UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

AUG 27 2011

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

Dear Mr. Chairman:

The Department is pleased to provide the "Department of Defense Evaluation of the TRICARE Program Fiscal Year (FY) 2011 Report to Congress." The enclosed report responds to the annual requirement outlined in section 717 of the National Defense Authorization Act for FY 1996, (P.L. 104-106). I apologize for the delay in transmitting the report.

The $50 billion FY 10 Unified Medical Program (UMP) supports the physical and mental health of 9.6 million beneficiaries worldwide. The Military Health System extends from theater medical care for our deployed Active and Reserve Component forces, to the daily "peacetime" health services provided in our military treatment facilities and purchased civilian care sources. The FY 10 UMP is 11 percent larger than in FY 08, commensurate with increases in population served, workload produced or purchased, and medical inflation. Health care costs associated with caring for our wounded, ill, or injured were $2.9 billion in FY 10 (almost 6 percent of expenditures), 29 percent more than $2.2 billion spent in FY 08. Improved efficiencies have helped moderate some costs, such as increased use of pharmacy home delivery. Beneficiary-reported satisfactions with key aspects of the TRICARE health plan and customer service have improved during this time. The Department continues efforts to improve access to our system for Service members, especially those wounded, ill, or injured returning from operational deployment.

A copy of this letter has been sent to the President of the Senate, the Speaker of the House and the other congressional defense committees. Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

Clifford L. Stanley

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

27

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

Dear Mr. Chairman:

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As stated

cc:
The Honorable Lindsey Graham
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

The Honorable Howard P. "Buck" McKeon
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

APR 27 2011

The Honorable Joe Wilson
Chairman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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Enclosure:
As stated

cc:
The Honorable Susan A. Davis
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

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

Dear Mr. Chairman:

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Enclosure:
As stated

cc:
The Honorable Thad Cochran
Vice Chairman

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WASHINGTON, DC 20301-4000

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Chairman, Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington. DC 20510

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Vice Chairman

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WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

The Honorable Harold Rogers
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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Sincerely,

Clifford L. Stanley

Enclosure:
As stated

cc:
The Honorable Norman D. Dicks
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

The Honorable C. W. Bill Young
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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The Honorable Norman D. Dicks
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

APR 27 2011

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

Dear Mr. President:

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As stated

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4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

27 20

The Honorable John A. Boehner
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

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Sincerely,

Clifford L. Stanley

Enclosure:
As stated

Keeping Warfighters Ready. For Life.

Evaluation of the TRICARE Program

Fiscal Year 2011 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, 2011

The **Evaluation of the TRICARE Program: Fiscal Year 2011 Report to Congress** is provided by the TRICARE Management Activity (TMA), Health Program Analysis and Evaluation Directorate (TMA/HPA&E), in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD/HA). Once the Report has been sent to the Congress, an electronic version will be available at: *http://www.tricare.mil/tma/StudiesEval.aspx*.

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 – Soldiers arrive by air and convoy to help the Iraqi Army distribute humanitarian aid to the citizens of Faddaqhryah and Bahar in the Basra Province of Iraq.

B – U.S. Army Soldier monitors his radio while a CH-47 Chinook helicopter lands at the Paruns District Center in the Nuristan province of Afghanistan.

C – A Port Security Unit Petty Officer returns home after deploying in support of Operation Iraqi Freedom.

D – Retired Army sergeant demonstrates a balance and agility exercise for Veterans Affairs therapists and prosthetists during a military amputee advanced skills training workshop.

E – Oil is collected in skimming boom attached to a U.S. Coast Guard cutter off the coast of Florida, in response to the 2010 Deepwater Horizon/BP oil spill.

F – F/A-18 Super Hornets deploy heat flares during a combat patrol over Afghanistan.

G – An USAF Airman transports equipment and relief supplies in support of humanitarian airlift operations to locations throughout Pakistan.

H – Marines and sailors observe from a mountain north of Golestan, Afghanistan.

I – Commander of Submarine Group 10 talks to a Pearl Harbor survivor at the Veterans Affairs Hospital in Phoenix.

J – U.S. Army Soldier talks to an Afghan while patrolling the streets in Wardak Province's Tangi Valley, Afghanistan.

K – A USAF Airman helps rack litter-bound patients onto the aircraft before flight.

L – U.S. Army Officer practices walking in the completed version of the second generation Power Knee 2.

M – Flight deck directors guide an F/A-18C Hornet toward the catapults aboard a U.S. Navy aircraft carrier.

N – Women veterans applaud during the ceremony celebrating the 10th anniversary of the Women in Military Service for America Memorial at Arlington National Cemetery.

A MESSAGE FROM JONATHAN WOODSON, M.D., ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

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A MESSAGE FROM JONATHAN WOODSON, M.D., ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

It is an honor and a privilege to provide my first report to the Congress, since my appointment in December 2010, of 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 us to recount the progress of many of the strategic initiatives the Military Healthy System (MHS) has pursued to improve our performance in terms of cost, quality, and access. These initiatives support the Quadruple Aim strategy we began in the fall of 2009, focusing on the primacy of Readiness, and continuous efforts to improve our population's health and our beneficiaries' experience of care, while managing per capita costs.

TRICARE already meets or exceeds most of the new health care provisions that took effect September 23, 2010, under the Patient Protection and Affordable Care Act (PPACA). The PPACA provides new or expanded options and consumer protections for those with private health insurance coverage. Most provisions under PPACA, such as restrictions on annual limits, lifetime maximums, "high user" cancellations, or denial of coverage for pre-existing conditions, have not been a concern for the over 9.6 million Active Duty military and retiree families under TRICARE. Because TRICARE is an entitlement provided for by law, TRICARE's coverage has no lifetime cap. Under the basic entitlement, TRICARE costs are determined by legislation, and in general, Active Duty families and military retirees pay low, or no, annual or monthly fees, unlike coverage under most commercial health insurance plans. There is no cost for medical care for Active Duty Service members.

One provision under PPACA that was not already addressed in the FY 2010 TRICARE entitlement was coverage for dependents up to the age of 26. The recent PPACA requires civilian health plans that provide medical coverage to children to make that coverage available until the child turns 26 years of age. TRICARE's age limit for dependent children was 21, or age 23 if the dependent child is a full time college student or has been determined to be incapable of self-support. The recently signed NDAA for FY 2011 includes a provision that extends dependent medical coverage up to age 26. Beginning later in the spring of FY 2011, qualified dependents up to age 26 will be able to purchase TRICARE coverage on a month-to-month basis. See *http://www.tricare.mil/tya* for more information.

This report presents the results of many of the established and evolving measures senior MHS leadership follows to assess the performance of the $50 billion MHS, serving more than 9.6 million beneficiaries worldwide in meeting operational and humanitarian mission requirements consistent with our strategic vision, strategy, and goals. In this report, where programs are mature, and data permit, results are trended over the most recent three fiscal years; and where appropriate and feasible, MHS data are compared with corresponding comparable civilian benchmarks, such as with our beneficiary surveys of access to and satisfaction with the experience of care. — *Jonathan Woodson, M.D.*

MHS PURPOSE, MISSION, VISION, AND STRATEGY

The MHS Strategic Plan, published in 2008, continues to reflect the purpose, mission, vision, and overall strategy of senior DoD and MHS leadership. 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 around 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.

This report reflects our 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/About_MHS/Organizations/MHS_Offices_and_Programs/OfficeOfStrategyManagement.aspx*.

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. MHS provides long-term health coaching and health care for more than 9.6 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.

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 lifelong 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.

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.

MHS STRATEGIC DIRECTION AND PRIORITIES IN FY 2011 AND BEYOND

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 with 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 work together to serve the needs of a population. MHS adopted 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**
  Reducing the generators of ill health by encouraging healthy behaviors and decreasing 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.

There are 11 strategic imperatives supporting improved performance in one or more of the four elements of the Quadruple Aim. These strategic imperatives are established and routinely monitored by MHS senior leadership. Some of the strategic imperatives relative to the Quadruple Aim include:

- **The Population Health Aim** includes strategic imperatives such as Engaging Patients in Healthy Behaviors monitored by various measures, to include the use of tobacco, prevalence of obesity, and use of preventive services among the MHS population.
- **The Experience of Care Aim** includes strategic imperatives of Evidence-Based Care (supported by hospital quality indexes), Wounded Warrior Care (supported by turn-around times for Medical Evaluation Board processing and favorable experience ratings), and Access to the Medical Home (supported by survey-based measures of getting timely care, doctors' communication, and primary care third available appointments).
- **The Readiness Aim** includes strategic imperatives of Individual and Family Medical Readiness and Psychological Health and Resiliency.
- **The Per Capita Costs Aim** includes the strategic imperatives of Aligning Incentives to Promote Outcomes and Increase Stakeholder Value, supported by measures of Enrollee Utilization of Emergency Services and Annual Cost Per Equivalent Life (PMPM).
- **The Learning and Growth** strategic imperative is supported by staff satisfaction and Health Services Research.

MHS STRATEGIC DIRECTION AND PRIORITIES IN FY 2011 AND BEYOND *(CONT'D)*

Patient-Centered Medical Home

Military health care is implementing the Patient-Centered Medical Home (PCMH) model. PCMH is an established model for primary care designed to improve continuity of care and to enhance access through patient-centered care and effective patient provider communication. One of the core principles of the PCMH is that patients have a consistent relationship with their provider and team that deliver first contact, continuous, and comprehensive care. The PCMH model is designed to help patients establish trust with their provider, lower utilization of hospital services, and lower the overall cost of care. These attributes of the PCMH are associated with better outcomes, reduced mortality, fewer hospital admissions for patients with chronic diseases, and increased patient compliance. Additionally, the PCMH model will make primary care in MHS look similar to the eyes of patients across all of DoD's MTFs.

The PCMH policy was established on September 18, 2009, based on recommendations from a Tri-Service working group. Each of the Service Surgeons General has committed to making the PCMH the cornerstone of our health care delivery system. The plan is to implement these PCMH concepts in all of our MTFs and to work with our managed care support contractors to do the same with network providers over the next three to five years. The PCMH is a major initiative that directly impacts all elements of the Quadruple Aim. MHS strives to provide comprehensive care for its beneficiaries through a team of health care providers responsible for a given number of patients. Within each team, patients are also assigned to individual providers who play a central role in promoting coordinated care and who encourage engagement of their patients receiving care. Early data from established PCMHs in MTFs have shown improvement in: access to care, quality health outcomes, patient satisfaction, staff satisfaction, and total health costs per patient.

Expanding psychological health care capacity for military families is another primary issue to be resolved on three fronts in the next five years or less: the shortfall of care providers who accept TRICARE; bridging the cultural differences between military and civilian providers; and outreach to local community providers. In addition to the services provided through TRICARE, DoD is working with United States Department of Agriculture and the Department of Health and Human Services to build community capacity for psychological health care for military families.

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2010

Stakeholder Perspective

- The nearly $50 billion ($49.8) FY 2010 Unified Medical Program (UMP) expenditures were 11 percent greater than FY 2008 expenditures ($44.9 billion). The $5 billion growth in expenditures over these three years was due to increases in the direct care as well as purchased care costs (21 percent and 18 percent, respectively). At almost $51 billion, FY 2011 is programmed to be 2 percent greater than FY 2010. The UMP was 7.5 percent of the FY 2010 total Defense budget (including the normal cost contribution to the accrual fund for retirees), and is expected to be 9.3 percent of the FY 2011 Defense budget as currently programmed (Ref. pages 23–24).
- The number of beneficiaries eligible for DoD medical care increased from 9.4 million in FY 2008 to 9.7 million at the end of FY 2010 (Ref. page 16).
- The number of enrolled beneficiaries increased from 5.3 million in FY 2008 to 5.5 million in FY 2010 (Ref. page 21).
- The percentage of beneficiaries using MHS services increased from 81.2 percent in FY 2008 to 83.2 percent in FY 2010 (Ref. page 22).

MHS Workload and Cost Trends*

- Total MHS workload increased from FY 2008 to FY 2010 for all major components—inpatient (+6 percent), outpatient (+17 percent), and prescription drugs (+8 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 increased by 3 percent, outpatient workload by 11 percent, and prescription workload by 4 percent from FY 2008 to FY 2010. Overall, direct care costs increased by 12 percent. Purchased care workload increased for all service types, especially for outpatient services, which increased by 22 percent. Overall, purchased care costs increased by 17 percent (Ref. pages 26–29).
- The purchased care portion of total MHS health care expenditures remained steady at about 50 percent from FY 2008 to FY 2010. As a proportion of total MHS health care expenditures (excluding TFL), FY 2010 purchased care expenditures were 61 percent for prescription drugs, 57 percent for inpatient care, and 44 percent for outpatient care (Ref. page 29).
- Increases in purchased care costs were mitigated somewhat in FYs 2009 and 2010 by three actions: implementation of the Outpatient Prospective Payment System for reimbursement of hospital outpatient services, rebates from drug manufacturers for TRICARE retail pharmacy name-brand drugs, and an intensive campaign to educate beneficiaries on the benefits of home delivery pharmacy services (Ref. pages 28–29).
- Out-of-pocket costs for MHS beneficiary families under age 65 are between $4,200 and $5,000 lower than those for their civilian counterparts. Out-of-pocket costs for MHS senior families are $2,800 lower than those for their civilian counterparts (Ref. pages 79, 81, 84).

* 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.

Access to Care

- **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 2010 (Ref. page 32).
- **Availability and Ease of Obtaining Care:** MHS beneficiary ratings for getting needed care and getting care quickly improved between FY 2008 and FY 2010 but continued to lag the civilian benchmark (Ref. page 33).
- **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 34).
- The second year of a four-year survey indicates that nine of 10 physicians, and eight of 10 providers overall, (nonphysicians and physicians combined) are aware of TRICARE in general, and seven of 10 physicians 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 36).
- **MHS Provider Trends:** The number of TRICARE participating providers continues to increase, but at a slower rate than in previous years. The number of primary care providers has increased at a slightly greater rate than the number of specialists (Ref. page 35).

Experience of 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 2008 to FY 2010 (exceeding the civilian benchmark in FYs 2009 and 2010 for health plan). Global satisfaction ratings of health care improved, but still lag the civilian benchmark (Ref. pages 41–45).
- Health care satisfaction levels remained stable for Prime enrollees and increased for non-enrollees (Ref. pages 41–45).

Population Health

- **Meeting Preventive Care Standards:** For the past three years, 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 2010 self-reported rates for smoking (15 percent) and obese (25 percent) beneficiaries remained above the desired HP 2010 adjusted goals (12 percent smoking; 15 percent obese) (Ref. pages 58–60).
- **Force Protection:** Overall MHS dental readiness remained stable between FY 2008 and FY 2010 (Ref. page 89).

Readiness

- **Enrollment in TRICARE Reserve Select (TRS):** TRS enrollment and purchased plans have increased fivefold from FY 2007 to FY 2010. There were about 12,000 plans and 35,000 covered lives at the end of FY 2007, and almost 63,000 plans covering 161,000 lives at the end of FY 2010 (Ref. page 87).

WHAT IS TRICARE?

TRICARE is a family of health plans for 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 primary care manager (PCM), a health care professional who is responsible for helping the patient manage his or her care, promoting preventive health services (e.g., routine exams, immunizations), and arranging for specialty provider services as appropriate. Access standards apply to waiting times to get an appointment and waiting times in doctors' offices. A point-of-service (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, via TRICARE retail network pharmacies, and through the TRICARE Pharmacy Home Delivery program (formerly called TRICARE Mail Order Pharmacy)
  - 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 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 2010 SUPPORTING THE MHS QUADRUPLE AIM

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 MHS aggressively works to sustain the TRICARE program through good fiscal stewardship, it also refines and enhances 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 its beneficiaries.

Contract and Organizational Changes

Transition to the three new regional contracts in the United States, known as "T-3" (TRICARE 3rd Generation), was initially slated for completion April 1, 2010, but has been delayed. Protests filed with TMA and the Government Accountability Office (GAO) put the transition on hold in all three regions. In late 2009, the GAO sustained the protests by Health Net and the current South Region contractor, Humana Military Healthcare Services, and recommended re-evaluation of proposals for both the North and South Regions.

The North Region contract was awarded to Health Net Federal Services, LLC, on May 13, 2010. TMA issued an amended Request for Proposals (RFP) for the TRICARE South Region on May 5, 2010. The original bidders will all have the opportunity to respond. An agency-level protest regarding the West Region award to TriWest Healthcare Alliance Corp. is still pending. The current contracts have been extended to prevent coverage interruptions.

New TRICARE Overseas Program Contract

The new TRICARE Overseas Program (TOP) contract went into effect on September 1, 2010. International SOS Assistance, TRICARE's overseas contractor, is partnering with MTFs to give TRICARE Prime beneficiaries more comprehensive health care services overseas. International SOS operates host-nation provider networks around overseas MTFs and in remote locations.

International SOS Assistance, Inc., will also manage TRS enrollment and customer support to overseas-based National Guard and Reserve members, as well as overseas TRS claims including pharmacy claims. TRS members living or traveling overseas may contact one of the TRICARE Overseas regional call centers to obtain assistance in finding a host-nation provider.

Base Realignment and Closure for DoD's TRICARE Management Activity

More than 3,000 personnel from Health Affairs/TRICARE Management Activity (HA/TMA) and the service medical headquarters currently operating throughout the National Capital Region (NCR) will join forces at a single campus at 7700 Arlington Boulevard, Falls Church, Va. The move is one of many changes mandated under 2005 Base Realignment and Closure (BRAC) Commission recommendations approved by the President and Congress. Staff will begin moving in the summer of 2011.

TRICARE Area Office Europe Changes Title

TRICARE Area Office (TAO) Europe has changed its name to TRICARE Area Office Eurasia-Africa. The new title does not add any new territory to the area the TAO supports, but rather recognizes that the office's responsibilities extend far beyond the European continent. TAO Eurasia-Africa supports the European and African continents, all Middle Eastern countries, Pakistan, Russia, and several former Soviet Republics.

TRICARE® Gets an Update to Its Name and Logo

The TRICARE name and logo were registered in 2010 as trademarks of TRICARE Management Activity. The U.S. Patent and Trademark Office requires that the trademark be used in its correct format, without variation. The placement of the ® must be located consistently to the top right of the "E" in TRICARE and must be visible in print and on the Internet. Approved versions of the logo are available for download at *www.tricare.mil/logo*.

QUADRUPLE AIM: EXPERIENCE OF CARE

Wounded Warrior Care

Warrior Transition Battalion Complex

The first completed Warrior Transition Battalion (WTB) complex—a $54 million facility—is located at Fort Riley, Kan., the home of the first WTB in the Army. The complex allows wounded Service members and their families to take part in physical and behavioral health activities, to receive quality outcome-focused care and service, and to access conscious care.

Prior to the building of the WTB complex, soldiers assigned to this battalion lived in temporary mobile housing units. In the new WTB barracks, each Service member has his or her own room, already furnished with television, laptop, bed, desk, and recliner.

New Center for Treatment of Traumatic Brain Injury and Psychological Health Conditions

The National Intrepid Center of Excellence opened June 24, 2010, at National Naval Medical Center in Bethesda, Md. The center specializes in the treatment of Service members

and veterans diagnosed with traumatic brain injury and psychological health conditions.

The center is a project of the Intrepid Fallen Heroes Fund, a nonprofit organization funded by private donations from individuals, corporations, and nonprofit organizations. The funds helped build and equip the center; it will now be turned over to DoD to operate. The center will conduct research, test new treatments, and provide comprehensive training and education to patients, providers, and families.

Technology Program Aids Wounded Service Members

A recent enhancement to the Computer/Electronic Accommodations Program (CAP) now allows Service members to keep their assistive technologies when they leave Active Duty. Service members who get out and return to work for the federal government can receive the CAP tools they need in their new workplace. CAP provides assistive technologies for wounded Service members to help empower them for continued employment.

Access to Care

TRICARE Retired Reserve Launches

TRICARE Retired Reserve (TRR) began September 1, 2010. Retired Reservists and their eligible family members may qualify to purchase TRICARE health coverage through TRR if they are under the age of 60 and are not eligible for, or enrolled in, the Federal Employees Health Benefit (FEHB) program. They must also be members of the retired Reserve of a Reserve component and qualified for nonregular retirement. See page 11 for information on TRR premiums.

Autism Services Demonstration Extended to March 2012

The Enhanced Access to Autism Services Demonstration is extended to March 14, 2012. The demonstration allows reimbursement for applied behavior analysis (ABA) rendered by providers (tutors) who are not otherwise eligible to be reimbursed by TRICARE for ABA services. Providers of ABA collect data on a child's behavior and use that information to teach the children positive behaviors while suppressing harmful or undesired ones, and improve their social and communication skills.

The demonstration is open to children of Service members in the U.S. who are registered in TRICARE's Extended Care Health Option (ECHO) and diagnosed with an autism spectrum disorder (ASD). Information about ECHO is at *www.tricare.mil/ECHO* and information about the Enhanced Access to Autism Services Demonstration is at *www.tricare.mil/autismdemo*.

Preauthorization of Skilled Nursing Facility Care

Effective May 1, 2010, skilled nursing facilities must now obtain preauthorization when medically necessary skilled nursing services extend beyond Medicare's 100-day limit and TRICARE becomes the primary payer for a beneficiary. The preauthorization, which requires medical documentation, is requested by the skilled nursing facility—not the beneficiaries or their families.

Medicare and TRICARE cover medically necessary skilled nursing care and rehabilitative therapies, including room and board, prescription medication, and laboratory work that are provided in the skilled nursing facility. Medicare covers only the first 100 days of skilled nursing facility care, while TRICARE for Life covers treatment as long as it is medically necessary.

For skilled nursing care benefits to be covered, the facility must be Medicare-certified and enter into a participation agreement with TRICARE. Beneficiaries must have a qualifying hospital stay of at least three consecutive days, not including the day of discharge. Beneficiaries must also enter the skilled nursing facility within 30 days of being discharged from the hospital and the care must meet TRICARE medical necessity guidelines.

Streamlined Certification Procedure for Psychiatric Partial Hospitalization

The certification procedure for psychiatric partial hospitalization has been streamlined in 2010, making it available to more beneficiaries. Partial hospitalization programs (PHPs) at TRICARE-authorized hospitals are now considered TRICARE-authorized providers and no longer need a separate certification. Freestanding PHPs, however, must be certified and must be participating TRICARE providers.

The TRICARE PHP benefit is provided through day, evening, or weekend program options. Partial hospitalization care is usually provided for a minimum of three hours a day, five days per week. However, the TRICARE benefit also includes care sometimes referred to as intensive outpatient treatment, which may be provided three hours a day, three days a week. Because there are no "emergency" admissions to PHPs, prior authorization is required for all PHP admissions.

Coverage for Complications

DoD published a proposed rule in the August 6, 2010, *Federal Register* to allow coverage for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident of treatment provided in an MTF, when the initial noncovered service has been authorized by the MTF commander and the MTF is unable to provide the necessary treatment of the complications.

This proposed rule protects TRICARE beneficiaries from incurring financial hardships due to the current regulatory restrictions that prohibit TRICARE coverage of treatment of the complications resulting from noncovered medical procedures, even when those procedures

were conducted in a DoD facility. The final rule is in coordination for publication.

TRICARE Offers New and Improved Pharmacy Benefits

TRICARE home delivery and retail pharmacy contracts have been combined into one new contract called TRICARE Pharmacy. The new program includes benefits such as: the Specialty Medication Care Management program in the home delivery pharmacy; the expansion of assistance to help beneficiaries switch their MTF prescriptions to home delivery; and a single call center phone number: 1-877-363-1303. TRICARE beneficiaries do not have to do anything to get this improved benefit.

Express Scripts, Inc., was selected to provide mail-order, retail, and specialty pharmacy services for the TRICARE Pharmacy Program. For more information visit *www.tricare.mil/pharmacy* or *www.express-scripts.com/TRICARE.*

TRICARE Extends Over-the-Counter Medication Demonstration Project

TRICARE's over-the-counter (OTC) medication demonstration project, scheduled to end November 4, 2009, has been extended. The program allows TRICARE beneficiaries to substitute OTC versions for certain prescription drugs.

Participants in the OTC demonstration program were temporarily required to pay a $3 copay because the extension coincided with a new contract. But, as of December 28, 2009, all system changes have been completed and the program will not require any copayment.

Examples of OTC medications available through the program include the allergy medications cetirizine and loratadine, and heartburn medications (proton-pump inhibitors).

To use the program, beneficiaries need a prescription from their health care provider for the OTC drug. Information about the TRICARE Pharmacy Program is at *http://www.tricare.mil/pharmacy.*

Customer Service

Beneficiary Web Enrollment: Easing Permanent Change of Station

As many as 400,000 PCS moves could occur in 2011. A memorandum sent to all armed service secretaries of manpower and Reserve affairs, dated May 3, 2010, asked that PCS orders include information about transferring TRICARE enrollment online. Using the BWE Web site to transfer TRICARE enrollment can ease the PCS process for families and ensure continuity of health care.

Depending on beneficiary status and circumstances, the BWE Web site may allow enrollment changes, contact information updates, and more through one of three log-on methods: Common Access Card (CAC), "myPay" PIN, or Department of Defense self-service log-on. BWE is available only in the U.S., and Active Duty Service members should contact their new MTF to determine whether they can make changes through the Web, or should wait until they reach their new duty station. For more information, see *www.tricare.mil/bwe*.

TRICARE Online: New Feature Allowing Users to Save Their Personal Health Information

TRICARE Online is MHS's Internet point of entry that provides all 9.6 million DoD beneficiaries with access to available health care services and information through an enterprise-wide secure portal. TRICARE Online users who receive their care at an MTF can schedule appointments, order prescription refills, and view their personal health records.

Blue Button, a new feature available at *www.tricareonline.com*, allows users to save their personal health data. The new feature creates a personal health summary in a Portable Document Format (PDF) file on the beneficiary's computer, including details such as medication and allergy profiles and demographic information.

Successful Medicare and TRICARE Pilot Project Ended

My Personal Health Record, South Carolina (MyPHRSC), a Medicare pilot project allowing TFL beneficiaries living in South Carolina to maintain their health records electronically, ended September 30, 2010.

The MyPHRSC pilot project gave beneficiaries direct access to important health data and provided TMA with important information on how to securely and safely exchange data between systems. MyPHRSC users had access to their Medicare information from the past 24 months, including medical conditions, hospitalizations, and doctor visits. Users could also enter their own information, such as medications, allergies, and notes about the services they received.

In January 2009, an agreement between Medicare and DoD allowed Medicare-eligible TRICARE beneficiaries in South Carolina to add TRICARE for Life (TFL) pharmacy data to their PHR through a secure download from DoD. During the pilot project, 278 TFL beneficiaries participated in MyPHRSC and added their TRICARE pharmacy data to their PHRs. While the pilot project has ended, the participating beneficiaries can still access their TRICARE data via TRICARE Online.

Evidence-Based Care

COPD Programs

Beneficiaries suffering from chronic obstructive pulmonary disease, or COPD, can receive extra help. COPD is a group of lung diseases that includes emphysema, chronic bronchitis, and, in some cases, asthma.

TriWest Healthcare Alliance is offering a new lung health service to West Region TRICARE beneficiaries eligible for its disease management programs. TriWest's disease management department already offered support to beneficiaries with diabetes, asthma, and heart failure. The COPD program, begun in September, is a no-cost entitlement for those who are eligible. Beneficiaries can find additional resources at *www.triwest.com/copd* and *www.tricare.mil*.

Health Net Federal Services, LLC, has established an enhanced program managing COPD for TRICARE North Region beneficiaries. A team of licensed disease specialists, including RNs, respiratory therapists, dieticians, and social workers, is assigned to each patient's case. The team works with each patient to help the patient learn how to monitor, regulate, and control the disease through regular screenings; medication, diet, and exercise; and effective communication with medical professionals.

Chronic Care Management Overseas

Healthways International, in agreement with International SOS Assistance, Inc., will provide chronic care management services for the TRICARE Overseas Program beneficiaries with asthma, diabetes, hypertension, depression, and anxiety disorders, and for those needing cancer screening. These beneficiaries are located in 146 countries around the world.

QUADRUPLE AIM: POPULATION HEALTH

Engaging Patients in Healthy Behaviors

Expanded Breast Cancer and Cervical Cancer Screening for MHS Females

DoD published a final rule in the August 6, 2010, *Federal Register* implementing section 703 of the National Defense Authorization Act (NDAA) for Fiscal Year 2007 (FY 2007). The legislation authorizes breast cancer screening and cervical cancer screening for female beneficiaries of MHS, instead of constraining such testing to mammograms and Pap smears. This rule ensures that new breast and cervical cancer screening procedures can be added to the TRICARE benefit, as such procedures are proven to be a safe, effective, and nationally accepted medical practice. This rule was effective September 7, 2010.

TRICARE Standard Pays for Preventive Care

As announced in last year's report (see page 9), and starting September 1, 2009, TRICARE Standard now waives all cost shares for six preventive services. These services include colorectal cancer, breast cancer, cervical cancer and prostate cancer screenings; immunizations; and well-child visits for children under 6 years of age.

Flu Vaccinations without Copays from TRICARE Retail Pharmacies

Beneficiaries can visit TRICARE retail network pharmacies to receive seasonal flu, H1N1 flu, and pneumonia vaccines at no cost. This expanded coverage is available to all TRICARE beneficiaries eligible to use the TRICARE retail pharmacy benefit. Other vaccines must still be administered in a doctor's office or authorized convenience clinic to be fully covered by TRICARE's preventive health services cost-share waiver.

To receive the vaccines, beneficiaries can call their local TRICARE pharmacy to make sure it participates in the vaccine program and has the vaccine in stock. Participating pharmacies can be found at *http://www.express-scripts.com/TRICARE* or call Express Scripts at 877-363-1303.

TRICARE Dental Program Outreach to Children

United Concordia, administrator of the TRICARE Dental Program (TDP), provided educational dental health materials to children and teachers in stateside DoD elementary schools as part of the company's outreach initiatives. United Concordia sent oral health flip books and DVDs as teaching aids to all teachers who expressed interest in presenting an oral health lesson in their classrooms. United Concordia provided outreach materials to children and educational professionals at 35 DoD schools.

TRICARE on the Internet and Social Media

TRICARE uses the Internet and social media to reach out to beneficiaries and keep them informed.

On the Web: TRICARE and the regional health care contractors post a range of educational materials online to educate beneficiaries on the risks and prevention of heart disease at *www.health.mil/Themes/Heart_Health.aspx*. The Web sites focus on risk factors associated with developing heart disease and include information relating to the symptoms and stages of heart disease.

Podcasts: The weekly TRICARE Beneficiary Bulletin podcasts give beneficiaries quick, weekly updates they can access on their own schedule. Podcasts are at *www.tricare.mil/iTunes* or in the Apple iTunes Store under "TRICARE." E-alerts for new podcasts and other TRICARE benefit news are at *www.tricare.mil/subscriptions*. Beneficiaries can also listen to the podcast on TRICARE's Facebook page, or by visiting the TRICARE Media Center at *www.tricare.mil/mediacenter*.

Facebook: TRICARE and the regional health care contractors all maintain Facebook pages to connect with military Service members, families, and customers. The Facebook pages highlight TRICARE news, benefit changes, healthy living tips, and stories that interest its military families.

Email: Beneficiaries can receive e-mail notifications of the latest TRICARE news and health information. Beneficiaries can subscribe to and receive as many or as few items as they like based on their beneficiary category or topics of interest. Beneficiaries can create an account at *www.tricare.mil/subscriptions*.

Obesity

Healthy Choices for Life Campaign

The Healthy Choices for Life campaign is designed to help parents by providing the information to prevent, rather than to treat, obesity. The campaign includes a series of articles such as: "Nutrition for Healthy Babies and Mothers," "Solid Choices When Choosing Solid Foods," and "Fighting Adult Obesity Begins with Preventing Childhood Obesity." Available at *www.tricare .mil/mediacenter*, each article in the series examines a stage of a child's development and explains the best food choices, how food contributes to growth, and its continuing importance.

Childhood Obesity

TRICARE observed Childhood Obesity Awareness Month during the month of September 2010. TRICARE is a participant in the Let's Move! program for military kids. The program works to combat the epidemic of childhood obesity through engaging every sector affecting a child's health. It provides schools, families, and communities with simple tools to help kids be more active, eat better, and get healthy. TRICARE's Web page at *www.tricare.mil/getfit* offers resources on childhood obesity to its beneficiaries. The page has links to informational Web sites and games emphasizing good nutrition and fitness for kids.

QUADRUPLE AIM: PER CAPITA COST

Provider Payment Rates Demonstration Project in Alaska Extended

TMA published a final notice in the July 8, 2010, *Federal Register*, extending a demonstration project in Alaska for individual provider payment rates through December 31, 2012. Under the demonstration, which initially began on January 1, 2007, payment rates for physicians and other noninstitutional individual professional providers in Alaska have been set at a rate higher than the Medicare rate.

TRICARE Hits One Billion Claims

On May 26, 2010, the one billionth TRICARE Encounter Data (TED) record was processed for TRICARE services around the world. The TED system helps civilian providers get paid promptly for the services they provide to TRICARE beneficiaries outside of MTFs. Records are processed for provider payments in less than 24 hours in most cases. The TED system has processed more than $140 billion of purchased services for TRICARE beneficiaries worldwide since 2004.

The ease and speed of the TED system give providers an incentive to participate in TRICARE. Increased participation in TRICARE networks provides beneficiaries better access to health care.

Dental Premiums

Monthly dental premiums increased slightly, beginning February 1, 2010. The new annual rates are effective for one year through January 31, 2011.

The monthly premium for an Active Duty single family member plan will increase from $12.12 to $12.69, and the monthly family plan premium will increase from $30.29 to $31.72.

For National Guard and Reserve family members, Individual Ready Reserve (IRR) sponsors, and separate IRR single family members, the monthly plan goes from $30.29 to $31.72, and the family plan premium will increase from $75.73 to $79.29.

TRICARE Retired Reserve Premiums

Qualified retired Reservists and their eligible family members may purchase TRICARE health coverage through TRR. For calendar year 2010, the TRR member-only monthly premium is $388.31 ($4,659.72 yearly), and the member and family monthly premium is $976.41 ($11,716.92 yearly). Premiums will be adjusted annually.

The comprehensive health care coverage provided by the premium-based TRR is similar to TRICARE Standard. After purchasing TRR, members will receive the TRICARE Retired Reserve Handbook, which includes details about covered services, how to get care, and who to contact for assistance. For more information, visit *www.tricare.mil/trr*.

QUADRUPLE AIM: READINESS

New Program to Train and Certify Medical Personnel in Deployment Mental Health

The Office of Force Health Protection and Readiness and the Deployment Health Clinical Center have established a new program to train and certify medical personnel in implementing deployment mental health assessments for Service members. Through the program, medical

personnel will learn to conduct effective deployment mental health screenings, education, and referral.

By law, mental health assessments are required for each member of the Armed Forces deployed in connection with a contingency operation. Before and after deployment mental health assessments are completed to identify and assess post-traumatic stress disorder (PTSD), depression, suicidality, and other mental health conditions, risks, and concerns.

Stress-Awareness Training

The Services have increased stress-awareness training, starting with new recruits, focusing heavily on noncommissioned officers, and extending to flag officers.

The Army, in a program with the University of Pennsylvania, has trained more than 1,200 soldiers to be resilience trainers to others, with plans to place them in every battalion.

The Navy has a program called ACT—ask, care, treatment, or ask about your shipmate, care for your shipmate, and help him or her get treatment. More than 100 sailors have been trained to teach others about controlling stress.

The Air Force has increased training and counseling, and held a "Wingman Day" in May to underscore that every airman, regardless of rank, needs to watch for changes in others and reach out to them if they suspect they're not well.

The Marine Corps recently created a hotline with the TRICARE West military health plan, which Marines and their families can call anonymously 24/7 to discuss stress. Also, the Marines focus on both physical and mental resilience, beginning at boot camp, and conduct pre-deployment immersion training to get young Marines accustomed to a combat environment.

"inTransition" Helps Ensure Continuity of Behavioral Health Care

A new program, inTransition, ensures continuity of behavioral health care for Service members as they move between health care systems or providers. The program is open to Service members in all branches who are currently receiving mental health treatment and are transitioning station or status, such as those going through a PCS or those going from MHS care to Veterans Affairs (VA) behavioral health care. The program is voluntary, confidential, and simple. The entire inTransition process happens over the phone.

Once enrolled, the transitioning Service member is assigned a personal transition support coach, who supports the Service member during the transition and helps him or her connect with a new behavioral health provider. Support coaches are licensed, master's- or doctoral-level mental health clinicians who understand military culture and respect the Service member's privacy.

Providers can enroll transitioning Service members in the program, or Service members can enroll themselves, 24 hours a day, 7 days a week, 365 days a year by calling any of the following numbers: within the continental United States: 1-800-424-7877, toll free; overseas: 1-800-424-4685, toll free/1-314-387-4700, collect.

Using the Internet to Identify and Treat Stress

TRICARE, the military Services, and the VA have begun using Internet-based tools to identify and treat Service members with traumatic brain injuries and post-traumatic stress disorder. Using Internet- and text-based technology is increasingly important to reach Service members, because these are media they are comfortable with, and because many beneficiaries—National Guard and Reserve members, and veterans who have separated from service—are widely dispersed and sometimes hard to reach.

Last year, VA officials started an Internet-based chat line for Service members to discuss stress.

Some 780,000 soldiers have responded to the Army's Internet-based Global Accessing Tool to measure resilience, and the service plans to expand its Web outreach. Also, the Army uses an Internet-based mental health screening to assess soldiers returning from deployments. The *Afterdeployment.org* Web site, which is similar to the Web-based TRICARE Assistance Program (see page 7 of the 2010 report), delivers content from diverse sources. In addition to offering Web-based tools targeting behavioral health issues, the revamped site showcases expanded content and easily accessed connections to real-time support. Facebook and Twitter announce the availability of new topic content. All topics are easily accessed from the home page, allowing users to link up to a vast matrix of expert information and other resources.

Families Overcoming Under Stress

The Families Overcoming Under Stress (FOCUS) program was developed in 2007 to help Navy and Marine Corps families cope with stress from multiple deployments and other pressures.

The program aims to offer practical help in situations where symptoms may be mild, acute, or anywhere in between. FOCUS uses a color code to help families pinpoint current stress levels. The colors range from green ("good to go") through the continuum to red ("not good to go").

That baseline guides the services best suited for clients. The services range from education and guidance on stress prevention to skills-based peer learning groups to

multi-session resilience training, which runs from eight to 10 weeks.

The Pentagon's military community and family policy office independently reviewed the program and cited it as a best-practice program. As a result, plans are under way to expand FOCUS to other branches of the military. Four Air Force and four Army locations are running pilot programs.

Humanitarian Relief in Haiti

The hospital ship USNS COMFORT (T-AH 20) departed Haiti March 10, 2010, after completing its humanitarian relief mission in the aftermath of the massive 7.0-magnitude earthquake that struck Port-au-Prince, Haiti. Officials say the disaster killed between 100,000 to 200,000 people and the Red Cross estimates that some 3 million people were affected.

COMFORT began its humanitarian relief efforts in Haiti on January 20, 2010. Over the course of seven weeks, the ship's U.S. military and civilian medical personnel treated 871 patients, receiving one patient every six to nine minutes at the height of the effort. COMFORT's medical staff also performed 843 surgeries aboard the ship during the mission, treating more than 540 critically injured earthquake survivors within the first 10 days. The hospital ship ran 10 operating rooms at full capacity to care for injured earthquake survivors requiring surgical care.

Before departing Haitian waters, the COMFORT off-loaded $2.5 million in relief supplies to help land-based medical treatment centers sustain follow-on care *(http://www.america.gov/st/text-trans-english/2010/March/20100309160950eaifas0.0267145.html).*

Learning and Growth

Humana Military Healthcare Services Receives URAC Reaccreditation for Web Site

Humana Military Healthcare Services received re-accreditation for its Web site from health care accrediting organization URAC. Washington, D.C.-based URAC establishes quality standards for the health care industry. The accreditation is based on the Web site's health content, policies, and procedures, disclosure, external linking, and privacy.

