

Evaluation of the TRICARE Program

Fiscal Year 2003
Report to Congress

The FY 2003 Evaluation of the TRICARE Program was performed jointly by the Institute for Defense Analyses (IDA) and the CNA Corporation for the Office of the Assistant Secretary of Defense (Health Affairs). The TRICARE Management Activity (Health Program Analysis and Evaluation) provided oversight and the Altarum Institute provided data management and processing. Key individual contributors to this analysis were:

Philip Lurie, Ph.D., IDA
Peter Stoloff, Ph.D., CNA
Lawrence Goldberg, Ph.D., IDA
Pradeep Gidwani, TMA/HPA&E
Richard R. Bannick, Ph.D., Altarum Institute
Richard D. Guerin, Ph.D., TMA/HPA&E
Michael Peterson, Dr.P.H., DVM
Michael C. Hartzell, DVM, MPH
Pat Golson, RN, TMA/HPA&E

Contents

INTRODUCTION.....	1
<i>A Message from Dr. Winkenwerder.....</i>	1
<i>New Benefits and Programs in FY 2002.....</i>	2
<i>What Is TRICARE?.....</i>	2
<i>Report Approach and Scope.....</i>	3
<i>Summary of Key Findings for FY 2002.....</i>	3
TRICARE WORLDWIDE PROGRAM OPERATIONS.....	6
<i>System Characteristics.....</i>	6
<i>Beneficiary Trends and Demographics.....</i>	7
<i>Defense Health Program Funding.....</i>	9
<i>MHS Workload Trends.....</i>	11
<i>Impact of New Benefits in FY 2002.....</i>	14
OUTCOMES AND EFFICIENCIES, REGIONS 1-12.....	16
<i>Access to Care.....</i>	16
<i>Claims Processing.....</i>	21
<i>Quality of Care.....</i>	25
BENEFICIARY SATISFACTION, REGIONS 1-12.....	27
FINANCIAL STABILITY AND PREDICTABILITY, REGIONS 1-12.....	31
<i>Utilization and Costs – Inpatient.....</i>	31
<i>Utilization and Costs – Outpatient.....</i>	38
<i>Utilization and Costs – Relative Share of MHS Inpatient and Outpatient Costs ...</i>	42
<i>Utilization and Costs – Prescription Drugs.....</i>	43
<i>Beneficiary Family Out-of-Pocket Costs.....</i>	46
<i>MHS Market Share Trends.....</i>	52
<i>Cost per Participant.....</i>	54
APPENDIX: METHODS AND DATA SOURCES.....	55
ABBREVIATIONS.....	57

INTRODUCTION

A Message from Dr. Winkenwerder:



TRICARE plays an integral role in accomplishing the mission of the Military Health System (MHS) in supporting the security of our nation. As reflected in our mission statement below, every mission we undertake is intended to support the primary purpose of readiness, both individual medical readiness and unit readiness. The Surgeons General of the Army, Navy, and Air Force and I are committed to the philosophy that the care and wellness of the family members of active-duty personnel, retirees, and their family members are integral to mission readiness and to the recruitment and retention of soldiers, sailors, airmen, and marines.

I am pleased to provide Congress with this annual report assessing the effectiveness of TRICARE performance between Fiscal Years (FY) 2000 and 2002 in improving the access to and quality of health care received by our eligible beneficiaries. This report responds to the National Defense Authorization Act for FY 1996 (Section 717) requiring such an assessment following the 1994 evolution, development, and deployment of the TRICARE managed care program expanding the traditional DoD indemnity medical benefit then known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This report continues to follow the approach of last year's report by comparing TRICARE with civilian-sector benchmarks, where appropriate and available, and evaluating trends over time to identify relevant changes. This report reflects the extent to which we have improved the performance of TRICARE over the past year. Improving the performance of TRICARE remains a key goal in my vision for a world-class Military Health System.

Mission

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.

Vision

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

Key Priorities and Goals

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

New Benefits and Programs in FY 2002

TRICARE continues to evolve, offering new programs, refining and enhancing existing benefits and programs, and improving the overall efficiency and effectiveness of our tri-Service health care organization. By the end of 2002, TRICARE:

- Celebrated the success of two significant programs for our retired, Medicare-eligible population aged 65 and older:
 - **TRICARE For Life** (October 1, 2001) adds TRICARE as a second payer to Medicare, offering the best of both benefits to our senior beneficiaries.
 - **TRICARE Senior Pharmacy** (April 1, 2001) offers access to a complete pharmacy benefit provided through either direct-care military facilities or purchased-care civilian facilities, including contracted network pharmacies and a national mail order program.
- Launched the **TRICARE Prime Remote for Active Duty Family Members, TRICARE Online** and the joint **DoD/VA Military Treatment Facility (MTF) Refill Mail Service**.
- Capitalized on the success of the **Pharmacy Data Transaction Service** to improve MHS efficiency and patient safety by linking all MHS prescriptions (MTF, civilian network pharmacy, and national mail order) into one database that identified more than 53,000 potentially life-threatening drug interactions since its June 2001 activation.

What Is TRICARE?

TRICARE responds to the challenge of maintaining medical combat readiness while providing the best health care for all eligible personnel. TRICARE brings together the world-wide health care resources of the Army, Navy, and Air Force (often referred to as “direct care”) and supplements this capability with networks of civilian health care professionals (referred to as “purchased care”) to provide better access and high quality service while maintaining the capability to support military operations. This health care program for active duty and retired members of the uniformed services, their families, and survivors was originally modeled on Health Maintenance Organization (HMO) plans offered in the private sector and similar government health-insurance programs. In addition to receiving care from military treatment facilities, where available, TRICARE offers beneficiaries three primary options:

- **TRICARE Standard** is the traditional indemnity benefit (also known as fee for service, or FFS), formerly known as CHAMPUS, open to all eligible DoD beneficiaries, except active-duty service members (and, until recently, Medicare-eligibles). No enrollment is required to obtain care from civilian providers. This option requires payment of an annual deductible (individual or family) and cost-sharing. TRICARE became second payer to Medicare in FY 2002 for Medicare-eligible military retirees and their family members.

- **TRICARE Extra** is based on a Preferred Provider Organization (PPO) model in which beneficiaries eligible for TRICARE Standard may decide to use preferred civilian network providers on a case-by-case basis (i.e., they may switch between the Standard and Extra benefit. Like Standard, no enrollment is required but, by using network providers, beneficiaries reduce their cost sharing by 5 percent. Under Extra, authorized contracted providers file claims for the beneficiary.
- **TRICARE Prime** is the HMO-like plan in which beneficiaries enroll in this benefit option where it is offered. 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. Prime offers enrollees additional benefits such as access standards in terms of maximum allowable waiting times to obtain an appointment, emergency services (24 hours per day, 7 days per week), and waiting times in doctors' offices; as well as preventive and wellness services (e.g., routine eye exams, immunizations, hearing tests, mammograms, Pap tests, prostate examinations). A point-of-service (POS) option permits enrollees to seek care from non-network providers, but with significantly higher cost sharing than under Standard.

Report Approach and Scope

This report continues to take the approach used in last year's report of comparing TRICARE with civilian-sector benchmarks (where available), extending the trends to cover an additional year of data. Until the FY 2002 Report to Congress, all previous TRICARE evaluations took the approach of comparing TRICARE in the evaluation year with the traditional benefit of direct care and CHAMPUS in FY 1994 adjusted for known, measurable changes that would likely have occurred even in the absence of TRICARE. Because the FY 1994 baseline is too far removed from present-day TRICARE experience, the FY 2002 report changed the focus of the evaluation from a "before and after" comparison to a look at recent trends in access, quality, utilization, and costs. This report summarizes nationwide trends under TRICARE, and, unless otherwise noted, compares the U.S. regions of TRICARE with comparable U.S. civilian-sector benchmarks. The 11 non-overseas regions are: 1 (Northeast), 2 (Mid-Atlantic), 3 (Southeast), 4 (Gulf South), 5 (Heartland), 6 (Southwest), 7/8 (TRICARE Central), 9 (Southern California), 10 (Golden Gate), 11 (Northwest), and 12 (Hawaii).

Summary of Key Findings for FY 2002

TRICARE Program Operations

Enrollment Trend

- Over four million beneficiaries, or almost 60 percent of the MHS population eligible for TRICARE Prime, were enrolled by the end of FY 2002. (Ref. page 8)

MHS Workload Trends and Impact of New Benefits in FY 2002

- Overall MHS workload increased for all major components of care between FY 2000 and FY 2002: inpatient dispositions (8 percent), outpatient visits (8 percent), and prescription drugs (28 percent). (Ref. pages 11-13)
 - These increases, for the most part, are attributable to increased purchased-care workload and, in the case of prescription drugs, the TRICARE Senior Pharmacy benefit. At the same time, direct-care workload has declined somewhat or remained the same (inpatient: 3 percent decline, outpatient: no change, prescription drugs: 4 percent decline). (Ref. pages 11-13)
- Most DoD Medicare-eligible beneficiaries have already taken advantage of the new TRICARE For Life (TFL) and TRICARE Senior Pharmacy (TSRx) benefits, with 81 percent filing health care claims and 58 percent filing a claim for prescriptions. (Ref. page 14)
 - Outpatient care and prescription drugs accounted for almost equal shares (42 percent and 41 percent, respectively) of the \$2.1 billion in TFL/TSRx expenditures in FY 2002. (Ref. page 15)

Outcomes and Efficiencies

Access To Care

- Access to and use of outpatient services remains high, with Prime enrollees as likely to have at least one outpatient visit as their civilian counterparts enrolled in managed care plans. (Ref. page 16)
- More MHS beneficiaries report their care was available and efficient in FY 2002 than the previous year in terms of “getting care when needed,” “getting an appointment quickly,” and “waiting less than 15 minutes to see a doctor.” (Ref. page 17)
- TRICARE beneficiaries are comparable to their civilian counterparts in reported satisfaction with obtaining a doctor of choice. (Ref. page 19)

Claims Processing

- Most MHS beneficiaries reported claims were processed properly (86 percent) and in a reasonable period of time (84 percent). (Ref. page 22)
- The percentage of claims processed within 30 days has exceeded the TRICARE goal of 95 percent for the past 3 years and the percentage of claims filed electronically increased to over 70 percent by the end of FY 2002. (Ref. pages 23-24)

Quality of Care

- TRICARE continues to meet or exceed most of the targeted national goals for preventive care measures in women’s health (mammograms, breast exams, Pap tests, and prenatal care), checking blood pressures, and testing for cholesterol. The exceptions are for smoking-cessation counseling and flu shots. (Ref. page 26)

Beneficiary Satisfaction

- MHS beneficiary satisfaction with the overall TRICARE plan, as well as with health care quality, personal physician, and specialty care are improving over time, but still lag the civilian benchmarks. (Ref. page 27)

Financial Stability and Predictability

Utilization and Costs

- Utilization of inpatient, outpatient, and prescription drug services by MHS beneficiaries enrolled in Prime is well above the levels observed in civilian HMOs. (Ref. pages 31, 38, 43)
- Utilization of inpatient and prescription drug services by nonenrolled beneficiaries without private health insurance who rely exclusively on the MHS for their care is also well above the levels observed in civilian PPOs, whereas their utilization of outpatient services is lower. (Ref. pages 32, 39, 44)

Beneficiary Family Out-of-Pocket Costs

- Out-of-pocket costs are lower for TRICARE beneficiaries than for their civilian counterparts. In particular, Medicare-eligible DoD beneficiaries now have only minimal out-of-pocket costs because of the new TRICARE for Life and TRICARE Senior Pharmacy benefits. (Ref. pages 48, 51)

Cost per Participant

- The DoD cost per beneficiary is higher than that experienced by civilian managed care organizations, but inflation-adjusted DoD costs actually declined in FY 2002 whereas civilian sector costs continued to rise. (Ref. page 54)

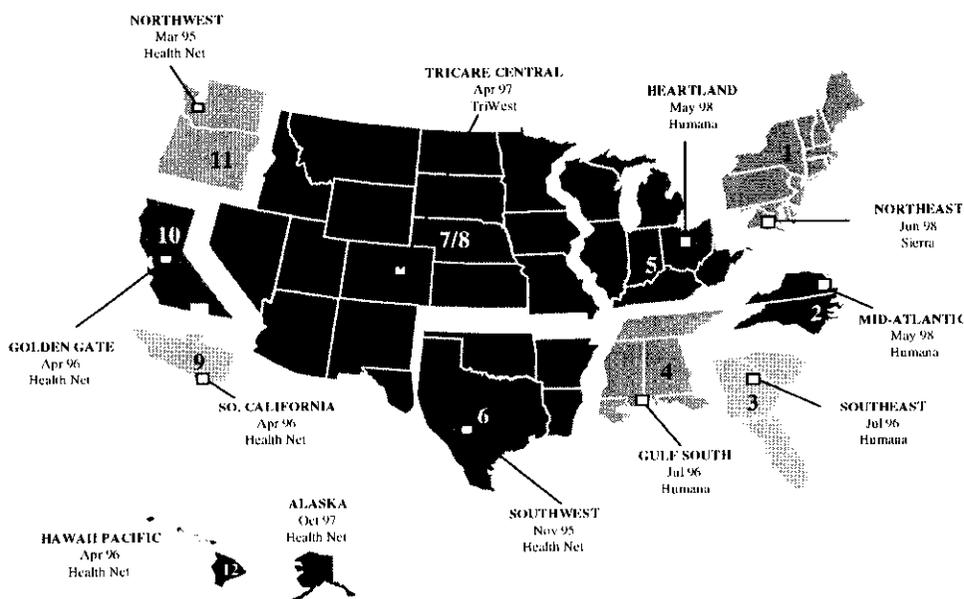
TRICARE WORLDWIDE PROGRAM OPERATIONS

System Characteristics

TRICARE Facts & Figures:	
Total Beneficiaries:	8.7 million
Prime Enrollees	4.1 million
Military Hospitals & Medical Centers	75
Medical Clinics	461
Total Military Health System Personnel	131,065
<i>Funded by FY 2003 Defense Health Program (DHP):</i>	
FY 2003 Defense Health Program Appropriation	\$21.4 billion
Estimated FY 2003 Receipts	\$4.4 billion*
* The DoD Medicare Eligible Retiree Health Care Fund, implemented in fiscal year 2003, is an accrual fund that pays for health care provided to Medicare-eligible beneficiaries, including payment for the TRICARE for Life benefit first implemented in fiscal year 2002.	

