS. CIVILIAN COUNTERPARTS



Sources: DoD beneficiary expenditures for TFL users from MHS administrative data, FYs 2007–2009; expenditures for TFL non-users and civilian counterparts from Medical Expenditure Panel Surveys and projections, 2006–2009; Medicare supplemental insurance coverage, before and after TFL, from Health Care Surveys of DoD Beneficiaries, 2000–2001 and 2006–2009.

* Physician Payment Review Commission. *Annual Report to Congress: Fiscal Year 1997*. Private Secondary Insurance for Medicare Beneficiaries, pp. 327–28.

2009 RESEARCH PRESENTED BY THE CENTER FOR HEALTHCARE MANAGEMENT STUDIES, TMA

Background

The DoD operates one of the largest highly integrated health care systems in the nation, covering more than 9 million Active Duty, retiree, and dependent beneficiaries. The MHS shares in the common national effort to provide equitable, high-quality, affordable health care to diverse populations while reducing spiraling cost growth. Unlike other health plans, the MHS must also guarantee the medical readiness of its Active Duty beneficiaries and provide care for the wounded, roles that require greater flexibility and integration than is typical in civilian health plans.

To achieve its mission, the MHS has implemented a variety of policies designed to improve access to care, including no or reduced premiums and deductibles, elimination of copayments for Active Duty beneficiaries and their dependents, and provision of lifelong comprehensive health benefits to Medicare-eligible beneficiaries. The MHS thus provides a unique opportunity to examine proposed solutions to vexing problems, including racial and ethnic disparities in health care, financial incentives for preventive care, and patient perceptions of care of interest to policymakers contemplating expansions in health care coverage to socioeconomically diverse populations.

In recent panel discussion at the annual research proceedings of AcademyHealth, four research papers provided analyses of various perspectives on these important issues.

- **Racial & Ethnic Health Disparities in TRICARE:** Although disparities exist in self-reported health status and some measures of preventive care, disparities in the care received by black non-Hispanics and Hispanics under TRICARE were often smaller than those observed in the nation as a whole. These findings suggest the need to explore the characteristics of TRICARE that may be associated with more favorable outcomes for racial and ethnic minority groups.

  Implications for Policy, Practice, or Delivery: This study suggests the need for future research to identify factors that lead to smaller disparities in access and satisfaction within the TRICARE program. Such research may assist policy makers in designing systems of care in the private and other government health care systems that are more successful at reaching out to racial and ethnic minorities.

- **Looking Behind the Numbers—A Qualitative Exploration of Patient Experiences within the Military Health System:** Our findings are consistent with prior research in managed care systems, in that choice of provider, continuity of care, and access to physicians are central to how patients perceive their health care experiences, issues that are particularly evidence in the MHS direct care system.

  Implications for Policy, Practice, or Delivery: Our findings regarding differing patient experiences in direct care and purchased care will inform TMA leadership about potential improvements to the MHS and highlight the importance of choice, continuity of care, and communication to patient experience and perceptions about care. Demonstration projects testing the identified methods for improvement in these domains should be conducted.

- **Racial & Ethnic Disparities in Children's Health Care in the Military Health System:** These descriptive analyses reveal significant differences in health outcomes among children enrolled in TRICARE Prime, but the source of these differences is not known. Analysis of demographic characteristics revealed significant differences among racial and ethnic groups in age, primary source of medical care, and service branch of the parent sponsor. Possible explanations include differences in age, health risk or exposure, or disparities in provision of health care.

  Implications for Policy, Delivery, or Practice: Although many barriers to equitable provision of health care have been reduced or eliminated by the MHS, we find significant differences in health outcomes that remain to be explained. Further research into the nature of these differences will provide new insights into the nature and causes of health care disparities.

- **Effects of Patient Out-of-Pocket Cost Sharing on Colonoscopy & Sigmoidoscopy Use for Colorectal Cancer Screening:** The absence of roughly $100 in cost sharing increases screening colonoscopies (SC) rates by 34 percent to 49 percent for military dependents and retirees/dependents over age 50. For Prime (49 percent increase), some of this difference is due to selection effects, but the absence of cost sharing certainly has a large effect on this outcome.

  Implications for Policy, Practice or Delivery: The nonpartisan National Commission on Prevention Priorities found SCs and other Colonoscopy Colorectal Cancer (CRC) screening for adults over age 50 to be among the most cost-effective of all medical preventive services available. The policy of out-of-pocket cost sharing elimination should result in considerable increases in SC compliance for affected TRICARE beneficiaries.