Behavioral Health Communications Garner Awards for TRICARE

TMA received honors for mental and behavioral health care communications in the annual League of American Communications Professionals (LACP) 2009 Magellan Awards Communications Campaign Competition. TRICARE received the "Best Campaign on a Limited Budget" award, a gold award in the Community Relations category, and was selected for third place in the top 50 campaigns worldwide. The 2009 Magellan awards included nearly 400 government agencies, major corporations, and public relations firms worldwide.

MHS IT Awards

Government Computer News (GCN) honored three distinct MHS leaders and programs at the GCN Awards Gala. The annual event honors the men and women of government technology who have shown innovation and excellence in their achievements.

DoD's Patient Movement Items Tracking System (PMITS) received the 2009 Agency IT Award for outstanding achievement in the application of information technology.

The MHS webmaster received the 2009 "Rising Star" award for work successfully integrating various Web sites into one organizational site. The site, which received virtually zero visits in 2007, has averaged 190,000 hits a month this year.

The Defense Health Information Management System's AHLTA-Mobile and AHLTA-Theater product teams received an honorable mention award for outstanding information technology achievement in government.

First Overseas DoD Research Laboratory to Receive College of American Pathologists Laboratory Accreditation

The Navy medical research facility in Cairo, NAMRU-3 (Naval Medical Research Unit No. 3), is the first overseas DoD research laboratory to receive College of American Pathologists Laboratory Accreditation. NAMRU-3 serves as a World Health Organization reference laboratory for influenza and meningitis research in the eastern Mediterranean region.

The CAP-certified laboratory will serve as the premier training ground for future technicians throughout the eastern Mediterranean region. The mission of NAMRU-3 is to conduct infectious disease research (including the evaluation of vaccines, therapeutic agents, diagnostic assays, and vector control measures) and to carry out public health activities, principally aimed toward improved disease surveillance and outbreak response assistance.

Data Safeguards and Protections

TMA Privacy Office programs and activities have advanced TMA's ability to protect beneficiary information, fostered unprecedented levels of information sharing between DoD and other national health care entities, and responded to new and emerging data protection and information sharing challenges. During FY 2010, the TMA Privacy Office:

- Facilitated DoD's participation in the Nationwide Health Information Network through the development of the Data Use and Reciprocal Support Agreement (DURSA), eliminating the need for multiple point-to-

point data exchange agreements and enabling appropriate electronic health information exchanges in compliance with applicable information privacy and security laws.

- Played a leading role in defining privacy requirements and assuring that privacy safeguards, policies, and procedures are considered by system developers and policy makers throughout development and implementation stages of national emerging technologies, including the Virtual Lifetime Electronic Record (VLER), DoD Electronic Health Record Way Ahead, and the Nationwide Health Information Network.
- Enhanced regulatory compliance, expedited the processing of data requests, and fostered the use of MHS data through the establishment of a Research Data Identification Workgroup.
- Assumed a leadership role in assuring the integration of information privacy policies and practices associated with the successful opening of the Federal Health Care Center (FHCC), an integrated DoD and Veterans Health Administration treatment facility in Illinois.
- Expanded education and training programs through the Assist Visit Program, providing on-site assistance and enhanced process improvements for safeguarding beneficiary information.

BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2011[1]

Total Beneficiaries	9.6 million[2]
Military Facilities—Direct Care System	**Total[3] U.S.**
Inpatient Hospitals and Medical Centers	59 (44 in U.S.)
Ambulatory Care Clinics	363 (291 in U.S.)
Dental Clinics	281 (213 in U.S.)
Veterinary Facilities	255 (199 in U.S.)
Military Health System Personnel	138,224
Military	84,946 31,392 officers 53,554 enlisted
Civilian	53,278
Civilian Resources—Purchased Care System	
Network Individual Providers (primary care, behavioral health, and specialty care providers)	379,233
TRICARE Network Acute Care Hospitals	3,146
Contracted (Network) Retail Pharmacies	63,775
Contracted Worldwide Pharmacy Home Delivery Vendor	1
TRICARE Dental Program (TDP) (for Active Duty families, Reservists and families)	Almost 800,000 covered lives
Network dentists	65,099 52,711 general dentists 12,388 specialists
TRICARE Retiree Dental Program (for retired uniformed Service members and families)	Almost 1.2 million covered lives
Dental provider offices (includes general and specialty dental practices)	136,841
Total Unified Medical Program (UMP)	$50.9 billion[4]
(Includes FY 2011 receipts for Accrual Fund)	$11.0 billion

[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 2011 is 9,630,444, rounded to 9.6 million, based on the Managed Care Forecasting and Analysis System (MCFAS), OASD(HA) Acting CFO Memo, dated November 22, 2010.

[3] MTF data from real property reports, Office of the Chief Financial Officer, December 20, 2010.

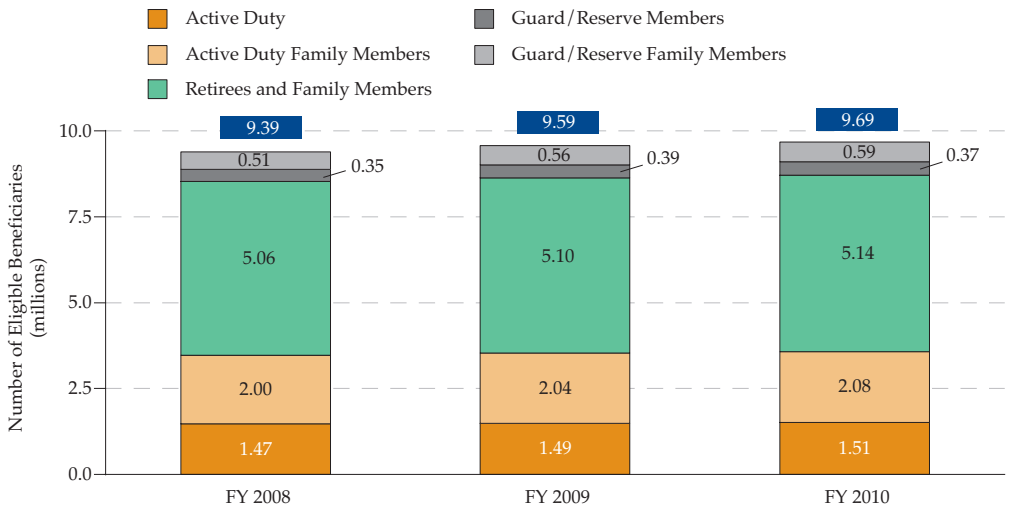
[4] Includes direct and private sector care funding, military personnel, military construction, and the Medicare-Eligible Retiree Health Care Fund (MERHCF) ("accrual fund") DoD Normal Cost Contribution paid by the U.S. Treasury.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Number of Eligible and Enrolled Beneficiaries Between FY 2008 and FY 2010

The number of beneficiaries eligible for DoD medical care (including TRS) increased from 9.39 million at the end of FY 2008 to 9.69 million* at the end of FY 2010. 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-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP

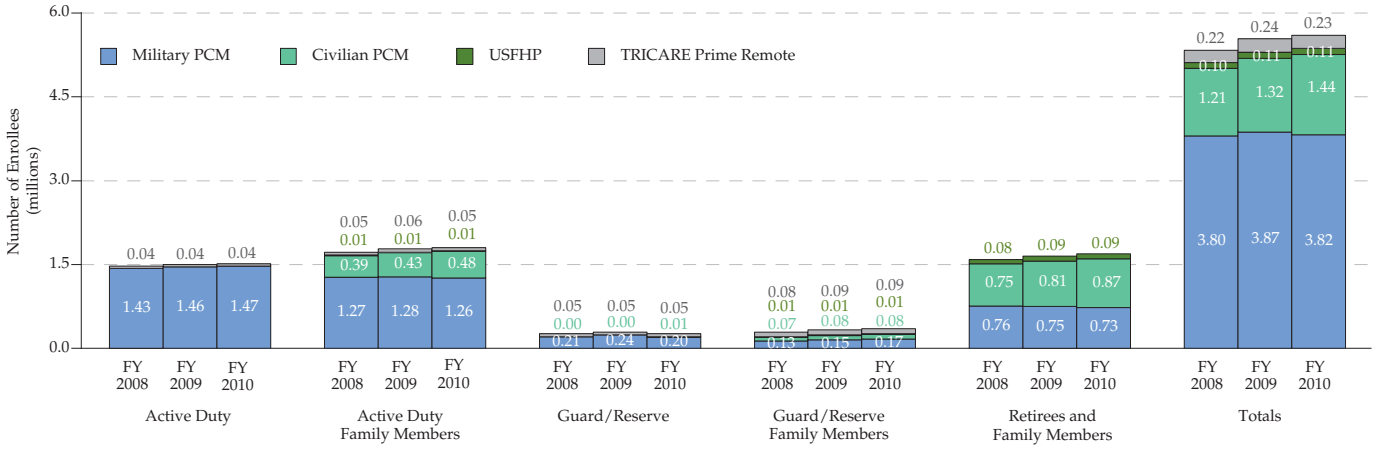


Source: DEERS 12/28/2010

* 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 2011 total, whereas the population reported on this page is the actual for the end of FY 2010.

- As MTF capacity remained tight, more enrollees (especially retirees) were assigned to civilian PCMs.
- TRICARE Prime Remote (TPR) enrollment grew by 8 percent from FY 2008 to FY 2010, due largely to increased enrollment of Guard/Reservists and their family members.

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



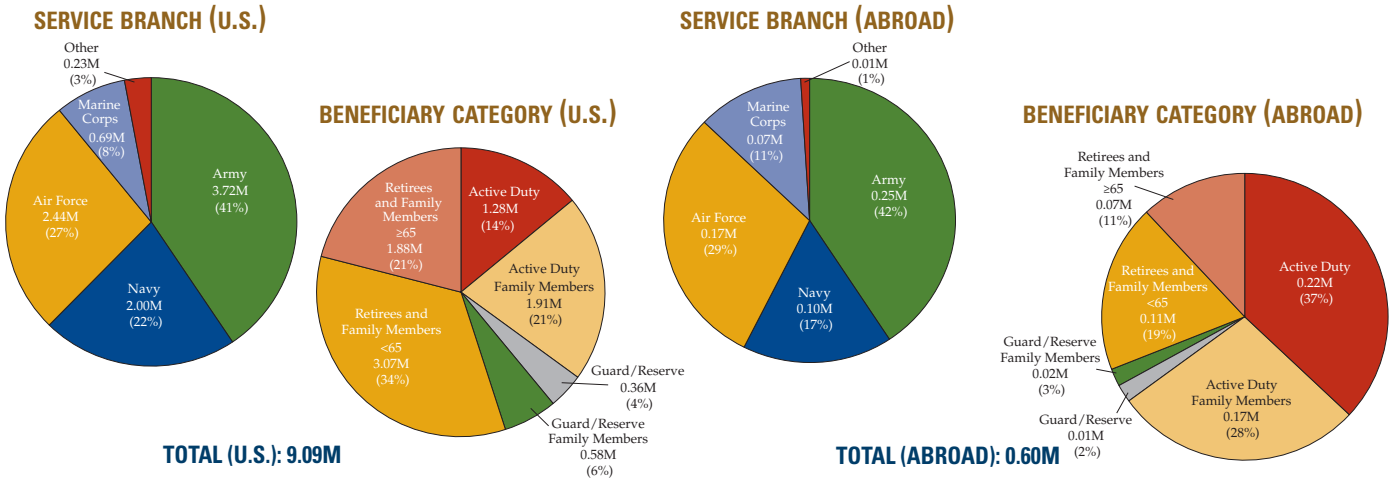
Source: DEERS 12/28/2010

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Eligible Beneficiaries in FY 2010

- Of the 9.69 million eligible beneficiaries at the end of FY 2010, 9.09 million (94 percent) were stationed or resided in the United States (U.S.) and 0.60 million were stationed or resided 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 constitute the largest percentage of the eligible population (55 percent) in the U.S., Active Duty personnel (including Guard/Reserve Component members on Active Duty for at least 30 days) and their family members make up the largest percentage (70 percent) of the eligible population abroad. The U.S. MHS population is presented at the state level on page 95, 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.

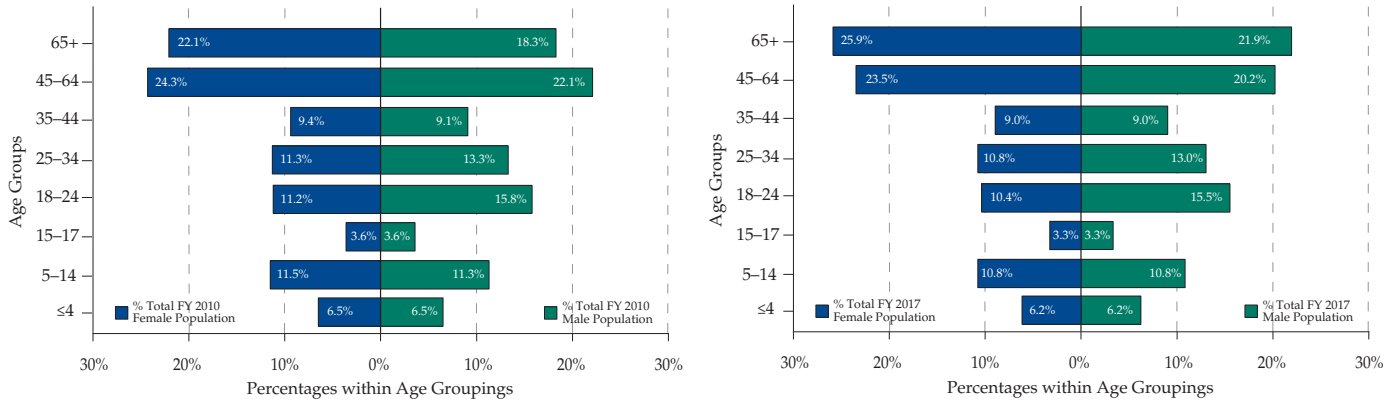
BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS AT THE END OF FY 2010



Source: DEERS, 12/28/2010

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

MHS END-YEAR POPULATION BY AGE AND GENDER: FY 2010 AND FY 2017



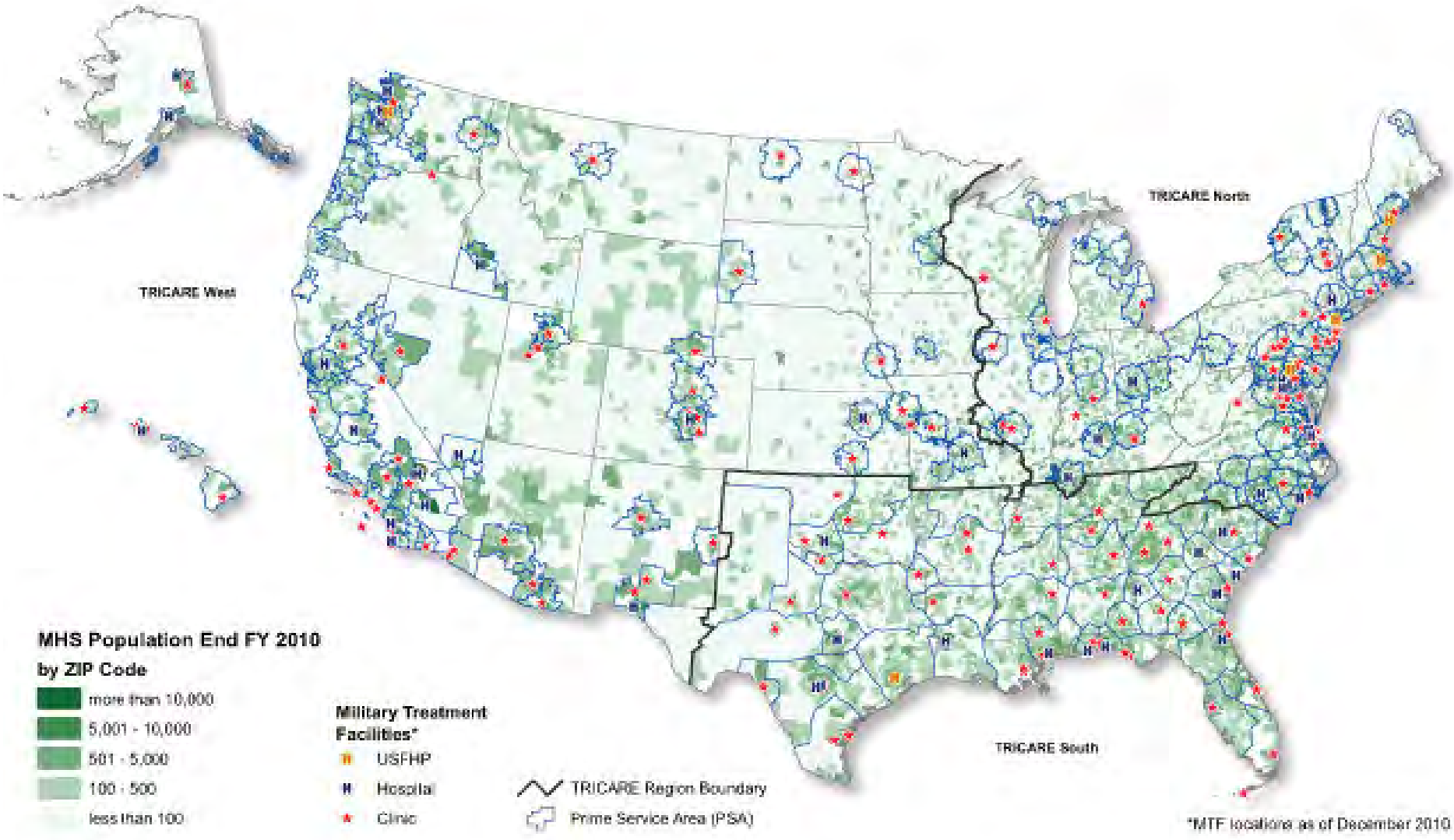
TOTAL MHS POPULATION (IN MILLIONS) BY AGE AND GENDER: CURRENT FY 2010 AND PROJECTED FY 2017

	Age Group								Total by Gender	Total MHS Population
	≤4	5–14	15–17	18–24	25–34	35–44	45–64	≥65		
FY 2010 Female MHS Beneficiaries	0.31	0.54	0.17	0.53	0.54	0.45	1.15	1.04	4.72	9.69
FY 2010 Male MHS Beneficiaries	0.32	0.56	0.18	0.78	0.66	0.45	1.10	0.91	4.96	9.69
FY 2017 Female MHS Beneficiaries, Projected	0.29	0.50	0.15	0.48	0.50	0.41	1.09	1.20	4.63	9.43
FY 2017 Male MHS Beneficiaries, Projected	0.30	0.52	0.16	0.75	0.62	0.43	0.97	1.05	4.80	9.43

Source: MCFAS, as of 12/28/2010

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs IN FY 2010



Source: MTF information from TMA Portfolio Planning Management Division (12/21/2010); residential population and Geographic Information Systems information from TMA/Health Program Analysis and Evaluation and DEERS 10/27/2010

The entire TRICARE Region South is considered a Prime Service Area, and Hawaii is also considered a PSA in its entirety and is part of TRICARE Region West.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Locations of U.S. MTFs (Hospitals and Ambulatory Care Clinics) in FY 2010

The map on the previous page shows the geographic dispersion of the approximately 9.1 million beneficiaries eligible for the TRICARE benefit residing within the United States (94 percent of the almost 9.7 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 to the Designated Provider Program benefit of the Uniformed Services Family Health Plan (USFHP). As provided by law, DoD has contracted with certain former U.S. Public Health Service hospitals to be TRICARE Prime designated providers. The 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.

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, 10/27/2010

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

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.

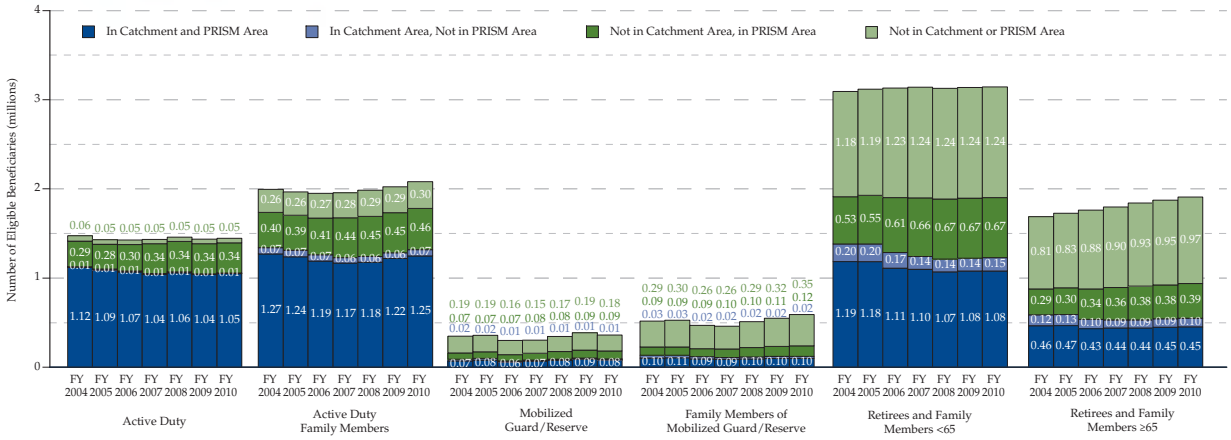
Because of Base Realignment and Closure (BRAC) actions, other facility closings and downsizings, and changes in the beneficiary mix over time, there has been a downward trend in the proportion of beneficiaries living in catchment areas (from 51 percent in FY 2004 to 46 percent in FY 2010). The percentage 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 2004–2010 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).
- After declining for several years, the number of Active Duty family members living in catchment areas had increased to almost its FY 2004 level by FY 2010.
- The number of retirees and family members living in catchment areas has leveled off after several years of declines.
- There has been a steady increase in the number of beneficiaries living in noncatchment PRISM areas.
- The mobilizations of National Guard and Reserve members have contributed disproportionately to the total number of beneficiaries living in noncatchment areas. Most Guard/Reserve members already live in noncatchment areas when recalled to Active Duty and their families continue to live there.

[1] The distance-based catchment and PRISM area concepts have been superseded within 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.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

TREND IN THE NUMBER OF ELIGIBLE BENEFICIARIES LIVING IN AND OUT OF MTF CATCHMENT AND PRISM AREAS (END-YEAR POPULATIONS)



Source: DEERS, 12/28/2010

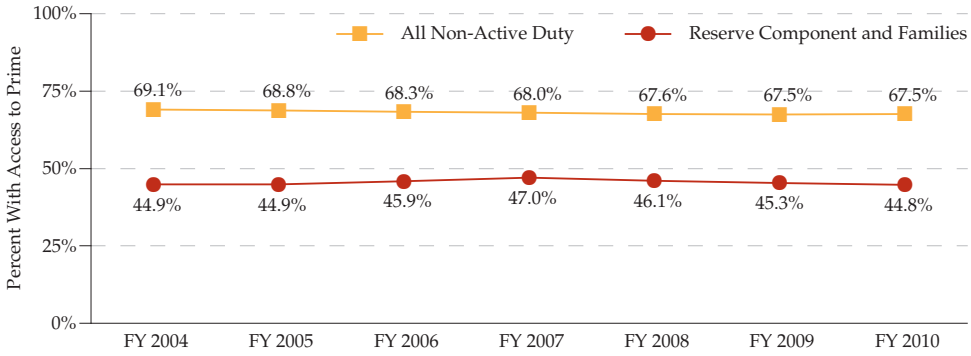
Note: In catchment and PRISM area refers to the area within 20 miles of a military hospital; it indicates proximity to both inpatient and outpatient care. In catchment, not in PRISM area refers to the area beyond 20 but within 40 miles of a military hospital; it indicates proximity to inpatient care only. Not in catchment, in PRISM area refers to the area within 20 miles of a freestanding military clinic (no military hospital nearby); it indicates proximity to outpatient care only. Not in catchment, or PRISM area 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 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 percentage of beneficiaries with access to MTF-based Prime (i.e., those living in a catchment or PRISM area) declined from 69.1 percent of the eligible non-Active Duty population (ADFMs and retirees and family members under age 65) in FY 2004 to 67.5 percent in FY 2010. The decline is largely due to the closings of military hospitals and clinics over that time period. Reserve Component members with access to MTF-based Prime increased steadily from FY 2004 to FY 2007 but have since declined to their FY 2004 level.

TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME



Source: DEERS 12/28/2010

- 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 ("noncatchment PSAs").
- The map on page 18 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 MCSCs have identified as a noncatchment PSA all portions of the region that lie outside MTF and BRAC PSAs.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

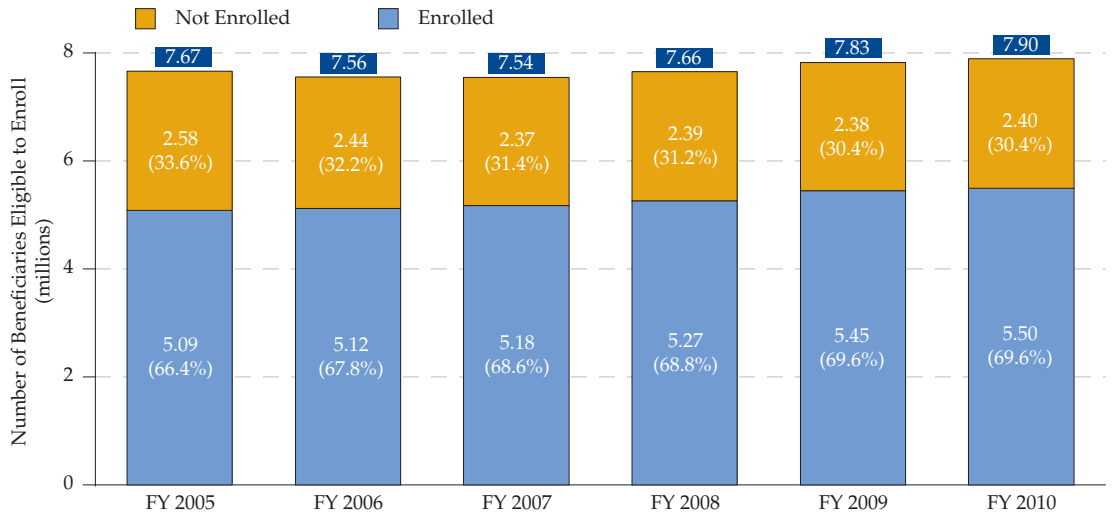
Eligibility and Enrollment in TRICARE Prime

Eligibility for and enrollment in TRICARE Prime was determined from the Defense Enrollment Eligibility Reporting System (DEERS). For the purpose of this 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 slowly but steadily increased since FY 2005.
- Enrollment in TRICARE Plus (not shown) has remained flat since FY 2005. This is likely due to limited capacity for TRICARE Plus enrollment at many MTFs.
- By the end of FY 2010, 70 percent of all eligible beneficiaries were enrolled (5.5 million enrolled of the 7.9 million eligible to enroll).

HISTORICAL END-YEAR ENROLLMENT NUMBERS



Source: DEERS, 12/28/2010

Note: Numbers may not sum to bar totals due to rounding. Detailed MHS enrollment data by state can be found in the Appendix, page 95.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

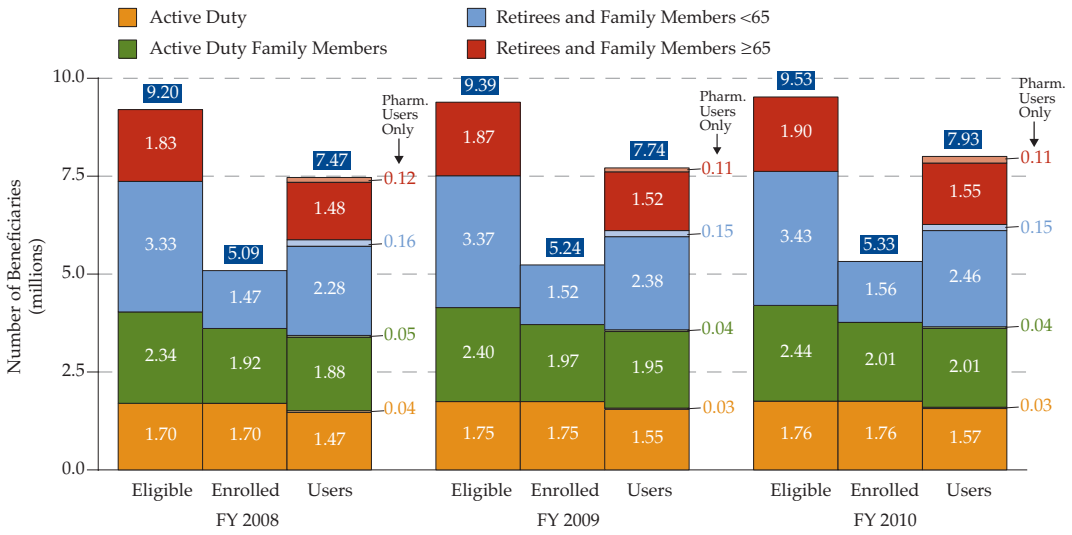
Recent Three-year Trend in Eligibles, Enrollees, Users

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 2008 to FY 2010 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. USFHP enrollees are excluded from both the eligible and enrollment counts because we did not have information on users of that plan.

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 2008 and FY 2010. Active Duty family members increased at the fastest rate of any beneficiary group (4.3 percent).
- The percentage of retirees and family members under age 65 enrolled in TRICARE Prime increased slightly, from 44 percent in FY 2008 to 45 percent in FY 2010. The increase is likely due to formerly non-MHS-reliant retirees switching from private health insurance coverage to TRICARE (see page 78).
- The overall user rate grew from 81.2 percent in FY 2008 to 83.2 percent in FY 2010. 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 MHS but the lowest user rate. Their MHS utilization rate is lower because many of them have Other Health Insurance (OHI).

AVERAGE NUMBERS OF FY 2008 TO FY 2010 ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY

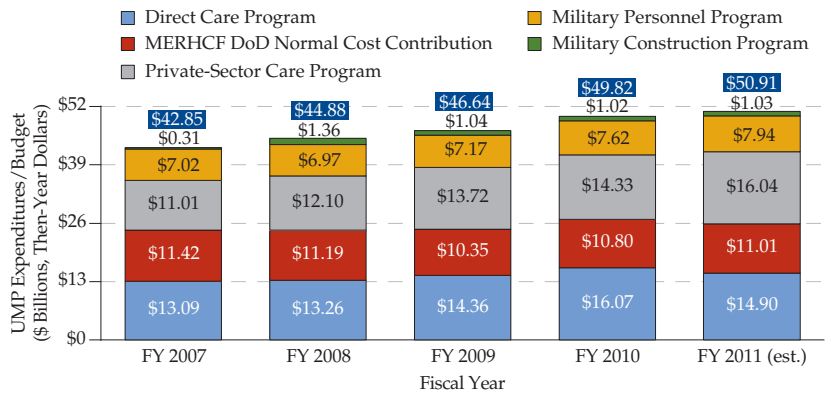


Sources: DEERS and MHS administrative data, 12/28/2010

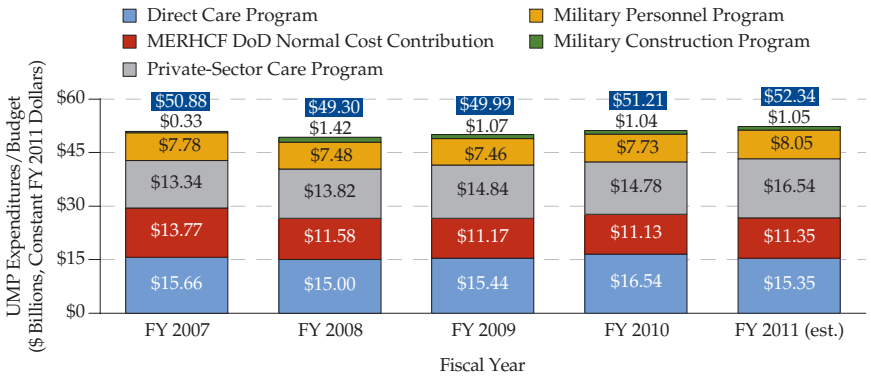
Note: Numbers may not sum to bar totals due to rounding. The bar totals reflect the average number of eligibles and enrollees, not the end-year numbers displayed in previous charts, to account for beneficiaries who were not eligible or enrolled for the entire year.

UNIFIED MEDICAL PROGRAM FUNDING

FY 2007 TO FY 2011 (EST.) UNIFIED MEDICAL PROGRAM ($ BILLIONS) IN UNADJUSTED, THEN-YEAR DOLLARS



FY 2007 TO FY 2011 (EST.) UNIFIED MEDICAL PROGRAM ($ BILLIONS) IN CONSTANT FY 2011 DOLLARS



Source: Cost and Budget Estimates OASD(HA)/OCFO as of 1/12/2011

As shown in the first chart to the left, in terms of unadjusted expenditures (i.e., "then-year" dollars, unadjusted for inflation), the UMP increased 16 percent from almost $43 billion in FY 2007 to nearly $50 billion in FY 2010, and is currently programmed for almost $51 billion (estimated) in FY 2011 (as reflected in the FYs 2007–2011 Budget Requests). Over half of the $8 billion growth in total expenditures from FY 2007 to the projected FY 2011 budget is in the private sector, purchased care component of the UMP. The FY 2007 to FY 2011 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.

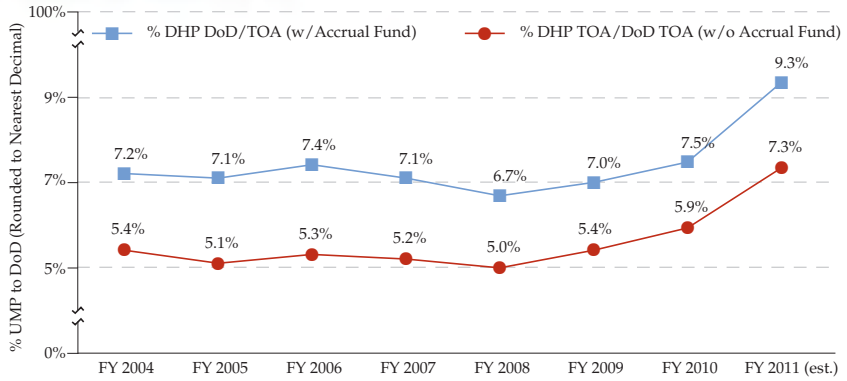
In constant-year FY 2011 dollar funding, when actual expenditures or projected funding are adjusted for inflation, the FY 2011 purchasing value ($52.3 billion) is currently programmed to be approximately the same as the FY 2007 purchasing value of $50.9 billion.

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

1. The DoD Medicare-Eligible Retiree Health Care Fund (MERHCF), also referred to herein as the "Accrual Fund," implemented in FY 2003, is an accrual fund that pays for health care provided in DoD/Coast Guard facilities to DoD retired, dependent of retired, and survivors who are Medicare-eligible beneficiaries. The fund also supports purchased care payments through the TFL benefit first implemented in FY 2002. There are three forms of contribution to Defense health care: (1) The accrual fund ($11B), the normal cost contribution funded by the UMP at the beginning of each fiscal year 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) $9.8B is paid by the Treasury to fund future health care liability accrued prior to October 1, 2002, for retired, Active Duty, Guard, and Reserves and their family members when they become retired and Medicare-eligible; and (3) $9.5B 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—$7.7B for purchased care, $1.8B for direct [MTF] care, both Operations and Maintenance as well as Military Personnel costs).
2. FYs 2007–2010 reflect Comptroller Information System actual execution.
3. FY 2007 actuals include supplementals ($1.2M) supporting Global War on Terrorism (GWOT) and other programs such as Traumatic Brain Injury/Psychological Health (TBI/PH), Wounded Warrior and Pandemic Influenza.
4. FY 2008 actuals include $1.454B O&M supplemental funding in support of GWOT.
5. FY 2009 actuals include Overseas Contingency Operations (OCO) and additional supplemental funding for Operations and Maintenance (O&M), Procurement, and Research, Development, Test and Evaluation (RDT&E).
6. FY 2010 current estimate includes O&M funding of $1,256.7 million in support of OCO requirements and $140.0 million ($132.0 million for O&M and includes $8.0 million for RDT&E) transferred from the Department of Health and Human Services for Pandemic Influenza Preparedness and Response.
7. FY 2011 includes $1.4B OCO supplemental funding for O&M.

UNIFIED MEDICAL PROGRAM FUNDING *(CONT'D)*

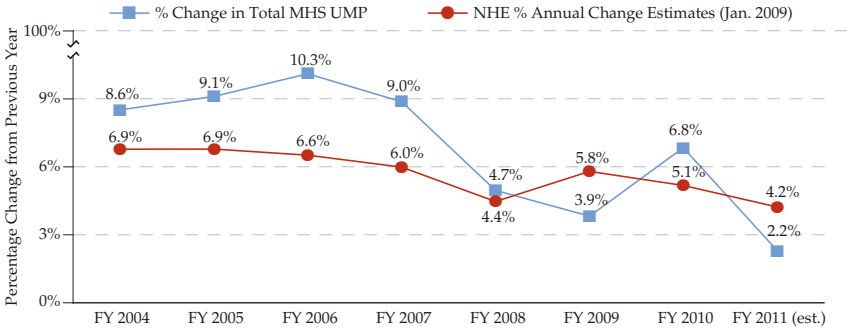
UMP EXPENDITURES AS A PERCENTAGE OF DEFENSE BUDGET: FY 2004 TO FY 2011 (EST.)



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 9.3 percent estimated for FY 2011, including the Accrual Fund (as currently reflected in the FYs 2008–2015 President's Budget Estimates). When the Accrual Fund is excluded, the UMP's share is expected to increase from 5.4 percent in FY 2004 to 7.3 percent in FY 2011.

COMPARISON OF CHANGE IN ANNUAL UMP AND NHE EXPENDITURES OVER TIME: FY 2004 TO FY 2011 (EST.)



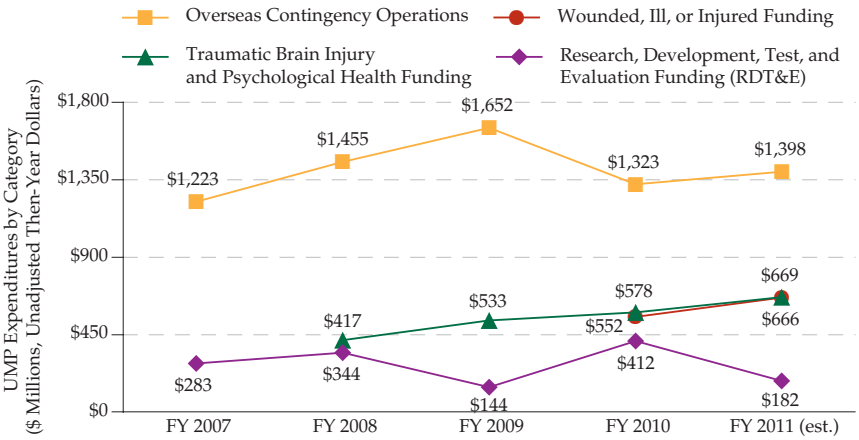
Sources:

1. Centers for Medicare and Medicaid Services, Table 1, National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Calendar Years 2004–2019.
2. *Https://www.cms.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp.* The health spending projections were based on the 2008 version of the NHE released in January 2010, updated to take into account the impact of health reform and other relevant legislation and regulatory changes (base year = 2005), 11/16/2010.

Comparison of Unified Medical Program and National Health Expenditures Over Time

The U.S. Department of Health and Human Services (DHHS) estimates that, while National Health Expenditures (NHE) will continue to increase over time, the projected rate of growth will decline by almost 3 percentage points from FY 2004 to FY 2011. NHE expenditures are projected to remain between 4 and 5 percent through FY 2011. The annual rate of growth in the UMP increased from FY 2004 to FY 2006, reaching a peak of 10 percent growth in FY 2006, and declining to between 4 and 6 percent growth in the past three years. FY 2011 is currently projected to be 2 percent larger than FY 2010.