TRICARE is administered on a regional basis. Excluding overseas programs, the country is divided into 11 geographical regions (Regions 1-12, where 7/8 is a combined region) with a senior military officer designated as the Lead Agent for each region. Lead Agents and their support staff help coordinate primary and referral direct and purchased care within their regions.

TRICARE Health Service Regions, Lead Agents, Operational Start Dates, and Contractors



Beneficiary Trends and Demographics

Trend in the Number of Eligible Beneficiaries Between FY 2000 and FY 2002

There are approximately 8.7 million DoD beneficiaries eligible for military medical care worldwide. DoD health care beneficiaries are commonly grouped into one of six categories:

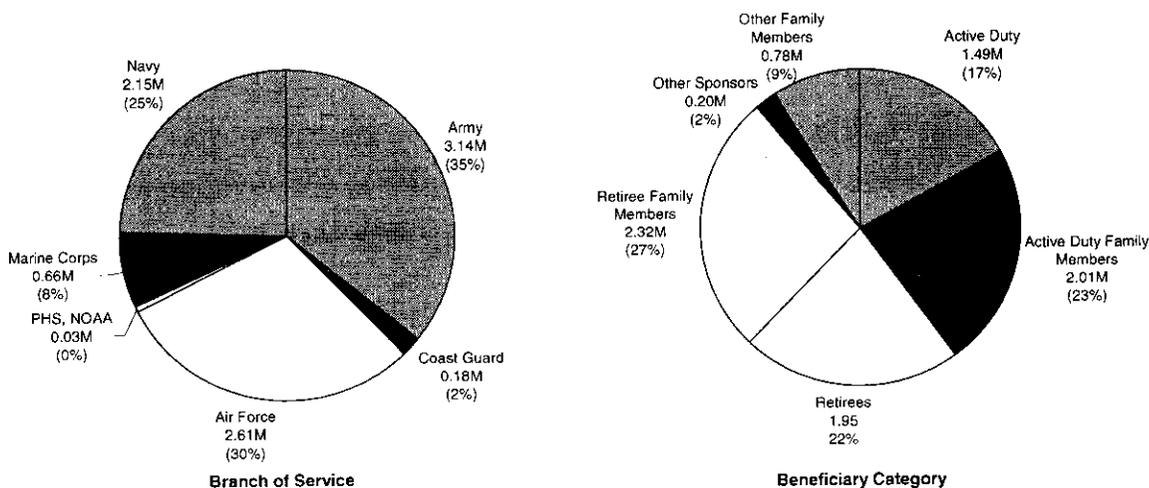
- Active-duty personnel,
- Family members of active-duty personnel,
- Retirees and their family members under 65 years of age,
- Retirees and their family members age 65 and older,
- Other beneficiaries under age 65, and
- Other beneficiaries age 65 and older.

The latter two groups of beneficiaries include primarily survivors of active-duty and retired sponsors.

Eligible Beneficiaries in FY 2002

- 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, National Oceanic and Atmospheric Administration).
- Whereas active-duty personnel and their family members comprise 45 percent of the eligible population (19 and 26 percent, respectively), retirees and their family members comprise the largest component with 49 percent (34 percent under age 65 and 15 percent age 65 and over, respectively).

Beneficiaries Eligible for DoD Health Care Benefits in FY 2002

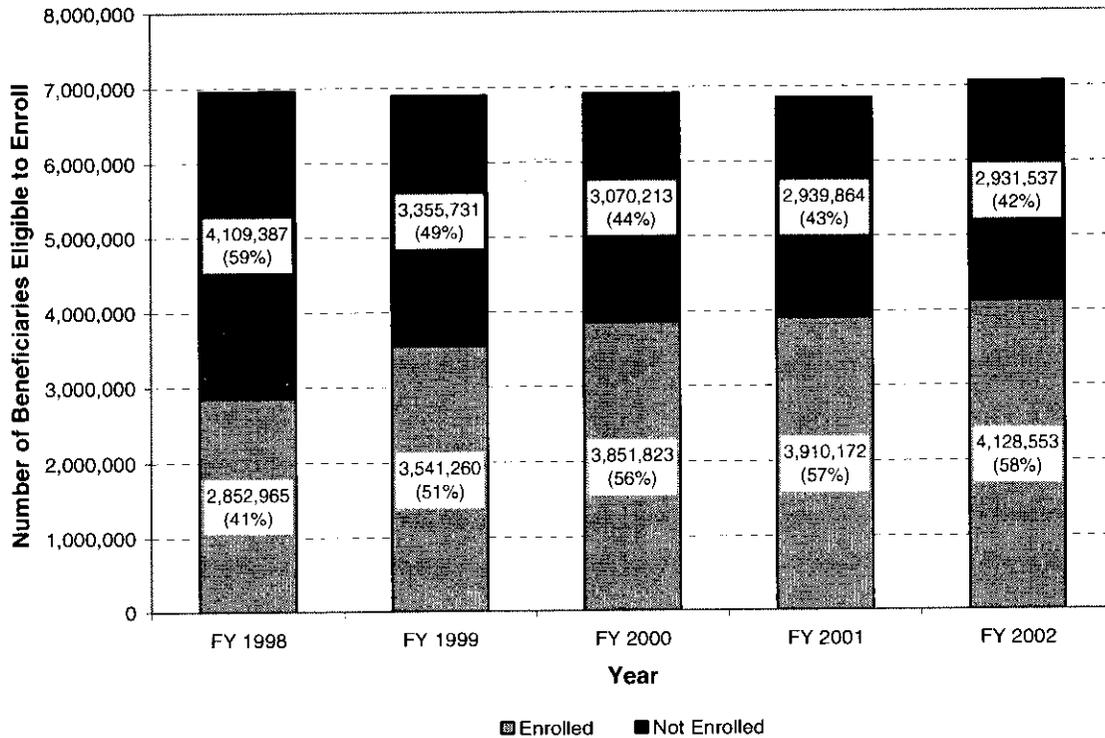


Eligibility and Enrollment in TRICARE Prime

We determined eligibility and enrollment in TRICARE Prime from the Defense Enrollment Eligibility Reporting System (DEERS). The eligibility counts exclude most beneficiaries age 65 and over (some were eligible for TRICARE Senior Prime) but include beneficiaries living in remote areas where Prime may be unavailable. The enrollment rates displayed below may therefore be somewhat understated.

- TRICARE Prime enrollment, both in raw numbers and as a percentage of those eligible to enroll, has steadily increased since FY 1998, when the last regional Managed Care Support Contracts became fully operational (Regions 1, 2, and 5).
- By the end of FY 2002, nearly 60 percent of all eligible beneficiaries were enrolled in Prime.
- Additional analysis (not shown) reveals that:
 - Active-duty personnel and their family members continue to account for the majority of enrollments in Prime.
 - In general, the proportion enrolled within various age groups (e.g., 0-17, 25-34, 55-64) is similar for males and females. The exception is the 18-44 age group, which reflects the higher proportion of men on active duty.
 - The proportion enrolled decreases with age.

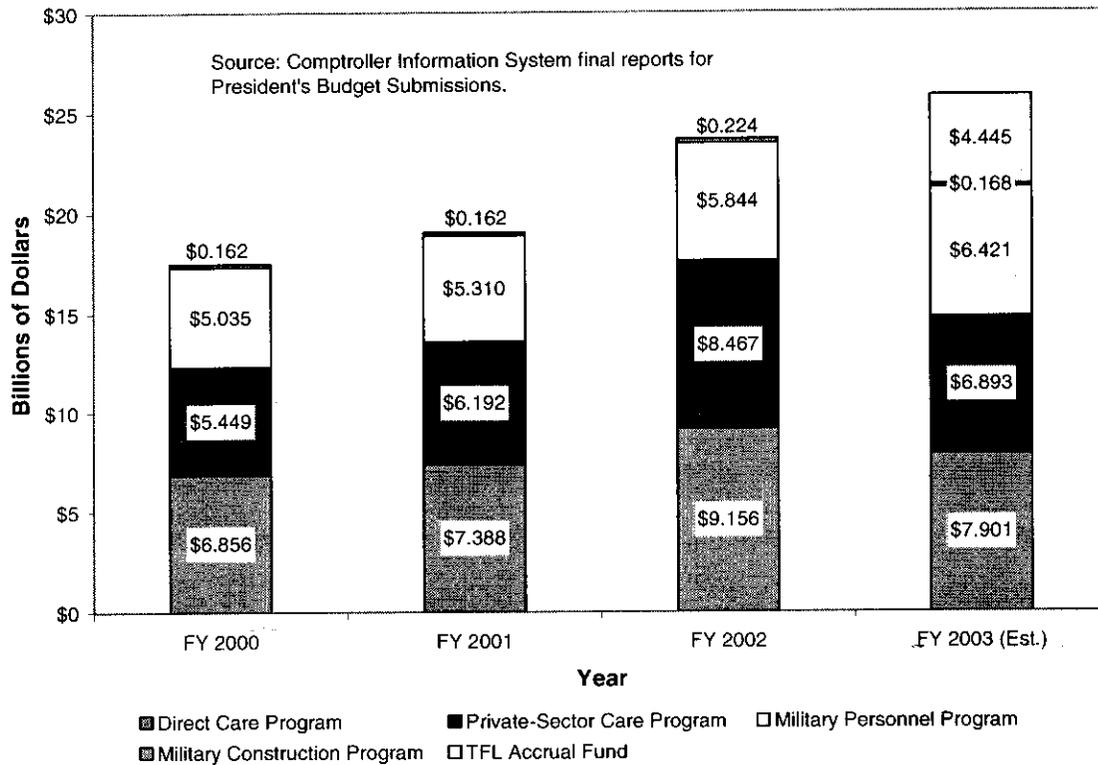
Historical Enrollment Numbers and Rates



Defense Health Program Funding

The Defense Health Program (DHP) Total Obligational Authority and Military Personnel resourced by the DHP increased from \$17.5 billion in FY 2000 to \$25.8 billion in FY 2003. The FY 2003 DHP includes the DoD Medicare-Eligible Retiree Health Care Fund (the "Accrual Fund") for the TRICARE for Life (TFL) benefit, which began in October 2001.

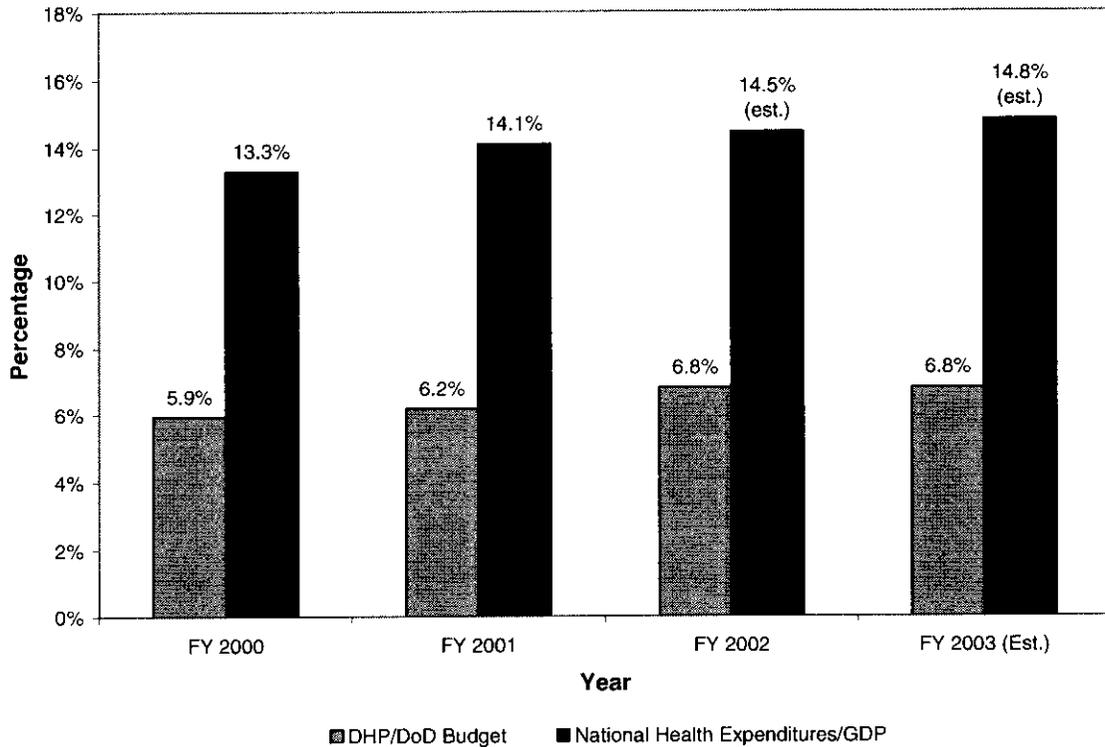
FY 2000 to FY 2003 Defense Health Program



Defense Health Program Share of Defense Budget

- Defense Health Program (DHP) expenditures rose from 5.9 percent of DoD Total Obligational Authority (TOA) in FY 2000 to 6.8 percent in FY 2002. The increase is due in part to the new TRICARE for Life (TFL) benefit, which provides Medicare wrap-around coverage for beneficiaries age 65 and over.
- DHP expenditures are expected to remain at 6.8 percent of DoD TOA in FY 2003.
- National health expenditures rose from 13.3 percent of GDP in FY 2000 to 14.8 percent (est.) of GDP in FY 2003, a rate of increase (11.4 percent) slower than that of the DHP (14.7 percent).