Source: From the Center for Health Care Management Studies, OASD(HA)/TMA-HPA&E, 11/9/2009

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 (excluding Medicare and Medicaid). We made the comparisons using health care system performance metrics from the national CAHPS. The CAHPS program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care.

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® CCAE database provided by Thomson Reuters, 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 2007–FY 2009) to gauge trends in access, quality, utilization, and costs.

Notes on methodology:

- Numbers in charts or text may not sum to the expressed totals due to rounding.
- Unless otherwise indicated, all years referenced are Federal fiscal years (October 1–September 30).
- 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 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 statistically significant if the significance level was less than or equal to 0.05.
- All workload and costs are estimated to completion based on separate factors derived from MHS administrative data for direct care and recent claims experience for purchased care.
- Data were current as of:
  - HCSDB/CAHPS—12/11/2009
  - Eligibility/Enrollment data—12/4/2010
  - MHS Workload/Costs—2/5/2010
  - Web sites uniform resource locators (URLs)—2/18/2010
- 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 NDAA 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 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 worldwide Adult HCSDB is conducted on a quarterly basis (every January, April, July, and October). The Child HCSDB is conducted once per year, from a sample of DoD children age 17 and younger.

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.

The HCSDB is fielded to a stratified random sample of beneficiaries. In order to calculate representative rates and means from their responses, sampling weights are used to account for different sampling rates and different response rates in different sample strata. Beginning with the FY 2006 report, weights were adjusted for factors, such as age and rank, which do not define strata but make some beneficiaries more likely to respond than others. Because of the adjustment, rates calculated from the same data differ from past evaluation reports and are more representative of the population of TRICARE users.

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 and 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 can be benchmarked to civilian managed care health plans. More information on CAHPS can be obtained at *www.ahcpr.gov*.

Results provided from the HCSDB are based on questions taken from the CAHPS Version 3.0 Questionnaire (for 2007 and 2008) and the CAHPS Version 4.0 Questionnaire. Rates calculated from Version 3.0 responses are compared to benchmarks from the most recent available National CAHPS Benchmarking Database (NCBD), 2006. The Version 4.0 responses are compared to the 2008 NCBD. Because of the wholesale changes in the questionnaire, changes in rates are only meaningful when compared to changes in the relevant benchmark.

In most cases, when composites are presented, in order to make responses from 2007 and 2008 comparable, a composite is constructed from Version 3.0 questions to match the Version 4.0 composite. For "Getting Care Quickly" and "Getting Needed Care," that means only two questions are used for 2007 and 2008, rather than four questions as in past years. For "How Well Doctors Communicate," only responses for beneficiaries who indicate they have a personal doctor are included. The exception is the "Customer Service" composite, where Version 4.0 questions are not comparable to Version 3.0. In that case, the original Version 3.0 composite is presented in comparison to Version 3.0 benchmarks. It should also be recognized that the general tenor of the questions supporting both "Getting Needed Care" and "Getting Care Quickly" shifted between CAHPS versions 3.0 and 4.0. In CAHPS 3.0 the question was framed as "How much of a problem was it to…?", while in CAHPS 4.0 the question was framed as "How often was it easy to…?" The MHS results presented herein are comparable to the NCBD for the year and version specified).

The NCBD collects CAHPS results voluntarily submitted by participating health plans and is funded by the U.S. Agency for Healthcare Research and Quality and is administered by Westat, Inc. Both benchmarks and TRICARE results are adjusted for age and health status. Differences between the MHS and the civilian benchmark were considered significant at less than or equal to .05, using the normal approximation. 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. Beneficiaries' health plans are identified from a combination of self-report and administrative data. Within the context of the HCSDB, Prime enrollees are defined as those enrolled at least six months.

RWPs and 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 cases in MTFs and purchased acute 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.

DATA SOURCES *(CONT'D)*

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 several different RVU measures to reflect the relative costliness of the provider effort for a articular procedure or service. In this report, Organizational Work RVUs are used to measure direct care outpatient workload and Simple RVUs are used to measure purchased care outpatient workload. According to TMA, Organizational Work RVUs are the best direct care measure to compare the volume of provider work with the purchased care claims' Simple RVUs. See: *www.tricare.mil/ocfo/bea/downloads/SADR%20%20MDR%20%20Current%20%2031%20July%2007.doc* for definitions of these RVU measures.