MEDICAL COST OF WAR—CARING FOR OUR WOUNDED, ILL, OR INJURED



Source: Cost and budget estimates OASD(HA)/OCFO, 1/12/2011

Notes:

1. Traumatic Brain Injury and Psychological Health expenditures shown for FY 2008 include FY 2007 and FY 2006.
2. The Wounded, Ill, or Injured funding line is included in overall OCO funding from FY 2007 to FY 2009 but is identified separately beginning in FY 2010.

Medical Cost of War—Caring for Our Wounded, Ill, or Injured

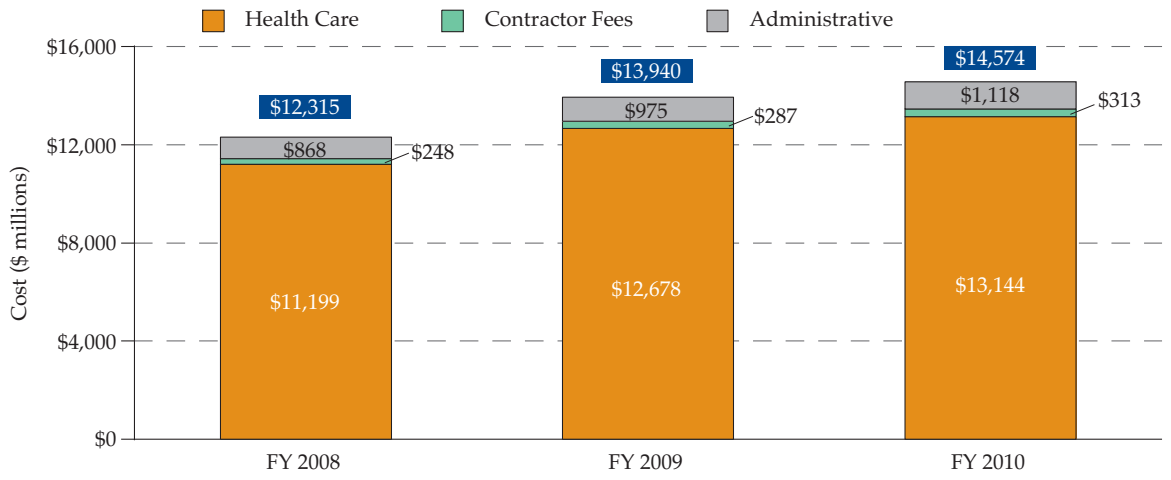
The graph at left reflects the total actual Defense Health Program (DHP) funding for overseas contingency operations (OCO) since FY 2007 (top line). This is a unique funding source that is included in the previous expenditure/budget data. In addition, DHP funds spent specifically for care for traumatic brain injury, wounded ill or injured, and psychological health, as well as research and development, are reflected in the lower lines (these funds are within the DHP operations and maintenance funding line, and are also included in the earlier budget chart, but are not included in the OCO funding line in this chart).

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 OCO, funds authorized and executed under the DHP carryover authority, and other miscellaneous expenses. It excludes costs for non-DoD beneficiaries and MERHCF expenses.

- Total private sector care costs grew from $12,315 million in FY 2008 to $14,574 million in FY 2010, an increase of 18 percent. Private sector health care costs grew by 17 percent whereas administrative costs grew by 29 percent and contractor fees by 26 percent.
- Excluding contractor fees, administrative expenses increased from 7.2 percent of total private sector care costs in FY 2008 ($868M of $12,067M) to 7.8 percent in FY 2010 ($1,118M of $14,261M). Including contractor fees (in both administrative and total costs), administrative expenses increased from 9.1 percent of total private sector care costs in FY 2008 ($1,116M of $12,315M) to 9.8 percent in FY 2010 ($1,431M of $14,574M).

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, 11/3/2010

Note: The FY 2008, FY 2009, and FY 2010 totals in the chart above are greater than the Private Sector Care Program costs because the former include carryover funding. TMA has congressional authority to carry over a certain percentage of funding into the following year. The FY 2008, FY 2009, and FY 2010 amounts carried forward from the prior year appropriation were $212M, $226M, and $246M, respectively. The amount authorized to be carried over from year to year historically had 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)

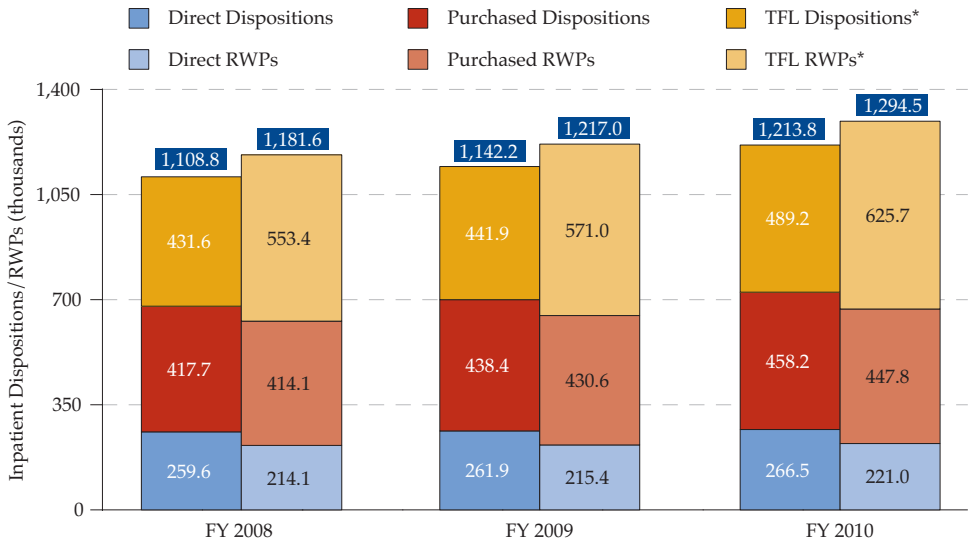
MHS Inpatient Workload

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. In FY 2010, TRICARE implemented the Medicare Severity Diagnosis Related Group (MS-DRG) system of classifying inpatient hospital cases to conform with changes made to the Medicare Prospective Payment System. The new DRG classifications resulted in a corresponding change in the calculation of RWPs, which has been applied to the data from FY 2008 to FY 2010.

Total inpatient dispositions (direct and purchased care combined) increased by 7 percent between FY 2008 and FY 2010, whereas RWPs increased by 6 percent, excluding the effect of TFL.

- Direct care inpatient dispositions and RWPs each increased by 3 percent over the past three years.
- Excluding TFL workload, purchased care inpatient dispositions increased by 10 percent and RWPs by 8 percent between FY 2008 and FY 2010.
- Including TFL workload, purchased care dispositions increased by 12 percent and RWPs by 11 percent between FY 2008 and FY 2010.
- While not shown, about 8 percent of direct care inpatient dispositions and RWPs were performed abroad in FY 2010. 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, 1/13/2011

* Purchased care only

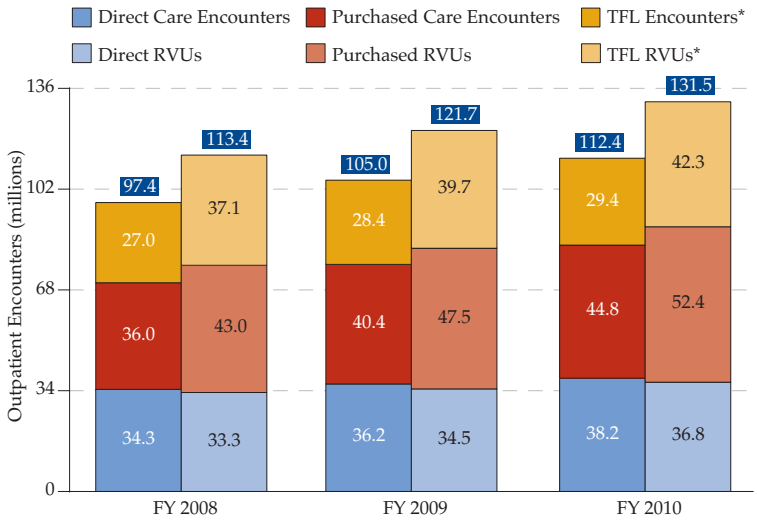
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT'D)*

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. In FY 2010, TRICARE developed an enhanced measure of RVUs that accounts for units of service (e.g., 15-minute intervals of physical therapy) and better reflects the resources expended to produce an encounter. The enhanced RVU measures have been applied to the data from FY 2008 to FY 2010.

Total outpatient workload (direct and purchased care combined) increased between FY 2008 and FY 2010 (encounters increased by 18 percent and RVUs by 17 percent), excluding the effect of TFL.

TRENDS IN MHS OUTPATIENT WORKLOAD



Source: MHS administrative data, 1/13/2011

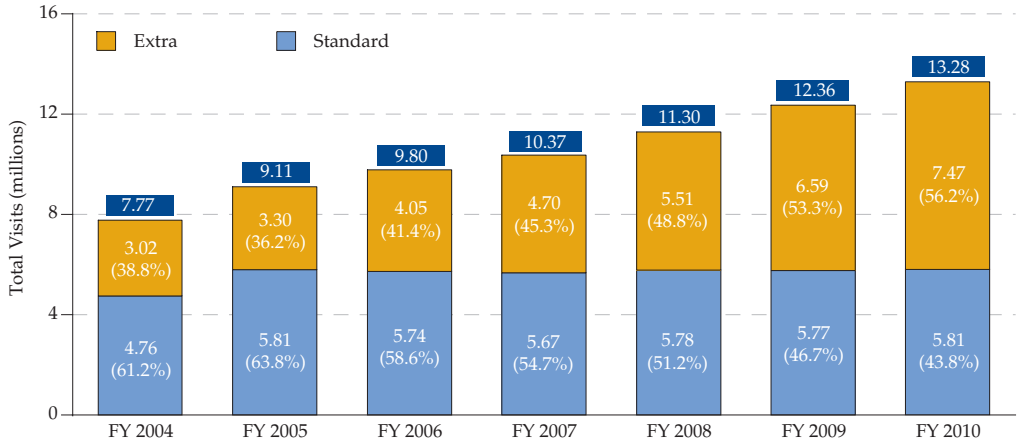
* Purchased care only.

- Direct care outpatient encounters and RVUs each increased by 11 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 24 percent and RVUs by 22 percent. Including TFL workload, encounters and RVUs each increased by 18 percent.
- While not shown, about 11 percent of direct care outpatient workload (both encounters and RVUs) was performed abroad. Purchased care and TFL outpatient workload performed abroad accounted for 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 2004, Extra visits accounted for only 39 percent of all non-Prime visits. By 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 (53 percent). In FY 2010, 56 percent of all non-Prime visits were to Extra providers.

TRENDS IN EXTRA VS. STANDARD VISITS



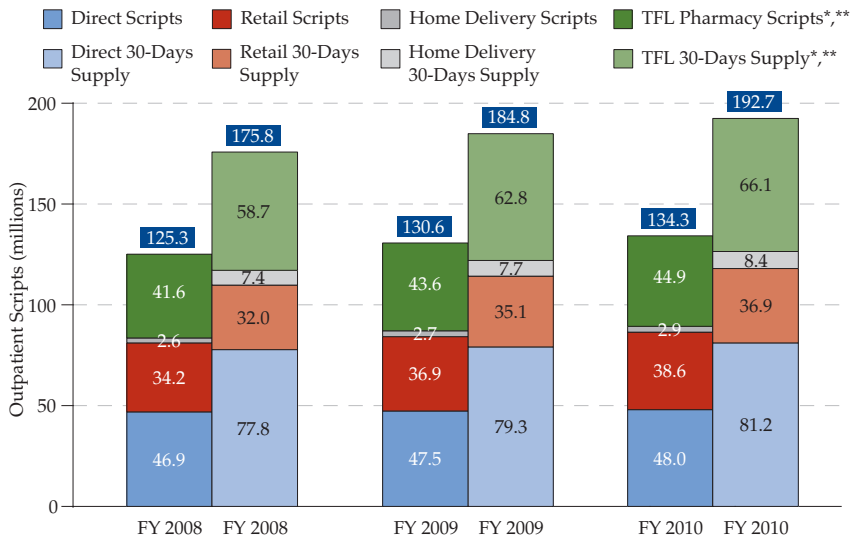
Source: MHS administrative data, 1/13/2011

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

MHS Prescription Drug Workload

TRICARE beneficiaries can fill prescription medications at MTF pharmacies, through home delivery (mail order), at TRICARE retail network pharmacies, and at non-network pharmacies. Total 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 (all sources combined) increased between FY 2008 and FY 2010 (prescriptions increased by 7 percent and days supply by 8 percent), excluding the effect of TFL purchased care pharmacy usage.

TRENDS IN MHS PRESCRIPTION WORKLOAD

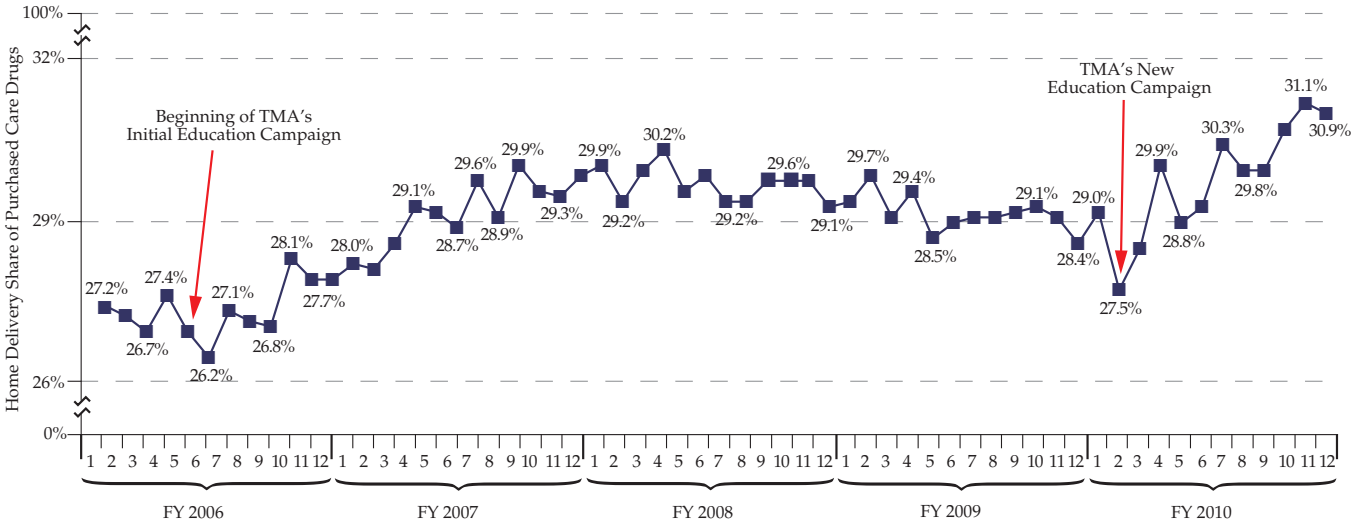


Source: MHS administrative data, 1/13/2011
* Home delivery workload for TFL-eligible beneficiaries is included in the TFL total. ** Purchased care only.

- Direct care prescriptions increased by 2 percent and days supply by 4 percent between FY 2008 and FY 2010.
- Purchased care prescriptions increased by 13 percent and days supply by 15 percent from FY 2008 to FY 2010, excluding TFL utilization. Including TFL utilization, purchased care prescriptions increased by 10 percent and days supply by 13 percent.
- While not shown, almost 7 percent of direct care prescriptions were issued abroad. Purchased care prescriptions issued abroad accounted for little more than 1 percent of the worldwide total.

Although TRICARE pharmacy home delivery services have been available to DoD beneficiaries since the late 1990s, they have never been heavily used. Home delivery of prescription medications 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 an education campaign in February 2006 to increase beneficiary awareness of the benefits offered by home delivery of prescription drugs. In November 2009, DoD consolidated its pharmacy services under a single contract (called TPharm) and launched another intensive campaign to further educate beneficiaries on the benefits of home delivery services.

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



Source: MHS administrative data, 1/13/2011

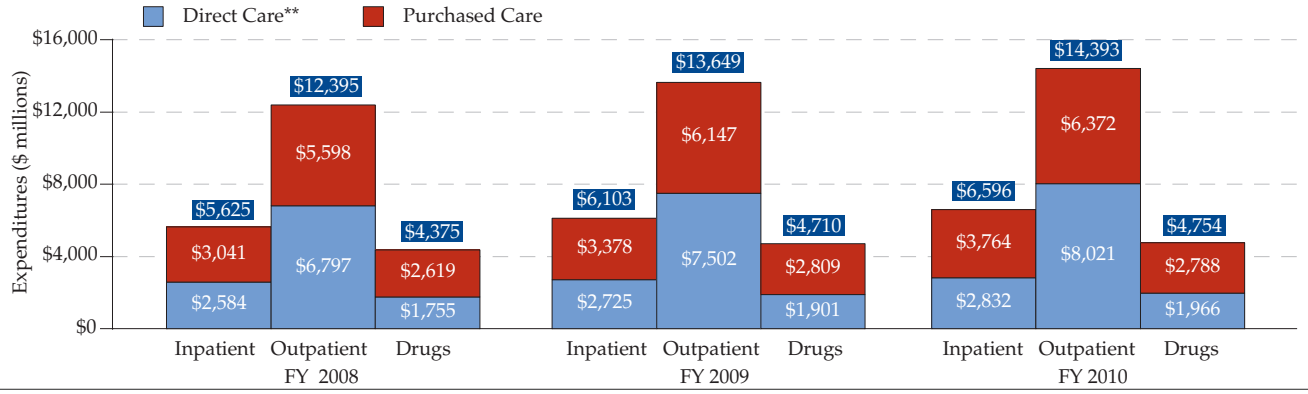
The home delivery share of total purchased care utilization had been steadily increasing from the inception of the initial TMA education campaign until January 2008, when it reached a peak. The home delivery share then gradually declined through November 2009, when it began a climb upward to a new peak in August 2010, presumably due to TMA's new education campaign.

MHS COST TRENDS

Total MHS costs (excluding TFL) increased between FY 2008 and FY 2010 for inpatient and outpatient services but declined for prescription drugs. The National Defense Authorization Act for FY 2008 mandated that the TRICARE retail pharmacy program be treated as an element of DoD and, as such, be subject to the same pricing standards as other Federal agencies. As a result, drug manufacturers began providing rebates to DoD on most brand-name drugs beginning in mid-FY 2009; this accounts for the decline in prescription drug costs in FYs 2009 and 2010. The proportion of total MHS costs accounted for by inpatient and outpatient services increased slightly, but the proportion accounted for by prescription drugs declined because of the rebates. Overall, direct care costs increased by 12 percent and purchased care costs increased by 17 percent.

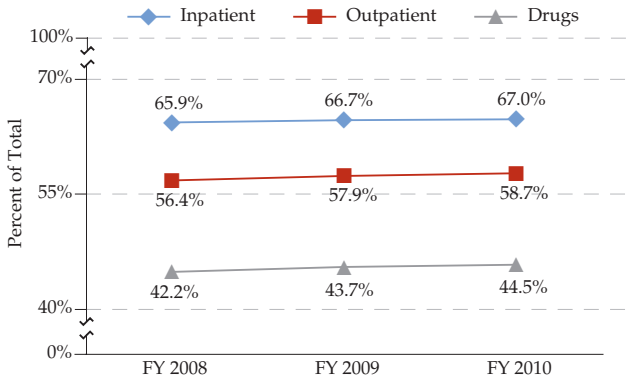
- The share of DoD expenditures on outpatient care relative to total expenditures on inpatient and outpatient care remained at 69 percent from FY 2008 to FY 2010. For example, in FY 2010, DoD expenses for inpatient and outpatient care totaled $20,989 million, of which $14,393 million was for outpatient care, for a ratio of $14,393/$20,989 = 69 percent.
- Increases in purchased care outpatient costs were mitigated somewhat by TRICARE's implementation of the Outpatient Prospective Payment System (OPPS) in May of 2009. The OPPS aligns TRICARE with current Medicare rates for reimbursement of hospital outpatient services.*
- In FY 2010, DoD spent $2.18 on outpatient care for every $1 spent on inpatient care.
- The proportion of total expenses for care provided in DoD facilities remained at about 50 percent from FY 2008 to FY 2010.

TREND IN DoD EXPENDITURES FOR HEALTH CARE (EXCLUDING TFL)

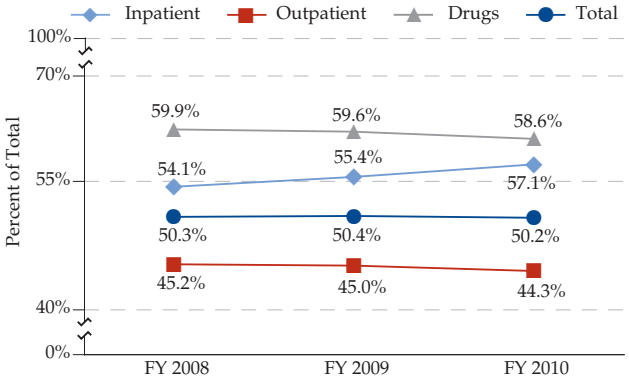


Source: MHS administrative data, 1/13/2011
* TMA News Release 09–35, May 19, 2009, accessed from *http://www.tricare.mil/pressroom/news.aspx?fid=527*
** Direct care prescription costs include an MHS-derived dispensing fee.

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, 1/13/2011
Note: TFL purchased care costs are excluded from the above calculations.

- The purchased care share of total inpatient utilization increased slightly from 66 percent in FY 2008 to 67 percent in FY 2010. The purchased care share of total outpatient utilization increased from 56 percent to 59 percent and the purchased care share of total prescription utilization increased from 42 to 45 percent.
- The purchased care share of total MHS inpatient costs increased from 54 percent in FY 2008 to 57 percent in FY 2010. For outpatient costs, the purchased care share declined slightly from 45 to 44 percent. The purchased care share of prescription drug costs also declined slightly, from 60 to 59 percent, but the decline was due solely to the drug rebates.

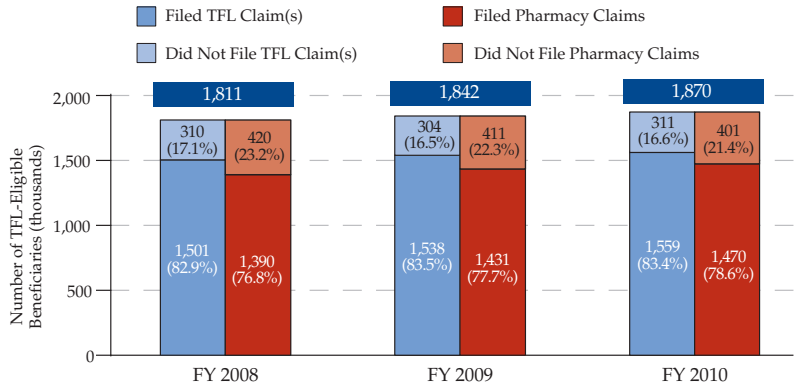
IMPACT OF TRICARE FOR LIFE IN FYs 2008–2010

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 1.87 million at the end of FY 2008 to 1.94 million at the end of FY 2010.
  - The percentage eligible for TFL remained about the same from FY 2008 to FY 2010. At the end of FY 2010, about 96 percent (1.87 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 (by either choice or ineligibility).

TFL-ELIGIBLE BENEFICIARIES FILING TFL HEALTH CARE AND PHARMACY CLAIMS IN FY 2008 TO FY 2010



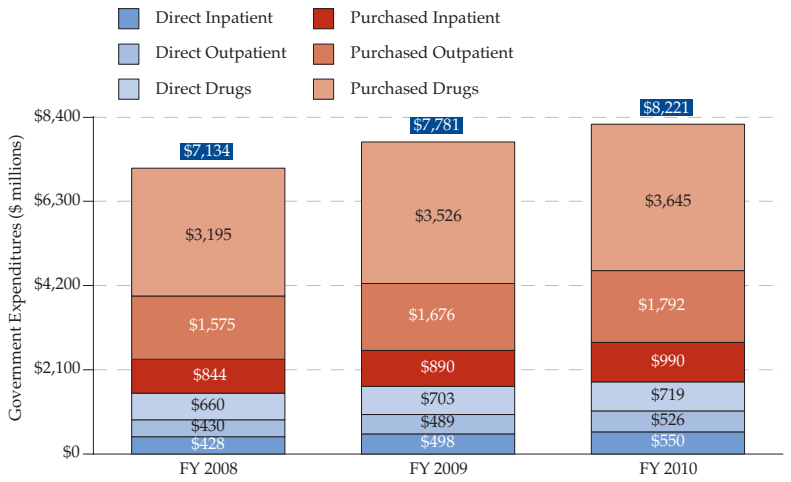
Source: MHS administrative data, 1/13/2011

- The percentage of TFL-eligible beneficiaries who filed at least one claim remained at about 83 percent between FY 2008 and FY 2010.
  - 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 77 percent in FY 2008 to 79 percent in FY 2010.

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 $7,134 million in FY 2008 to $8,221 million in FY 2010 (15 percent).

MERHCF EXPENDITURES FROM FY 2008 TO FY 2010 BY TYPE OF SERVICE



Source: MHS administrative data, 1/13/2011
* Direct care prescription costs include an MHS-derived dispensing fee.

- Total DoD direct care expenses for MERHCF-eligible beneficiaries increased by 18 percent from FY 2008 to FY 2010. The most notable increase was in direct inpatient expenses (28 percent).
  - From FY 2008 to FY 2010, 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 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FY 2008. That figure rose to 52 percent in FY 2010.
- Total purchased care MERHCF expenditures increased by 14 percent from FY 2008 to FY 2010. Inpatient expenditures rose by 17 percent, outpatient expenditures by 14 percent, and prescription drug expenditures by 14 percent.

PROVIDING A CARE EXPERIENCE THAT IS PATIENT AND FAMILY CENTERED, COMPASSIONATE, CONVENIENT, EQUITABLE, SAFE, AND OF THE HIGHEST QUALITY

Sustaining the benefit is anchored on a number of supporting factors, including access to, and promptness of, health care services, quality of health care, customer services, and communication with health care providers. This section enumerates several areas routinely monitored by 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 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) satisfaction with the health plan in general, as well as quality of health care, including physician and speciality care; (5) Joint Commission quality metrics in MTFs compared with Commission findings nationwide; and (6) access to and satisfaction with MTF care.

The health care surveys used by MHS and many commercial plans ask beneficiaries to rate various aspects of their health care. MHS beneficiaries who have used TRICARE are compared with the civilian benchmark. The civilian benchmark is based on health system performance metrics from the national Consumer Assessment of Healthcare Providers and Systems (CAHPS).

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

ACCESS TO MHS CARE

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

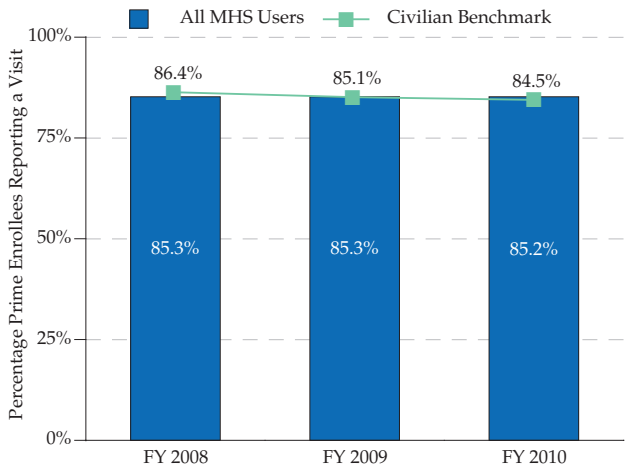
- Access based on reported use of the health care system in general
- Availability and ease of obtaining care and communicating with providers
- Responsive customer service
- Quality and timeliness of claims processing

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 2010.
- The MHS Prime enrollee rate exceeded the civilian benchmark in FY 2010.

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



Note: DoD data were derived from the FYs 2008–2010 HCSDB, as of 12/17/2010, 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 (NCBD). FY 2008 and part of FY 2009 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 NCBD. FY 2010 and part of FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared with the 2009 NCBD, the latest benchmark available.

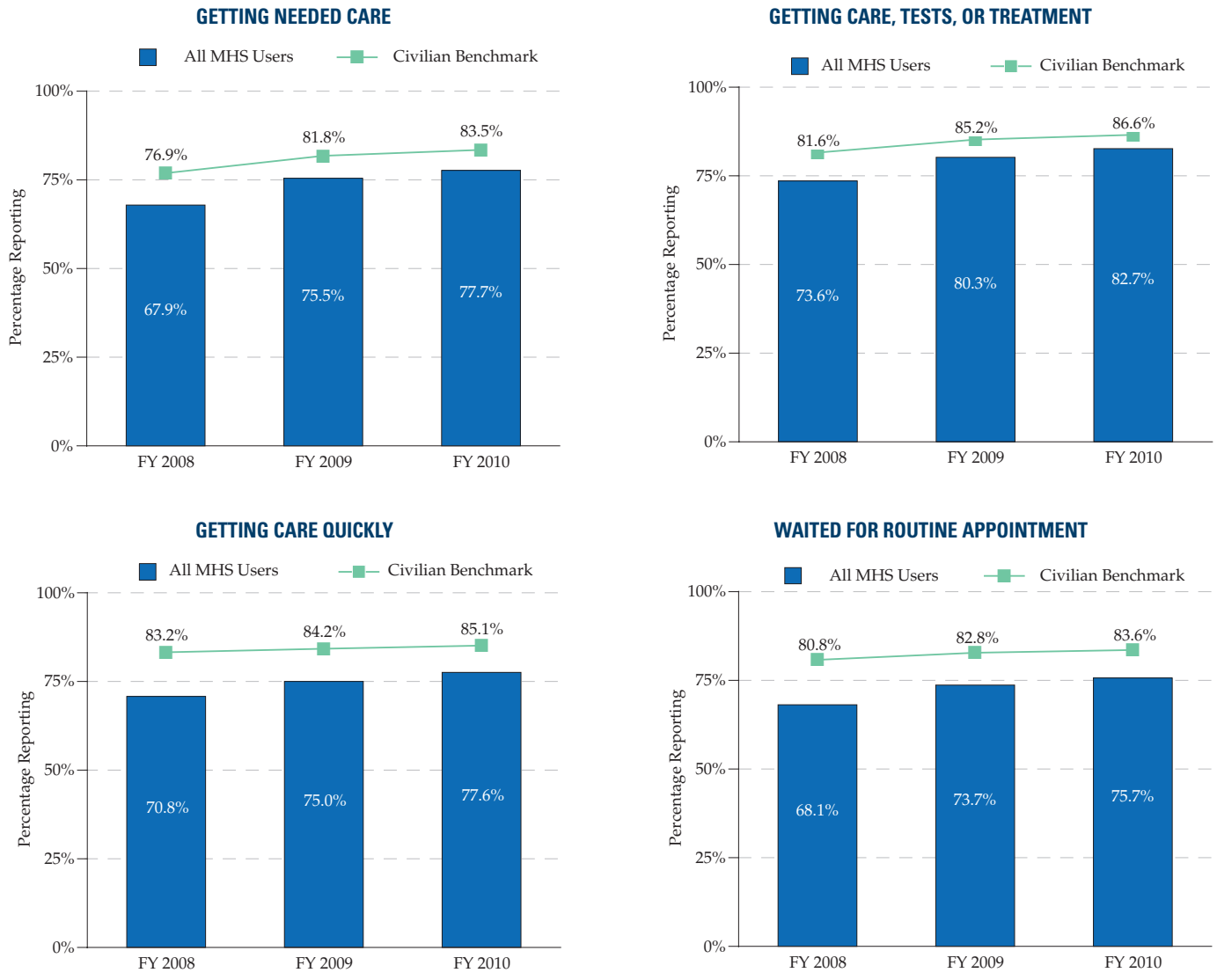
ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS *(CONT'D)*

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 2008 and FY 2010, 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 also improved between FY 2008 and FY 2010, but continued to lag the civilian benchmark.

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



Note: DoD data were derived from the FYs 2008–2010 HCSDB, as of 12/17/2010, 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 NCBD. FY 2008 and part of FY 2009 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 NCBD. FY 2010 and part of FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared with the 2009 NCBD, the latest benchmark available.

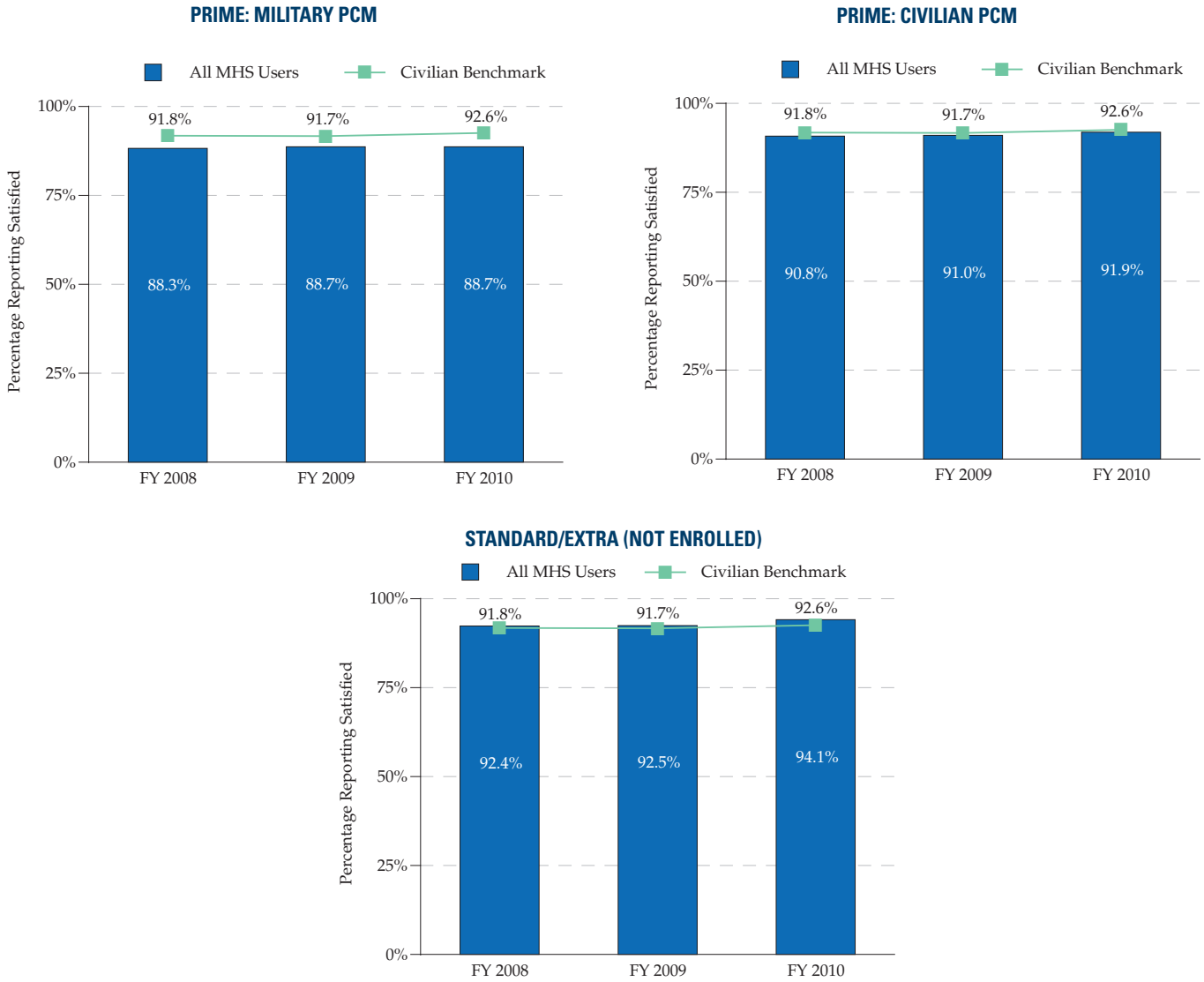
ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS *(CONT'D)*

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 remained stable between FY 2008 and FY 2010, but lagged the civilian benchmark, which was also stable during this period.
- Satisfaction levels of Prime enrollees with civilian PCMs with their providers equaled the civilian benchmarks (no statistically significant difference). Satisfaction levels of non-enrollees equaled the civilian benchmark in FYs 2008–2009 and exceeded the benchmark in FY 2010.

TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION



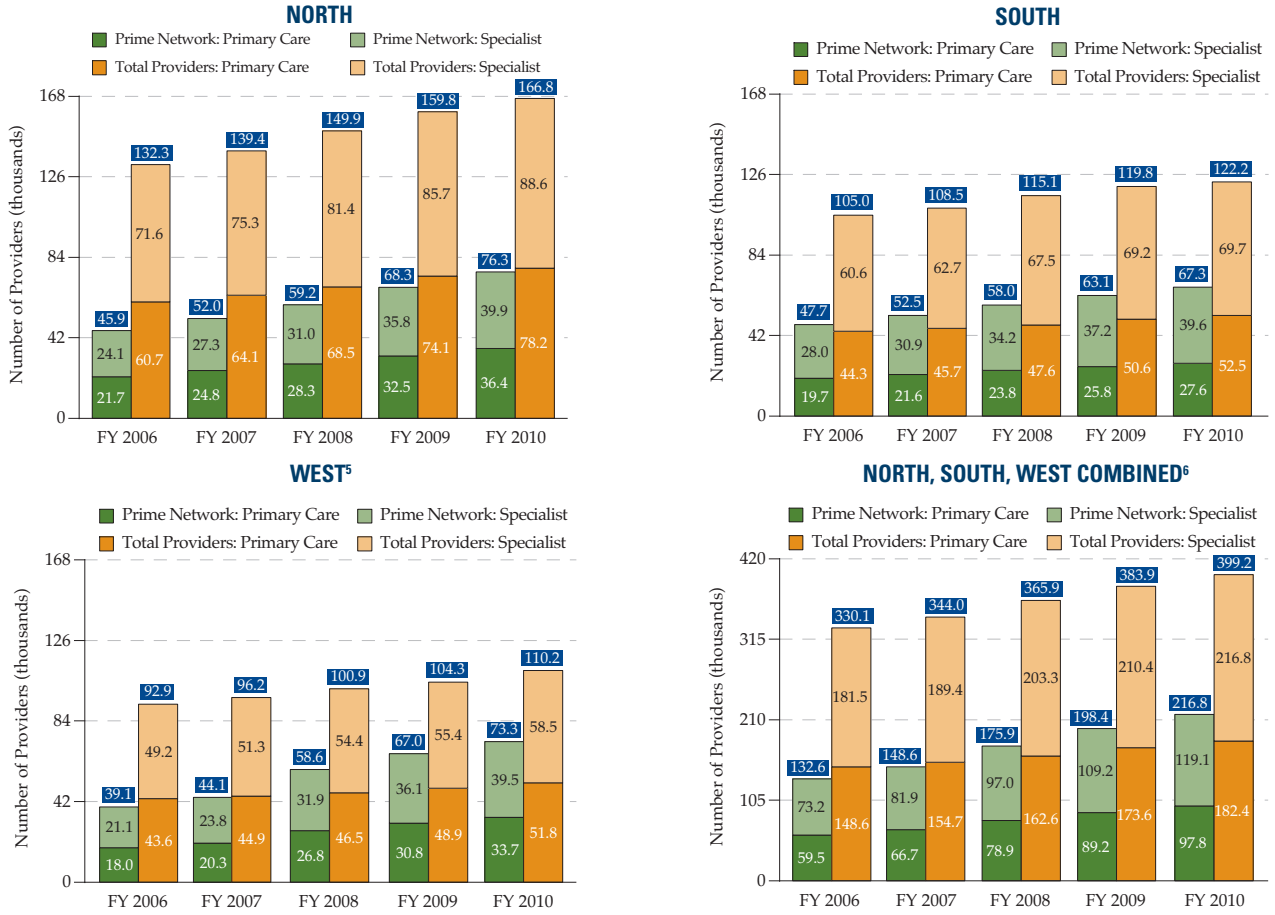
Note: DoD data were derived from the FYs 2008–2010 HCSDB, as of 12/17/2010, and adjusted for age and health status. Ratings are based on the percentage reporting "usually" or "always." "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Civilian benchmark is obtained from the NCBD. FY 2008 and part of FY 2009 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 NCBD. FY 2010 and part of FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared with the 2009 NCBD, the latest benchmark data available.