DHP as Percentage of Defense Budget Compared to National Health Expenditures as Percentage of GDP



Note: Source of national health expenditure data and FY 2002-03 projections is the Centers for Medicare and Medicaid Services.

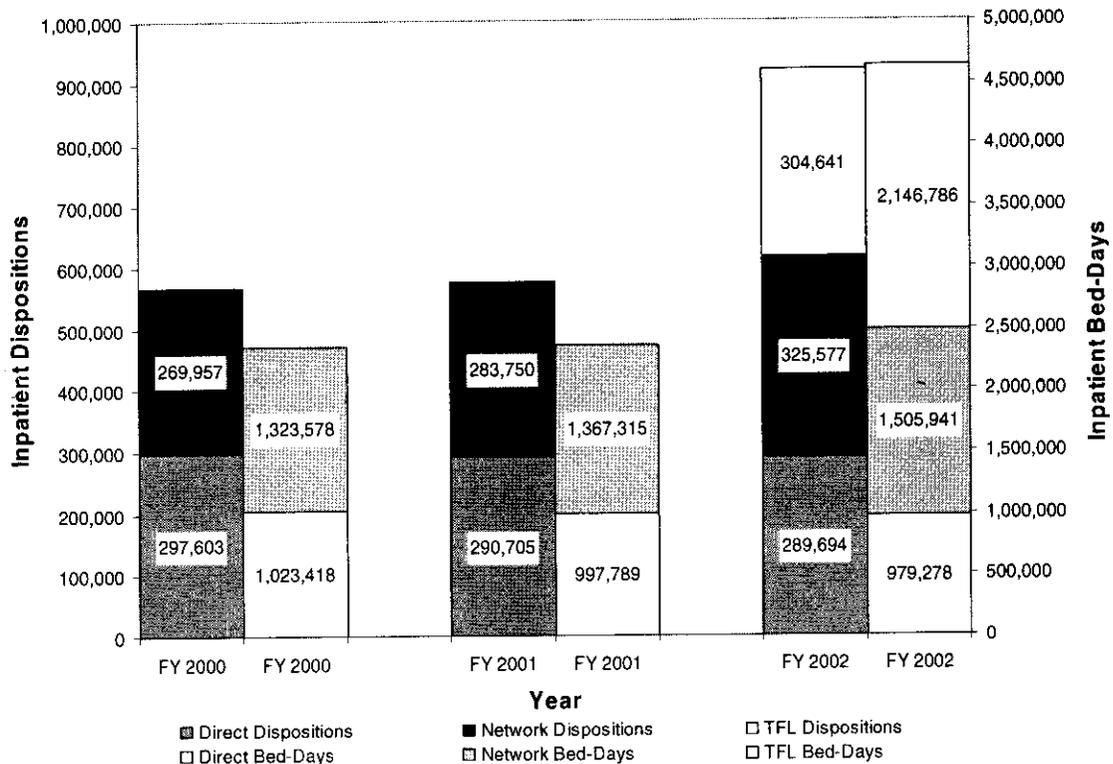
MHS Workload Trends

MHS Inpatient Workload

Total MHS inpatient workload (measured as the number of inpatient dispositions or bed-days) increased from FY 2000 to FY 2002 (dispositions increased by 8 percent and bed-days by 6 percent), excluding the effect of TRICARE for Life (TFL).

- Direct-care inpatient dispositions declined by 3 percent and bed-days declined by 4 percent.
- Purchased-care inpatient dispositions increased by 21 percent excluding TFL workload and by 133 percent including TFL.
- Purchased-care inpatient bed-days increased by 14 percent excluding TFL workload and by 176 percent including TFL.

Trends in MHS Inpatient Workload

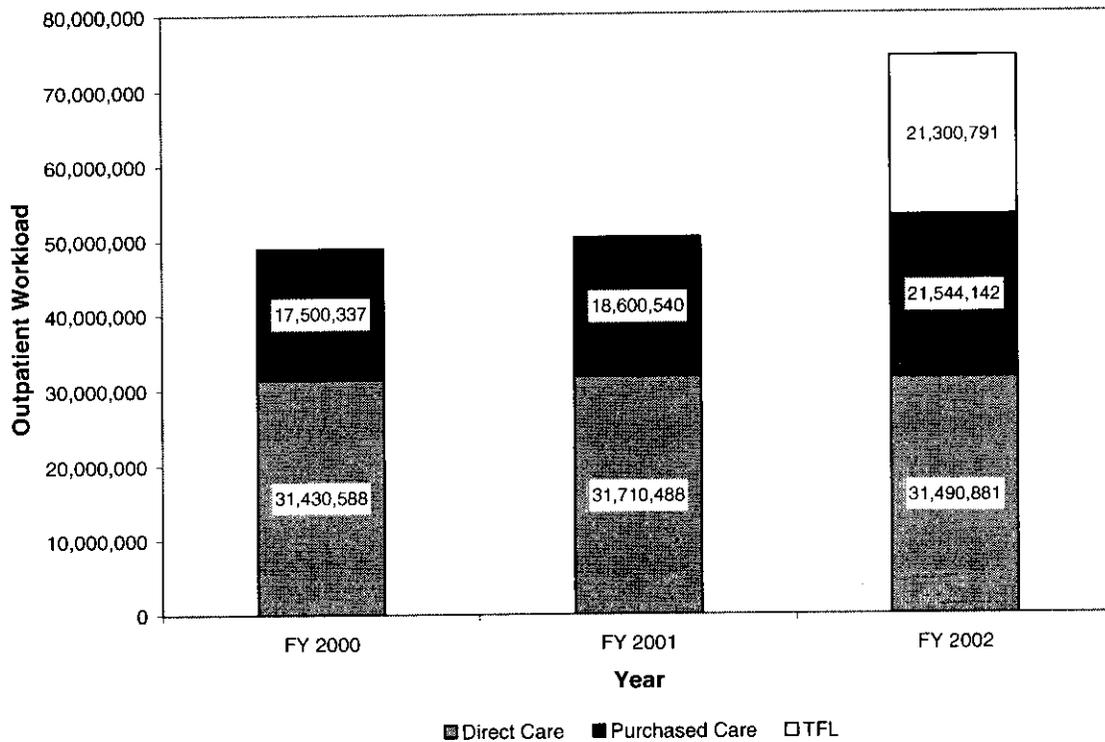


MHS Outpatient Workload

Total MHS outpatient workload (measured as the number of outpatient visits and ambulatory procedures) increased by 8 percent from FY 2000 to FY 2002, excluding the effect of TFL.

- Direct care outpatient workload remained about the same.
- Purchased care outpatient workload increased by 23 percent excluding TFL workload and by 145 percent including TFL.

Trends in MHS Outpatient Workload

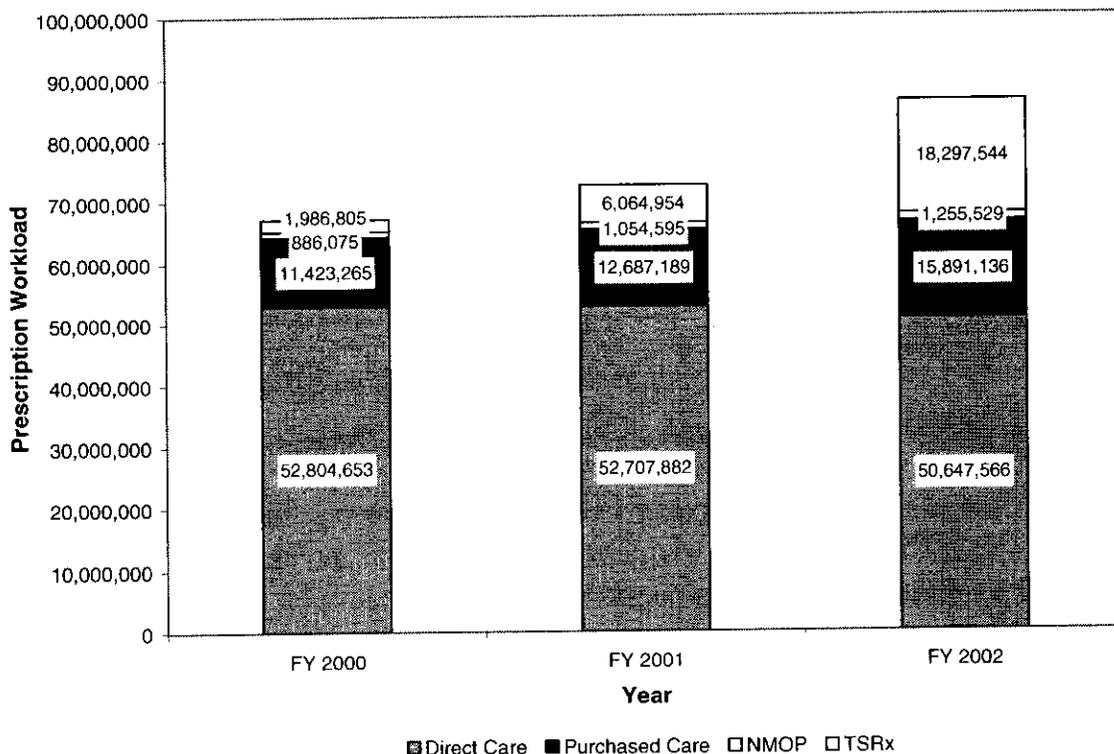


MHS Prescription Drug Workload

Prescription drugs include all initial and refill prescriptions filled at military pharmacies, network pharmacies, and the National Mail Order Pharmacy (NMOP). Prescription workload is shown as actual prescription counts, unadjusted for differences in the average days supply from these sources.

- Total MHS prescription workload increased by 28 percent from FY 2000 to FY 2002. All but 4 percent of the increase was due to the impact of the TRICARE Senior Pharmacy (TSRx) benefit, introduced in April 2001.
- Direct care prescription workload reversed a longstanding trend by declining 4 percent in FY 2002.
- Purchased care prescription workload increased each year from FY 2000 to FY 2002 (11 percent in FY 2001 and 25 percent in FY 2002), excluding the impact of the TSRx benefit. Including the impact of TSRx, purchased care prescription workload increased by 39 percent in FY 2001 and by another 79 percent in FY 2002.