Access and Quality

Measures of MHS access and quality were derived from the 2007, 2008, and 2009 administrations of the HCSDB. The comparable civilian-sector benchmarks came from the NCBDs for 2006 and 2008 as noted on the previous page.

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 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 MHS and beneficiary utilization and 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); HCSRs—purchased care claims information for the previous generation of contracts; TRICARE Encounter Data (TED—purchased care claims information for the new generation of contracts) for inpatient, outpatient, and prescription services; and 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 in early February 2010 as referenced above.

The CCAE database contains the health care experience of several million individuals (annually) covered under a variety of health plans offered by large employers, 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 Thomson Reuters, Inc. to compute quarterly benchmarks for HMOs and PPOs, broken out by product line (MED/SURG, OB, PSYCH) and several sex/age group combinations. The quarterly breakout, available through the second quarter of FY 2009, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2009 data to completion. Product lines were determined by aggregating Major Diagnostic Categories (MDCs) as follows: OB = MDC 14 (Pregnancy, Childbirth and Puerperium) and MDC 15 (Newborns and Other Neonates with Conditions Originating in Perinatal Period), PSYCH = MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders), and MED/SURG = all other MDCs. 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 older 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.

MILITARY HEALTH SYSTEM POPULATION: PRIME ENROLLEES AND TOTAL POPULATION BY STATE

State	Enrolled	Total Population
AK	72,263	89,637
AL	95,285	205,913
AR	39,402	92,837
AZ	106,450	203,782
CA	510,380	855,247
CO	142,800	225,210
CT	22,886	51,132
DC	24,348	28,852
DE	17,297	33,269
FL	340,048	676,026
GA	292,317	454,973
HI	118,945	158,304
IA	12,067	42,950
ID	22,198	49,006
IL	81,872	158,294
IN	29,096	90,486
KS	79,014	124,762
KY	103,720	161,260
LA	71,920	127,886
MA	28,993	70,131
MD	151,266	233,700
ME	25,567	43,091
MI	26,852	95,509
MN	17,451	64,550
MO	75,859	158,405
MS	67,012	121,578
MT	12,939	33,259
NC	335,248	509,153
ND	21,489	31,974
NE	32,746	60,456
NH	13,609	29,182
NJ	39,775	90,004
NM	47,568	84,492
NV	52,233	98,502
NY	88,058	182,869
OH	71,276	162,311
OK	98,624	164,951
OR	25,574	70,806
PA	54,018	167,853
RI	11,280	24,179
SC	136,523	241,878
SD	14,712	30,798
TN	89,118	188,168
TX	547,223	872,116
UT	32,801	67,311
VA	467,434	756,107
VT	5,139	12,920
WA	234,280	355,783
WI	21,788	71,707
WV	10,231	37,692
WY	12,951	23,075
Subtotal	**5,051,945**	**8,984,335**
Overseas	352,432	599,295
Total	**5,404,377**	**9,583,630**

Notes:
1. Source of data is from HA/TMA administrative data systems, as of November 2009 for end of FY 2009.
2. "Enrolled" includes PRIME (Military and Civilian Primary care manager [PCM]), TPR (and Overseas equivalent), Uniformed Services Family Health Plan (USFHP); and excludes members in TRICARE for Life and TRICARE Plus.