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 2006. 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 2006 and FY 2010, the North Region saw the largest increase in the total number of TRICARE providers (26 percent), followed by the West Region (19 percent) and the South Region (17 percent).
- The West Region saw the largest increase in the number of Prime network providers (87 percent), followed by the North Region (66 percent) and the South Region (41 percent).
- The total number of TRICARE providers increased by 8 percent in catchment areas and by 24 percent in noncatchment areas (not shown).[3]
- The number of Prime network providers increased by 43 percent in catchment areas and by 70 percent in noncatchment areas (not shown).

TRENDS IN PRIME NETWORK AND TOTAL PARTICIPATING PROVIDERS[4]



Source: MHS administrative data, 1/25/2011

[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 19, the catchment area concept is being replaced within 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 CIVILIAN PROVIDER ACCEPTANCE OF, AND MHS BENEFICIARY ACCESS TO, TRICARE STANDARD AND EXTRA

Purpose of Study

The Department has completed the second year of four planned annual surveys to determine civilian physician acceptance of new TRICARE Standard patients. 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 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 percent) reported awareness of the TRICARE program in general, and about eight of 10 physicians (81 percent) accepted new TRICARE Standard patients, if they accepted any patients at all.

RESULTS OF COMBINED 2008–2009 BENEFICIARY AND PROVIDER SURVEYS

Provider survey results after two years:

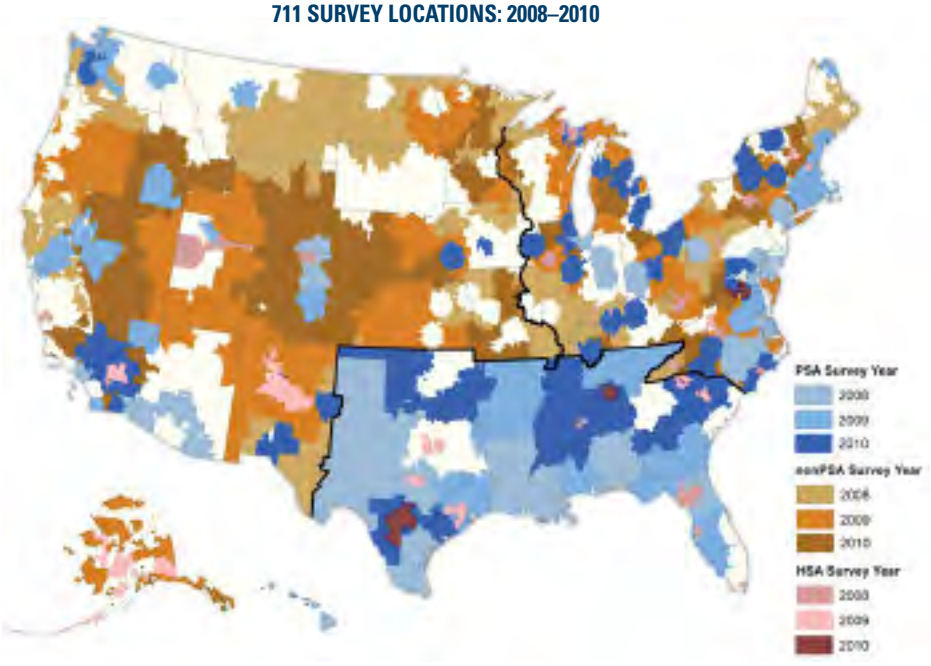
- **Awareness of the TRICARE program:**
  - There was a high level of provider awareness of the TRICARE program in general: almost **9 of 10 physicians** are aware of TRICARE, which is equal to the results of the 2005–2007 physician-only benchmark survey (both 87%).
  - Overall, **8 of 10 providers** (physician as well as non-physician behavioral health providers, such as psychologists and social workers) are aware of the TRICARE program.
- **Provider acceptance of new TRICARE patients:**
  - About 7 of 10 physicians accept new TRICARE Standard patients if they are accepting any new patients at all—this is lower than the 2005–2007 benchmark (69% vs. 81%).
  - About **6 of 10 providers overall** (physician and behavioral health) accept new TRICARE patients if they are accepting any new patients.
- Behavioral health providers (psychiatrists and nonphysicians) generally report **lower awareness and also lower acceptance** of new TRICARE Standard and Medicare patients, than nonpsychiatrist physicians.
- Provider awareness and acceptance of new TRICARE Standard patients are lower in areas with Prime networks (Prime Service Areas, PSAs) than in non-PSA locations.

Beneficiary survey results:

- In general, Standard/Extra (S/E) users in PSAs, compared to users in non-PSAs:
  - are as likely or more likely to receive preventive care;
  - report less access to getting needed care and getting care quickly;
  - report more problems finding personal doctors, getting to see specialists, and less timely urgent care than S/E users in non-PSAs.

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

711 SURVEY LOCATIONS: 2008–2010



Source: OASD(HA)/TMA-HPA&E and administrative data, 11/19/2010

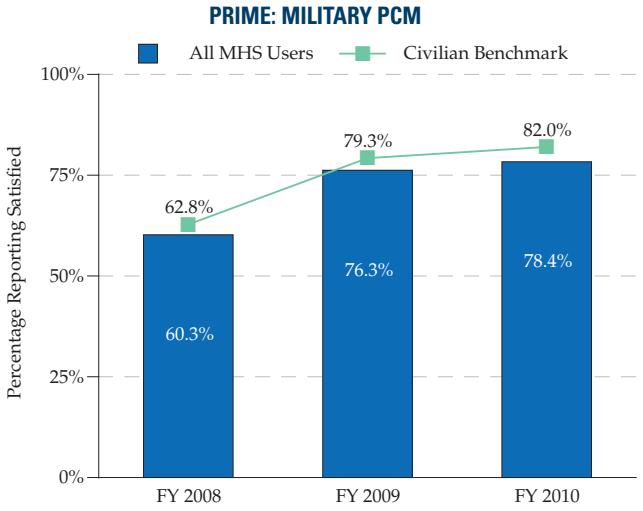
CUSTOMER SERVICE

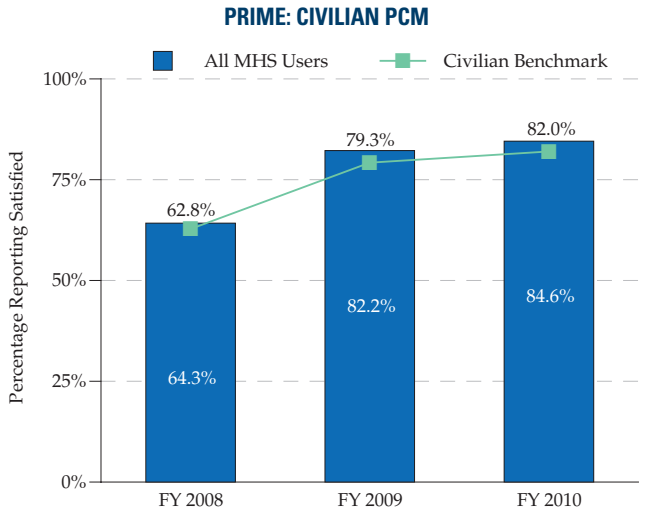
SATISFACTION WITH CUSTOMER SERVICE

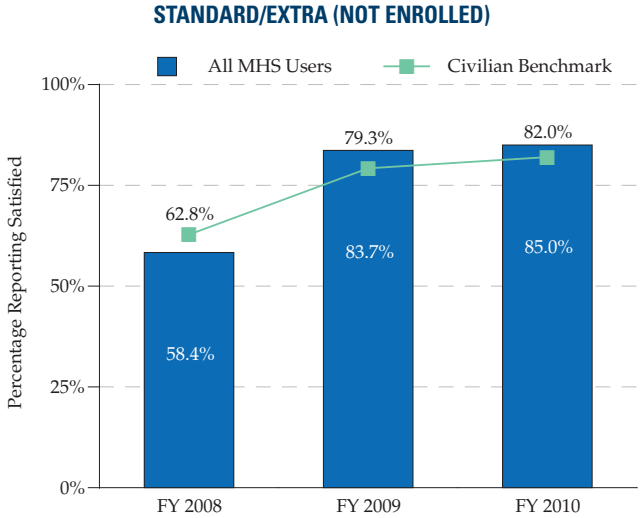
Access to and understanding written materials about one's health plan are important determinants of overall satisfaction with the plan.

- MHS beneficiaries' reported satisfaction with customer service, in terms of understanding written materials, getting customer assistance, and dealing with paperwork, increased between FY 2008 and FY 2010.
- MHS enrollees with civilian PCMs reported levels of satisfaction comparable to the civilian benchmark in FY 2008, and exceeded it in FY 2009 and FY 2010 (top right chart below).
- MHS MTF enrollee and non-enrollee (users of Standard or Extra) satisfaction improved between FY 2008 and FY 2010. Non-enrollee satisfaction exceeded the civilian benchmark in FY 2009 and FY 2010, 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 2008–2010 HCSDB, as of 12/17/2010, 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 NCBD. FY 2008 and part of FY 2009 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 NCBD. FY 2010 and part of FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared with the 2009 NCBD, the latest benchmark data available.

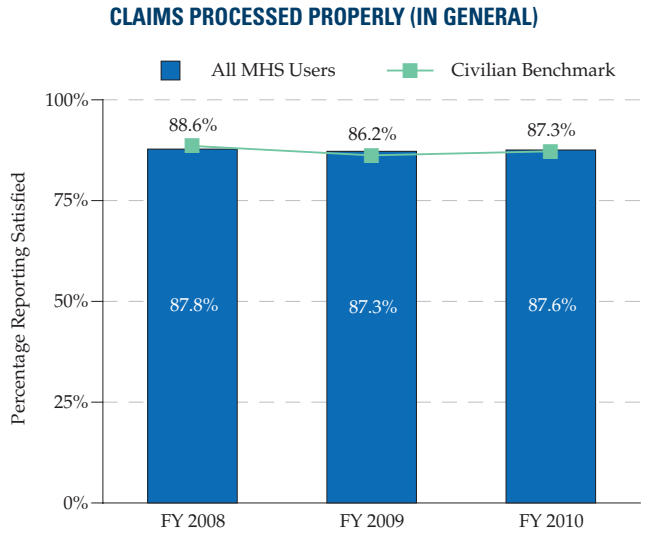
CLAIMS PROCESSING

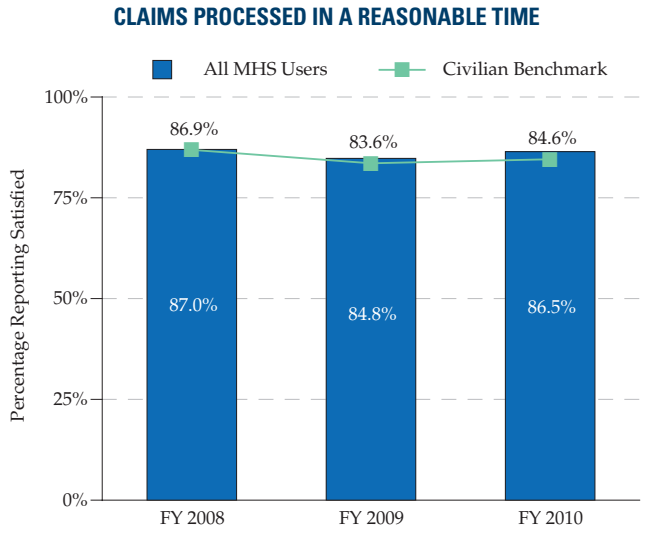
Claims processing is often cited as a "hot button" issue for beneficiaries as well as their providers. This is usually the case for the promptness of processing, as well as the accuracy of claims and payment. MHS monitors the performance of TRICARE claims processing through two means—surveys of beneficiary 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 2008 to FY 2010. Satisfaction with processing in a reasonable period of time decreased slightly in FY 2009, but recovered in FY 2010.
- MHS satisfaction levels for claims processed properly were comparable (i.e., not statistically significantly different) to the civilian benchmark in FY 2008 and FY 2010, and exceeded the benchmark in FY 2009.
- Satisfaction levels for claims processed in a reasonable period of time were comparable to the civilian benchmark in FY 2008, and exceeded the benchmark in FY 2009 and FY 2010.
- 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)





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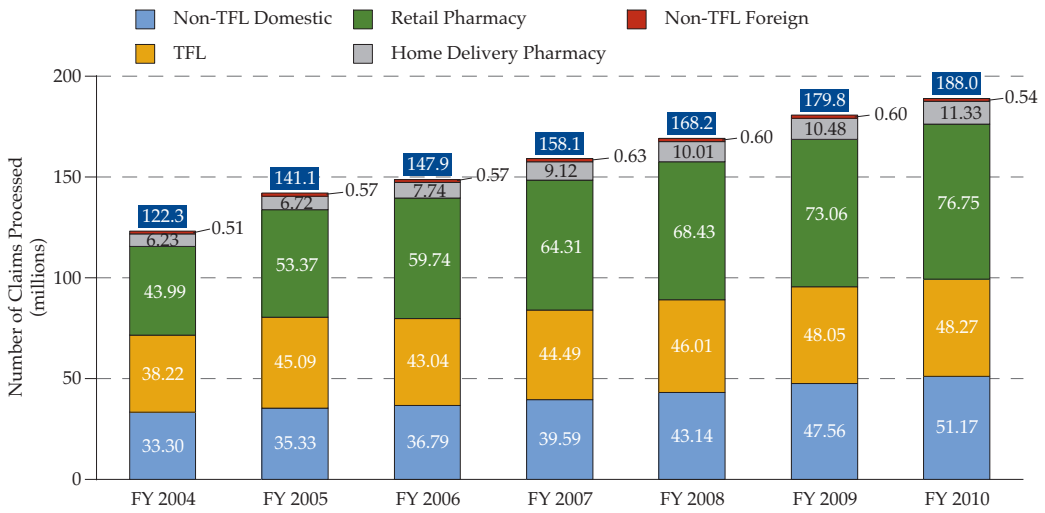
CLAIMS PROCESSING *(CONT'D)*

ADMINISTRATIVELY REPORTED CLAIMS FILING BY CONTINENTAL UNITED STATES (CONUS, THE LOWER 48 STATES)/TRICARE FOR LIFE (TFL)/OUTSIDE THE CONTINENTAL U.S. (OCONUS)

The number of claims processed continues to grow, due to increases in purchased care workload, including claims from seniors for TFL, pharmacy, and TRICARE dual-eligible beneficiaries. Claims processing volume increased by more than one-half (54 percent) between FY 2004 and FY 2010, and more than 4 percent between FY 2009 and FY 2010. This increase is due to the 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 home delivery prescriptions increased the fastest between FY 2004 and FY 2010 (74 percent and 82 percent, respectively).

TREND IN THE NUMBER OF TRICARE CLAIMS PROCESSED, FY 2004 TO FY 2010



Source: MHS Administrative data, 11/15/2010

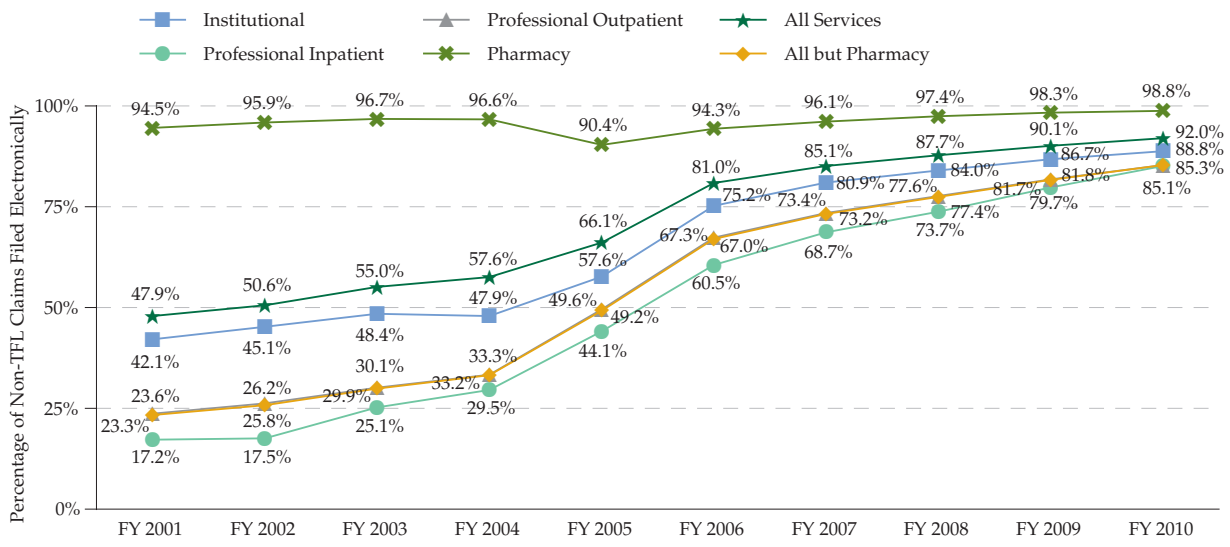
ELECTRONIC CLAIMS PROCESSING

TRENDS IN ELECTRONIC CLAIMS FILING

TRICARE continues to work with providers and claims processing contractors to increase the processing of claims electronically, rather than in mailed, paper form. Electronic claims submissions use more efficient technology requiring less transit time between 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 92 percent in FY 2010, up nearly two percentage points from the previous year and more than 34 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.
- Pharmacy claims are almost entirely electronic, reaching nearly 99 percent in FY 2010. The real growth in electronic claims remains in the other categories reflected individually below, as well as in the "All but Pharmacy" trend line, reaching to over 85 percent in 2010 (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 data, 11/15/2010

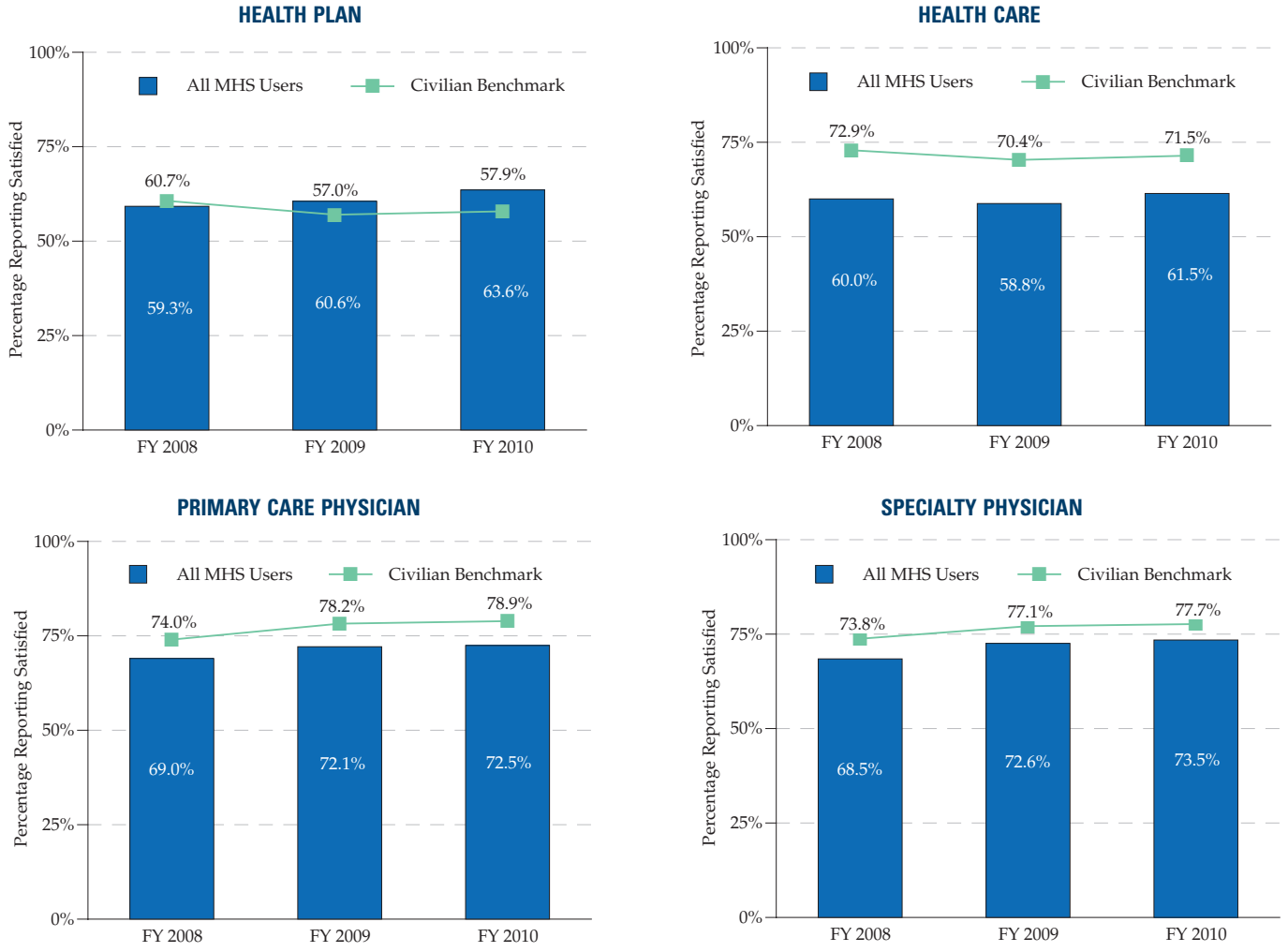
Foreign claims are excluded.

CUSTOMER REPORTED EXPERIENCE AND SATISFACTION WITH KEY ASPECTS OF TRICARE

In this section, 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. Health plan ratings depend on access to care and how the plan handles various service aspects such as claims, referrals, and customer complaints.

- Satisfaction with the overall TRICARE plan and health care improved between FY 2008 and FY 2010, while the civilian benchmarks decreased. Satisfaction with one's personal or specialty physician also improved during this three-year period, as did the civilian benchmarks.
- MHS satisfaction rates continued to lag civilian benchmarks, with the exception of Health Plan, which was lower than the civilian benchmark in FY 2008, and exceeded the benchmark in FYs 2009 and 2010.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS



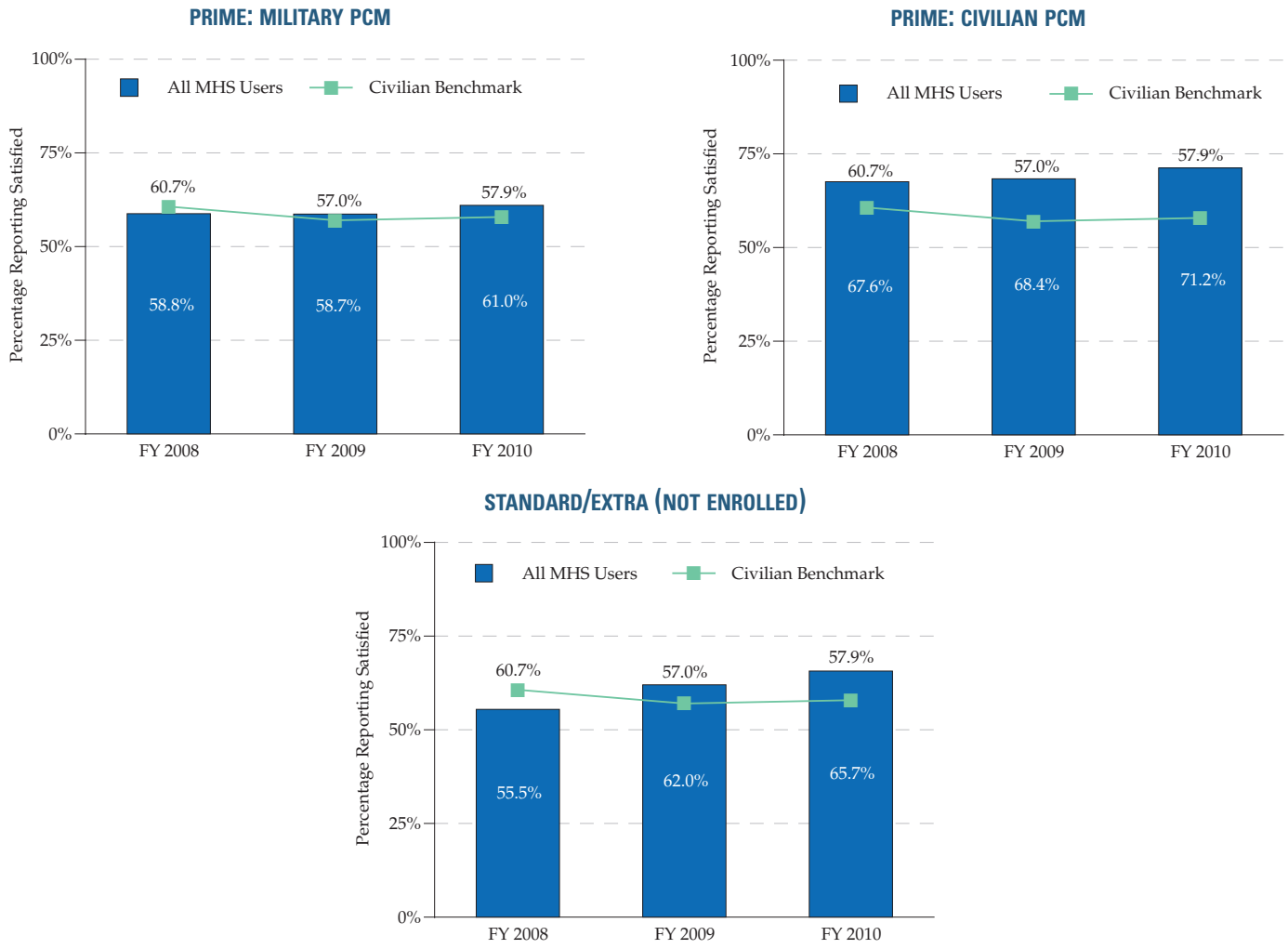
Note: DoD data were derived from the FYs 2008–2010 HCSDB, as of 12/17/2010, and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Civilian benchmark is obtained from the NCBD. FY 2008 and part of FY 2009 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 NCBD. FY 2010 and part of FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared with the 2009 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 with the TRICARE health plan increased for Prime enrollees and non-enrollees during FY 2008 to FY 2010 while the civilian benchmark decreased.
- During each of the past three years (FY 2008 to FY 2010), 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 2008, but higher levels of satisfaction in FY 2009 and FY 2010.

TRENDS IN SATISFACTION WITH HEALTH PLAN BY ENROLLMENT STATUS



Note: DoD data were derived from the FYs 2008–2010 HCSDB, as of 12/17/2010, 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 NCBD. FY 2008 and part of FY 2009 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 NCBD. FY 2010 and part of FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared with the 2009 NCBD, the latest benchmark data available.

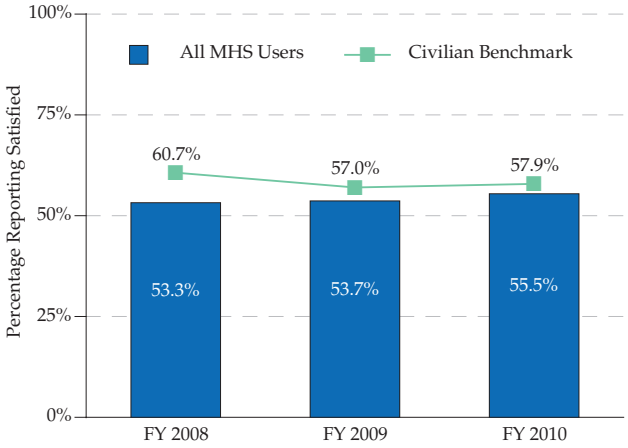
SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY

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

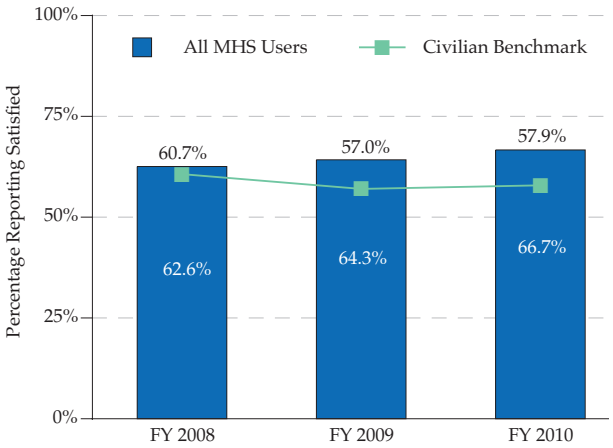
- Satisfaction with the TRICARE health plan improved for all three beneficiary categories between FY 2008 and FY 2010. Satisfaction of Active Duty beneficiaries continued to lag the civilian benchmark.
- ADFM and retired and family member satisfaction ratings exceeded the civilian benchmark in all three years (FYs 2008–FY 2010).

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY

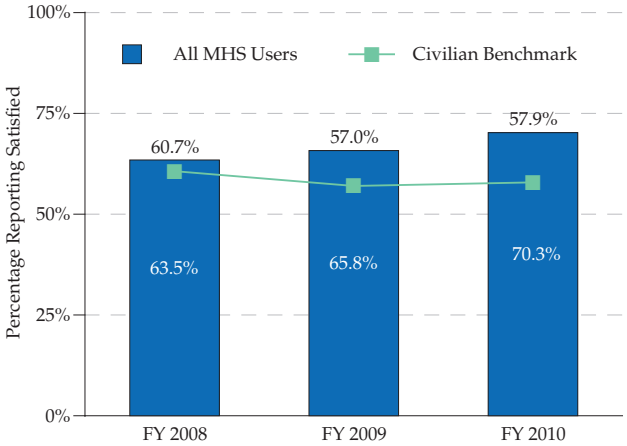
ACTIVE DUTY



ACTIVE DUTY FAMILY MEMBERS



RETIRED AND FAMILY MEMBERS



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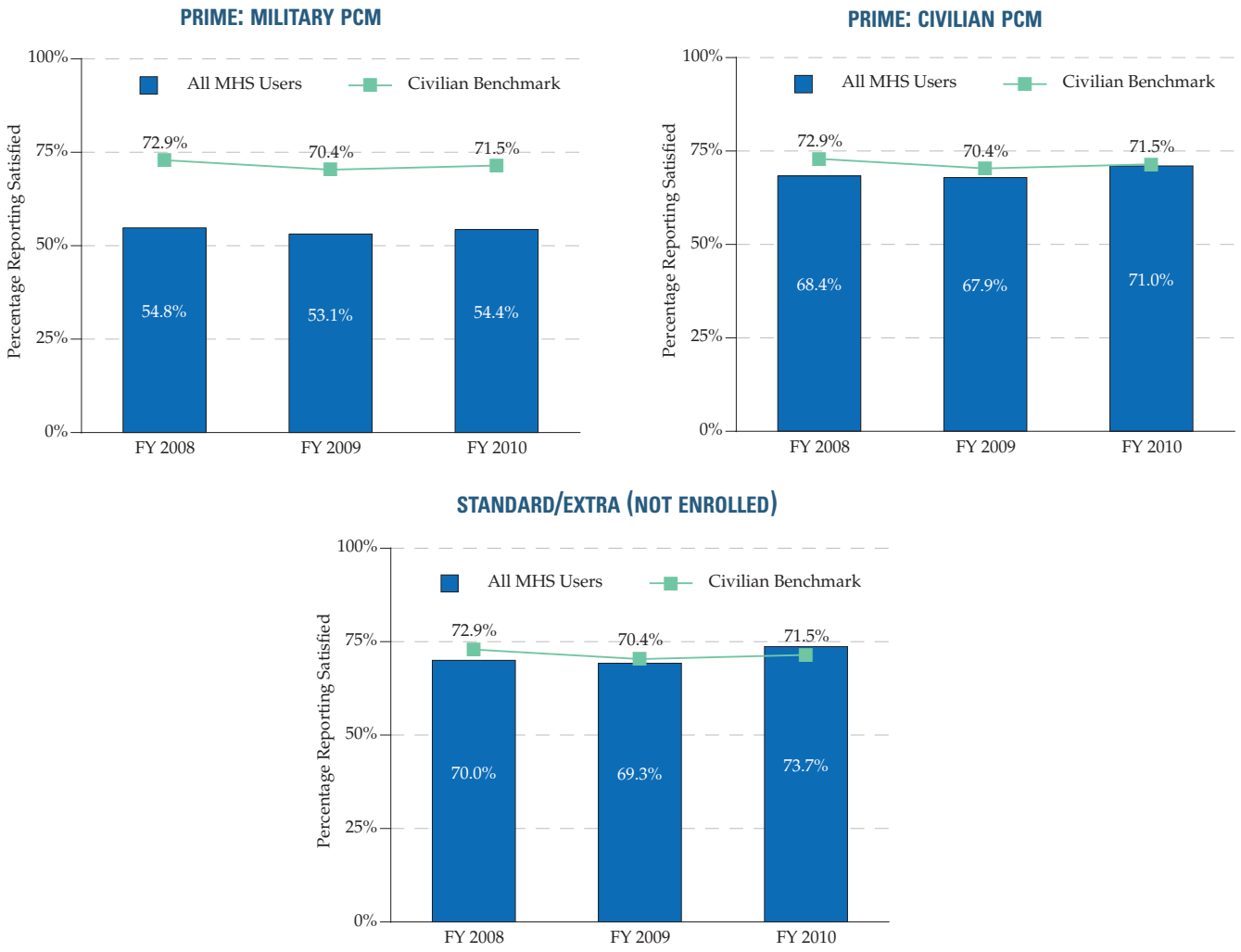
SATISFACTION WITH THE HEALTH CARE BASED ON ENROLLMENT STATUS

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

- Non-enrollee satisfaction increased during FYs 2008–2010. It was below the civilian benchmark during FY 2008 (bottom chart), but exceeded the benchmark in FY 2010.
- Between FY 2008 and FY 2010, the satisfaction level of Prime enrollees with military PCMs remained stable. While the satisfaction level of Prime enrollees with civilian PCMs appears to have increased, there was no statistically significant change. Satisfaction levels of Prime enrollees continue to lag the civilian benchmark.

TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BASED ON ENROLLMENT STATUS



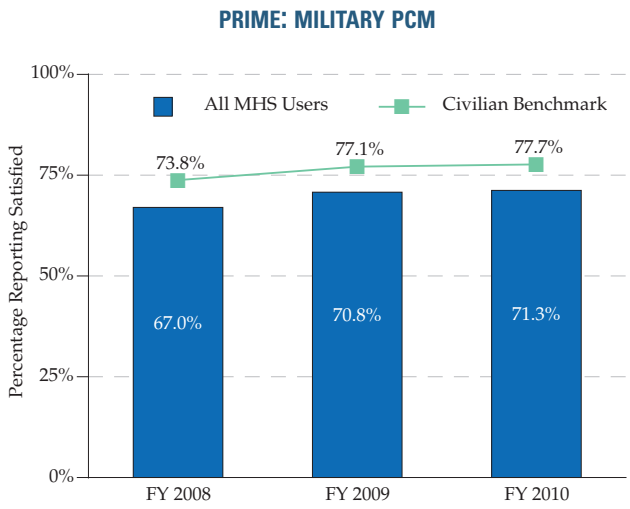
Note: DoD data were derived from the FYs 2008–2010 HCSDB, as of 12/17/2010, and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Civilian benchmark is obtained from the NCBD. FY 2008 and part of FY 2009 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 NCBD. FY 2010 and part of FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared with the 2009 NCBD, the latest benchmark data available.

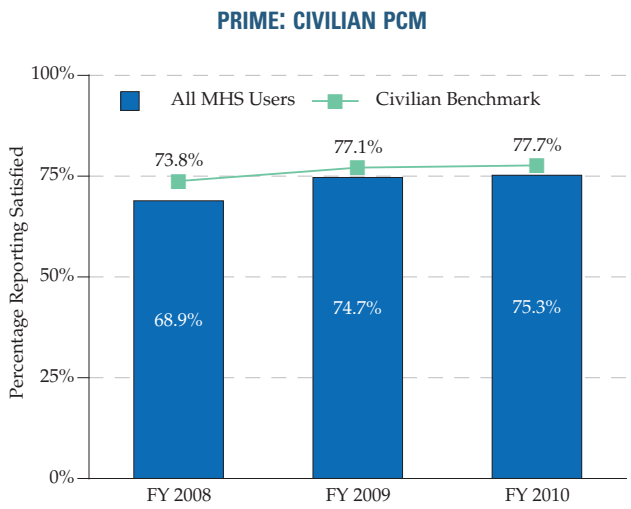
SATISFACTION WITH ONE'S SPECIALTY PROVIDER BASED ON ENROLLMENT STATUS

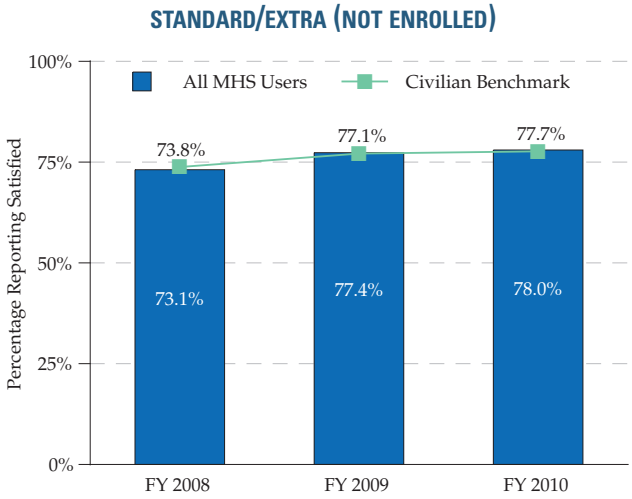
MHS user satisfaction with specialty providers differs by enrollment status.

- Satisfaction levels of Prime enrollees with military PCMs continue to lag the civilian benchmark, but increased between FY 2008 and FY 2010. Non-enrollee satisfaction levels also increased during this period and remained comparable to the civilian benchmark, which also increased. Prime enrollees with civilian PCMs satisfaction levels increased, but remained below the civilian benchmark in FY 2010.

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







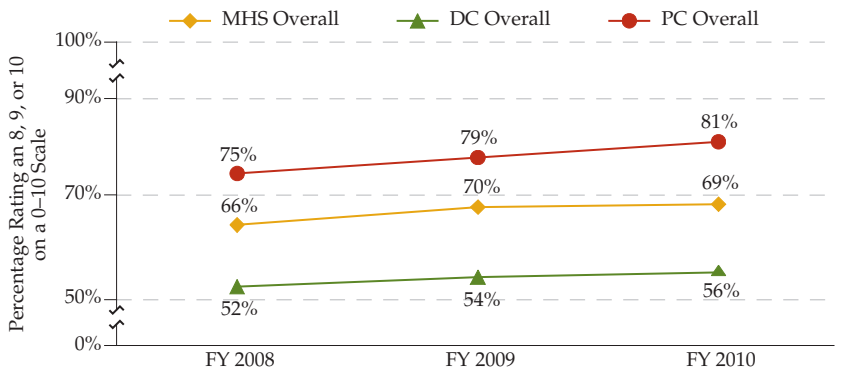
Note: DoD data were derived from the FYs 2008–2010 HCSDB, as of 12/17/2010, and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Civilian benchmark is obtained from the NCBD. FY 2008 and part of FY 2009 results are based on questions taken from the CAHPS Version 3.0 Questionnaire and compared with the 2006 NCBD. FY 2010 and part of FY 2009 results are based on questions from the CAHPS Version 4.0 Questionnaire and compared with the 2009 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)

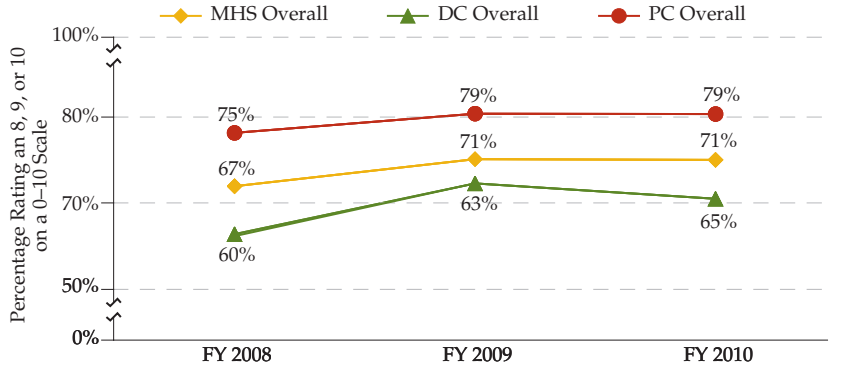
The goal of the OASD(HA)/TMA TRICARE Outpatient Satisfaction Survey (TROSS) is to monitor and report on the experience and satisfaction of MHS beneficiaries who have received outpatient care in an MTF or civilian outpatient setting. The TROSS is based on the Agency for Healthcare Research and Quality's (AHRQ) Consumer Assessments of Health Plans Study (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.