Trends in MHS Prescription Workload



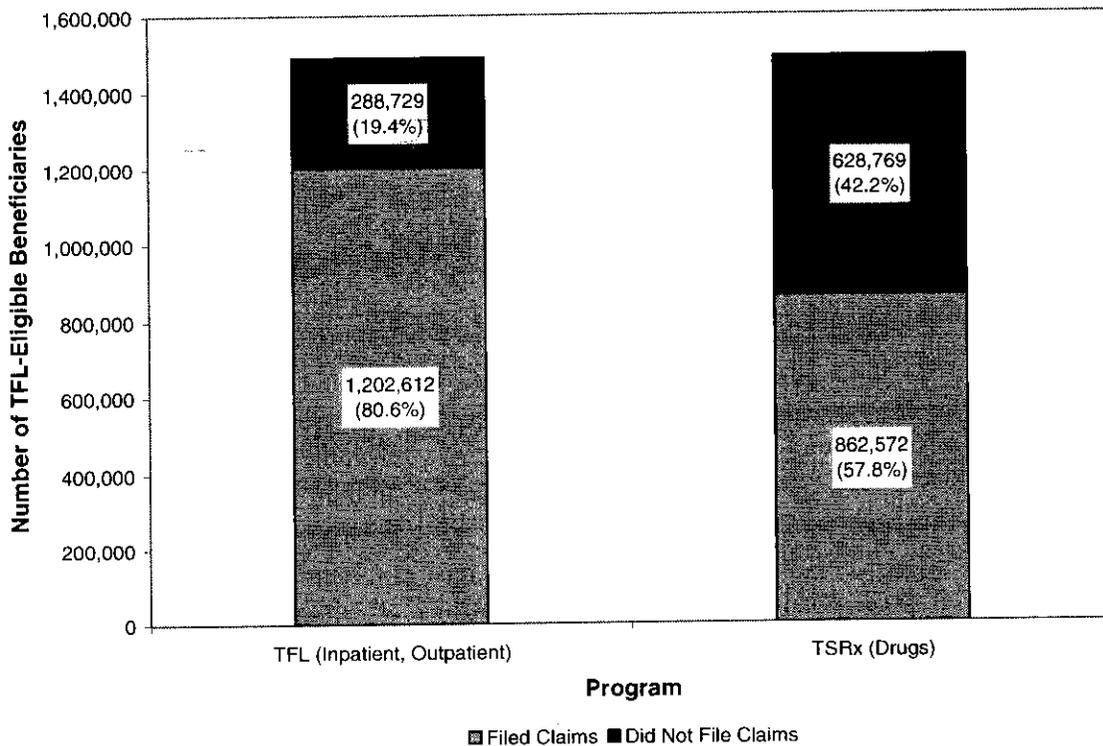
Note: Prior to TSRx, select groups of Medicare-eligible beneficiaries were authorized access to purchased-care prescription drugs if they resided in a location where an MTF was closed due to Base Realignment and Closure (BRAC) or if they participated in the TRICARE Senior Supplement Demonstration. These benefits were later folded into the TSRx program when it was introduced in April 2001. For ease of presentation, we label all these benefits as TSRx.

Impact of New Benefits in FY 2002

TRICARE for Life and TRICARE Senior Pharmacy Claims

- There were almost 1.6 million Medicare-eligible DoD beneficiaries by the end of FY 2002.
 - About 1.5 million were eligible for the TRICARE for Life (TFL) and TRICARE Senior Pharmacy (TSRx) benefits, whereas the remainder were ineligible for TFL because they did not have Medicare Part B coverage.
- About 81 percent of TFL-eligible beneficiaries filed at least one claim in FY 2002.
 - The reasons some beneficiaries do not file claims are varied, including not receiving any care at all, retaining Medicare supplemental insurance that pays for most costs not covered by Medicare, and maintaining enrollment in a Medicare risk HMO that has small or no enrollment fees and copayments.
- About 58 percent of TFL-eligible beneficiaries filed at least one TSRx claim.
- In FY 2002, TFL/TSRx claims accounted for about one-third of all beneficiary claims and government purchased health care costs.

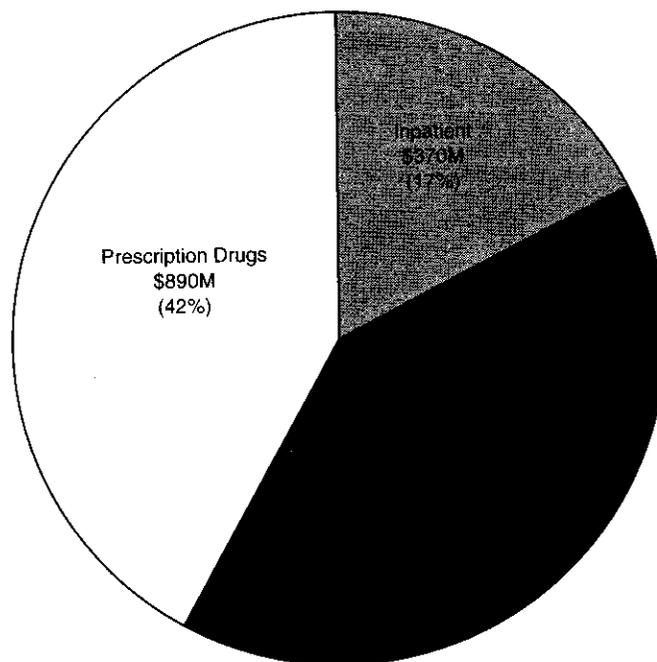
TFL-Eligible Beneficiaries Filing TFL and TSRx Claims in FY 2002



TRICARE for Life and TRICARE Senior Pharmacy Expenditures

- Outpatient care and prescription drugs accounted for almost equal shares (42 percent and 41 percent, respectively) of the \$2.1 billion the MHS spent for the TFL/TSRx benefits in FY 2002.
- Inpatient care accounted for only 17 percent of total TFL/TSRx expenditures.

DoD TFL Expenditures in FY 2002 by Type of Service



OUTCOMES AND EFFICIENCIES, REGIONS 1-12

Access to Care

Using survey data, we examined three categories of access to care:

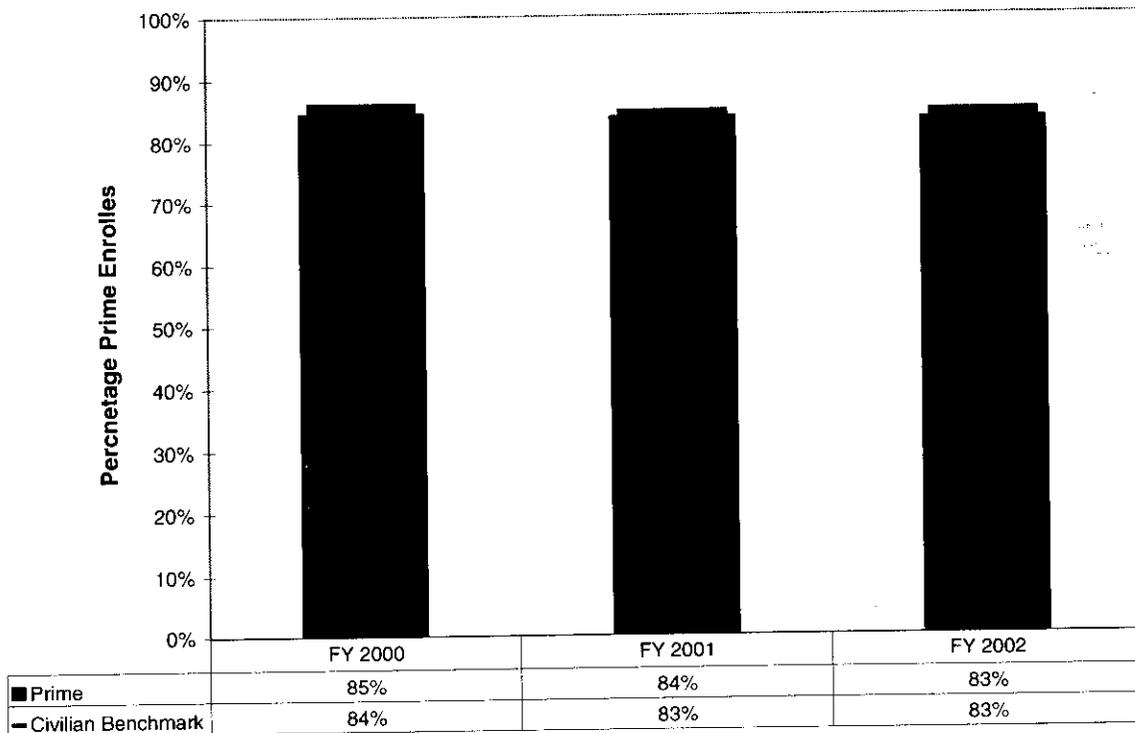
- Access based on reported use of the health care system in general,
- Availability and ease of obtaining care, and
- Efficiency of the process of receiving care.

Access

Ability to see a doctor reflects successful access to the health care system.

- Access to and use of outpatient services remains high.
- Prime enrollees, compared to their civilian counterparts enrolled in managed care plans, are equally likely to have at least one outpatient visit (nearly 83 percent of Prime enrollees reported they had one or more outpatient visits in FY 2002).

Trends in Prime Enrollees Having at Least One Outpatient Visit



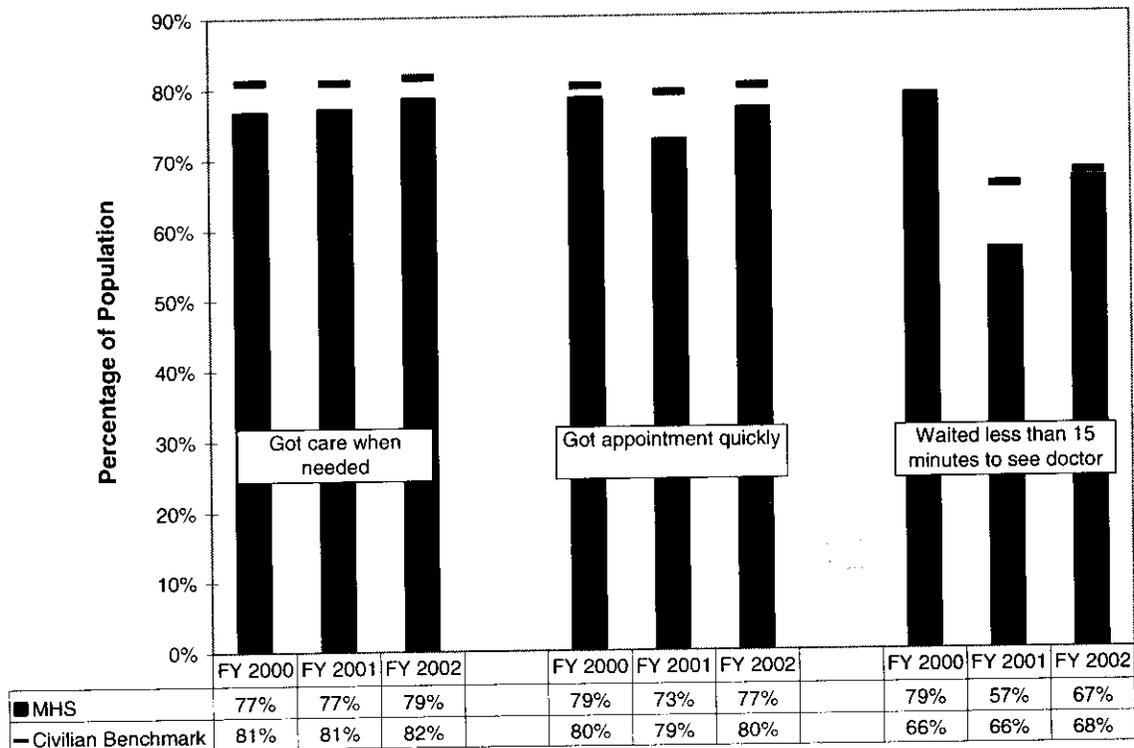
Notes: Data for DoD were derived from the 2000–2002 DoD Surveys of Health Care Beneficiaries. The civilian benchmark is based on those in the general population enrolled in more than 500 HMOs and HMOs with a Point of Service (POS) option that are represented in the National Consumer Assessment of Health Plans Survey (CAHPS) Benchmarking Database. Data were adjusted for differences in age, gender, and health status.

Availability and Efficiency of Obtaining Care

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

- MHS beneficiary ratings improved in the past 2 years, with more MHS beneficiaries reporting their care was available and efficient (in all three measures below) in FY 2002 than in FY 2001.

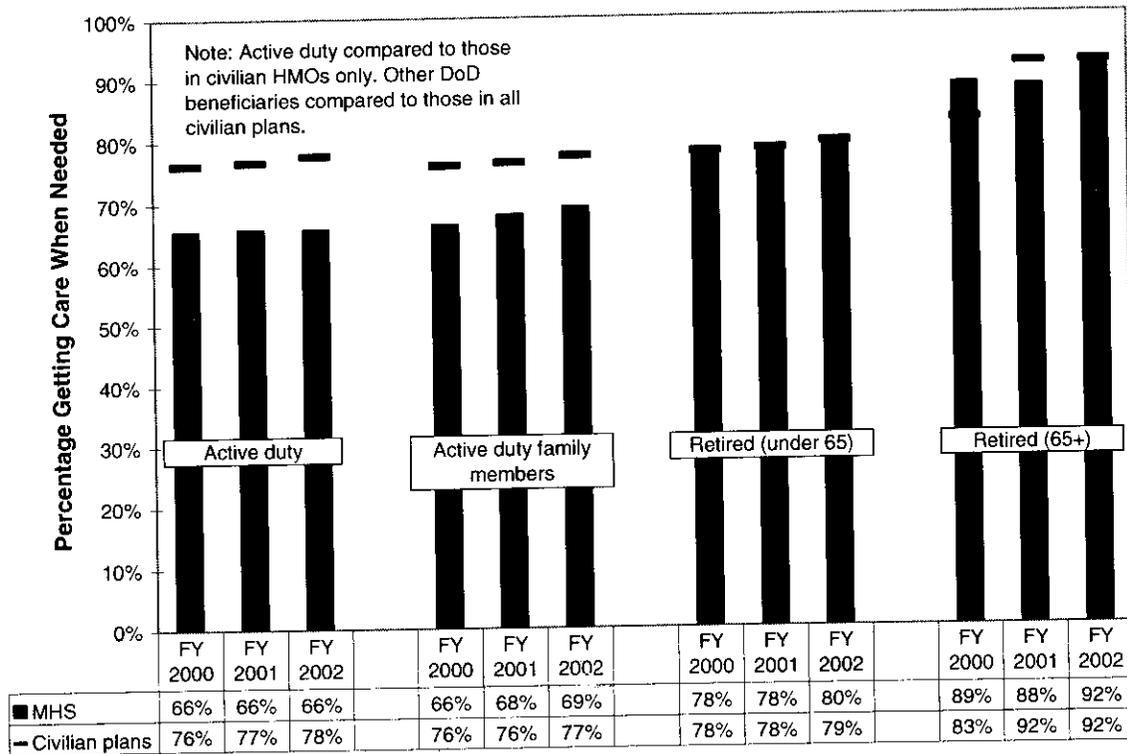
**Trends in Availability and Efficiency of Obtaining Care for all MHS Beneficiaries
(All Sources of Care)**



Getting Care When Needed by Beneficiary Category

- Retired beneficiaries report more frequently they are able to receive care when they need it.
- The level of reported access for retirees is the same as for those in commercial plans.