ABBREVIATIONS

AD	Active Duty
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
AHLTA	Armed Forces Longitudinal Technology Application
AHRQ	Agency for Healthcare Research and Quality
AMI	Acute Myocardial Infarction
ASD	Assistant Secretary of Defense
AT	Assistive Technology
BAMC	Brooke Army Medical Center
BHIE	Bidirectional Health Information Exchange
BMI	Body Mass Index
BRAC	Base Realignment and Closure
BWE	Beneficiary Web Enrollment
CAC	Children's Asthma Care
CAHPS	Consumer Assessment of Health Care Providers and Systems
CAP	Computer/Electronic Accommodations Program
CCAE	Commercial Claims and Encounters
CDC	Centers for Disease Control
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHDR	Clinical Data Repository/Health Data Repository
CMAC	CHAMPUS Maximum Allowable Charges
CMS	Centers for Medicare and Medicaid Services
CONUS	Continental United States
CRC	Colorectal Cancer
CSS	Customer Satisfaction Survey
CV	Cardiovascular
DCoE	Defense Centers of Excellence
DEERS	Defense Enrollment Eligibility Reporting System
DES	Disability Evaluation System
DFAS	Defense Finance and Accounting Service
DHP	Defense Health Program
DHHS	U.S. Department of Health and Human Services
DLAP	DoD Lifestyle Assessment Program
DoD	Department of Defense
DoDI	Department of Defense Instruction
DoDP&T	Department of Defense Pharmacy and Therapeutic
DRG	Diagnosis-Related Group
DTF	Dental Treatment Facility
DUA	Data Use Agreements
DURSA	Data Use and Reciprocal Support Agreement
DVER	Defense and Veterans Eye Injury Registry
ECHO	Extended Care Health Option
E-Gov	E-Government
EHR	Electronic Health Record
ESI	Express Scripts Inc.
FHIE	Federal Health Information Exchange
FMLA	Family and Medical Leave Act
FTE	Full-Time Equivalent
FY	Fiscal Year
HA	Health Affairs
H-CAHPS	Hospital-CAHPS
HF	Heart Failure
HCSDB	Health Care Survey of DoD Beneficiaries
HCSR	Health Care Service Record
HEC	Health Executive Council
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HP	Healthy People
HPA&E	Health Program Analysis and Evaluation
HRB	Health Related Behaviors
IIP	Information Interoperability Plan
LDSI	Laboratory Data Sharing Initiatives
LOS	Length of Stay
MCS	Managed Care Support

ABBREVIATIONS *(CONT'D)*

MCSC	Managed Care Support Contractor
MDC	Major Diagnostic Category
MEB	Medical Evaluation Board
MED/SURG	Medical/Surgical
MERHCF	Medicare-Eligible Retiree Health Care Fund
MHS	Military Health System
MOU	Memorandum of Understanding
MTF	Military Treatment Facility
NCBD	National CAHPS Benchmarking Database
NDAA	National Defense Authorization Act
NHE	National Health Expenditures
NHN	National Health Information Network
NNMC	National Naval Medical Center
NQF	National Quality Forum
NRD	National Resource Directory
OASD	Office of the Assistant Secretary of Defense
OB/GYN	Obstetrician/Gynecologist
OCO	Overseas Contingency Operations
OCONUS	Outside Continental United States
OHI	Other Health Insurance
O&M	Operations and Maintenance
OMB	Office of Management and Budget
OPPS	Outpatient Prospective Payment System
PCM	Primary Care Manager
PDF	Portable Document Format
PDHRA	Post-Deployment Health Reassessment
PH	Psychological Health
PHI	Protected Health Information
PIA	Privacy Impact Assessment
PIN	Personal Identification Number
PN	Pneumonia
POS	Point-of-Service
PPO	Preferred Provider Organization
PRISM	Provider Requirement Integrated Specialty Model
PSA	Prime Service Area
RC	Reserve Component
RVU	Relative Value Unit
RWP	Relative Weighted Product
SADR	Standard Ambulatory Data Record
SC	Screening Colonoscopies
SCIP	Surgical Care Improvement Project
SIDR	Standard Inpatient Data Record
TAMP	Transitional Assistance Management Program
TBI	Traumatic Brain Injury
TDP	TRICARE Dental Program
TED	TRICARE Encounter Data
TFL	TRICARE for Life
TGRO	TRICARE Global Remote Overseas
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TOA	Total Obligational Authority
TPharm	TRICARE Pharmacy
TPR	TRICARE Prime Remote
TRAC2ES	Transportation Command Regulating and Command & Control Evacuation System
TRDP	TRICARE Retiree Dental Program
TRIAP	TRICARE Assistance Program
TRISS	TRICARE Inpatient Satisfaction Survey
TRO	TRICARE Regional Office
TROSS	TRICARE Outpatient Satisfaction Survey
TRS	TRICARE Reserve Select
UCCI	United Concordia Companies Inc.
UMP	Unified Medical Program
USFHP	Uniformed Services Family Health Plan
VA	Department of Veterans Affairs
VCE	Vision Center of Excellence
VISTA	Veterans Health Information Systems and Technology Architecture
VLER	Virtual Lifetime Electronic Health Record
WRAMC	Walter Reed Army Medical Center
WWRC	Wounded Warrior Resource Center

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