OVERALL RATING OF HEALTH CARE



- MHS enrollee overall rating of their health care (the percentage rating 8, 9, or 10 on a 1–10 scale) improved from 66 percent in 2008 to 69 percent in 2010. Outpatient health care services increased their satisfaction rating the most: 75 percent in 2008 vs. 81 percent in 2010. The MTF-based direct care rating also increased from 52 percent in 2008 to 56 percent in 2010.

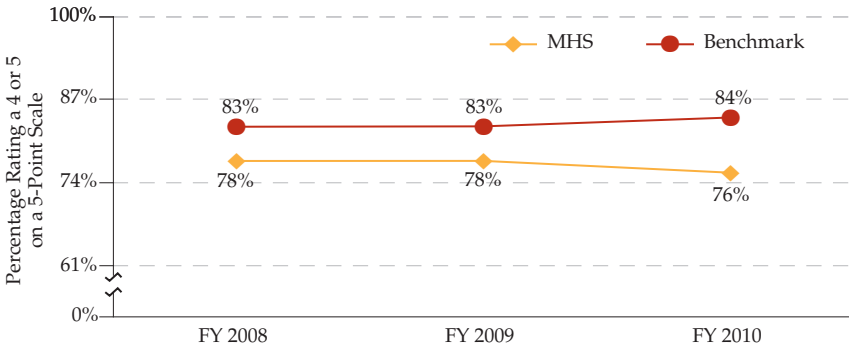
OVERALL RATING OF HEALTH PLAN



- Beneficiary overall rating of the health plan among MHS enrollees (the percentage rating 8, 9, or 10 on a 1–10 scale) improved from 67 percent in 2008 to 71 percent in 2010. Outpatient health care services increased their satisfaction rating from 75 percent in 2008 to 79 percent in 2010. The MTF-based direct care rating increased the most, from 60 percent in 2008 to 65 percent in 2010.

Note: Terms mentioned above: "MHS Overall" refers to both the users of direct and purchased care components, "DC Overall" refers to MTF-based care and "PC Overall" refers to care provided in the private sector through the claims-based reimbursement process. The years are depicted in TROSS years (e.g., May 2009–April 2010).

TROSS: EASE OF MAKING APPOINTMENT THROUGH PHONE, MHS ONLY



- The reported ease of making appointments by telephone decreased slightly from 78 percent (the percentage rating 4 or 5 on a 5-point scale) in 2008 to 76 percent in 2010.

Note: The years are depicted in TROSS years (e.g., May 2009–April 2010).

Source: OASD(HA)/TMA-HPA&E TROSS—2008–2010 (through May of each year). Data are as of 10/12/2010.

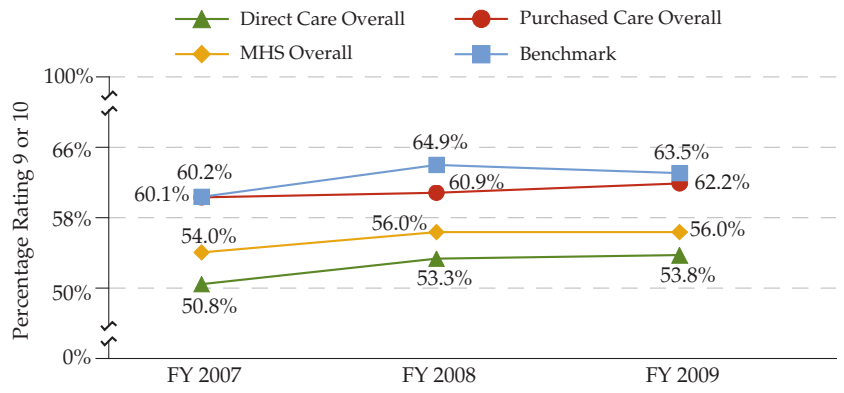
SURVEYS OF MHS BENEFICIARY ACCESS TO AND EXPERIENCE WITH HEALTH CARE SERVICES FOLLOWING TREATMENT *(CONT'D)*

TRICARE INPATIENT 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 Agency for Healthcare Research and Quality (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

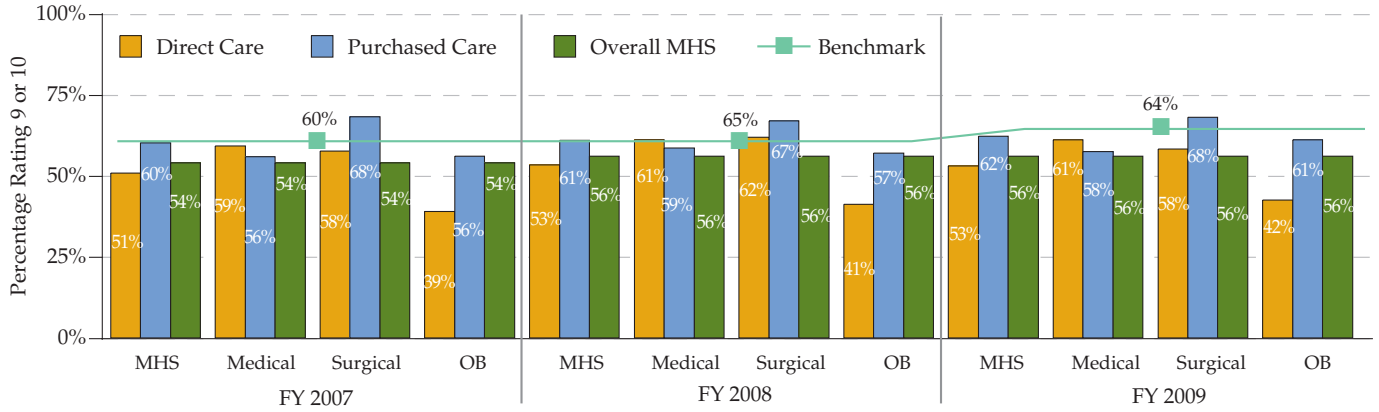


Source: TRICARE Inpatient Satisfaction Survey, as of 12/14/10. Data are adjusted to account for the sampling design and nonresponse. Ratings are on a 0–10 point scale with "Satisfied" defined as a rating of 9 or better.

Note: Terms above include 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.

- 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 four years, from 51 percent in FY 2006 to 56 percent in FY 2009.
- Surgical purchased care ratings of the hospital met or exceeded the benchmark each year from FY 2006 to FY 2009. MHS beneficiaries who were discharged from either surgical or obstetric purchased care services rated their hospital higher than beneficiaries discharged from counterpart services in direct care hospitals each year. In addition, MHS beneficiaries who were discharged from medical services within direct care hospitals rated their hospital higher than beneficiaries discharged from purchased care hospitals each year.

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



Source: TRICARE Inpatient Satisfaction Survey, as of 12/14/10. 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.

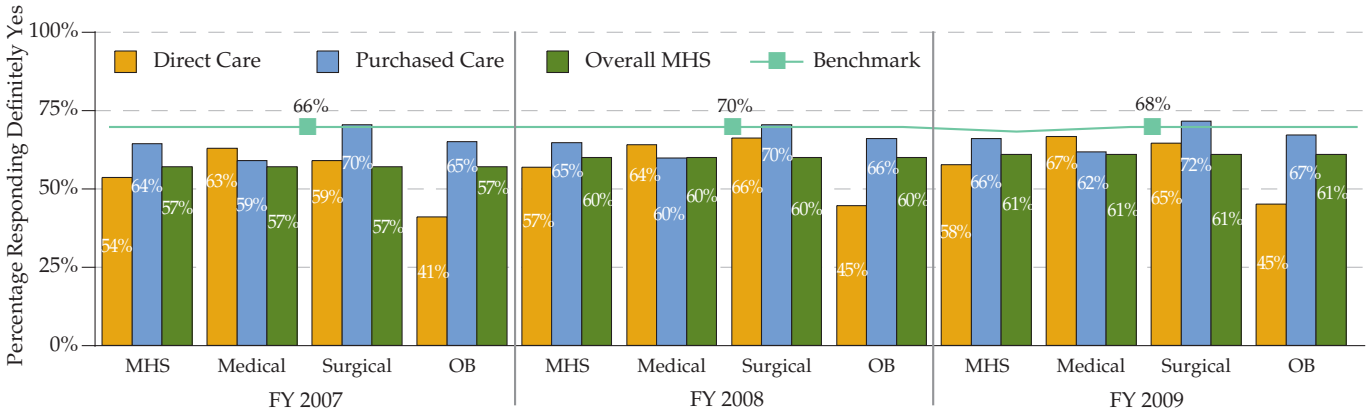
Note: Terms above include the direct care (i.e. MTF-based care) and purchased care (i.e., care provided in the private sector, through claims-based reimbursement). "MHS" overall refers to the combination of responses from users of the direct and purchased care components.

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

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

- Overall MHS "willingness to recommend" ratings increased between FY 2007 and FY 2009.
- Direct care ratings generally increased each year for all survey product lines.
- Surgical purchased care ratings met or exceeded the civilian benchmark each year.
- Purchased care ratings generally increased each year for all survey product lines.

TRISS: WILLINGNESS TO RECOMMEND HOSPITAL



Source: TRICARE Inpatient Satisfaction Survey, as of 12/14/10. Data are adjusted to account for the sampling design and non response. Ratings represent responses of "Definitely Yes."

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.

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 to and satisfaction with MHS direct and purchased care experience:
  - TRICARE Inpatient Satisfaction Survey (TRISS)—event-based after a discharge from a hospital;
  - TRICARE Outpatient Satisfaction Survey (TROSS)—event-based following an outpatient visit;
  - Health Care Survey of DoD Beneficiaries (HCSDB)—population based.

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 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, courtesy and respect from medical staff, getting needed care and getting care quickly, respect for family and friends, and respondent perception of MHS.
- These results suggest that improving respect for family and friends, perceptions of MHS, and doctor's communication have 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

Ranking	TRISS 2009 Direct Care MHS—Medical Rating of Hospital	TROSS 2009 Direct Care MHS—Medical Satisfaction with Health Care	HCSDB 2009 Direct Care CONUS Satisfaction with Health Care
#1	Family & Friends	Perception of MHS	Doctor's Communication
#2	Pain Control	Office Staff	Getting Care Quickly
#3	Responsiveness of Hospital Staff	Doctor's Communication	Getting Needed Care

Sources: OASD(HA)/TMA-HPA&E TRICARE Inpatient Satisfaction TRICARE Outpatient Satisfaction Survey, FYs 2007, 2008, and 2009 (through May 2009). Surveys as of 12/14/10

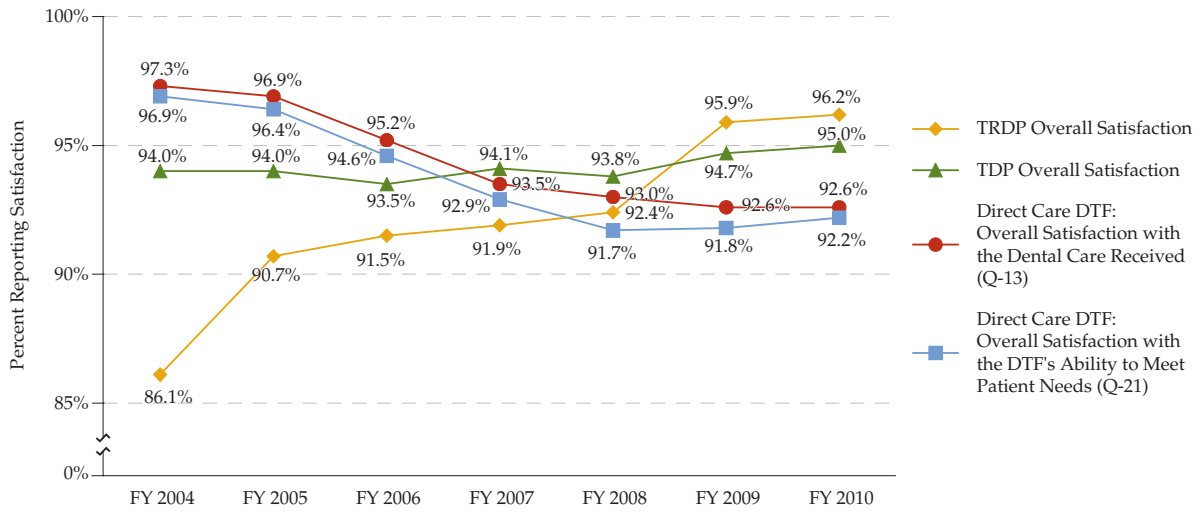
TRICARE DENTAL PROGRAMS CUSTOMER SATISFACTION

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.

- **Military Dental Treatment Facilities (DTFs):** Satisfaction with dental care reported by patients receiving dental care in military DTFs was 92.6 percent in FY 2010, 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 OCONUS family members. During FY 2010, the Tri-Service Center for Oral Health Studies collected 207,844 DoD Dental Patient Satisfaction Surveys from patients who received dental care at the Services' DTFs. The overall DoD dental patient satisfaction with the ability of the DTFs to meet their dental needs as well as satisfaction with the dental care received remained steady at about 92 percent and 93 percent, respectively, from 2008 to 2010.
- The **TRICARE Dental Program:** FY 2010 composite TDP overall average enrollee satisfaction increased over a percentage point from FY 2008, reaching 95 percent in FY 2010. The 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, 2010, the TDP serviced 836,686 contracts (almost 792,000 in the U.S.), covering almost 1,981,866 lives (1,879,372 in the U.S.). Although not shown, the TDP survey 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 68,090 dentists, comprising 13,110 specialists and 54,980 general dentists.
- The **TRICARE Retiree Dental Program** overall retired enrollee satisfaction rate increased nearly four percentage points, 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 of 71,546 dentists includes 20,715 specialists and 50,831 general 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, 11/2/2010

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.

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

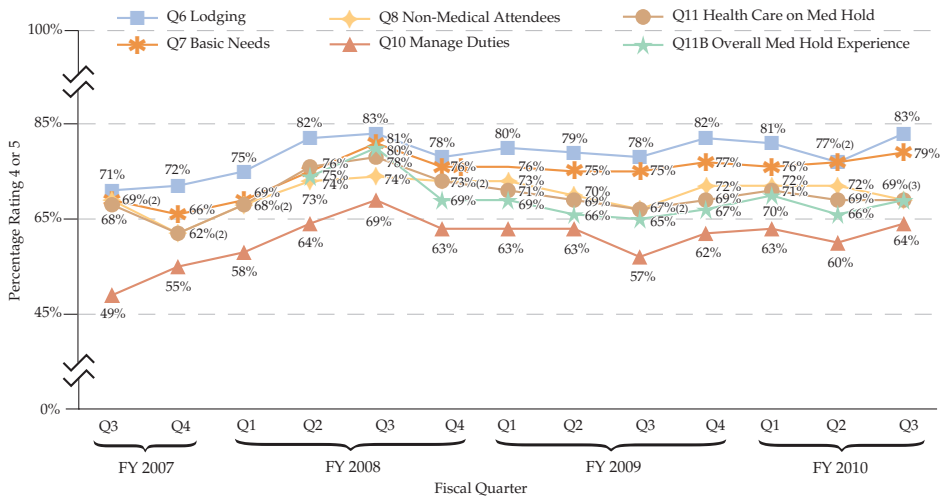
The Office of the Assistant Secretary of Defense (Health Affairs), TRICARE Management Activity has telephonically surveyed Service members returning from operational deployment (Afghanistan and Iraq) since May 2007. The Department began the monthly Telephone Survey of Ill or Injured Service Members Post-Operational Deployment as one of several responses to a Secretary of Defense tasking to establish a mechanism to identify any problems in Service member care, recuperation, or reintegration and to provide actionable information to the Services to resolve shortcomings or establish mechanisms for improvement.

For nearly three years, the survey has been a continuous monthly collection of their experiences. During this time, we have expanded the survey from its original focus on newly arrived Service members aeromedically evacuated from operational theaters to a focus mostly on those who have used the MHS for a year or more. Because it was soon surveying members within 30 to 45 days of departing theater, it was limited in identifying actionable information about long-term or chronic health care, and especially issues related to the disability evaluation system (DES). The survey was therefore 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 (VA) 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).

Since May 2007, over 35,000 surveys have been completed of over 137,000 sampled Service members returning from operational theater for an effective response rate of over 39 percent (averaging between 35 and 51 percent each month). Cumulatively, the majority of the sample is Army (76 percent), followed by Air Force (11 percent), Marines (9 percent), Navy (5 percent), and Coast Guard (0.1 percent). Response rates essentially mirror the sample percentages.

➤ **Summary of Results:** The focus of the survey is to identify problem areas to resolve. Over the past 38 months, through the current quarter of reporting (Q3 FY 2010), Service members have rated favorably most aspects of medical hold, outpatient health care, and support services including support for care in VA facilities. However, some measures continue to challenge MHS.

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



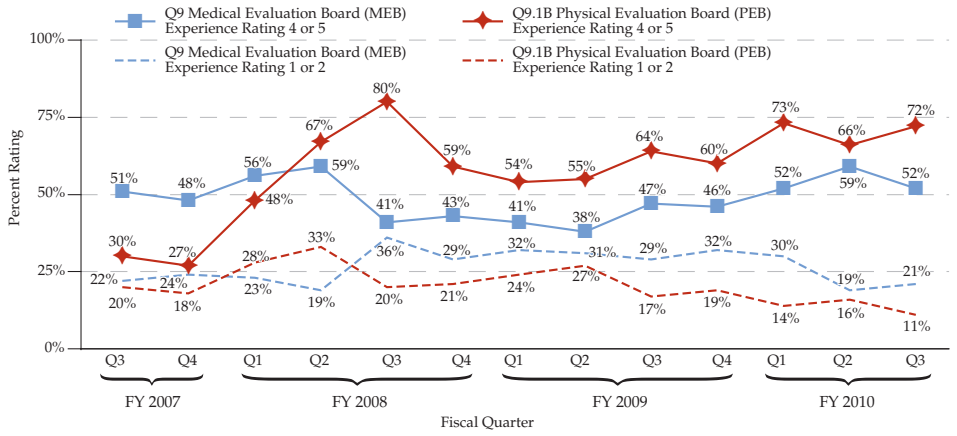
Source: OASD(HA)/TMA-HPA7E monthly Survey of Ill or Injured Service Members Post Operational Deployment, 12/30/2010

* 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 in the first month of Q1 FY 2009 to include Service members completing a PDHA or PDHRA.

➤ **Medical Hold:** Most Service members rate favorable (4 or 5 on 1–5 scale) various aspects of their experience in Medical Hold/Holdover/Warrior Transition Unit.

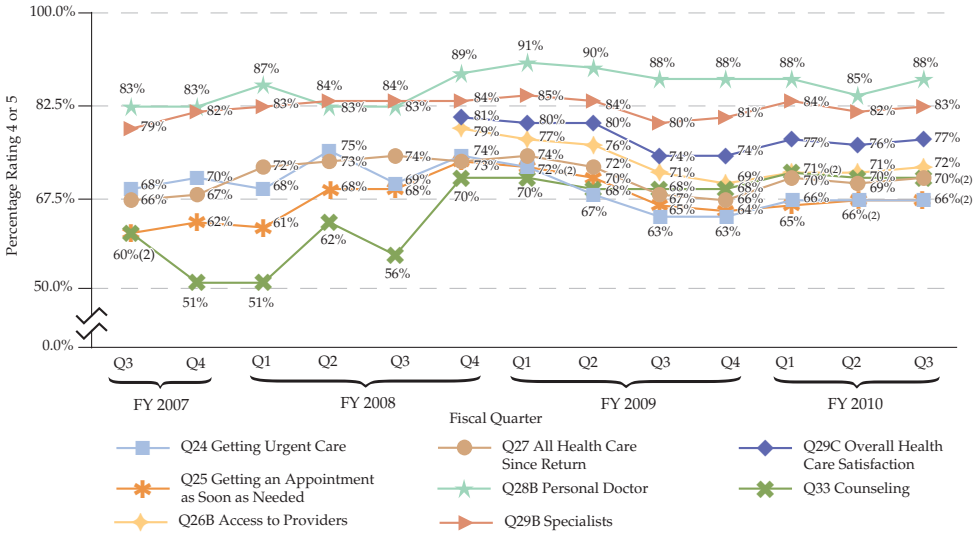
SURVEY OF WOUNDED, ILL, OR INJURED SERVICE MEMBERS POST-OPERATIONAL DEPLOYMENT *(CONT'D)*

DES RATINGS OVER TIME: FAVORABLE AND UNFAVORABLE RATINGS OF MEDICAL EVALUATION BOARD AND PHYSICAL EVALUATION BOARD



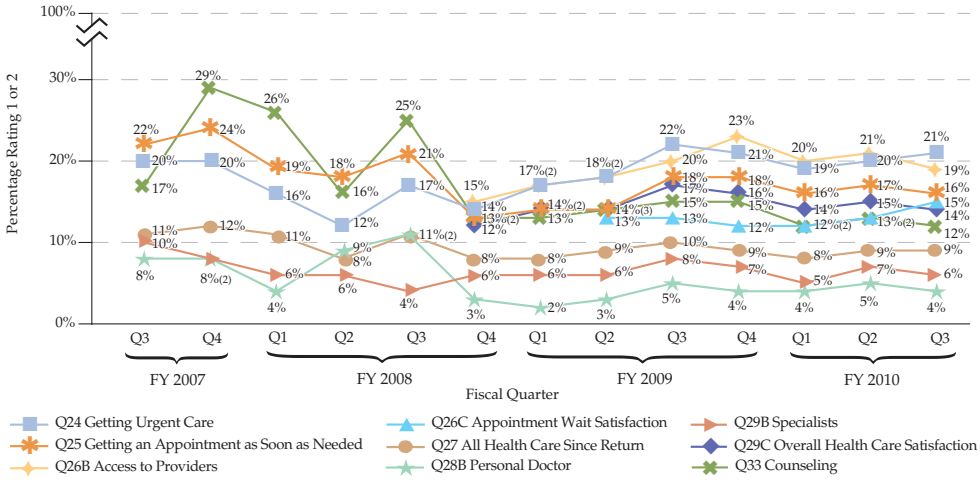
AMBULATORY CARE: PERCENTAGE OF TOP 2 RATINGS OVER TIME

(PERCENTAGE RATING 4 OR 5 ON 5-POINT SCALE)*



AMBULATORY CARE: PERCENTAGE OF BOTTOM 2 RATINGS OVER TIME

(PERCENTAGE RATING 1 OR 2 ON 5-POINT SCALE)*



Source: OASD(HA)/TMA-HPA&E Monthly Survey of Ill or Injured Service Members Post-Operational Deployment, 12/30/2010

- **DES:** While about one-half of Service members have rated their "MEB Experience" favorably over time, one-third have rated the experience as unfavorable. However, by Q2 FY 2010 unfavorable ratings appeared to be improving (previous six-quarter trend hovering around 30 percent unfavorable ratings have decline to 20 percent).
  - But, it is still too early to state whether this trend continues (showed slight reversal).
  - Most negative comments reflect concerns about the process being slow and time consuming, confusing, and with insufficient or unclear communication.

- **Outpatient (Ambulatory) Care:** Most Service members rate favorably their outpatient care (middle chart). Service members are more satisfied with their providers (personal doctors, specialists), but express more concern with access to them. Specifically, while relatively low, unfavorable ratings have not improved for certain aspects of access to care that are drivers of the overall experience of care: "ability to see providers when needed," "getting urgent care," and "getting appointments" (bottom chart).
  - Service members report 67 percent of the time that their medical record is available to the VA when care was referred by DoD (not shown).
  - Over one-third of Service members (36 percent) reported they could have benefited from treatment or counseling for personal or family problems; of those personnel, over one-half reported seeking care (55 percent), and most (87 percent) of those seeking care thought it was helpful (not shown).

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.

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 HEC provides ongoing oversight of data-sharing projects. Two such projects are the Federal Health Information Exchange (FHIE), which supports the transfer of electronic health information from DoD to VA at the time of a Service member's separation, and the pre-deployment/post-deployment health assessments that are conducted on Service members and demobilized Reserve and National Guard members as they leave and return from duty in a theater of operations.

DoD and VA have also aligned their disability evaluations for Service members separating from the military. Service members entering the Services' medical evaluation boards will simultaneously apply for VA disability claims. Just one evaluation physical will be conducted by the VA. Both VA and DoD will use this physical for disability-evaluation purposes. The change means a shortened wait time after separating to receive a VA disability check. Once Service members separate, they'll have severance/retirement from the Services and disability from the VA within 30 days of separation. The old system took from five months to more than a year from post-separation to check in hand.

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

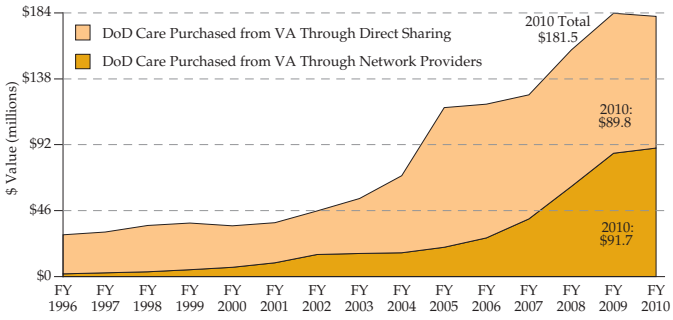
DoD/VA SHARING IT METRICS (CUMULATIVE)

	Starting Point	Recent Years		
	FY 2005	FY 2008	FY 2009	FY 2010
Millions of unique patients for which DoD has transferred data to the Federal Health Information Exchange (FHIE) repository	3.1	4.5	5.0	5.3
Number of Pre- and Post-Deployment Health Assessment forms sent electronically to VA	452,000	2,400,000	2,700,000	2,800,000
FHIE transfer includes the following:				
Millions of laboratory results sent to VA	42.3	67.1	75.6	83.1
Millions of radiology reports sent to VA	6.8	11.0	12.3	13.5
Millions of pharmacy records sent to VA	42.6	69.1	78.0	85.5
Millions of standard ambulatory data records sent to VA	40.3	68.2	85.7	99.0
Millions of consultation reports sent to VA	0.97	2.8	3.5	4.2

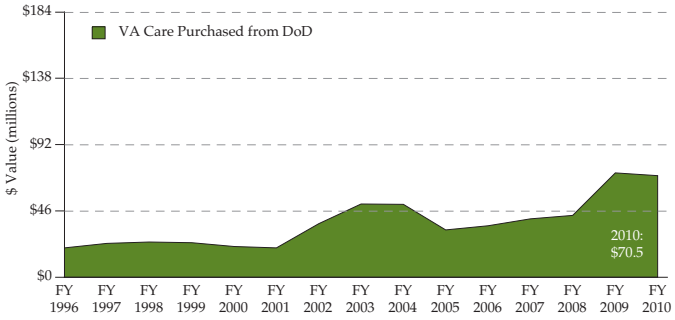
Source: OCIO/ERM, 11/5/2010

The charts below show the total extent of health care services sharing over the past 15 years, and the dramatic rise over the past five years. DoD has always purchased more care from the VA than vice-versa (on average, between 1996 and 2004, DoD purchased $1.44 from the VA for every $1.00 provided to the VA), but over the last five years DoD has purchased $3.06 for every $1.00 provided to the VA.

DoD/VA SHARING: HEALTH CARE SERVICES 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 11/5/2010

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

Launched in 2005, AHLTA is the military's Electronic Health Record (EHR). It provides a centralized repository of beneficiary health information. DoD health care providers document encounters in AHLTA. The records are centrally stored in the Clinical Data Repository (CDR), which enables secure, 24x7 online access from anywhere in the world, including the theater environment. Theater encounters, accessible to DoD and VA health care providers alike are transmitted daily to the CDR and included in the Service member's EHR.

A key metric for monitoring AHLTA tracks the patient encounters documented in the system. As shown in the chart below, on average, AHLTA documented 81,629 medical encounters daily in FY 2008, or almost 84 percent of all MHS encounters. By FY 2010, AHLTA documented, on average, almost 99,000 medical encounters daily, or more than 89 percent of all MHS encounters. The numbers in the chart include much of the in-theater care, which fluctuates with deployment and total in-theater care.

ARMED FORCES HEALTH LONGITUDINAL TECHNOLOGY APPLICATION ENCOUNTERS, FY 2008 TO FY 2010

Fiscal Year	AHLTA Encounters	Total MHS Encounters	AHLTA %	AHLTA Avg. Daily Encounters	Total MHS Avg. Daily Encounters
2008	29,876,240	35,734,270	83.61%	81,629	97,635
2009	33,770,269	38,994,154	86.60	92,521	106,833
2010	32,992,061	37,061,874	89.02	98,779	110,964

Source: OCIO/ERM as of 11/12/2010

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 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 multistakeholder 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) utilize these nationally recognized hospital quality measures to evaluate care provided in hospitals across the nation. MHS uses 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: acute myocardial infarction (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 the Joint Commission to meet hospital accreditation requirements as well as presented to facility leadership for analysis and identification of improvement opportunities. Data on the same measure sets for hospitals enrolled in an 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.

The tables that follow present some of the hospital quality measures MHS routinely monitors, reflecting overall DoD data, as well as separately by MTF (direct care) and purchased care, as compared to the nationally published data. Some of these measures are also presented in the accompanying trend-line charts to reflect change over time at the DoD level relative to the civilian average.

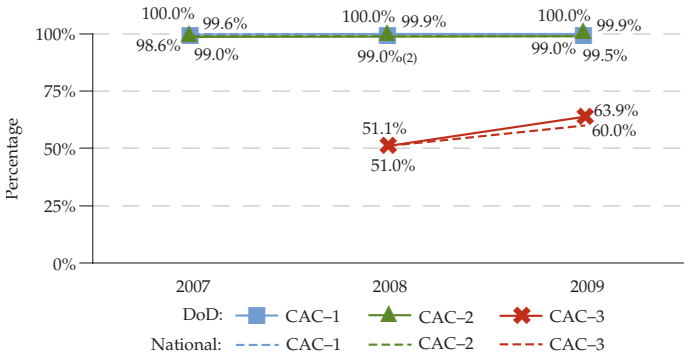
MHS HOSPITAL QUALITY MEASURES—DoD COMPARED TO NATIONAL CIVILIAN HOSPITAL COMPARE AND ORYX DATA: FY 2007–FY 2009

DoD data displayed in the following charts include all patients who meet the National Hospital Measures technical specifications for the 59 inpatient MTFs and approximately 1,985 civilian hospitals participating in contracted care networks.

	2007	2008	2009
CAC–1 Children Who Received Reliever Medication While Hospitalized for Asthma			
DoD	99.6%	99.9%	99.9%
MTF	99.6	99.7	100.0
Purchased Care	99.6	99.9	99.9
National	100.0	100.0	100.0
CAC–2 Children Who Received Systemic Corticosteroid Medication (Oral and IV Medication That Reduces Inflammation and Controls Symptoms) While Hospitalized for Asthma			
DoD	98.6%	99.0%	99.5%
MTF	97.0	98.7	99.2
Purchased Care	98.8	99.0	99.5
National	99.0	99.0	99.0
CAC–3 Children and Their Caregivers Who Received a Home Management Plan of Care Document While Hospitalized for Asthma			
DoD		51.1%	63.9%
MTF		24.0	38.4
Purchased Care		54.3	65.7
National		51.0	60.0

➤ **Children's Asthma Care:** Although performance for the medication management measures for children's asthma care is near 100 percent, the home management plan of care measure presents an opportunity for improvement. CAC–3 data for 2007 are not available in the national data file.

DoD HOSPITAL QUALITY MEASURE: CAC



Source: OASD(HA), Office of the Chief Medical Officer, 12/30/2010

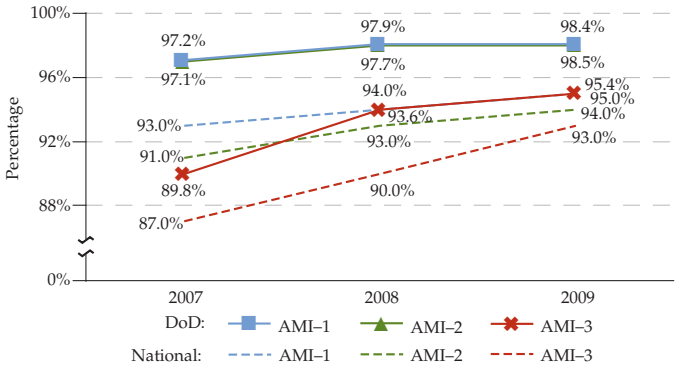
NATIONAL HOSPITAL QUALITY MEASURES— MILITARY HEALTH SYSTEM HOSPITALS PERFORMANCE *(CONT'D)*

MHS HOSPITAL QUALITY MEASURES—DoD COMPARED TO NATIONAL CIVILIAN HOSPITAL COMPARE AND ORYX DATA: FY 2007–FY 2009

	2007	2008	2009
AMI–1 Heart Attack Patients Given Aspirin at Arrival			
DoD	97.2%	97.9%	98.4%
MTF	99.1	98.7	98.8
Purchased Care	97.2	97.9	98.4
National	93.0	94.0	95.0
AMI–2 Heart Attack Patients Given Aspirin at Discharge			
DoD	97.1%	97.7%	98.5%
MTF	97.7	98.6	97.7
Purchased Care	97.1	97.7	98.5
National	91.0	93.0	94.0
AMI–3 Heart Attack Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)			
DoD	89.8%	93.6%	95.4%
MTF	98.0	95.1	97.1
Purchased Care	89.7	93.6	95.4
National	87.0	90.0	93.0
AMI–4 Heart Attack Patients Given Smoking Cessation Advice/Counseling			
DoD	98.1%	98.9%	99.3%
MTF	84.4	91.8	91.6
Purchased Care	98.1	99.0	99.3
National	92.0	95.0	97.0
AMI–5 Heart Attack Patients Given Beta Blocker at Discharge			
DoD	97.0%	97.8%	98.4%
MTF	97.3	97.6	97.0
Purchased Care	97.0	97.8	98.4
National	91.0	93.0	94.0

➤ **Acute Myocardial Infarction:** DoD overall performance is slightly above the national rate for acute myocardial infarction measures. MTFs continue to improve on the timing of percutaneous coronary intervention.

DoD HOSPITAL QUALITY MEASURE: AMI

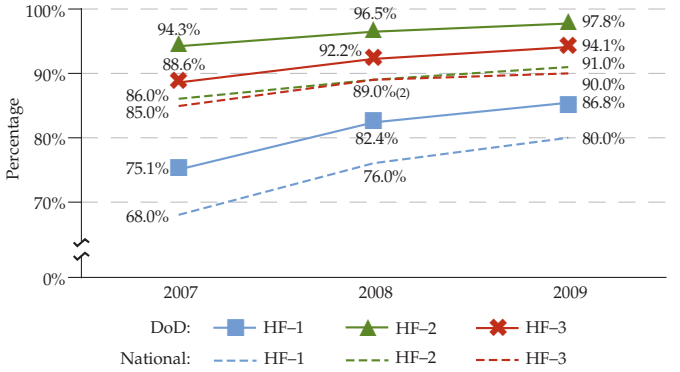


	2007	2008	2009
AMI–8a Heart Attack Patients Given PCI Within 90 Minutes of Arrival			
DoD	67.4%	81.2%	87.3%
MTF	59.7	53.4	66.0
Purchased Care	67.4	81.3	87.3
National	63.0	77.0	84.0

	2007	2008	2009
HF–1 Heart Failure Patients Given Discharge Instructions			
DoD	75.1%	82.4%	86.8%
MTF	58.5	68.9	79.8
Purchased Care	75.2	82.4	86.8
National	68.0	76.0	80.0
HF–2 Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function			
DoD	94.3%	96.5%	97.8%
MTF	94.6	95.3	95.6
Purchased Care	94.3	96.5	97.8
National	86.0	89.0	91.0
HF–3 Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)			
DoD	88.6%	92.2%	94.1%
MTF	96.5	93.5	95.0
Purchased Care	88.5	92.2	94.1
National	85.0	89.0	90.0
HF–4 Heart Failure Patients Given Smoking Cessation Advice/Counseling			
DoD	95.1%	97.5%	98.4%
MTF	73.4	86.5	86.0
Purchased Care	95.2	97.5	98.4
National	88.0	91.0	93.0

➤ **Heart Failure:** All DoD heart failure measures continue to improve over time. The overall performance of DoD on these measures is slightly above the national rate. Although MTFs lag on the documentation of smoking-cessation advice/counseling measure, current data reveals that the rate is improving.

DoD HOSPITAL QUALITY MEASURE: HEART FAILURE



Source: OASD(HA), Office of the Chief Medical Officer, 12/30/2010

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

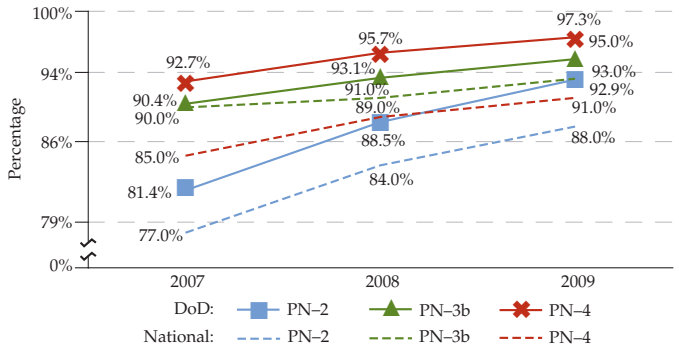
MHS HOSPITAL QUALITY MEASURES—DoD COMPARED TO NATIONAL CIVILIAN HOSPITAL COMPARE AND ORYX DATA: FY 2007–FY 2009

	2007	2008	2009
PN–2 Pneumonia Patients Assessed and Given Pneumococcal Vaccination			
DoD	81.4%	88.5%	92.9%
MTF	53.0	61.6	73.2
Purchased Care	81.5	88.7	93.0
National	77.0	84.0	88.0
PN–3b Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior to the Administration of the First Hospital Dose of Antibiotics			
DoD	90.4%	93.1%	95.0%
MTF	84.2	85.9	85.0
Purchased Care	90.4	93.2	95.1
National	90.0	91.0	93.0
PN–4 Pneumonia Patients Given Smoking Cessation Advice/Counseling			
DoD	92.7%	95.7%	97.3%
MTF	74.6	83.0	83.1
Purchased Care	92.8	95.8	97.4
National	85.0	89.0	91.0
PN–5c Pneumonia Patients Given Initial Antibiotic(s) Within 6 Hours After Arrival			
DoD	93.5%	93.9%	94.9%
MTF	86.6	88.3	89.3
Purchased Care	93.6	93.9	95.0
National	93.0	93.0	94.0
PN–6 Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s) PN6a+6b for ORYX			
DoD	89.3%	89.7%	91.9%
MTF	91.4	88.3	91.9
Purchased Care	89.3	89.7	91.9
National	87.0	87.0	89.0

	2007	2008	2009
SCIP Inf–1* Surgery Patients Who Were Given an Antibiotic at the Right Time (Within One Hour Before Surgery) to Help Prevent Infection			
DoD	88.4%	93.2%	96.3%
MTF	78.1	75.9	88.4
Purchased Care	88.5	93.4	96.4
National	83.0	89.0	93.0
SCIP Inf–2* Surgery Patients Who Were Given the Right Kind of Antibiotic to Help Prevent Infection			
DoD	92.9%	96.4%	97.6%
MTF	93.3	95.6	97.0
Purchased Care	92.9	96.4	97.6
National	90.0	94.0	95.0
SCIP Inf–3* Surgery Patients Whose Preventive Antibiotics Were Stopped at the Right Time (Within 24 Hours After Surgery)			
DoD	80.7%	89.8%	93.5%
MTF	81.6	86.5	91.6
Purchased Care	80.7	89.8	93.5
National	76.0	87.0	91.0
SCIP VTE–1 Surgery Patients Whose Doctors Ordered Treatments to Prevent Blood Clots After Certain Types of Surgeries**			
DoD	85.2%	91.6%	93.5%
MTF	90.7	92.3	93.8
Purchased Care	85.1	91.6	93.5
National	80.0	87.0	89.0

➤ **Pneumonia:** DoD performance on the pneumonia measures is consistent with the average performance across the nation. Though trending in a positive direction, the PN measures provide a number of opportunities for MTFs to improve.