**Trends in Availability of Obtaining Care by Beneficiary Category
(All Sources of Care)**



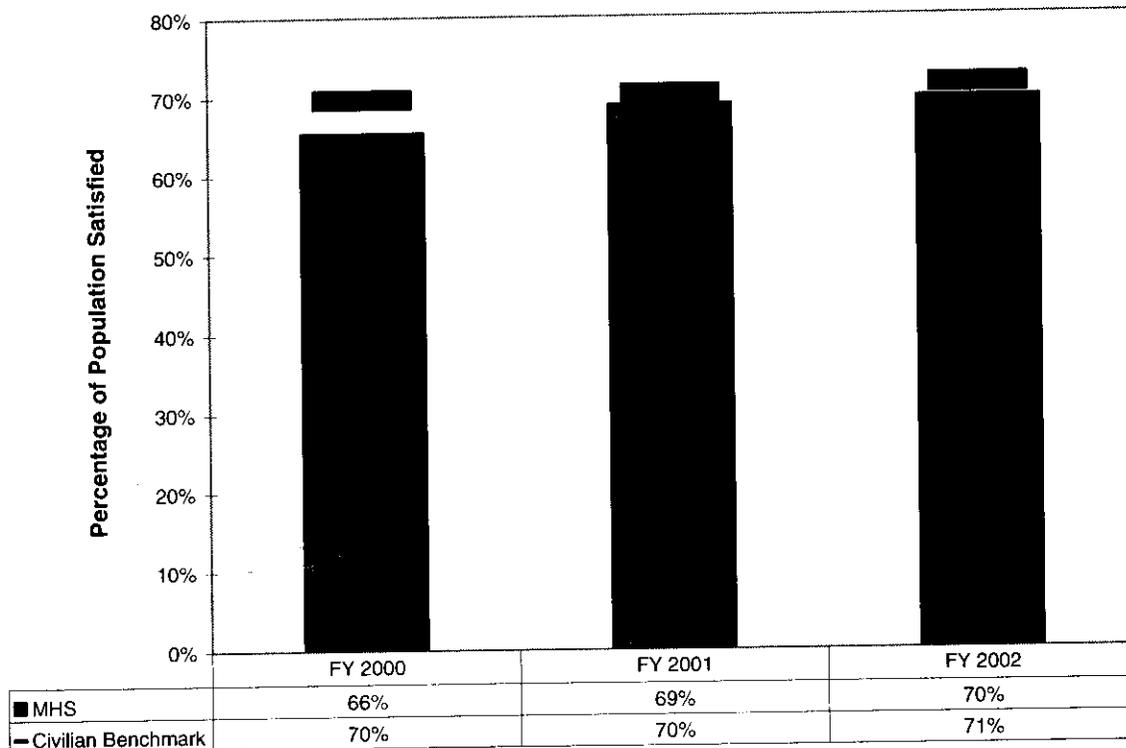
Notes: Data for DoD were derived from the 2000–2002 DoD Surveys of Health Care Beneficiaries. The civilian benchmark is based on those in the general population enrolled in more than 500 HMOs and HMOs with a POS option that are represented in the National CAHPS Benchmarking Database. Data were adjusted for differences in age, gender, and health status.

Getting a Health Provider of Choice

Being able to choose a doctor one is happy with is a major determinant of an individual's satisfaction with a health plan.

- The majority (70 percent in FY 2002) of MHS beneficiaries are able to get a personal doctor they are happy with.
- Satisfaction with their choice is improving over time.
- The DoD trend and level of satisfaction in obtaining a provider of choice is comparable to commercial health plans in FY 2002.

Trends in Getting a Doctor of One's Choice



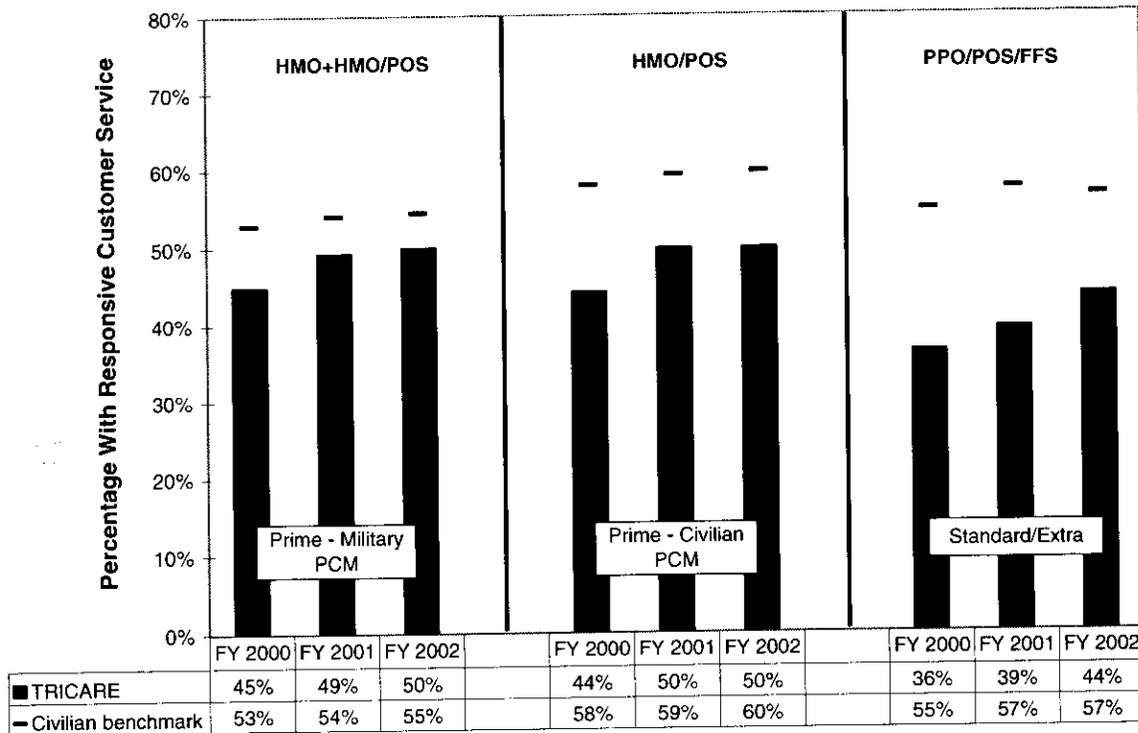
Notes: Data for DoD were derived from the 2000–2002 DoD Surveys of Health Care Beneficiaries. The civilian benchmark is based on those in the general population enrolled in more than 500 HMOs and HMOs with a POS option that are represented in the National CAHPS Benchmarking Database. Data were adjusted for differences in age, gender, and health status.

Customer Service

Access to and understanding written materials about one's health plan is an important determinant of overall satisfaction with the plan.

- Customer service responsiveness, beneficiary ease of understanding written materials, and dealing with paperwork is steadily improving.
- Those enrolled in Prime (both with military providers as well as with civilian providers) reported fewer problems with customer service compared to those who were not enrolled.
- Ratings for TRICARE customer service were not as high as those reported by enrollees in commercial plans.

Trends in Responsive Customer Service



Notes: Data for DoD were derived from the 2000–2002 DoD Surveys of Health Care Beneficiaries. The civilian benchmark is based on those in the general population enrolled in more than 500 HMOs and HMOs with a POS option that are represented in the National CAHPS Benchmarking Database. Data were adjusted for differences in age, gender, and health status.

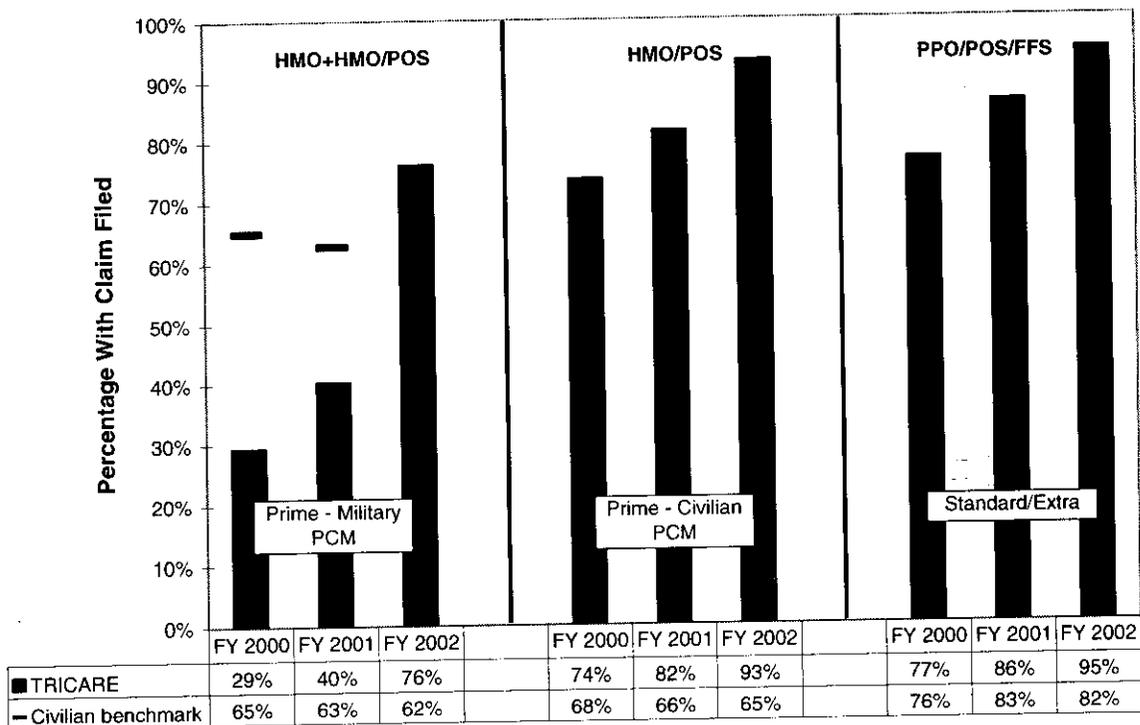
Claims Processing

Claims Filed by Providers

TRICARE has simplified claims processing for Prime enrollees and those using the network of preferred providers. TRICARE participating providers have agreed to file claims for MHS patients. Survey data provide details on beneficiaries' perceptions of the claims filing process.

- MHS beneficiaries increasingly report claims are being filed for them by their health care providers, exceeding that reported on average in some commercial plans.

Trends in Claim Filing for Different TRICARE Options

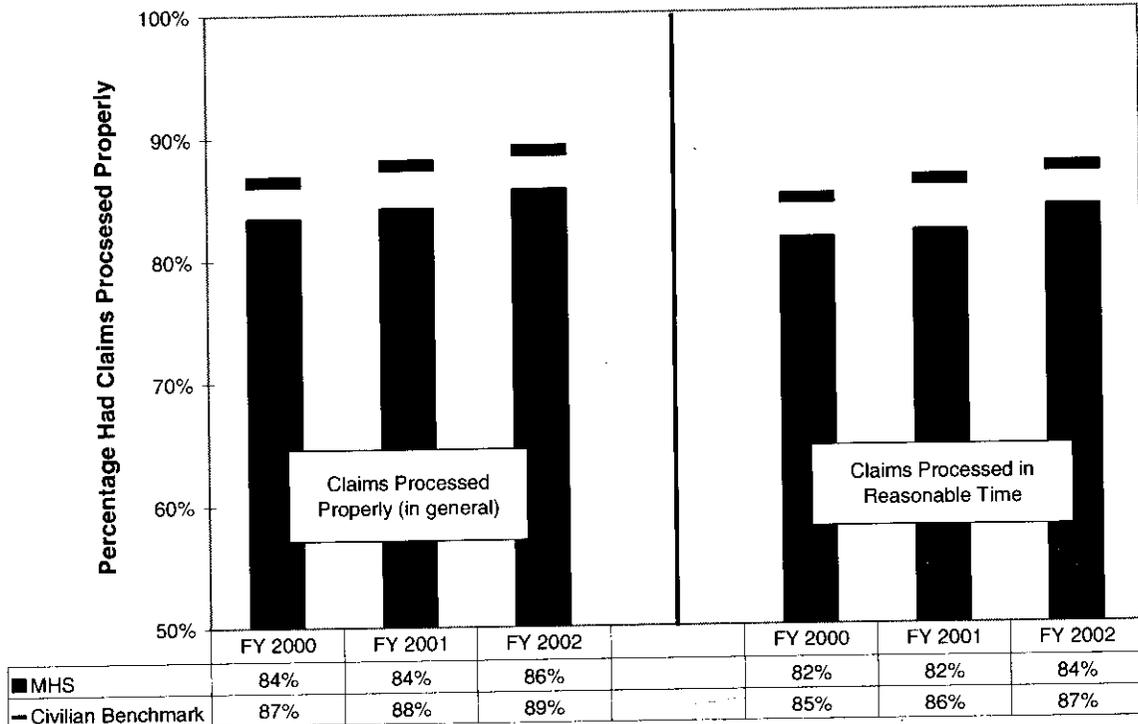


Notes: Data for DoD were derived from the 2000–2002 DoD Surveys of Health Care Beneficiaries. The civilian benchmark is based on those in the general population enrolled in more than 500 HMOs and HMOs with a POS option that are represented in the National CAHPS Benchmarking Database. Data were adjusted for differences in age, gender, and health status.