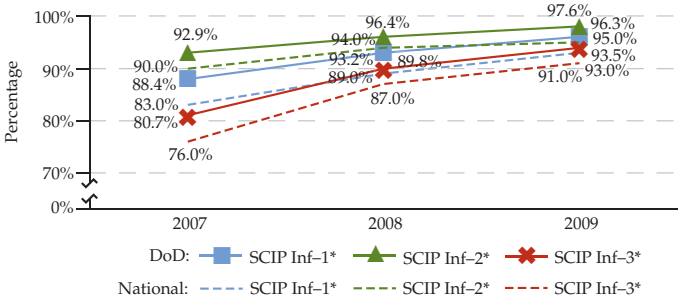
DoD HOSPITAL QUALITY MEASURE: PNEUMONIA



	2007	2008	2009
PN–7 Pneumonia Patients Assessed and Given Influenza Vaccination			
DoD	78.6%	85.8%	90.2%
MTF	37.6	53.1	65.4
Purchased Care	78.9	86.1	90.5
National	75.0	82.0	86.0

➤ **Surgical Care:** The overall performance of DoD for the surgical care improvement project measures is consistent with the national rate. MTFs are improving the timing of prophylactic antibiotic administration.

DoD HOSPITAL QUALITY MEASURE: SCIP INF.



	2007	2008	2009
SCIP VTE–2 Patients Who Got Treatment at the Right Time (Within 24 Hours Before or After Their Surgery) to Help Prevent Blood Clots After Certain Types of Surgery**			
DoD	81.7%	89.0%	91.5%
MTF	87.4	90.6	92.5
Purchased Care	81.6	89.0	91.5
National	80.0	84.0	88.0

Source: OASD(HA), Office of the Chief Medical Officer, 12/30/2010

* Surgical Care Improvement Project—Infection
** Surgical Care Improvement Project—Venous Thromboembolism Prophylaxis

HEALTHY AND RESILIENT INDIVIDUALS, FAMILIES, AND COMMUNITIES

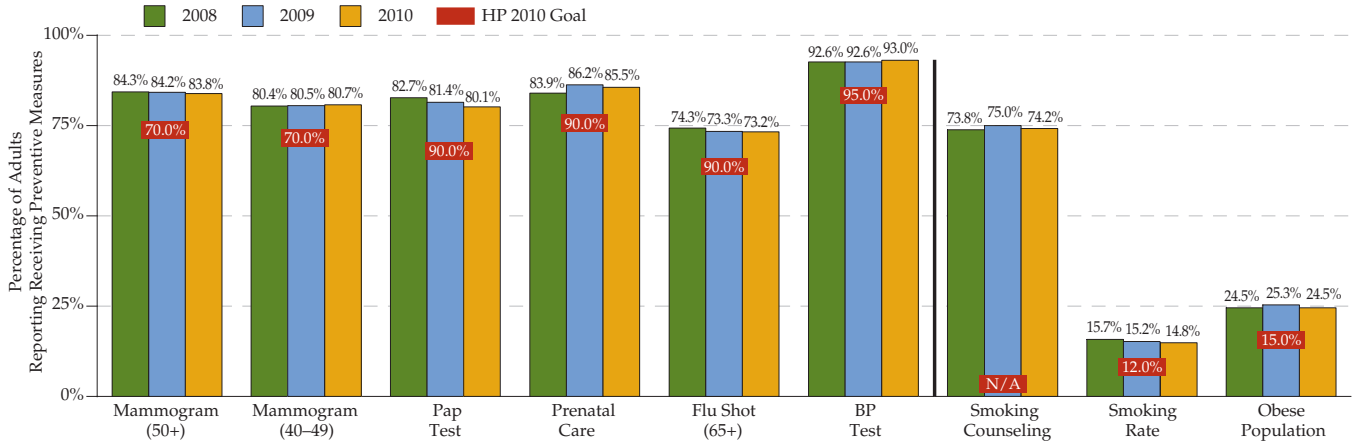
This section focuses on scanning the health care environment for relevant benchmarks, applying their metrics, and striving to meet or exceed those standards. The metrics presented here focus on health promotion activities through Building Healthy Communities.

ENGAGING PATIENTS IN HEALTHY BEHAVIORS

The Healthy People 2010 (HP 2010) goals are a list 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 MHS.

- 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, 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 smoking rate among all MHS beneficiaries decreased slightly from FY 2008 through FY 2010 to under 15 percent. While the proportion of smoking MHS beneficiaries appears lower than the overall U.S. population (not shown), it continued to exceed the HP 2010 goal of a 12 percent or lower rate of tobacco use for individuals smoking at least 100 cigarettes in a lifetime, and smoking in the last month.
- **Obesity:** The overall proportion of all MHS beneficiaries identified as obese has remained relatively constant from FY 2008 to FY 2010. The MHS rate of 24.5 percent obese in FY 2010, using self-reported data, did not reach the HP 2010 goal of 15 percent, but is below the most recently identified U.S. population average of 31 percent (not shown).
- Still other areas continue to be monitored in the absence of specified HP standards, such as smoking-cessation counseling, which decreased slightly to 74 percent in FY 2010.

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FY 2008 TO FY 2010



Source: Health Care Survey of DoD Beneficiaries and the NCBD as of 12/17/2010

NOTE: Unlike the objective for all other categories, the objective for Smoking Rate and Obese Population is for actual rates to be below the HP 2010 goals.

MHS-TARGETED PREVENTIVE CARE MEASURES

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

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

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

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

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

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 the last 12 months.

USE OF TOBACCO IN THE MHS POPULATION

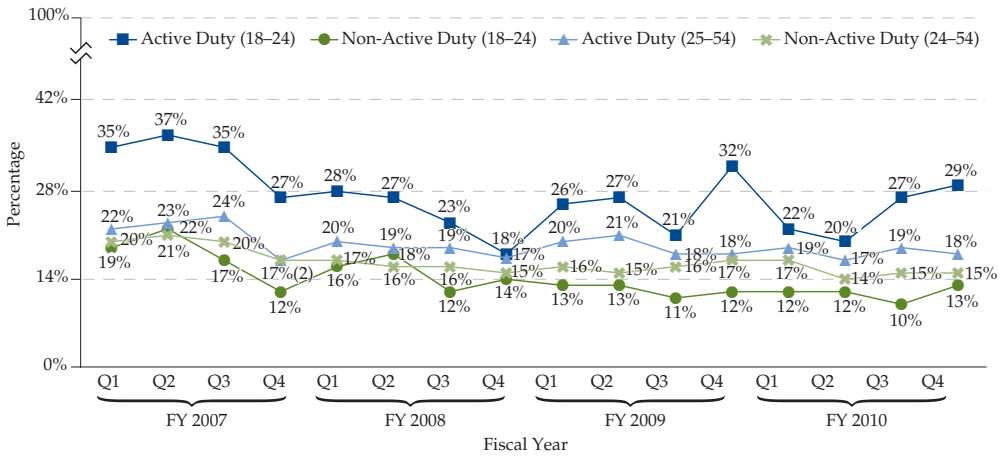
Measures of the prevalence of tobacco use among Active Duty and their family members reflect unhealthy behavior among MHS beneficiaries that is modifiable with potentially significant positive health effects in our population, including a reduction in tobacco-related illnesses.

Why is it important? Smoking-cessation counseling is a TRICARE benefit; tobacco use among people aged 18–24 is a particular focus of such efforts within the military because difficult-to-change habits can be formed during these years and because they are generally regarded as the group most vulnerable to habit formation. Measures of tobacco use allow MHS to assess the success rate of tobacco-cessation programs and other healthy lifestyle/health promotion efforts among specific high-risk demographic groups.

What does our performance tell us? The population-based Health Care Survey of DoD Beneficiaries (HCSDB) is an appropriate method for measuring the performance of MHS in identifying self-reported healthy and unhealthy behaviors in the MHS population. MHS leadership monitors quarterly the prevalence of self-reported tobacco use in Active Duty and their families, and across relevant age groups.

- **MHS Cigarette Smoking:** The top chart shows that, relative to the other categories, cigarette use among Active Duty Service members aged 18–24 remains at high levels (hovering between 18 and 29 percent), and, aside from variation from quarter to quarter, annual levels for all Active Duty have not significantly changed over the past three years (from FY 2008 to FY 2010). Rates of smoking among older Active Duty and non-Active Duty of all ages are lower than in the younger population.

MHS CIGARETTE USE RATE



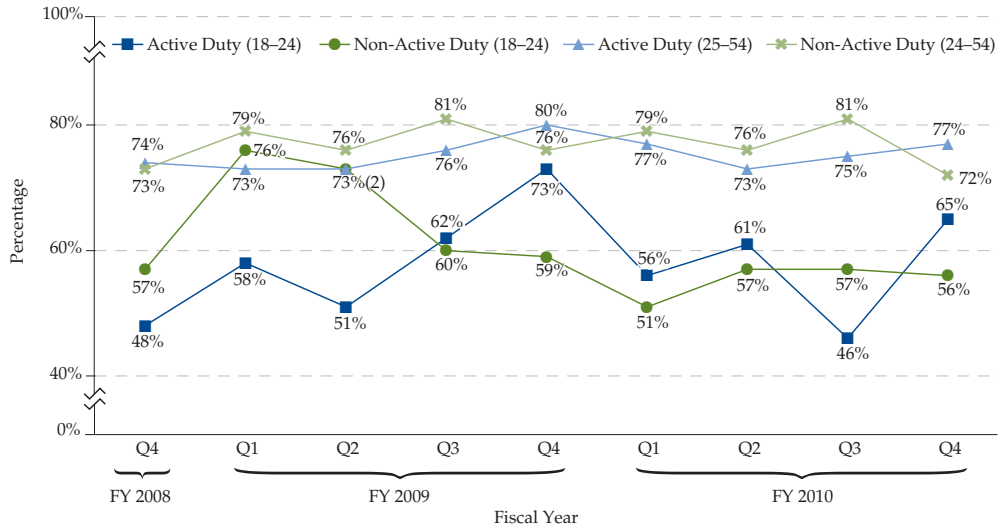
- **MHS Smokeless Tobacco Use:** Similarly, the use of smokeless tobacco among Active Duty and their family members, while much lower than cigarette smoking rates, has not changed appreciably between 2008 and 2010. Active Duty smokeless tobacco use continues at about 10–15 percent of the population, while non-Active Duty use is stable at less than 5 percent (See chart on next page).

MHS Smoking-Cessation Counseling: This measures among four categories of MHS beneficiaries the proportion of office visits where smokers are counseled by physicians to quit smoking.

Why is it important? This measure allows MHS to assess the success rate of tobacco use cessation programs and other healthy lifestyle/health promotion efforts among specific high-risk demographic groups.

What does our performance tell us? Active Duty Service members aged 18–24 are less likely than their older counterparts to be counseled to quit.

MHS SMOKING-CESSATION COUNSELING RATE

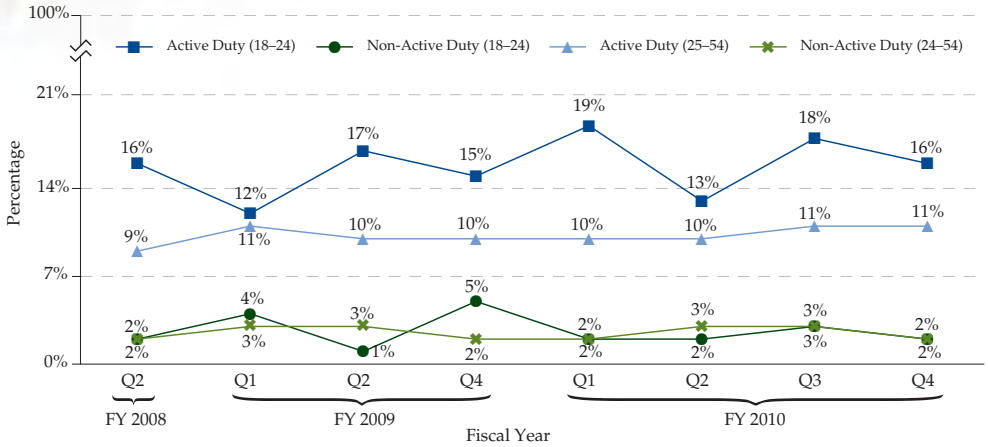


Source: OASD/HA TMA/HPA&E survey, data provided 11/18/2010

Note: Data from 4th quarter, FY 2007 to current have been recalculated to conform to CAHPS Version 4.0, which dropped its requirement to indicate when last smoked. This gives the appearance of reduced smoking, but that is not the case.

USE OF TOBACCO IN THE MHS POPULATION *(CONT'D)*

MHS SMOKELESS TOBACCO USE RATE



Source: OASD/HA TMA/HPA&E survey, data provided 11/18/2010

MHS PREVALENCE OF OBESITY

OVERWEIGHT IN THE MHS POPULATION

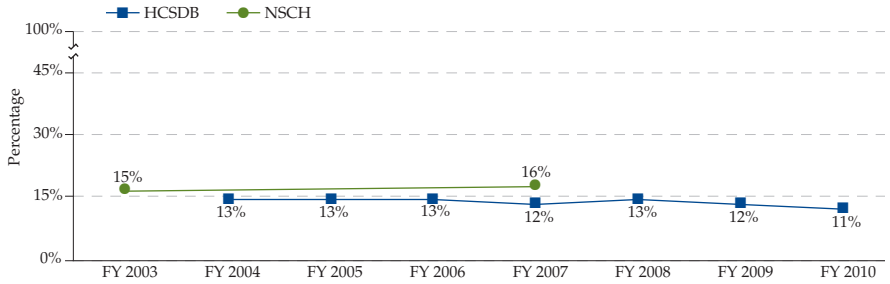
MHS monitors the health of our population through interaction with beneficiaries when they seek care in the direct or purchased care system, as well as through population-based surveys such as the annual HCSDB. The HCSDB asks respondents to provide their height and weight, from which we then calculate the body mass index (BMI) for the individual and assess the prevalence of being underweight, overweight, or obese in the MHS population.

The HCSDB-child version annually fielded worldwide also helps identify the prevalence of weight problems among MHS children, and asks parents to identify their child's height and weight. Comparison data are available from the National Survey of Child Health (NSCH) fielded 2003 and 2007 to a nationally representative civilian sample. NSCH parents' report of height/weight are compared to the same BMI-for-age norms as HCSDB.

The top chart shows that MHS children identified by BMI-for-age norms appear less likely to be obese than their civilian counterparts. Obesity does not appear to have changed from FY 2004 to FY 2010. These patterns are consistent for MHS children overall (shown), and separately, for boys and girls in the same age grouping (not shown).

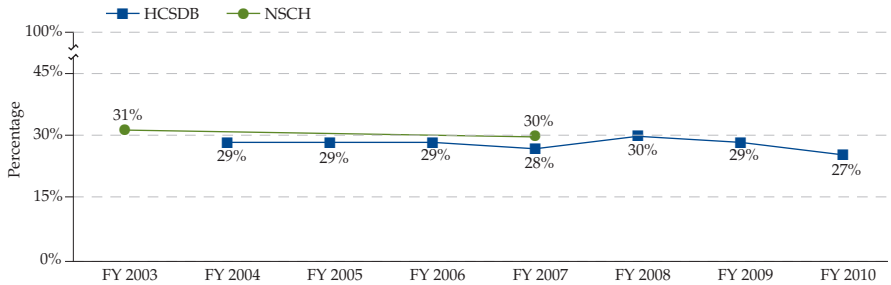
The lower chart shows there is no difference between MHS children who, combined, are either overweight or obese, and U.S. children in general.

PERCENTAGE OF MHS CHILDREN WHO ARE OBESE (10–17 YEAR OLDS WITH BMI-FOR-AGE ≥95TH PERCENTILE)



Note: The difference between HCSDB in 2006–2008 and NSCH in 2007 is statistically significant, $p < 0.01$.

PERCENTAGE OF MHS CHILDREN WHO ARE EITHER OBESE OR OVERWEIGHT (10–17 YEAR OLDS WITH BMI-FOR-AGE ≥85TH PERCENTILE)

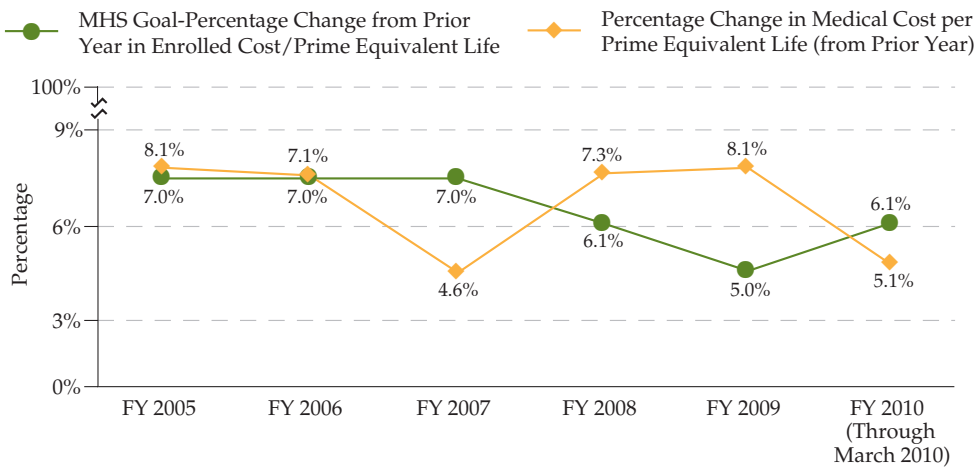


Source: Annual Health Care Survey of DoD Beneficiaries, Child (HCSDB-C), fielded 2004 to 2010 provided 12/22/2010. The survey was administered to a random sample of parents of children under age 18, eligible for TRICARE; parents respond to the survey for the specified child; they were asked about the child's height and weight. Reported height and weight were converted to Body Mass Index (BMI) and were compared to sex- and age-specific reference values in CDC 2000 growth charts to identify obese (≥95th percentile of BMI-for-age) and overweight (85th to 94th percentiles of BMI-for-age). Results reported here show overweight as including overweight and obese (≥85th percentile). Results from both surveys calculated using non-response adjusted sampling weights. Results restricted to children age 10 and above because of unreliability of younger children's results; NSCH benchmark data are not available for younger children.

SYSTEM PRODUCTIVITY: MEDICAL COST PER PRIME ENROLLEE

The goal of this financial and productivity metric in FY 2010 is to stay below a 6.1 percent annual rate of increase (revised upward 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 8.1 percent in FY 2008, and, with incomplete data for the fiscal year, may remain in the 5–6 percent range by the end of FY 2010.

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), 12/2/2010. Enrollees are adjusted for age, gender, and beneficiary category. FY 2010 data are current as of March 2010 reporting, with measure reported through March 2010.

INPATIENT UTILIZATION RATES AND COSTS

TRICARE Prime Inpatient Utilization Rates Compared with Civilian Benchmarks

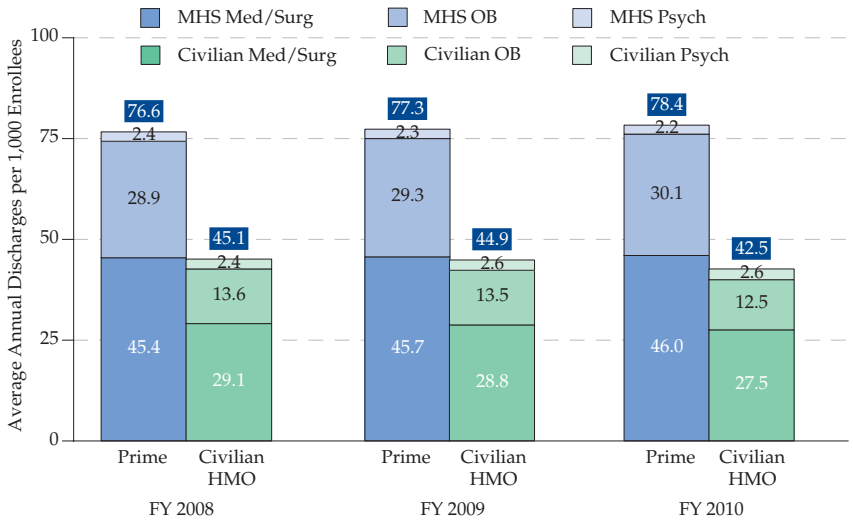
TRICARE Prime Enrollees

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 84 percent higher than the civilian HMO utilization rate in FY 2010 (78.4 discharges per 1,000 Prime enrollees compared with 42.5 per 1,000 civilian HMO enrollees). That is up from 70 percent higher in FY 2008.
- In FY 2010, the TRICARE Prime inpatient utilization rate was 68 percent higher than the civilian HMO rate for MED/SURG procedures, 140 percent higher for OB/GYN procedures, and 13 percent lower for PSYCH procedures.

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



Sources: MHS administrative data, 1/13/2011, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/29/2011

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2010 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

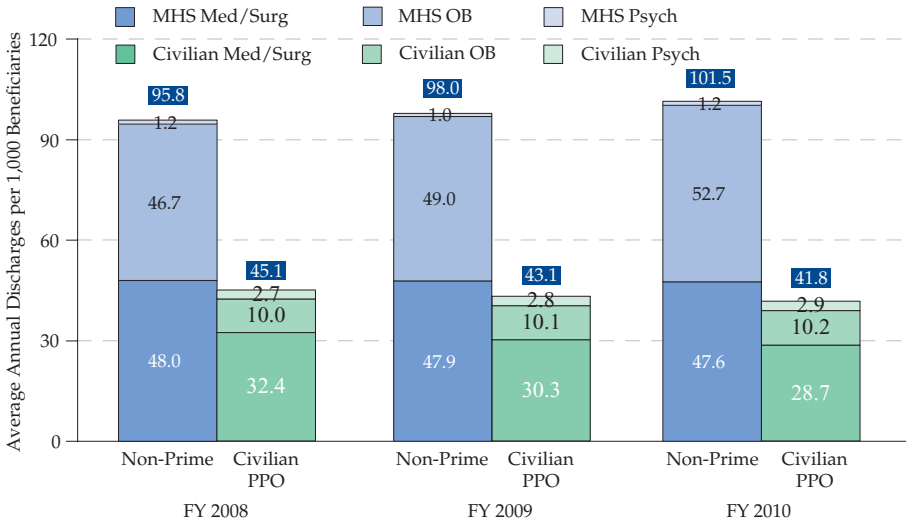
Non-Enrolled Beneficiaries

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 that between 11 and 13 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 triple the rate for civilian PPO participants. From FY 2008 to FY 2010, the inpatient utilization rate for non-enrolled beneficiaries increased by 6 percent while it declined by 7 percent in the civilian sector.
- By far the largest discrepancy in utilization rates between MHS and the private sector is for OB procedures. From FY 2008 to FY 2010, the MHS OB disposition rate increased by 13 percent, whereas it increased by only 2 percent in the civilian sector. In FY 2010, the MHS OB disposition rate was more than 5 times as high as the corresponding civilian rate.
- Of the three product lines considered in this report, only PSYCH procedures had lower utilization in MHS than in the civilian sector.

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



Sources: MHS administrative data, 1/13/2011, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/29/2011

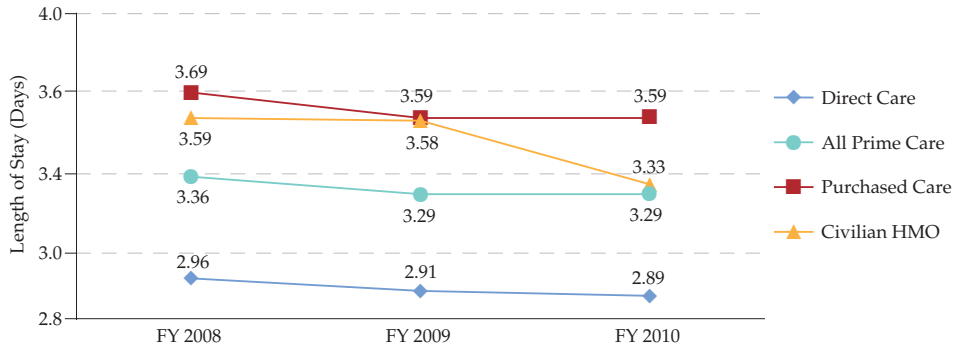
Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2010 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

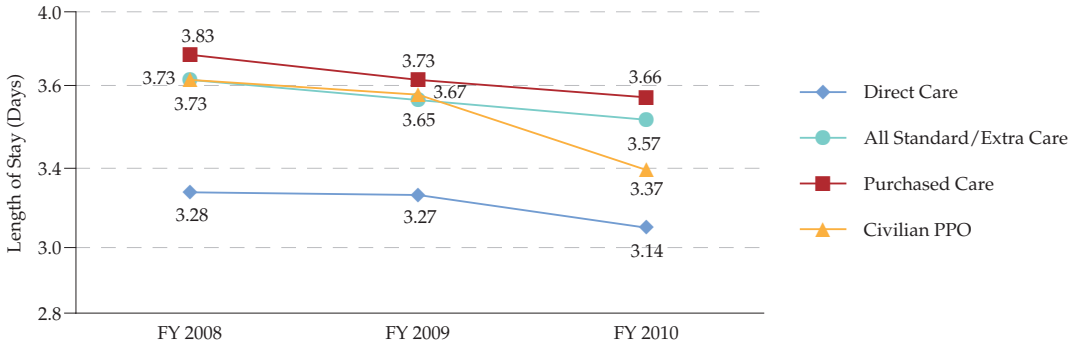
Average Length of Stay (LOS) in Acute Care Hospitals

- Average LOS for Prime enrollees in DoD facilities (direct care) declined by 2 percent between FY 2008 and FY 2010. Average LOS for space-available care declined by 4 percent over that period. Purchased care LOS declined by about the same percentages as direct care LOS for both enrolled and 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 2 percent between FY 2008 and FY 2010, whereas the average LOS for civilian HMOs declined by 7 percent. The average LOS for MHS-wide non-Prime care (space-available and Standard/Extra) declined by 4 percent, whereas the average LOS for civilian PPOs declined by 10 percent.
- In FY 2010, average LOS for MHS-wide Prime care was 1 percent lower than in civilian HMOs. The average LOS for non-Prime care was 6 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, 1/13/2011, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/29/2011

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 2010 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

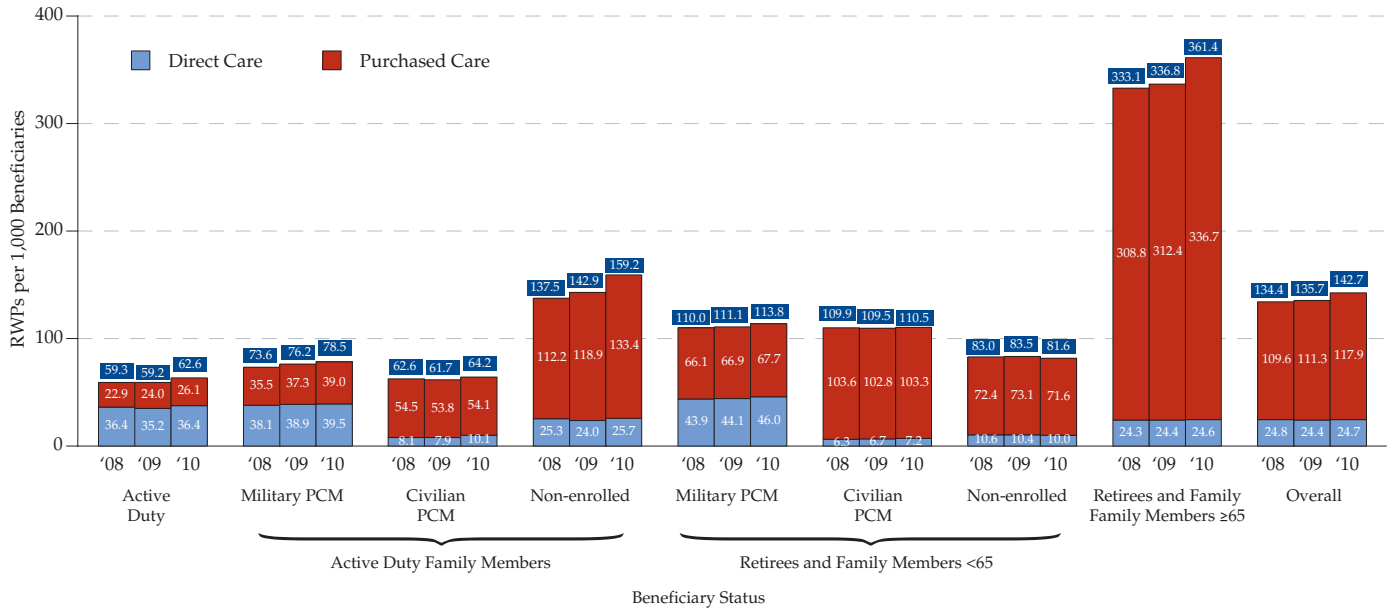
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

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. In FY 2010, TRICARE implemented the Medicare Severity Diagnosis Related Group (MS-DRG) system of classifying inpatient hospital cases to conform with changes made to the Medicare Prospective Payment System. The new DRG classifications resulted in a corresponding change in the calculation of RWPs, which has been applied to the data from FY 2008 to FY 2010.

- The direct care inpatient utilization rate (RWPs per 1,000 beneficiaries) increased substantially for ADFMs with a civilian PCM (25 percent) and for retirees and family members with a civilian PCM (13 percent). The direct inpatient utilization of most other beneficiary groups changed very little from FY 2008 to FY 2010.
- Purchased acute care inpatient utilization rates increased the most for non-enrolled ADFMs (19 percent). ADSMs also saw a large increase in inpatient utilization (14 percent). Beneficiaries with a civilian PCM saw slight declines in purchased inpatient utilization. The remaining beneficiary groups experienced modest increases.
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE is second payer), the percentage of per capita inpatient workload performed in purchased care facilities remained constant at about 70 percent from FY 2008 to FY 2010.
- From FY 2008 to FY 2010, the percentage of per capita inpatient workload (RWPs) referred to the network on behalf of beneficiaries enrolled with a military PCM (including Active Duty personnel) remained constant at about 49 percent from FY 2008 to FY 2010.

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



Source: MHS administrative data, 1/13/2011

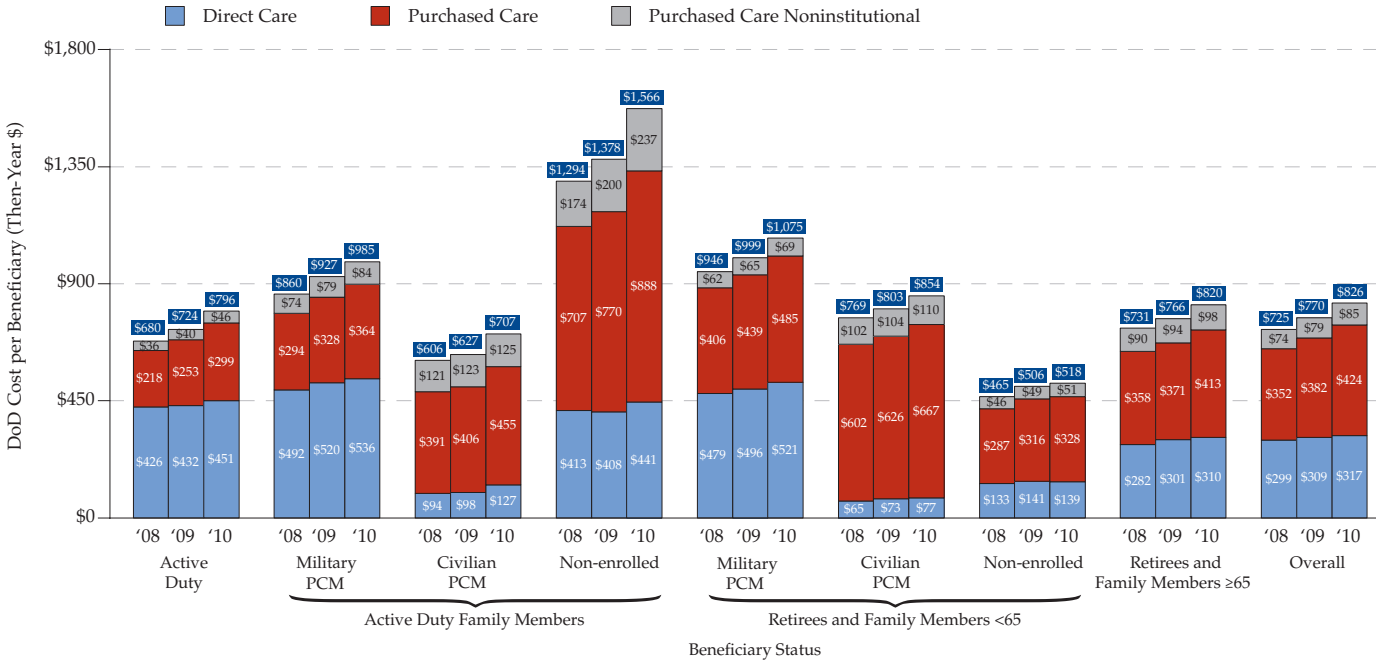
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

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 14 percent from FY 2008 to FY 2010. The increases were due largely to higher purchased care costs.

- The direct care cost per RWP increased from $12,068 in FY 2008 to $12,812 in FY 2010 (6 percent).
- Exclusive of TFL, the DoD purchased care cost (institutional plus noninstitutional) per RWP increased from $3,215 in FY 2008 to $3,597 in FY 2010 (12 percent).
- The DoD 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 COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/13/2011

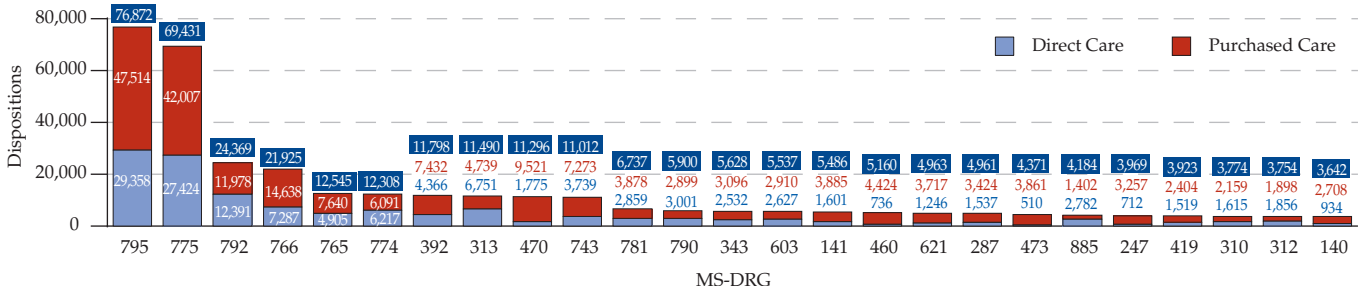
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Leading Inpatient Diagnoses

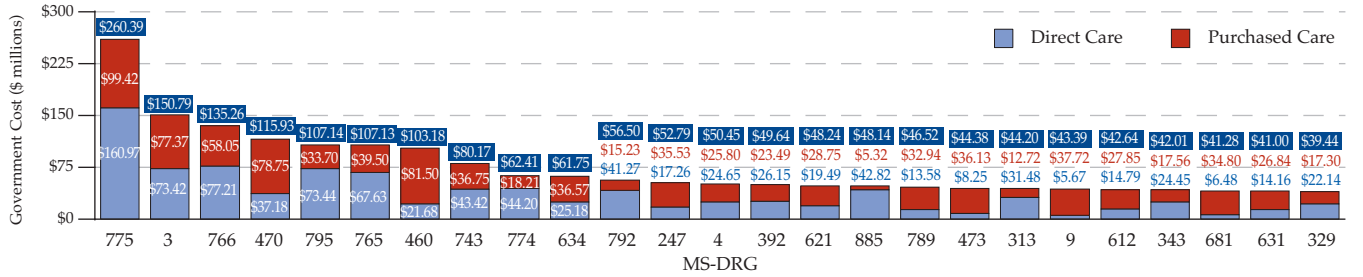
In FY 2010, TRICARE implemented the MS-DRG system of classifying inpatient hospital cases to conform with changes made to the Medicare Prospective Payment System. The new system is designed to better capture variations in severity of illness and resource usage by reclassifying many diagnosis codes with regard to complication/comorbidity (CC) status.

The top 25 MS-DRGs in FY 2010 accounted for 53 percent of all inpatient admissions (direct care and purchased care combined) in acute care hospitals. The leading diagnoses in terms of cost in FY 2010 were determined from institutional claims only; i.e., they include hospital charges but not attendant physician, laboratory, drug, or ancillary service charges. The top 25 DRGs in terms of cost in FY 2010 accounted for 38 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.

BY VOLUME



BY COST



Source: MHS administrative data, 1/13/2011

MS-DRGs

3 Ecmo or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.
4 Trach w MV 96+ hrs or PDX exc face, mouth & neck w/o maj O.R.
9 Bone marrow transplant
140 Simple pneumonia & pleurisy age 0–17
141 Bronchitis & asthma age 0–17
247 Perc cardiovasc proc w drug-eluting stent w/o mcc
287 Circulatory disorders except ami, w card cath w/o MCC
310 Cardiac arrhythmia & conduction disorders w/o CC/MCC
312 Syncope & collapse
313 Chest pain
329 Major small & large bowel procedures w MCC
343 Appendectomy w/o complicated principal diag w/o CC/MCC
392 Esophagitis, gastroent & misc digest disorders age >17 w/o MCC
419 Laparoscopic cholecystectomy w/o c.d.e. w/o CC/MCC
460 Spinal fusion except cervical w/o MCC
470 Major joint replacement or reattachment of lower extremity w/o MCC
473 Cervical spinal fusion w/o CC/MCC
603 Cellulitis age >17 w/o MCC
612 Neonate, birthwt <750g, discharged alive
621 O.R. procedures for obesity w/o CC/MCC
631 Neonate, birthwt 750–999g, discharged alive
634 Neonate, birthwt 1000–1499g, w/o signif o.r. proc, discharged alive
681 Neonate, birthwt >2499g, w signif o.r. proc, w mult major prob
743 Uterine & adnexa proc for non-malignancy w/o CC/MCC
765 Cesarean section w CC/MCC
766 Cesarean section w/o CC/MCC
774 Vaginal delivery w complicating diagnoses
775 Vaginal delivery w/o complicating diagnoses
781 Other antepartum diagnoses w medical complications
789 Neonate, birthwt >2499g, w/o signif o.r. proc, w mult major prob
790 Neonate, birthwt >2499g, w/o signif o.r. proc, w major prob
792 Neonate, birthwt >2499g, w/o signif o.r. proc, w other prob
795 Normal newborn
885 Psychoses

- The top six procedures by volume are all related to childbirth.
- Procedures performed in private sector acute care hospitals account for 61 percent of the total volume of the top 25 diagnoses but only 50 percent of the total cost.
- Admissions in direct care facilities exceed those in purchased care facilities for only five of the 25 top diagnoses. However, expenditures in direct care facilities exceed those in purchased care facilities for 12 of the top 25 diagnoses.
- Surgical procedures for obesity (without CC) are ranked 17th in volume among the top 25 diagnoses (they rank 13th if CCs are included). 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

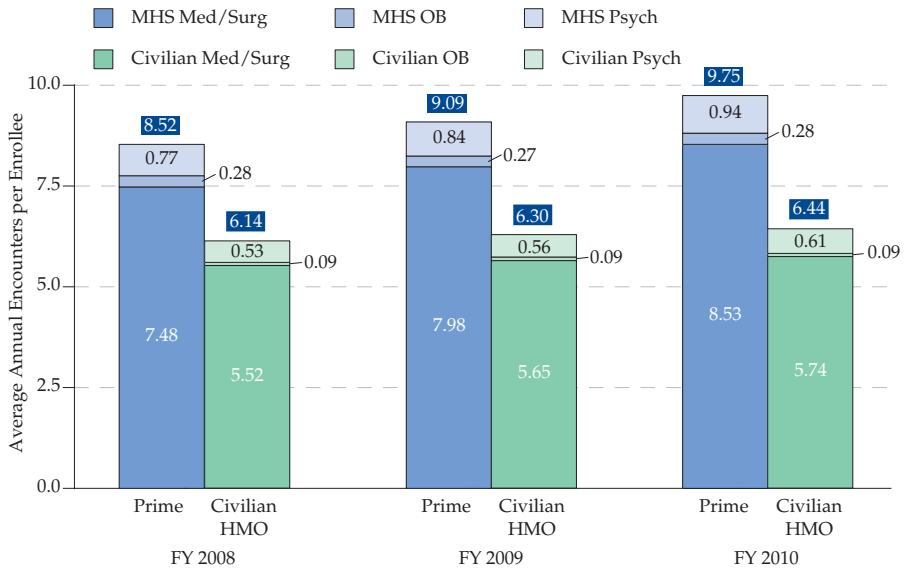
TRICARE Prime Enrollees

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 14 percent between FY 2008 and FY 2010. The civilian HMO outpatient utilization rate increased by only 5 percent over the same period.
- In FY 2010, the overall Prime outpatient utilization rate was 51 percent higher than the civilian HMO rate.
- In FY 2010, the Prime outpatient utilization rate for MED/SURG procedures was 49 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 2008 to 2010, but that is due in part to how the direct care system records bundled services.*
- The Prime outpatient utilization rate for PSYCH procedures was 54 percent higher than the corresponding rate for civilian HMOs in FYs 2008 to 2010. 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, 1/13/2011, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/29/2011

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2010 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)*

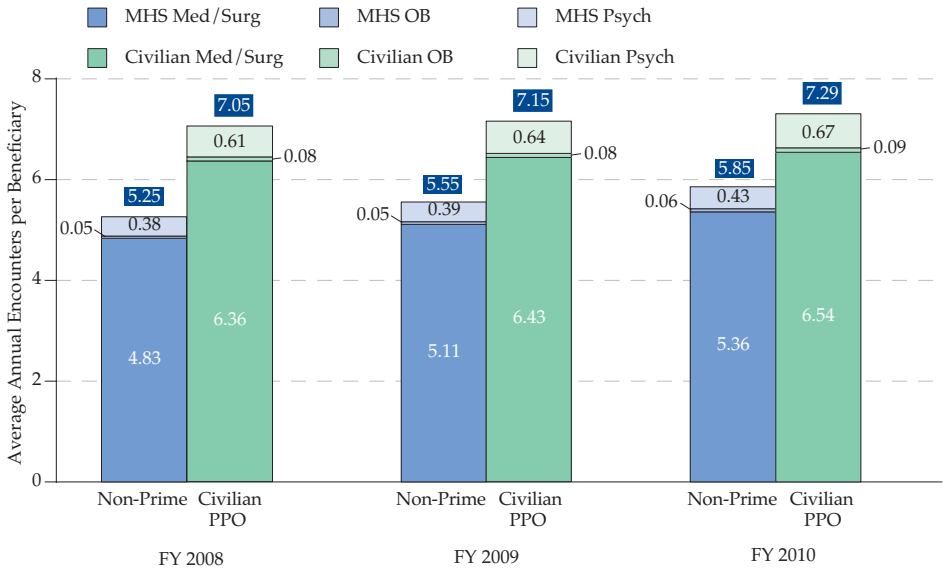
Non-Enrolled Beneficiaries

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 that between 11 and 13 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 11 percent from 5.3 encounters per participant in FY 2008 to 5.8 in FY 2010. The civilian PPO outpatient utilization rate increased from 7.0 to 7.3 encounters per participant over this period (3 percent).
- The overall TRICARE non-Prime (space-available and Standard/Extra) outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2010, TRICARE non-Prime outpatient utilization was 20 percent lower than in civilian PPOs.
- In FY 2010, the non-Prime outpatient utilization rate for MED/SURG procedures was 30 percent lower than the civilian PPO rate. MED/SURG 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 increased by 22 percent between FY 2008 and FY 2010, but was still about one third lower than the rate for civilian PPO participants.
- The PSYCH outpatient utilization rate of non-enrolled MHS beneficiaries increased by 12 percent from FY 2008 to FY 2010, whereas the rate increased by 10 percent for civilian PPO participants. In FY 2010, the PSYCH outpatient utilization rate for non-enrolled beneficiaries was 36 percent below that of civilian PPO participants. The latter observation, together with the utilization exhibited by Prime enrollees, suggests that MHS beneficiaries in need of extensive PSYCH counseling (primarily Active Duty members and their families) are more likely to enroll in Prime.

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



Sources: MHS administrative data, 1/13/2011, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/29/2011

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2010 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

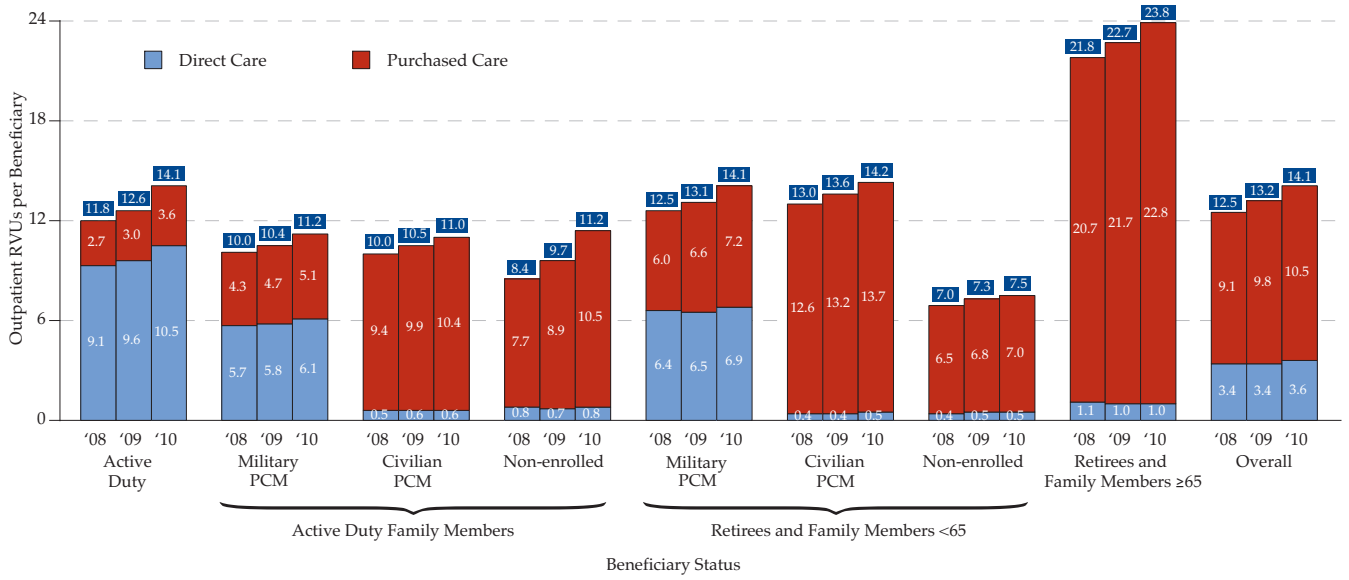
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

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.

- All beneficiary groups except seniors experienced an increase in direct outpatient utilization from FY 2008 to FY 2010. The direct care outpatient utilization rate increased by 17 percent for ADFMs with a civilian PCM and by 14 percent for ADSMs. Seniors experienced a decline of 3 percent.
- From FY 2008 to FY 2010, the purchased care outpatient utilization rate increased for all beneficiary groups. The largest increase (36 percent) was experienced by non-enrolled ADFMs. ADSMs also experienced a large increase in purchased care utilization (21 percent). However, there is no evidence that the increased purchased care utilization for these groups has come at the expense of direct care utilization. A combination of increased demand and limited MTF capacity is the most likely explanation for the increase.
- The TFL outpatient utilization rate increased by 7 percent in FY 2009 and by another 8 percent in FY 2010.*

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/13/2011

* 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.

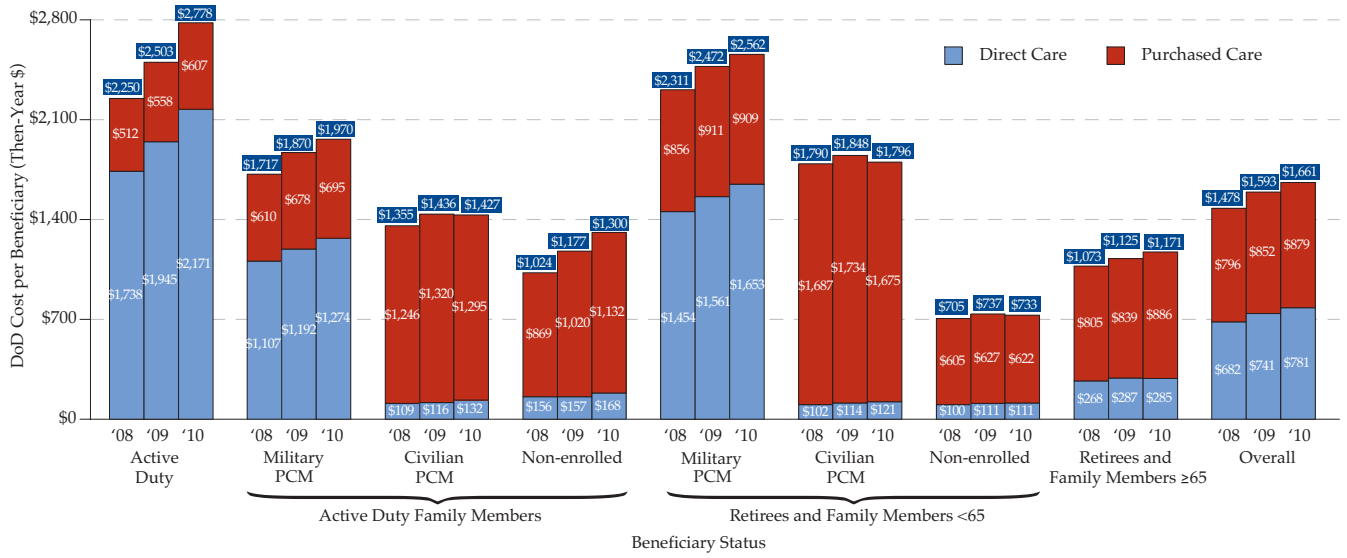
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

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 12 percent from FY 2008 to FY 2010.

- The direct care cost per beneficiary increased for all beneficiary groups. Active Duty members experienced the largest increase (25 percent), followed by ADFMs with a civilian PCM (21 percent) and retirees and family members with a civilian PCM (19 percent).
- Excluding TFL, the DoD purchased care outpatient cost per beneficiary increased by 8 percent in FY 2009 and by another 4 percent in FY 2010.
- The TFL purchased care outpatient cost per beneficiary increased by 8 percent in FY 2009 and by another 4 percent in FY 2010.* The direct care outpatient cost per senior increased by 9 percent in FY 2009 and by another 6 percent in FY 2010.

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/13/2011

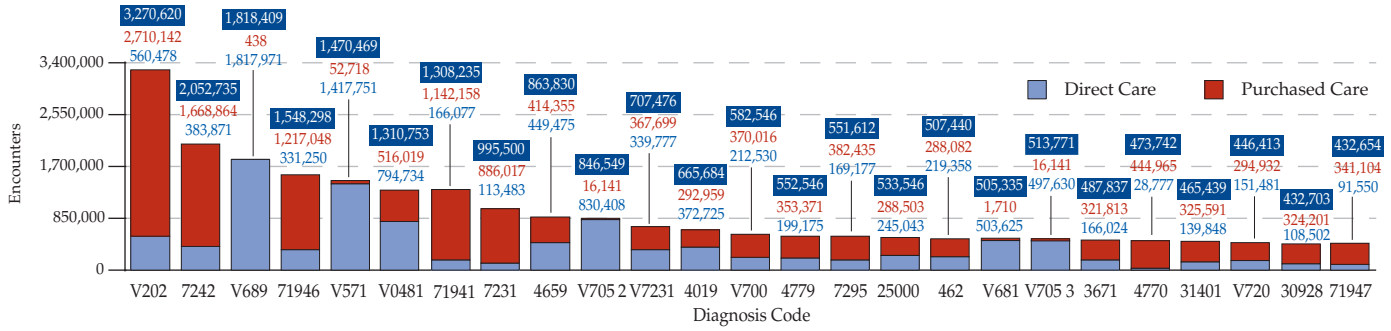
* The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there are a small number who are not.

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

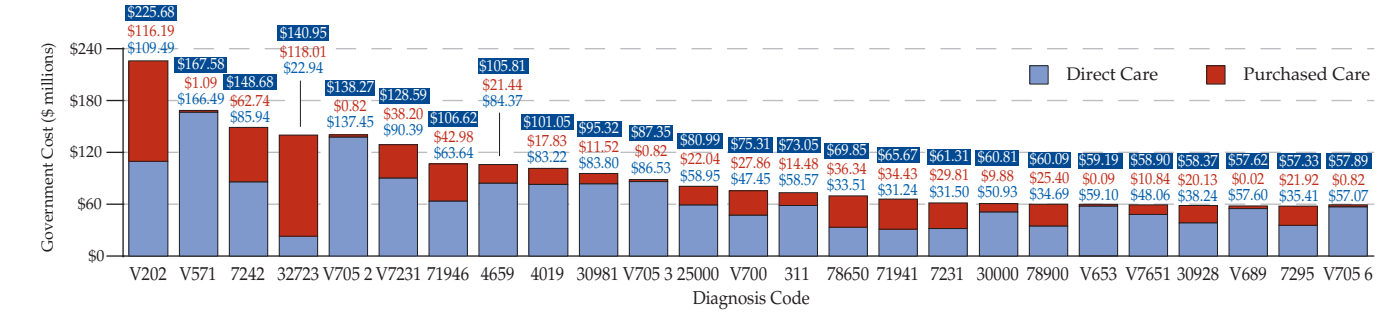
Leading Outpatient Diagnoses

The top 25 outpatient diagnoses in FY 2010 accounted for 30 percent of all outpatient encounters (direct care and purchased care combined) and 21 percent of total outpatient costs. Direct care drug expenses, which are included in outpatient costs in the direct care administrative data, are excluded from the cost totals in this section. TFL encounters are excluded from the calculations for both volume and cost.

BY VOLUME



BY COST



Source: MHS administrative data, 1/13/2011

Diagnosis Code

311	Depressive disorder, not elsewhere classified
462	Acute pharyngitis
3671	Myopia
4019	Essential hypertension, unspecified
4659	Acute upper respiratory infections of unspecified site
4770	Allergic rhinitis due to pollen
4779	Allergic rhinitis, cause unspecified
7231	Cervicalgia
7242	Lumbago
7295	Pain in limb
25000	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
30000	Anxiety state, unspecified
30928	Adjustment disorder with mixed anxiety and depressed mood
30981	Post-traumatic stress disorder
31401	Attention deficit disorder, with hyperactivity
32723	Obstructive sleep apnea (adult)(pediatric)
71941	Pain in joint involving shoulder region
71946	Pain in joint involving lower leg
71947	Pain in joint involving ankle and foot
78650	Chest pain, unspecified
78900	Abdominal pain, unspecified site
V0481	Need for prophylactic vaccination and inoculation, influenza
V202	Routine infant or child health check
V571	Care involving other physical therapy
V653	Dietary surveillance and counseling
V681	Issue of repeat prescriptions
V689	Encounters for unspecified administrative purpose
V700	Routine general medical examination at health care facility
V705 2	Other examination defined population
V705 3	Other examination defined population
V705 6	Periodic prevention examination
V720	Occupational examination
V7231	Routine gynecological examination
V7651	Special screening for malignant neoplasms, colon

- The top two diagnoses by volume are treated primarily in purchased care facilities, whereas the third-ranked diagnosis is treated almost exclusively in direct care facilities.
- Diagnoses treated in purchased care facilities account for 56 percent of the total volume of the top 25 diagnoses but only 29 percent of the total cost.
- Encounters in direct care facilities exceed those in purchased care facilities for only 8 of the 25 top diagnoses. However, expenditures in direct care facilities exceed those in purchased care facilities for 21 of the top 25 diagnoses.

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, home delivery 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.

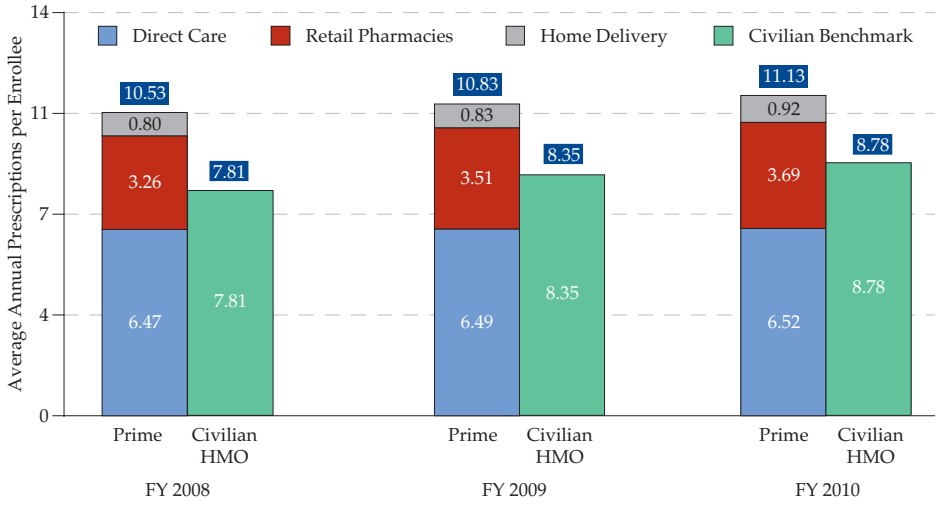
Direct care pharmacy data differ from private sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the TMA Pharmacy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

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 6 percent between FY 2008 and FY 2010; the civilian HMO benchmark rate rose by 12 percent. Even though civilian prescription utilization increased at a faster rate, the TRICARE Prime prescription utilization rate was still 27 percent higher than the civilian HMO rate in FY 2010.
- Prescription utilization rates for Prime enrollees at DoD pharmacies increased by less than 1 percent from FY 2008 to FY 2010, whereas the utilization rate at retail pharmacies increased by 13 percent.
- Enrollee home delivery prescription utilization increased by 15 percent from FY 2008 to FY 2010. Nevertheless, home delivery 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, 1/13/2011, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/29/2011

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2010 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)*

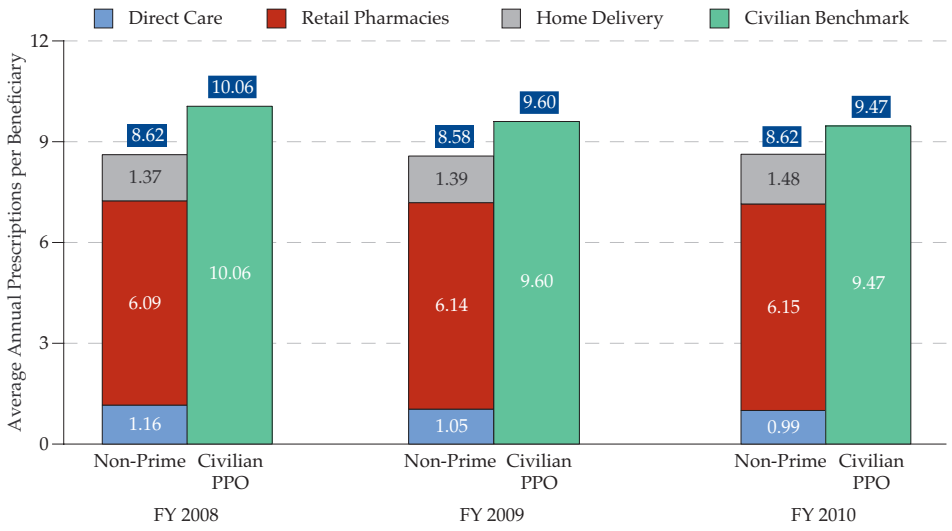
Non-Enrolled Beneficiaries

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 that between 11 and 13 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 remained about the same between FY 2008 and FY 2010. During the same period, the civilian PPO benchmark rate fell by 6 percent. Although the gap has narrowed, the TRICARE prescription utilization rate for non-enrollees is still 9 percent lower than the civilian PPO rate.
- The direct care prescription utilization rate for non-enrolled beneficiaries dropped by 15 percent from FY 2008 to FY 2010, but was offset by a corresponding increase in the purchased care rate.
- Non-enrollee home delivery prescription utilization increased by 8 percent from FY 2008 to FY 2010. Nevertheless, home delivery 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, 1/13/2011, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/29/2011

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2010 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.

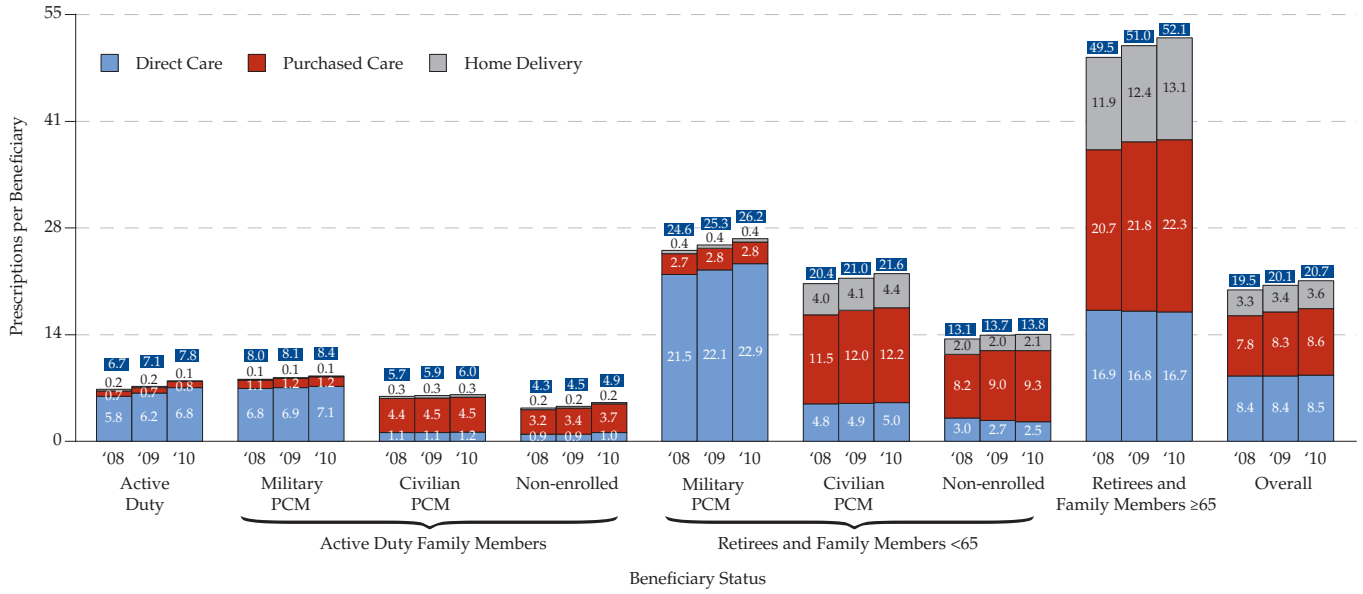
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

TRICARE Prescription Drug Utilization Rates by Beneficiary Status

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

- The total (direct, retail, and home delivery) number of prescriptions per beneficiary increased by 7 percent from FY 2008 to FY 2010, exclusive of the TFL benefit. Including TFL, the total number of prescriptions increased by 6 percent.
- The average direct care prescription utilization rate increased by less than 1 percent from FY 2008 to FY 2010. However, the rate increased by 18 percent for ADSMs and by 12 percent for non-enrolled ADFMs and for ADFMs with a civilian PCM. Those increases were offset by a decline of 15 percent in the direct prescription utilization rate of non-enrolled retirees and family members under age 65.
- Average per capita prescription utilization through nonmilitary pharmacies (civilian retail and home delivery) increased for all beneficiary groups, but most notably for non-enrolled ADFMs (18 percent). ADSMs and non-enrolled retirees and family members also experienced large increases in purchased care prescription utilization (11 percent each).
- Home delivery remains a relatively infrequent source of purchased care prescription utilization but its use has been increasing. When normalized by 30 days supply, home delivery utilization as a percentage of total purchased care prescription drug utilization increased by 11 percent.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/13/2011

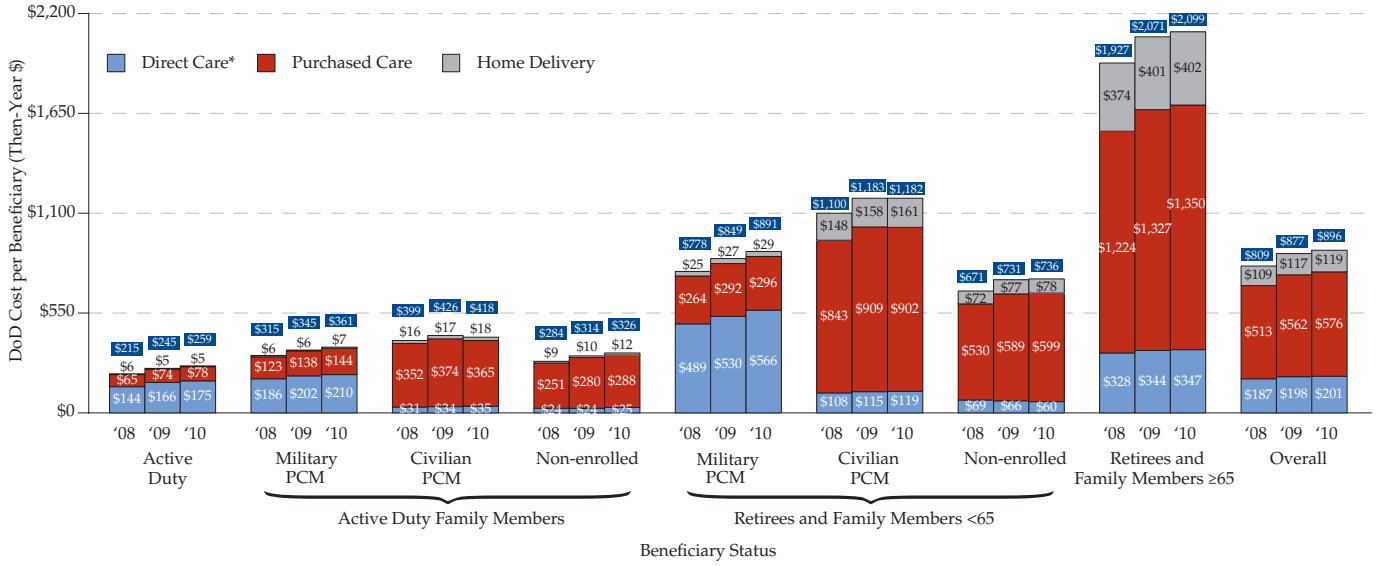
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

Prescription Drug Cost by Beneficiary Status

Although the drug rebates referenced on page 29 have slowed the overall growth of retail prescription drug costs, the rebates are not reflected in the chart below because they cannot be attributed to specific beneficiary groups.

- Exclusive of TFL, prescription drug costs rose by 13 percent between FY 2008 and FY 2010. Including TFL, prescription drug costs rose by 11 percent.
- Direct care costs per beneficiary increased by 8 percent but retail pharmacy costs rose by 14 percent exclusive of TFL and by 12 percent including TFL.
- Home delivery costs increased by 13 percent exclusive of TFL and by 9 percent including TFL.

AVERAGE ANNUAL DoD PRESCRIPTION COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/13/2011

* 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 in the U.S. 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 TRICARE for Life (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.

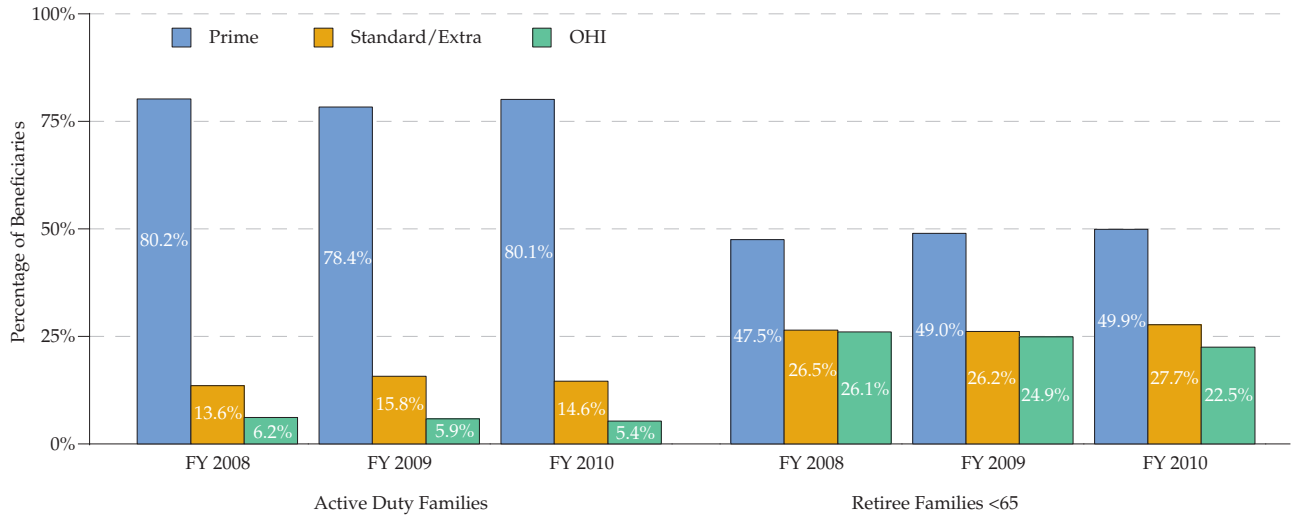
Health Insurance Coverage of MHS Beneficiaries Under Age 65

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 2010, 80.1 percent of Active Duty families and 49.9 percent of retiree families were in this group.
- TRICARE Standard/Extra: Family not enrolled in TRICARE Prime and no OHI coverage. In FY 2010, 14.6 percent of ADFMs and 27.7 percent of retiree families were in this group.
- OHI: Family covered by OHI. In FY 2010, 5.4 percent of Active Duty families and 22.5 percent of retiree families were in this group.

HEALTH INSURANCE COVERAGE OF BENEFICIARIES UNDER AGE 65



Source: FYs 2008–2010 Healthcare Surveys of DoD Beneficiaries (HCSDB)

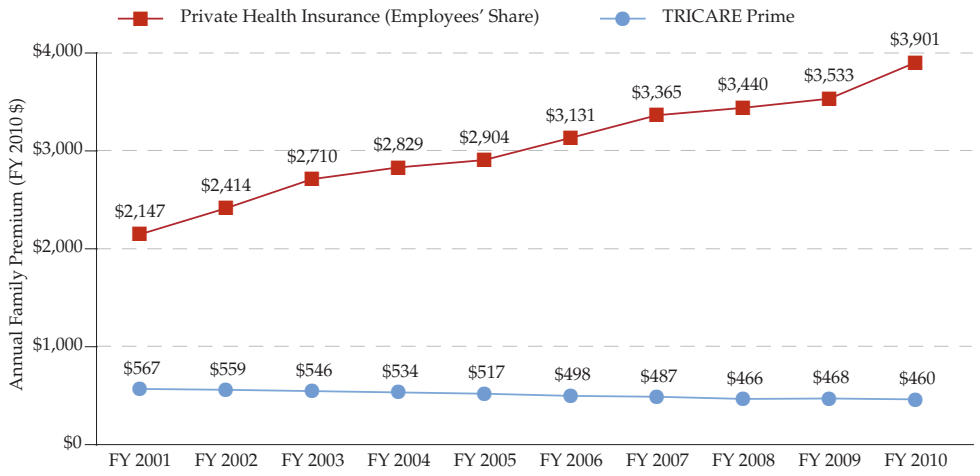
Note: The Prime group includes HCSDB respondents enrolled in Prime based on DEERS plus enrollees in the USFHP. The Standard/Extra group includes HCSDB respondents without OHI who are non-enrollees based on DEERS. The OHI group includes HCSDB respondents with private health insurance, i.e., FEHBP, a civilian HMO such as Kaiser, or other civilian insurance such as Blue Cross. A small percentage of Prime enrollees are also covered by OHI; these beneficiaries are included in the Prime group. Percentages may not sum 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 2010 dollars, the private health insurance premium increased by $1,754 (82 percent) from FY 2001 to FY 2010, whereas the TRICARE premium declined by $107 (–19 percent) during this period.

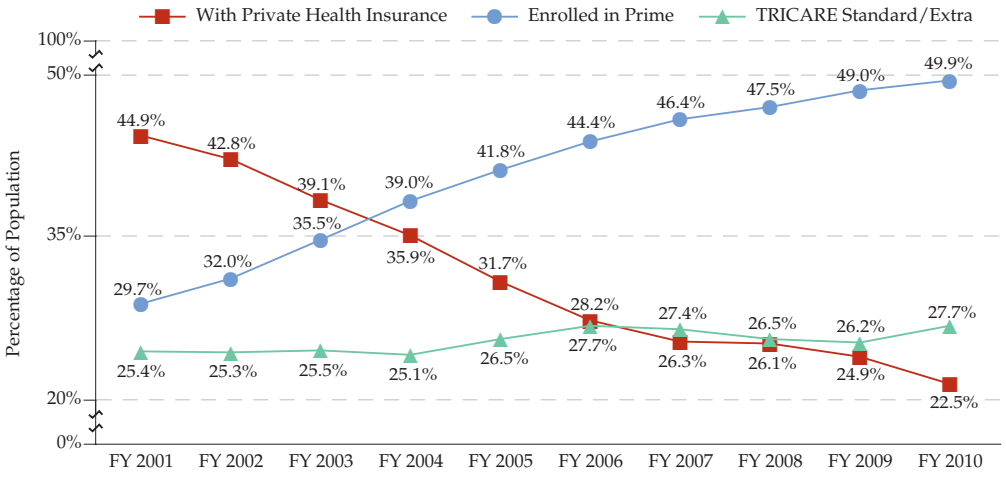
TREND IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT FEE



Sources: Employees' share of insurance premium for typical employer sponsored family health plan: Medical Expenditure Panel Surveys, 2000–2009; forecasted by Institute for Defense Analyses in FY 2010 based on trends in premiums from Kaiser Family Foundation surveys in 2008–2010.

Between FY 2001 and FY 2010, 22.4 percent of retirees switched from private health insurance to TRICARE. Most of these retirees likely switched because of the increasing disparity in premiums (and out-of-pocket expenses); in the past few years, some may have lost coverage due to the recession. As a result of declines in private insurance coverage, an additional 689,000 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, 2001–2010

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

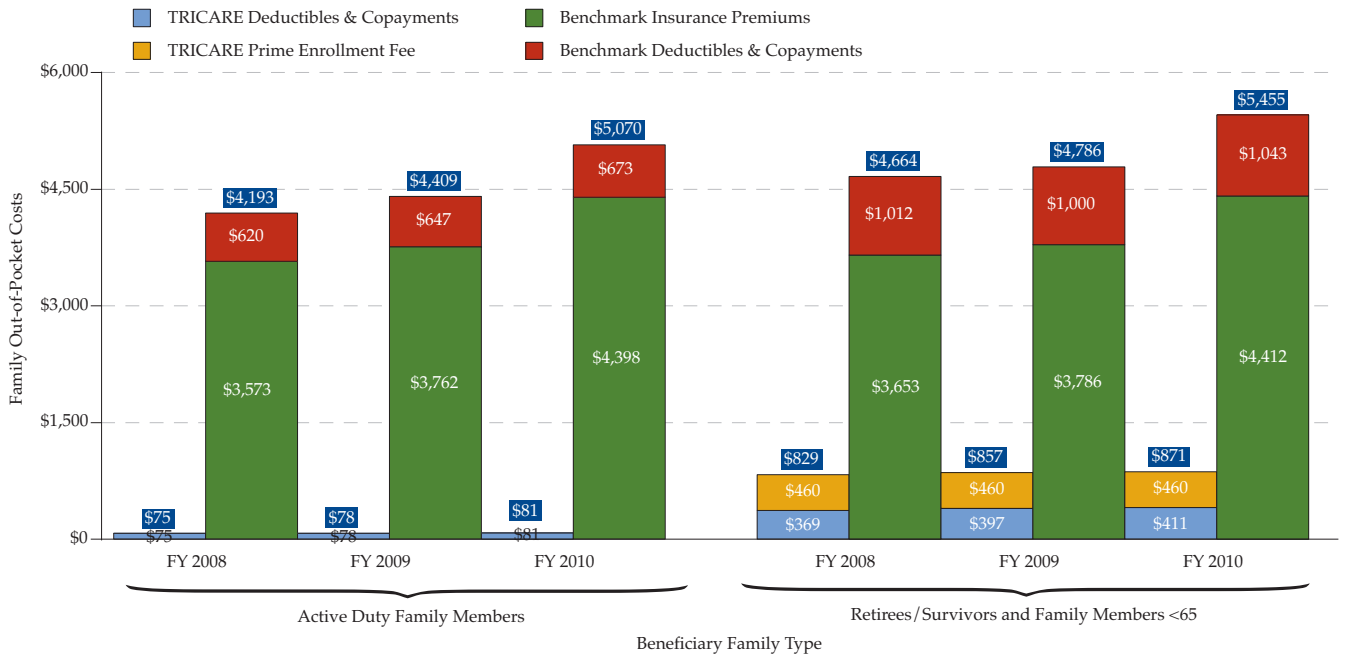
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

In FYs 2008–2010, 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 2010, costs for civilian counterparts were:
  - $5,000 more than those incurred by Active Duty families enrolled in Prime.
  - $4,600 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 2008–2010; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2007–2010; civilian insurance premiums for FYs 2008–2009 from the 2007–2009 Medical Expenditure Panel Surveys; premiums for FY 2010 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys in 2008–2010. Private health insurance coverage from Health Care Surveys of DoD Beneficiaries, FYs 2008–2010.