Beneficiary Perceptions of Claims Filing Process

- The majority of MHS beneficiaries (86 percent) feel their claims are processed properly and in a reasonable period of time.
- Beneficiary satisfaction with TRICARE claims processing is improving over time but still lags the civilian benchmark.

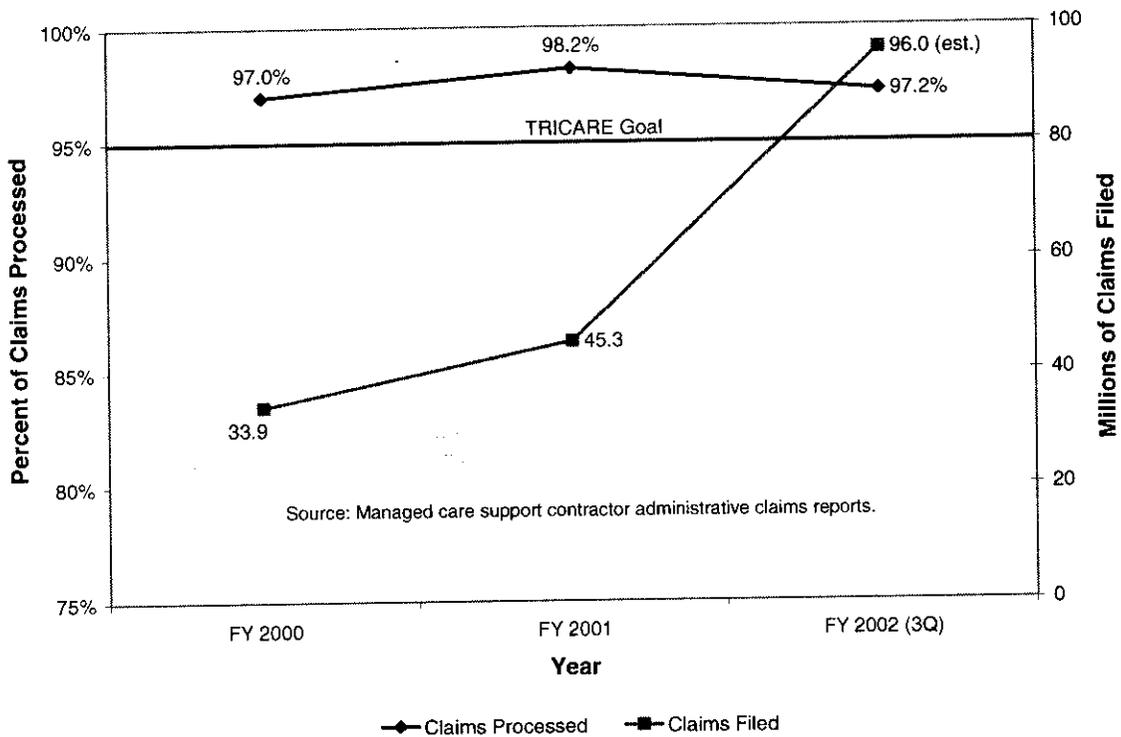
Trends in Self-Reported Aspects of Claims Processing (All Sources of Care)



TRICARE Claims Processing Efficiency

- Even with claims trebling between FY 2000 and FY 2002 (from 33.9 million to about 96 million in FY 2002), claims processing turnaround time has improved over the past 3 years.
- Claims processing within 30 days has exceeded the TRICARE goal of 95 percent.
- Although not shown on the graph, almost 100 percent of claims are now being processed within 60 days.
- The number of claims filed increased between FY 2001 and FY 2002 with the introduction of the TRICARE For Life (October 2001) and TRICARE Senior Pharmacy (April 2001) benefits.

Percentage of TRICARE Retained Claims Processed Within 30 Days

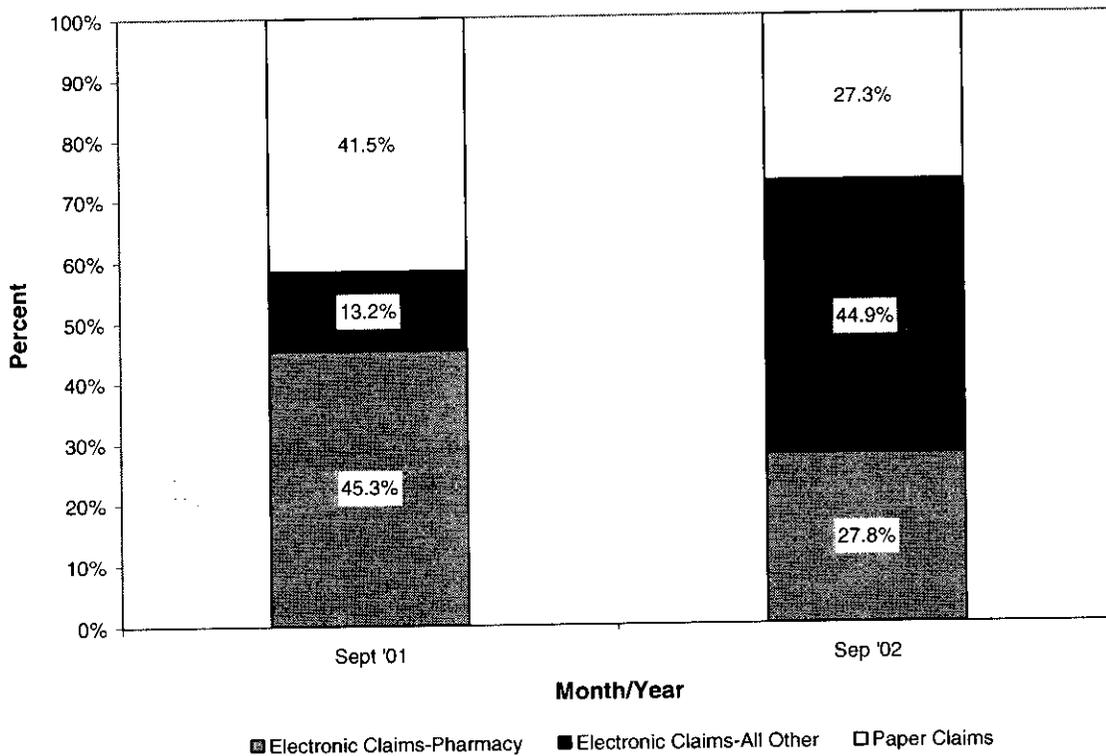


Trend Toward Electronic Claims

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

- The percentage of all claims processed electronically increased to over 70 percent in September 2002 from slightly under 60 percent in the same month the year before.
- Pharmacy claims have historically provided the bulk of electronic claims. However, while the number of pharmacy claims has increased, non-pharmacy claims now represent the largest proportion of electronic claims.

Efficiency of Processing TRICARE Claims: Paper vs. Electronic

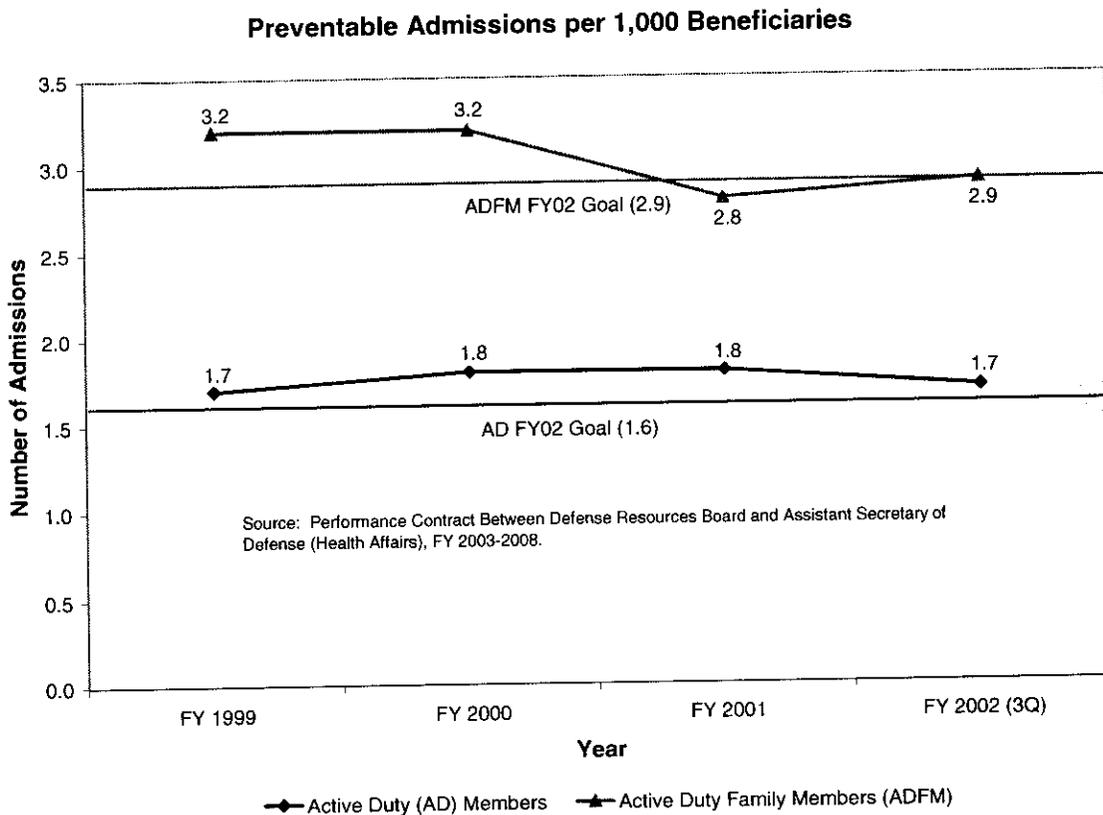


Quality of Care

Preventable Admissions

Preventable admissions (both direct and purchased care) are determined as specific diagnoses in nine clinical categories: chronic obstructive pulmonary disease, bacterial pneumonia, asthma, congestive heart failure, angina, cellulitis, diabetes, gastroenteritis, and kidney/urinary infections.

- The rate of preventable admissions over the past 4 years has remained about the same for active-duty personnel (at 1.7 to 1.8 per 1,000 members) and improved for their family members (decreasing from 3.2 to 2.9 per 1,000 members). While the active-duty preventable admission rate (1.8) was higher than the desired goal (1.6 per 1,000 members, where lower is better), the family member rate briefly improved by falling below the targeted 2.9 admissions per 1,000 members in FY 2001.

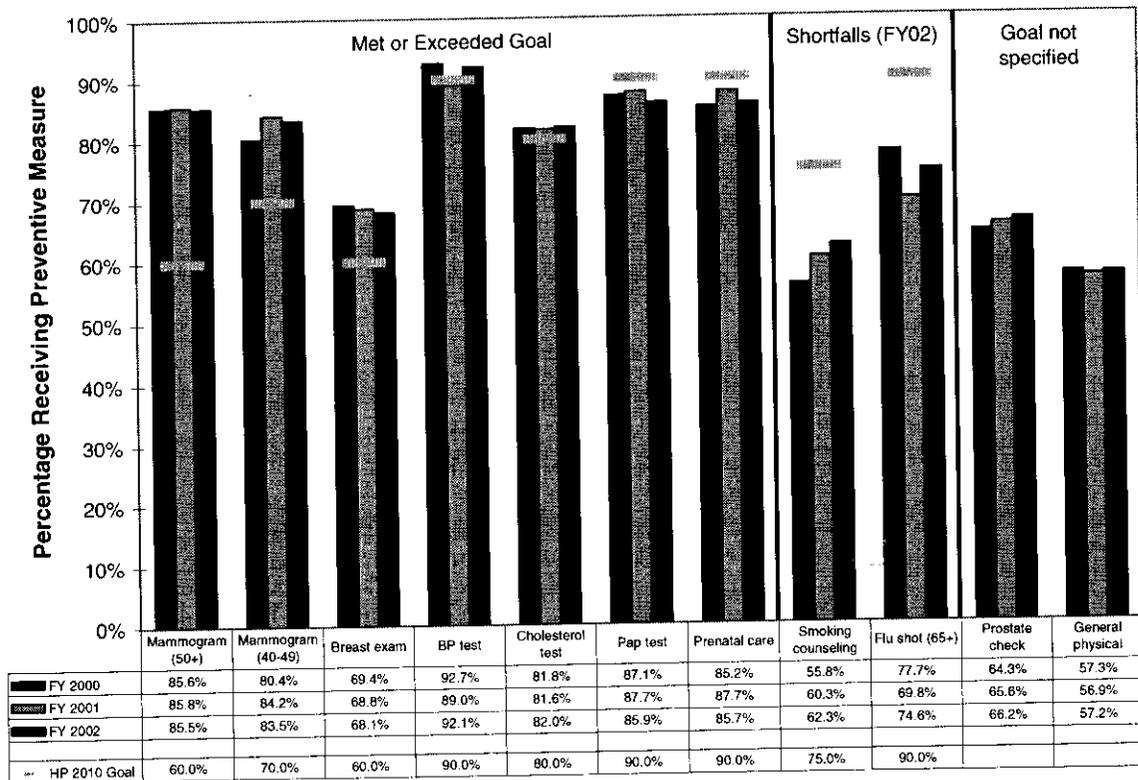


Meeting Preventive Care Standards

The MHS has set as goals selected national health-promotion and disease-prevention objectives specified by the Department of Health and Human Services in Healthy People 2010. Care levels under TRICARE are compared to these standards.