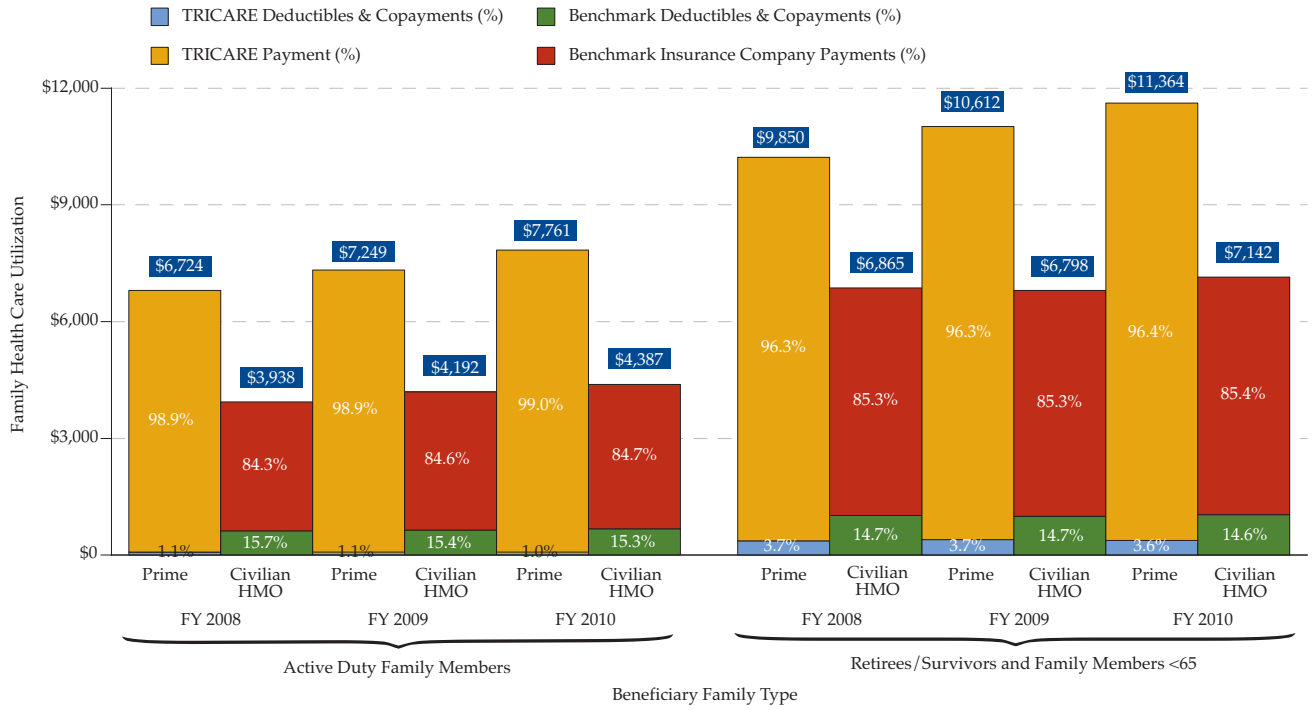
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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 2008–2010, TRICARE Prime enrollees had negligible coinsurance rates (deductibles and copayments per dollar of utilization) and, not surprisingly, much higher utilization compared with 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 coinsurance rates than civilian HMO counterparts.
  - In FY 2010, the coinsurance rate for Active Duty families was 1.0 percent versus 15.3 percent for civilian counterparts.
  - In FY 2010, the coinsurance rate for retiree families was 3.6 percent versus 14.6 percent for civilian counterparts.
- TRICARE Prime enrollees had 49–71 percent higher health care utilization than civilian HMO counterparts.
  - In FY 2010, Active Duty families consumed $7,800 of medical services versus $4,400 by civilian counterparts (71 percent higher).
  - In FY 2010, retiree families consumed $11,400 of medical services versus $7,100 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, FYs 2008–2010; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2007–2010.

* 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.

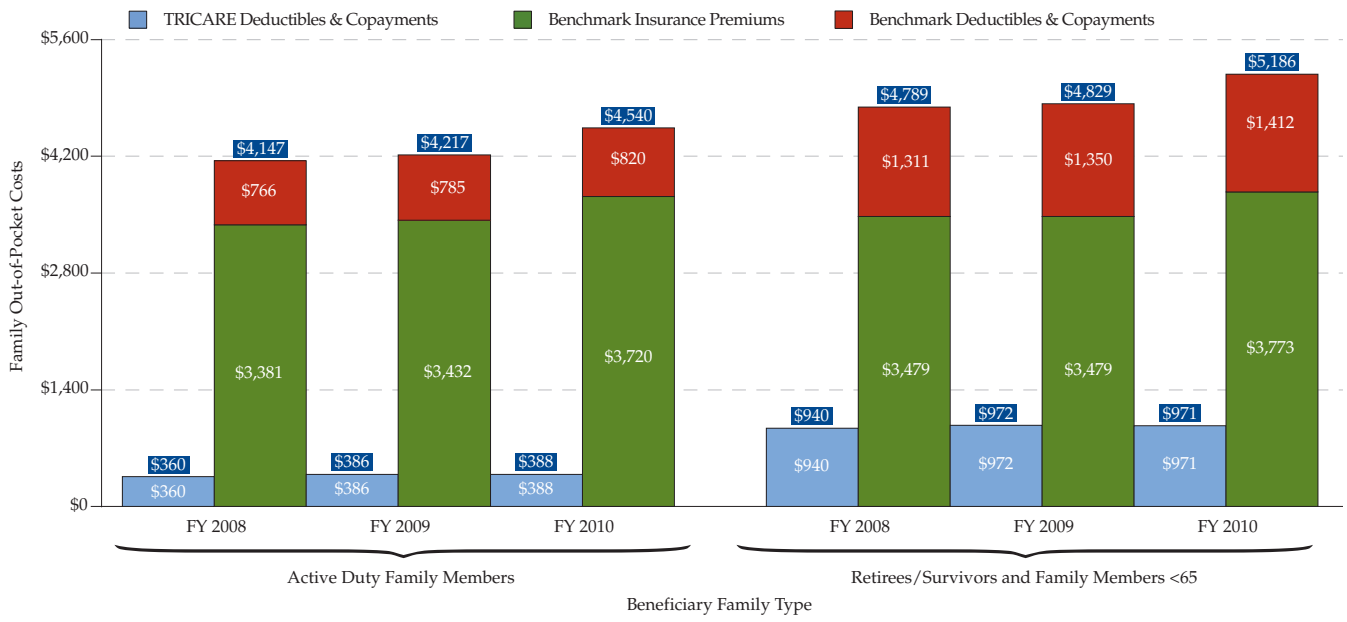
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

In FY 2008 to FY 2010, 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 2010, costs for civilian counterparts were:
  - $4,200 more than those incurred by Active Duty families who relied on Standard/Extra.
  - $4,200 more than those incurred by 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 2008–2010; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2007–2010; civilian insurance premiums for FYs 2008–2009 from the 2007–2010 Medical Expenditure Panel Surveys; premiums for FY 2010 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys in 2008–2010. OHI coverage from Health Care Surveys of DoD Beneficiaries, FYs 2008–2010.

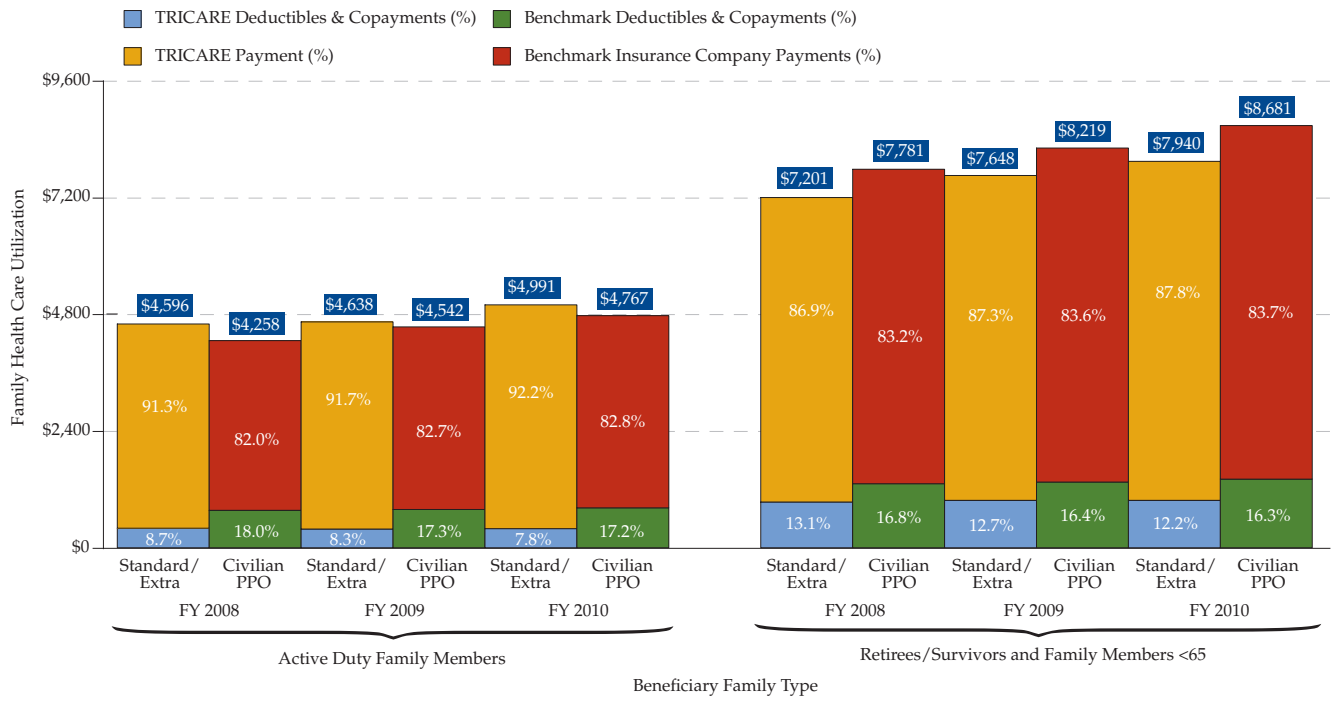
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

In FYs 2008–2010, families who relied on TRICARE Standard/Extra had lower average coinsurance 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 similar or slightly lower for TRICARE Standard/Extra families compared with civilian counterparts in FYs 2008–2010.

- TRICARE Standard/Extra reliant families had lower average coinsurance rates than civilian PPO counterparts.
  - In FY 2010, the coinsurance rate for Active Duty families was 7.8 percent versus 17.2 percent for civilian counterparts.
  - In FY 2010, the coinsurance rate for retiree families was 12.2 percent versus 16.3 percent for civilian counterparts.
- Despite lower coinsurance rates, health care utilization was about the same for TRICARE Standard/Extra families compared with their civilian PPO counterparts.
  - In FY 2010, Active Duty families consumed $5,000 of medical services versus $4,800 by civilian counterparts (4 percent more).
  - In FY 2010, retiree families consumed $7,900 of medical services versus $8,700 by civilian counterparts (9 percent less).

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, FYs 2008–2010; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2007–2010.

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

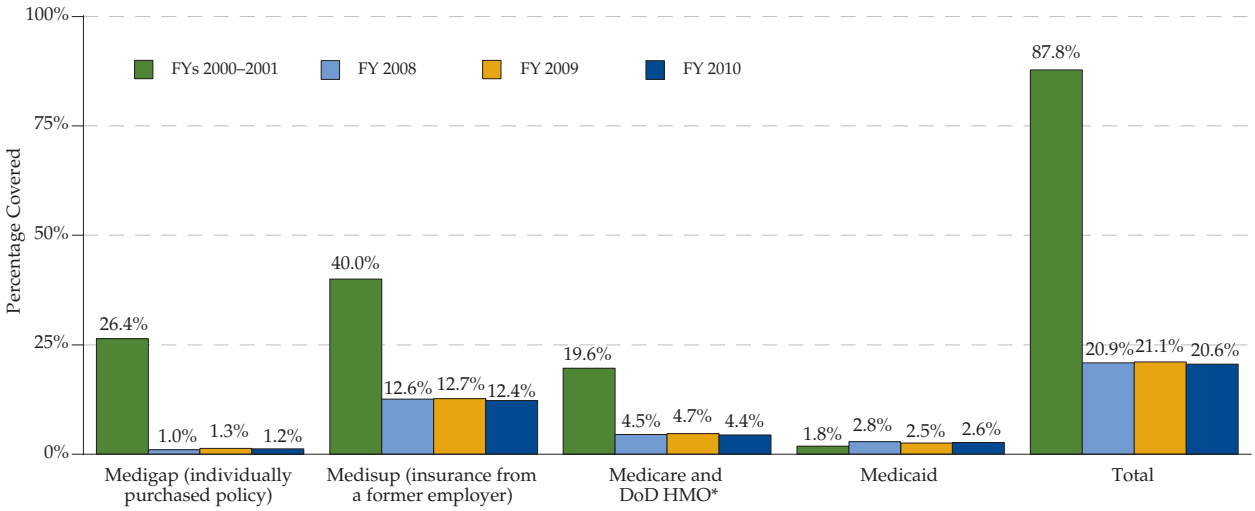
Health Insurance Coverage of MHS Senior Beneficiaries Before and After TFL*

In April 2001, DoD expanded drug benefits for seniors; and, on October 1, 2001, DoD implemented the TFL program, which provides Medicare wraparound coverage, i.e., TRICARE acts as second payer to Medicare, minimizing beneficiary out-of-pocket expenses.

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 2000–2001), 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 21 percent in FYs 2008–2010.
- Why do a fifth 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 FYs 2008–2010 Health Care Surveys of DoD Beneficiaries.

* Insurance coverage for DoD HMOs includes TRICARE Senior Prime (until December 2001) and the USFHP. Insurance coverage for OHI includes those without Medicare who are covered by FEHBP, a civilian HMO such as Kaiser, or other civilian health insurance such as Blue Cross.

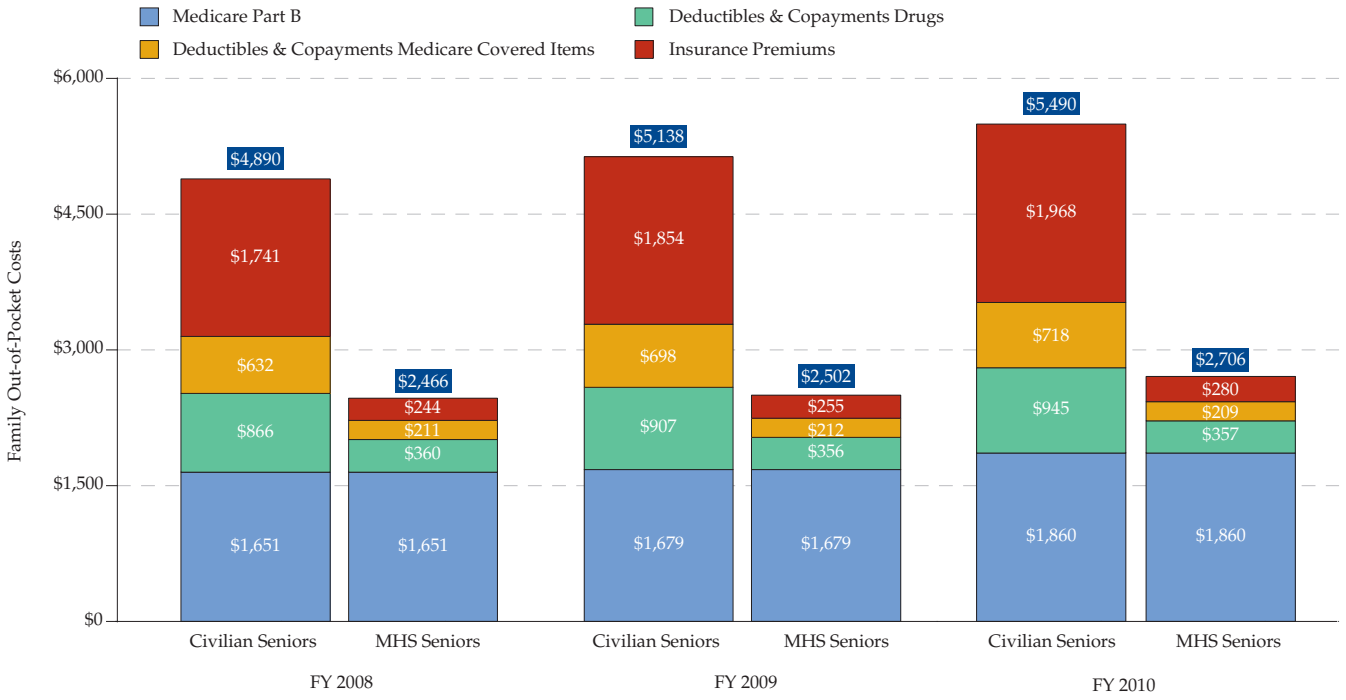
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT'D)*

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 supplemental 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 2008–2010, out-of-pocket costs for MHS senior families were about 50 percent less than those of "before TFL" civilian counterparts.
- In FY 2010, MHS senior families saved almost $2,800 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 2008–2010; expenditures for TFL non-users and civilian counterparts from Medical Expenditure Panel Surveys and projections, 2007–2010; 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 2007–2010; Medicare supplemental insurance coverage, before and after TFL, from Health Care Surveys of DoD Beneficiaries, 2000–2001 and FYs 2008–2010.

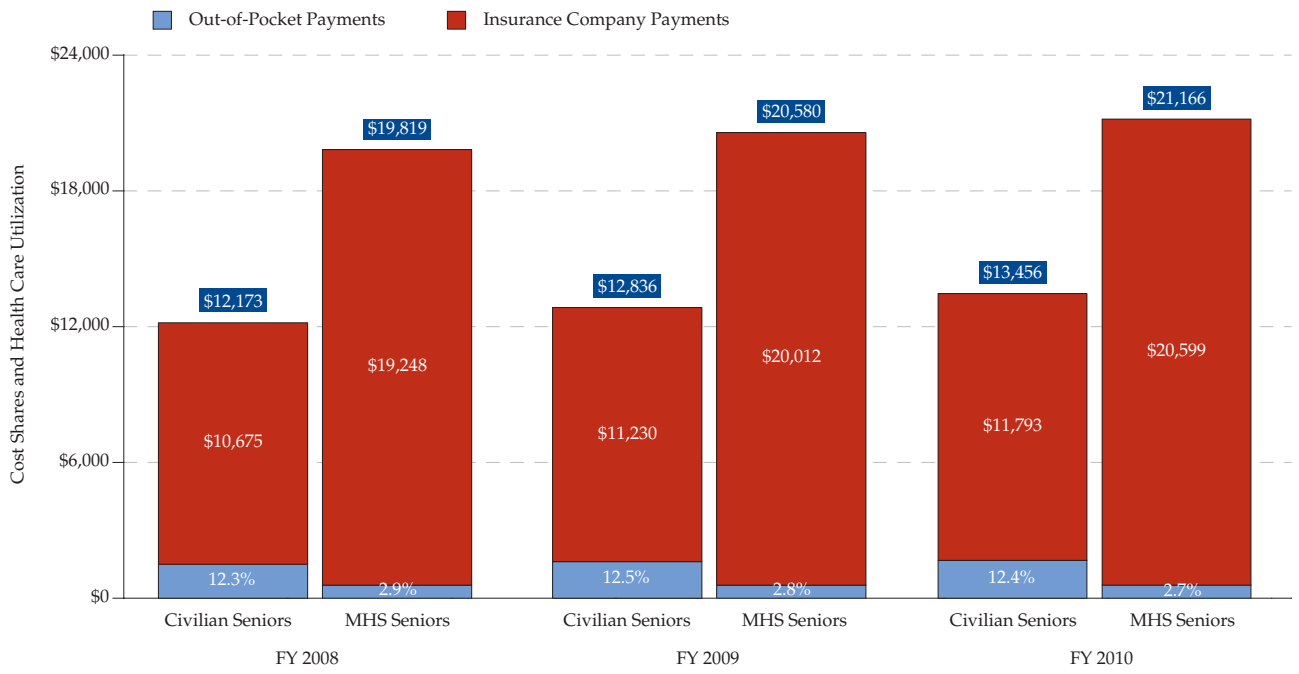
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT'D)*

Cost Shares and Health Care Utilization for MHS Versus Civilian Senior Families

Medicare supplemental insurance lowers the coinsurance 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 coinsurance rates, and, not surprisingly, utilization is higher for MHS seniors compared with "before TFL" civilian counterparts.

- TRICARE senior families have relatively low coinsurance rates.
  - In FY 2010, the coinsurance rate for MHS seniors was 2.7 percent; it was 12.4 percent for civilian counterparts.
- TRICARE senior families have relatively high health care utilization.
  - In FY 2010, MHS families consumed $21,200 of medical services compared with only $13,500 for civilian counterparts (57 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 2008–2010; expenditures for TFL non-users and civilian counterparts from Medical Expenditure Panel Surveys and projections, 2007–2010; Medicare supplemental insurance coverage, before and after TFL, from Health Care Surveys of DoD Beneficiaries, 2000–2001 and FYs 2008–2010.

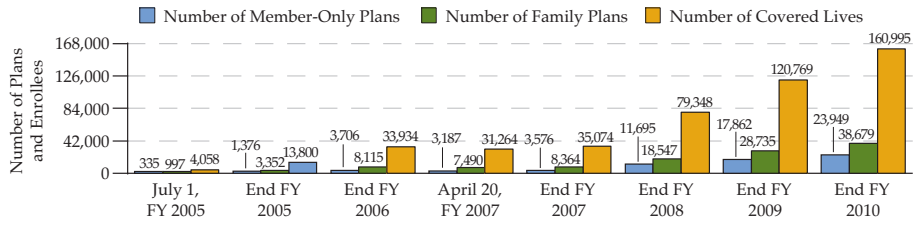
* Physician Payment Review Commission. *Annual Report to Congress: Fiscal Year 1997*. Private Secondary Insurance for Medicare Beneficiaries, pp. 327–28.

TRICARE RESERVE SELECT—PROGRAM ENROLLMENT

RC members now have a continuum of health coverage available for themselves and their eligible family members through MHS. They and their families are covered by TRICARE for up to 180 days before the sponsor reports to AD (early eligibility), and for up 180 days after deactivation through the Transitional Assistance Management Program (TAMP). Qualified Selected Reservists may purchase TRS coverage when not in mobilized status, to include the period following the 180 days of TAMP coverage. Additionally, the Department just launched, beginning October 1, 2010, the TRR program allowing qualified retired Reserve members and their qualified survivors to purchase retiree TRICARE Standard/Extra coverage. And, finally, upon reaching their 60th birthday, retired Reservists gain TRICARE coverage the same as regular retirees and their eligible families.

The premium-based TRS program offers comprehensive health care coverage similar to TRICARE Standard and TRICARE Extra. The TRS program was established by the 2005 NDAA for qualified members of the Selected Reserve and their immediate family members (*Federal Register*, June 21, 2006). It was subsequently revised to its present requirements and expanded eligibility effective October 1, 2007. The number of plans (member-only and family) and number of covered lives have increased fivefold since the October 2007 changes (from almost 12,000 plans and 35,000 covered lives beginning FY 2008 to over 63,000 plans and 160,000 covered lives by the end of FY 2010). The chart below presents TRS enrollment growth since plan inception.

TREND IN ENROLLMENT IN TRICARE RESERVE SELECT SINCE INCEPTION (JULY 2005 TO SEPTEMBER 2010)



Source: HA/TMA–TRICARE Operations, 10/29/2010

SELECTED RESERVE POPULATION IN THE U.S. RELATIVE TO MTF, PRIME, AND NON-PRIME SERVICE AREAS IN FY 2010

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, 10/27/2010

TRICARE RESERVE SELECT—PROGRAM ENROLLMENT *(CONT'D)*

- As of September 30, 2010, there were nearly 2 million Selected Reserve Service members and their families (855,591 Service members and 1,069,815 family members) in the United States.
- The map on the previous page depicts where the Selected Reservists and their family members reside in the U.S., relative to the direct care MTFs.
- As shown in the table, 81 percent of Selected Reservists and their family members in the United States live within the area covered by the TRICARE network in FY 2010 (ranging from 72 percent in the North and West TRICARE regions to 100 percent in TRICARE-South). Slightly over half (56 percent) of this population resides near an MTF, compared to 91 percent of the Active Duty and their family members.
- As shown below, almost two-thirds (64 percent) of the worldwide Selected Reserve population of 2.3 million sponsors and their family members are Army National Guard (41 percent) and Army Reserves (23 percent).

COMPARISON OF SELECTED RESERVE AND ACTIVE DUTY SPONSORS AND FAMILY MEMBER PROXIMITY TO MILITARY TREATMENT FACILITIES AND NETWORK PROVIDERS IN THE U.S.

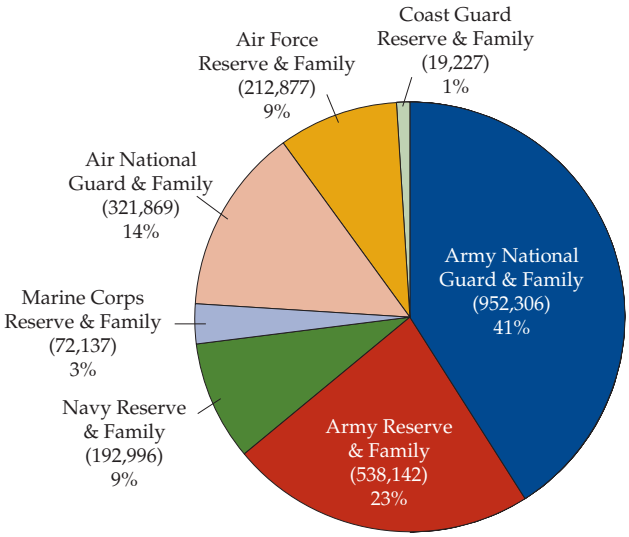
BENEFICIARY GROUP	Population Totals (Ending Sept. 30, 2010)	% in MTF Service Areas	% in PSAs
Active Duty and Their Families	3,166,192	91%	96%
Selected Reservists and Their Families	2,169,788	56%	81%

Notes on data: Population data source: OASD(RA) and DEERS for Selected Reserve (Reserves and National Guard); and MDR DEERS extract for Active Duty and their families. Data are as of 9/30/2010; extracted 11/1/2010. Populations for U.S. only.

Geographic Definitions:

MTF Service Areas are 40-mile circles around inpatient and outpatient MTFs, rounded to include all complete and partial zip codes, subject to overlap rules, barriers, and other policy overrides. Prime Service Areas are both MTF Service Areas as well as similar geographies around closed MTFs (BRAC Prime Service Areas) and other locations with high concentrations of MHS beneficiaries.

SELECTED RESERVE POPULATION: SPONSORS AND FAMILY MEMBERS BY SERVICE (AUGUST 2010)



Source: Data are as of the end of August 2010, from OASD/RA (M&P), 10/27/2010.

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 re-evaluation 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 2010 as shown below:

- Overall MHS dental readiness in the combined Classes 1 and 2 remains high. The FY 2010 combined Class 1 or Class 2 rate of 91.5 percent has increased by almost 2 percentage points over the FY 2008 rate of 89.6 percent.
- The rate for Active Duty personnel in Dental Class 1 has remained steady at around 39 percent over the past four fiscal years.

ACTIVE DUTY DENTAL READINESS: PERCENT CLASS 1 OR 2

Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 11/2/2010

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.

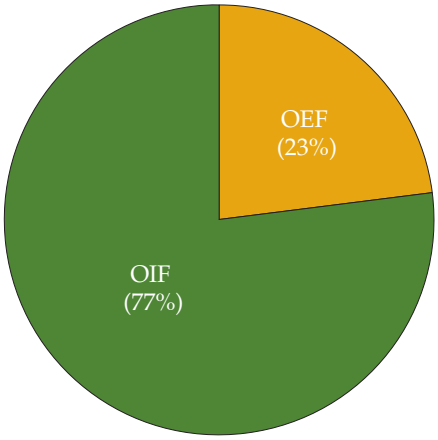
DEPLOYABLE MEDICAL CAPABILITY: PATIENT MOVEMENT OUTSIDE JOINT OPERATIONAL AREA

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 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

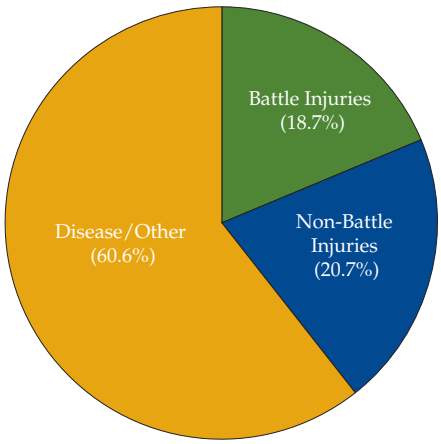


Source: U.S. Transportation Command Regulating and Command & Control Evacuation System (TRAC2ES) as of 10/12/2010

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

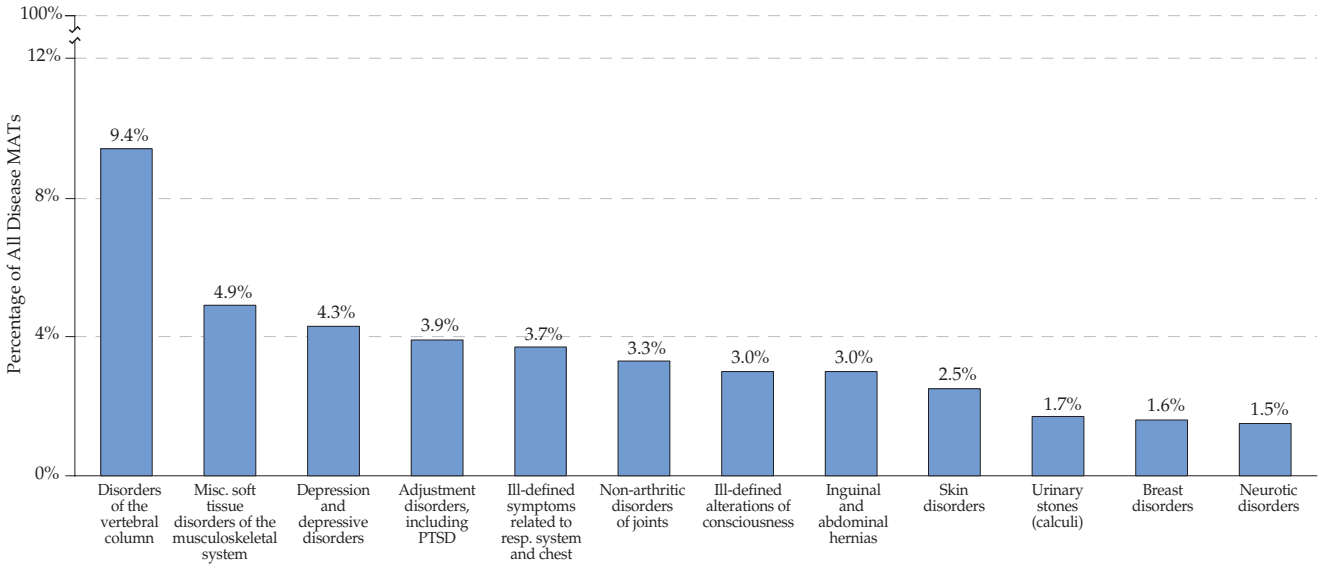
- Since October 2001, a total of 64,162 medical air transports have been provided, with disease and other conditions representing about 60 percent of the movement, and the remainder split almost equally between battle injuries and nonbattle injuries (each about one-fifth of total air transport movement).
- 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 10/12/2010

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 10/12/2010

2010 RESEARCH PRESENTED BY THE CENTER FOR HEALTHCARE MANAGEMENT STUDIES, TMA

Background

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. 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, 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 are typical in civilian health plans.

The Center for Health Care Management Studies within TMA was established in 2003 to promote and protect the health of MHS beneficiaries. The Center provides evidence-based health services research regarding access to and the costs, quality, and outcomes of health care services. Studies such as the following were completed in FY 2010 to complement the MHS strategic initiatives and the Quadruple Aim:

Effects of Deployment on the Health of Military Dependents

Military families are an exceptional group that makes great sacrifices to support the overseas missions of Active Duty and Guard/Reserve troops. Despite the strength of these families, there is mounting evidence that spouses and children are confronting unprecedented challenges as a result of long and repeated deployments. TMA contracted with a research team from Brandeis University/The CDM Group, Inc., to conduct the first systemwide study of the impact of deployment based on analysis of administrative health care data. Included in the sample were 130,371 spouses and their 337,122 child dependents. About half the family members were selected for study if they had a sponsor whose deployment overlapped FY 2007. The remaining half was a comparison group where the sponsor had not deployed for a two-year period inclusive of FY 2007. The analysis compares the pre-deployment and post-deployment health care service use of each group. The population of spouses had a median age of 31; 95 percent were female; 20 percent were married to officers; 80 percent had a military primary care manager; 6 percent were unenrolled (i.e., not in managed care or TRICARE Prime). The child dependents' median age was 8, with equal portions male and female. For sponsors in the deployed group, the 2007 deployment was, on average, the second deployment since 2001. Even among comparison group sponsors, a prior deployment since 2001 was most common; only 36 percent had never deployed.

Among its findings, the study reports that service utilization patterns change for child and non-pregnant spouse dependents in the first year after deployment, and these changes are specific to health sector (MTF vs. purchased care) and to health status. The key findings include the following:

- Among all non-pregnant spouse and child dependents, deployment of the sponsor is associated with increased rate of use of specialist office visits and of antidepressant and anti-psychotic (psychotropic) medications. These findings imply that emotional issues are being responded to with medications and specialty care.
- Deployment is associated with increased reliance on purchased care providers for all types of care and decreased reliance on MTFs. This shift to the civilian sector was more extensive than a smaller trend in the comparison group.

These findings imply that it is important for TRICARE to routinely monitor the medical services being used by families experiencing the stresses of repeated deployment, and to ensure that preventive care and behavioral health services are readily available for these families.

Characteristics of Provider Capacity of the Purchased Care Network for Military Beneficiaries and Implications for Network Management

As part of ongoing efforts to measure and monitor military beneficiaries' access to care, HPA&E contracted with Altarum Institute to analyze systemwide data on care delivered to MHS beneficiaries enrolled in TRICARE Prime, the HMO-like TRICARE benefit option. The study examined the characteristics of provider capacity within the network and the implication for network management, including consideration of innovative health care delivery initiatives. Capacity was defined as the availability and willingness of providers within this purchased care network to see TRICARE Prime beneficiaries. The analysis used TRICARE civilian provider claims data for outpatient care delivered in the past three years, FYs 2006–2008. Relative Value Units were used to measure workload to account for intensity of services. National Ambulatory Medical Care Survey data were used to estimate the average number of visits per year for selected specialties. The principal findings are that care provided to TRICARE Prime enrollees is not distributed evenly across the managed networks of providers, and that TRICARE Prime represents about 2 percent of network civilian providers' estimated workload. Specifically, about 10 percent of the estimated 315,000 network providers deliver two-thirds of the care. For the MHS-focused category, overall TRICARE Relative Value Units represent about 11 percent of these providers' estimated workloads. The care being delivered by the 315,000 network providers

Source: From the Center for Health Care Management Studies, OASD(HA)/TMA-HPA&E, 12/14/2010

2010 RESEARCH PRESENTED BY THE CENTER FOR HEALTHCARE MANAGEMENT STUDIES, TMA *(CONT'D)*

translates to about 4,700 full-time equivalent providers. These findings indicate that TMA's ability to influence network provider behavior may be limited except for a small number of "MHS-focused" providers. Monitoring of provider participation and satisfaction should include a focus on this critical subset of providers. In considering innovative delivery or financing initiatives, MHS-focused providers may be a better target for participation, as they have more incentive to participate. Understanding the characteristics of network provider capacity is critical to efficiently and effectively managing a provider network and in planning for innovative network care delivery initiatives such as patient-centered medical homes.

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® Commercial Claims and Encounters (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 2008–FY 2010) 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—12/17/2010
  - Eligibility/Enrollment data—12/28/2010
  - MHS Workload/Costs—1/13/2011
  - 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)

The HCSDB was developed by the TRICARE Management Activity to fulfill 1993 NDAA requirements and to provide a routine mechanism to assess TRICARE eligible beneficiary access to and experience with the Military Health System (MHS) or with their alternate health plans. 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/*). Note: "CAHPS" is no longer correct at this site.

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 worldwide 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 that do not define strata but make some beneficiaries more likely to respond than others. Because of the adjust- ment, 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 Consumer Assessment of Healthcare Providers and Systems (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 (AHRQ). 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 *https://www.cahps.ahrq.gov/default.asp.*

Results provided from the HCSDB are based on questions taken from the CAHPS Version 3.0 Questionnaire (for 2008 and part of 2009) and the CAHPS Version 4.0 Questionnaire. Rates are compared with the most recent benchmarks of the same version available at the beginning of the survey year. Thus, rates calculated from Version 3.0 responses are compared with benchmarks from the NCBD, 2006. The Version 4.0 responses from 2009 are compared with the 2008 NCBD and from 2010 are compared with 2009 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 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 2008, rather than four questions as in reports based only on CAHPS 3.0. 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 "Getting Needed Care" and "Customer Service" 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…?" 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 AHRQ and 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 0.05, 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 MHS. T-tests measure the probability that the difference between the change in the MHS estimate and the change in the benchmark occurred by chance. If p is less than 0.05, the difference is significant. Tests are performed using a z-test and standard errors calculated using SUDAAN to account for the complex stratified sample. The HCSDB has been reviewed by an Internal Review Board (and found to be exempt) and is licensed by DoD. 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.

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. MHS uses several different RVU measures to reflect the relative costliness of the provider effort for a particular procedure or service. In this report, we used Enhanced Work RVUs to measure both direct and purchased care outpatient workload. Enhanced Work RVUs were introduced by MHS in FY 2010 and account for units of service (e.g., 15-minute intervals of physical therapy) to better reflect the resources expended to produce an encounter. See *http://www.chevents.com/navymed/downloads/analytics/21_April_Wednesday/PPS(Changes%20in%20RVUs).Funk..ppt* for a more complete description of Enhanced Work RVUs.

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); TRICARE Encounter Data (TED—purchased care claims information) for inpatient and outpatient services; and Pharmacy Data Transaction Service (PDTS) claims within each beneficiary category. Costs recorded on 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 2010, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2010 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 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: ENROLLEES AND TOTAL POPULATION BY STATE

State	Total Population	Prime Enrolled	TRS Enrolled
AK	88,173	70,325	667
AL	207,876	95,690	3,645
AR	92,614	39,158	3,002
AZ	206,532	108,316	3,247
CA	857,771	514,269	9,912
CO	240,986	156,821	3,944
CT	51,017	23,362	836
DC	27,789	21,604	110
DE	33,831	17,624	460
FL	680,202	343,559	9,166
GA	458,419	293,941	5,208
HI	160,940	123,515	1,222
IA	47,201	15,199	2,145
ID	51,057	23,709	1,610
IL	157,014	80,322	3,590
IN	89,960	27,711	3,911
KS	133,828	85,532	2,587
KY	170,304	111,816	2,996
LA	136,899	79,099	2,946
MA	74,429	31,927	1,937
MD	237,671	155,028	2,021
ME	41,926	24,612	1,168
MI	97,566	27,156	2,680
MN	65,254	16,366	5,430
MO	156,677	74,802	5,480
MS	123,496	65,230	2,967
MT	34,427	13,573	1,139
NC	523,993	348,400	5,637
ND	32,867	21,470	1,196
NE	66,715	34,285	1,988
NH	30,863	15,145	617
NJ	86,675	39,881	1,680
NM	89,366	50,914	807
NV	100,030	53,081	1,201
NY	186,182	92,331	3,176
OH	163,204	69,750	5,343
OK	169,457	103,702	3,257
OR	71,465	24,911	1,581
PA	161,764	49,537	4,702
RI	24,905	11,983	470
SC	244,580	136,631	4,197
SD	32,435	15,125	2,347
TN	195,153	89,326	4,098
TX	870,772	542,705	13,964
UT	69,862	33,613	4,041
VA	759,539	474,889	5,238
VT	14,825	6,733	308
WA	357,621	235,964	4,127
WI	69,926	17,853	3,452
WV	37,780	9,651	993
WY	23,319	12,142	541
Subtotal	**9,107,157**	**5,130,288**	**158,987**
Overseas	578,348	371,030	2,008
Total	**9,685,505**	**5,501,318**	**160,995**

Notes:
1. Source of data is from HA/TMA administrative data systems, as of November 2010 for end of FY 2010.
2. "Prime 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, TRICARE Plus, and TRICARE Reserve Select (TRS).

ABBREVIATIONS

AD	Active Duty
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
AHLTA	Armed Forces Health 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 Healthcare 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
DoD P&T	Department of Defense Pharmacy and Therapeutics
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
MS-DRG	Medicare Severity Diagnosis Related Group
MTF	Military Treatment Facility
NCBD	National CAHPS Benchmarking Database
NDAA	National Defense Authorization Act
NHE	National Health Expenditures
NHIN	Nationwide 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
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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