- Most of the targeted Healthy People 2010 goals have been met or exceeded for the past several years.
- The MHS has *not* met its goals for counseling smokers and giving flu shots to the elderly for at least the past 3 years. However, there has been steady improvement in the level of counseling for cigarette smokers.

Trends in Meeting Preventive Care Standards



Note: The differences between the percentages of MHS beneficiaries reporting they received a Pap test or prenatal care and the Healthy People 2010 goals are not statistically significant.

MHS targeted HP 2010 Objectives:

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

Mammogram - Women age 40-49 who had mammogram in past 2 years; women age 50 or older who had mammogram in past year.

Pap test - All women who had a Pap test in last 3 years.

BP test - People who had a blood pressure check in last 2 years and know results.

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

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

General physical - People who had a general physical exam in last 12 months.

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

Cholesterol test - People who had a cholesterol screening in last 5 years.

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

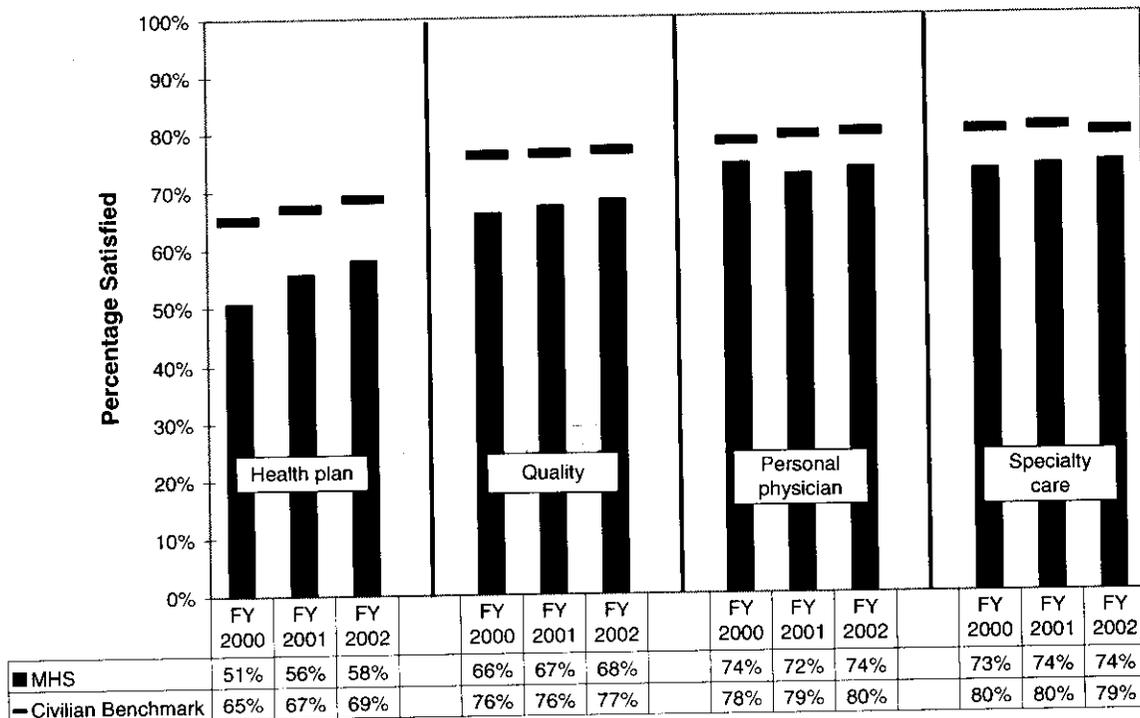
BENEFICIARY SATISFACTION, REGIONS 1-12

Satisfaction with Aspects of TRICARE

The health care consumer satisfaction surveys used by the MHS and many commercial plans ask beneficiaries to rate various aspects of their health plans. We compare the MHS with the civilian benchmark with respect to ratings of (1) the health plan, in general; (2) quality of health care; (3) personal physician; and (4) specialty care.

- Satisfaction with the overall TRICARE plan continues to improve each year.
- Satisfaction with health care quality, one's personal physician, and specialty care under TRICARE, while improving, lags the civilian benchmarks.

Trends in Health Plan Satisfaction Ratings



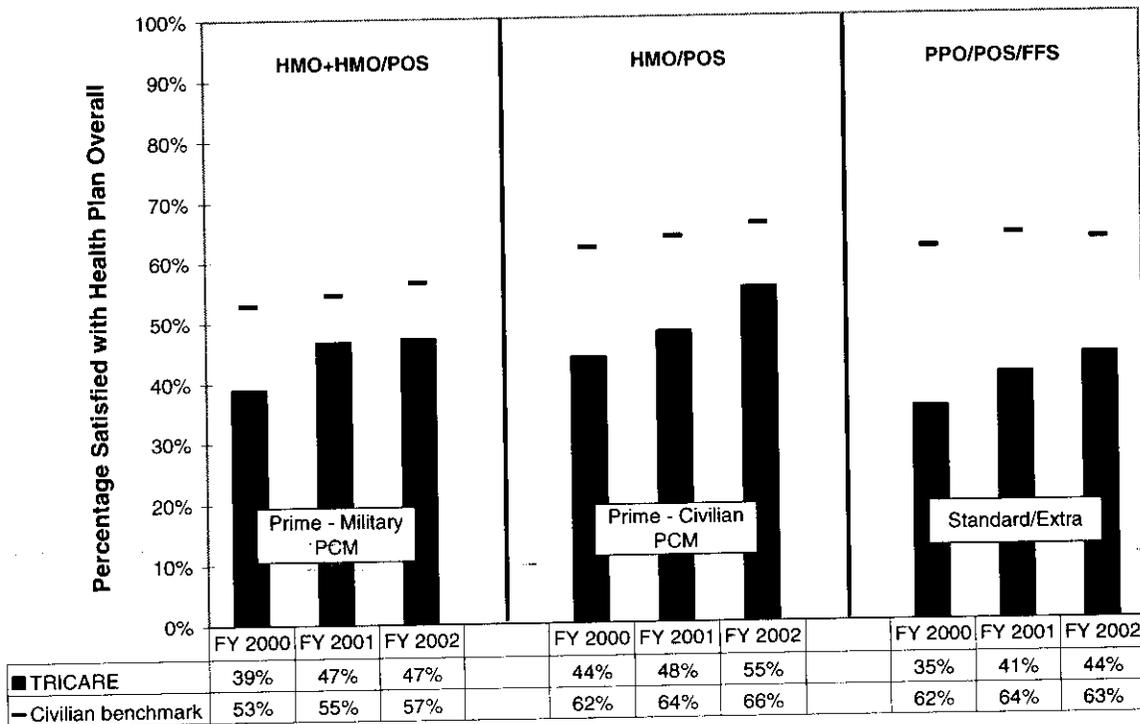
Note: Ratings are on a 0–10 scale. The generally accepted standard of a rating of 8 or better was used to define "satisfied."

Satisfaction with TRICARE Plan Options

DoD health care beneficiaries can participate in TRICARE in several ways. We compared satisfaction levels with one's health plan across the TRICARE options, and each TRICARE option is compared with its commercial plan counterpart.

- Overall satisfaction with each TRICARE option continues to improve or is maintained.
- Overall satisfaction with each TRICARE option lags that of its civilian plan counterpart.

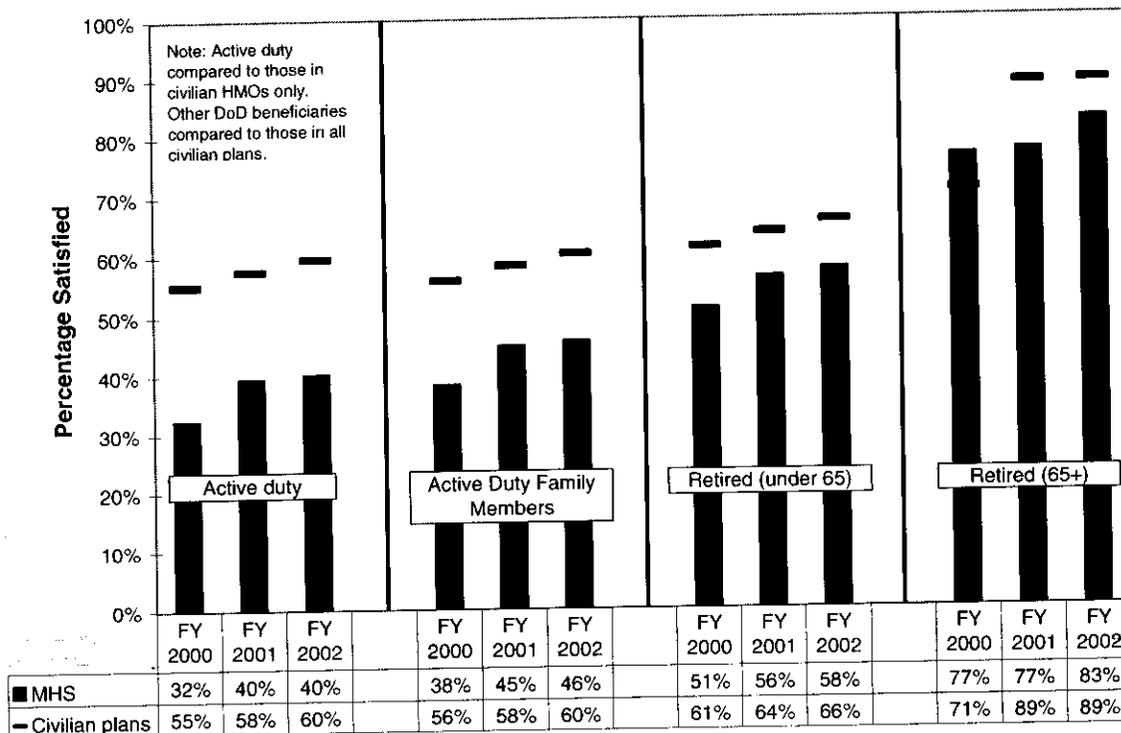
Trends in Satisfaction with Health Plan for Different TRICARE Options



Satisfaction by Beneficiary Category

- Satisfaction with TRICARE continues to improve for all beneficiary categories.
- Retired DoD beneficiaries have comparable levels of satisfaction with their health plan as compared to those in the general population with commercial health plans.

Trends in Satisfaction With Health Plan by Beneficiary Category



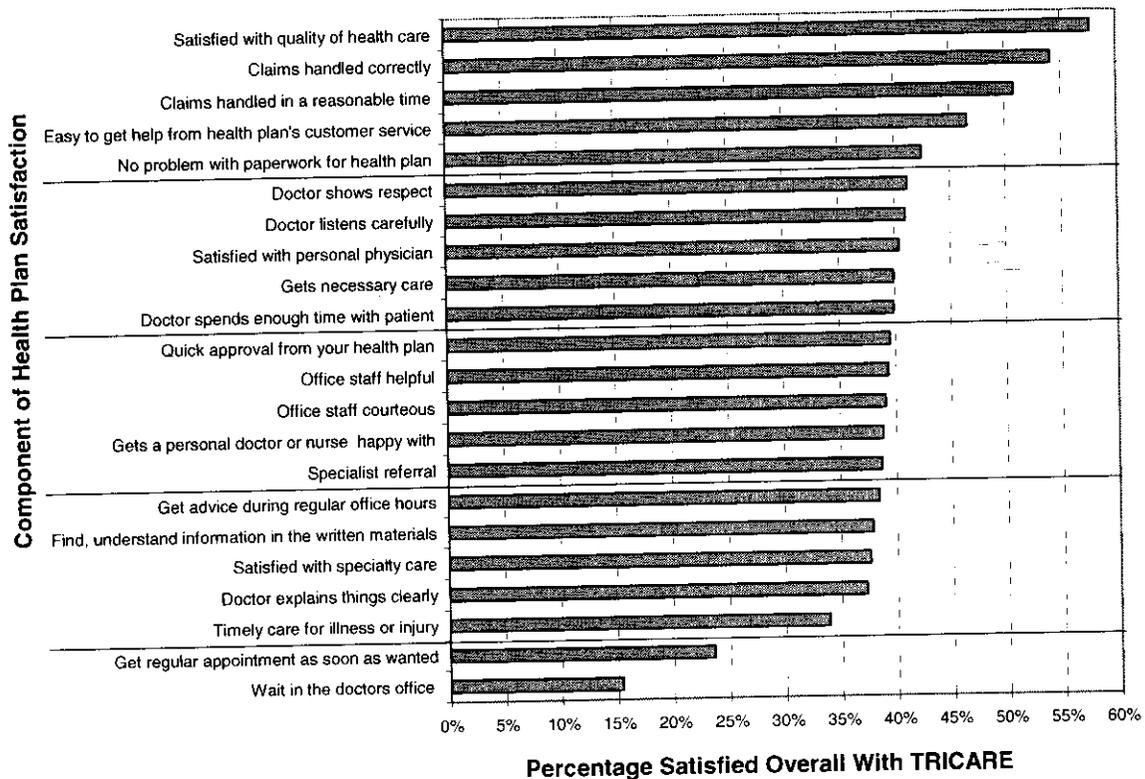
Note: Benchmark data for those 65 and over do *not* include Medicare enrollees.

Factors Underlying Satisfaction with TRICARE

We show the effects of satisfaction with specific aspects of the TRICARE plan on the probability (expressed as a percentage) of overall satisfaction with the TRICARE health plan. In general, we find:

- Satisfaction with quality of care, claims handling, and customer service are major determinants of overall satisfaction with TRICARE.
 - For example, the probability is 51 percent that beneficiaries were satisfied overall with TRICARE given that they reported they were satisfied with the timeliness of claims processing.
- Beneficiaries do not appear to associate having to wait more than 30 minutes in a doctor's office or getting regular appointments when needed with their overall satisfaction with TRICARE.
 - For example, the probability is only 15 percent that beneficiaries were satisfied overall with TRICARE given that they reported they were satisfied with their wait in the doctor's office.

Drivers of Health Care Satisfaction



FINANCIAL STABILITY AND PREDICTABILITY, REGIONS 1-12

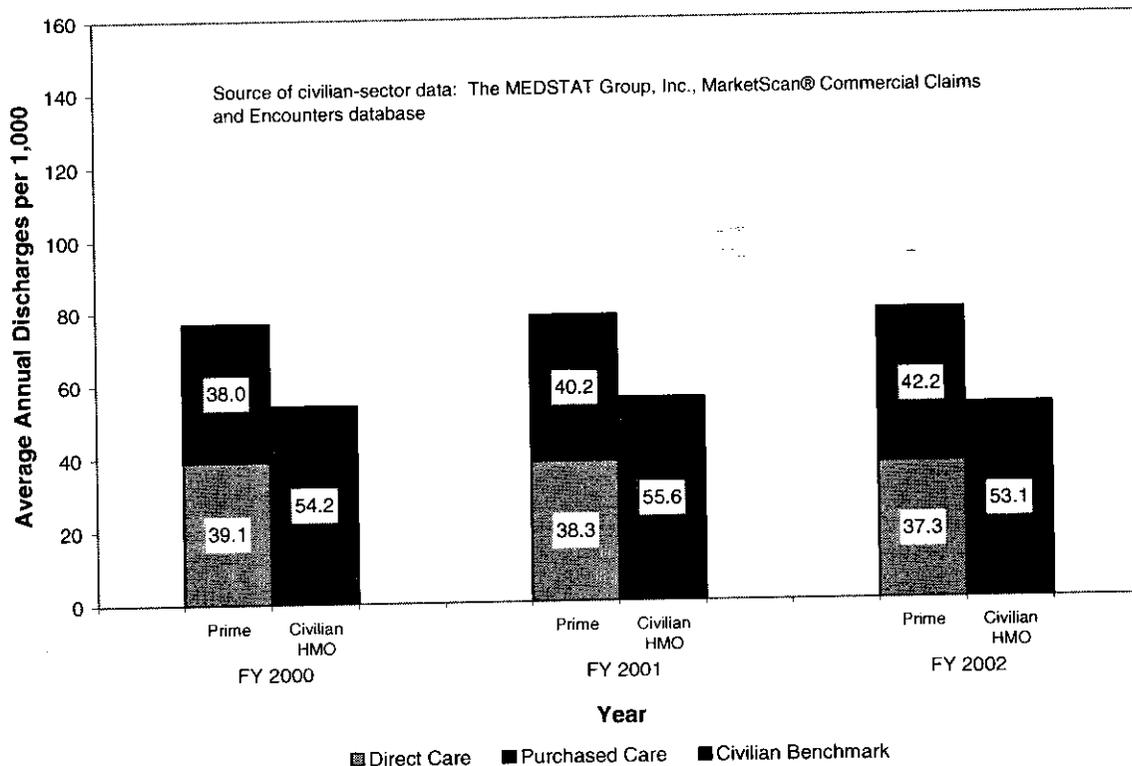
Utilization and Costs – Inpatient

TRICARE Inpatient Utilization Compared to Civilian Benchmarks

TRICARE Prime Enrollees:

- Total TRICARE Prime inpatient utilization (direct and purchased care utilization combined) remained well above the levels observed in civilian HMOs.
- Total TRICARE Prime utilization rose by 3 percent from about 77 discharges per 1,000 beneficiaries in FY 2000 to about 80 per thousand in FY 2002.
 - The growth was entirely in purchased care utilization, which rose by 11 percent from 38 to 42 discharges per 1,000 beneficiaries.

Inpatient Utilization: TRICARE Prime vs. Civilian HMO Benchmark

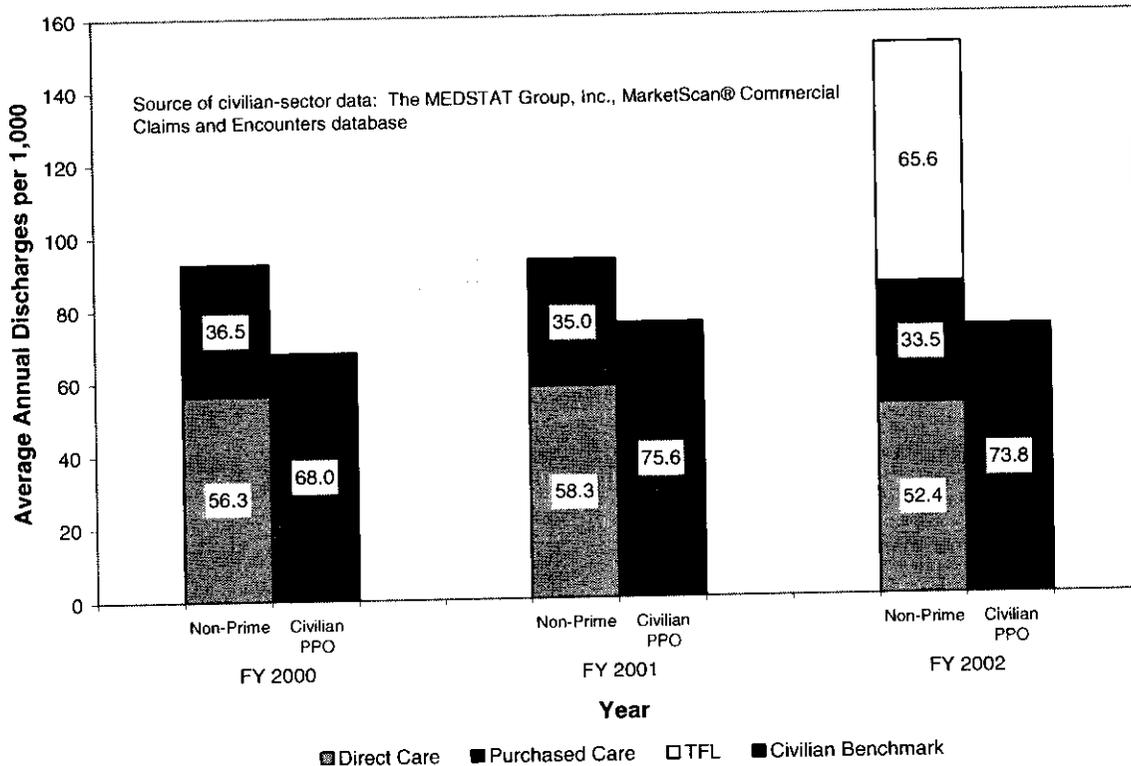


Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2002 civilian data are based on only 2 quarters of data, which were seasonally adjusted and annualized.

Beneficiaries not Enrolled in TRICARE Prime:

- The disparity between total TRICARE non-Prime inpatient utilization (excluding the effects of TFL) and the levels observed in civilian PPOs narrowed each year.
- TRICARE non-Prime direct care inpatient utilization declined by 7 percent from about 56 discharges per 1,000 beneficiaries in FY 2000 to about 52 in FY 2002.
- TRICARE non-Prime purchased care inpatient utilization declined by 8 percent from about 37 discharges per 1,000 beneficiaries in FY 2000 to about 34 in FY 2002.
- The apparently large increase in total inpatient utilization by nonenrolled beneficiaries in FY 2002 is illusory. The increase was due exclusively to the new TFL benefit, introduced for Medicare-eligible beneficiaries in FY 2002. Roughly the same levels of utilization were probably experienced in FY 2000 and FY 2001, but were not reported in any DoD medical databases because they were paid for by Medicare or other non-MHS sources.

Inpatient Utilization: TRICARE Non-Prime vs. Civilian PPO Benchmark

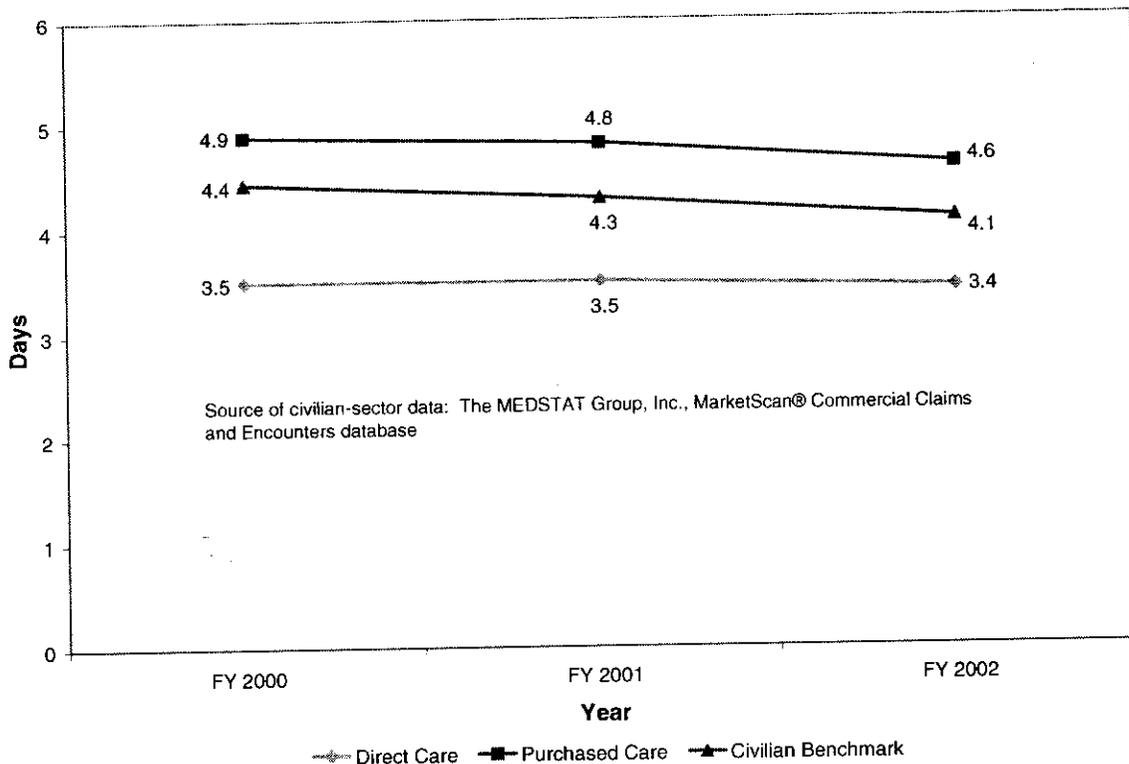


Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2002 civilian data are based on only 2 quarters of data, which were seasonally adjusted and annualized.

Average Lengths of Hospital Stays

- Average lengths of stay declined in both DoD facilities (direct care) and network facilities (purchased care) during the period from FY 2000 to FY 2002.
- Average lengths of stay in DoD facilities remained below those in network facilities.
- Average lengths of stay in TRICARE network facilities (excluding TFL utilization) remained about 0.5 days longer than in benchmark civilian facilities.

Inpatient Utilization: Trends in TRICARE Average Length of Stay

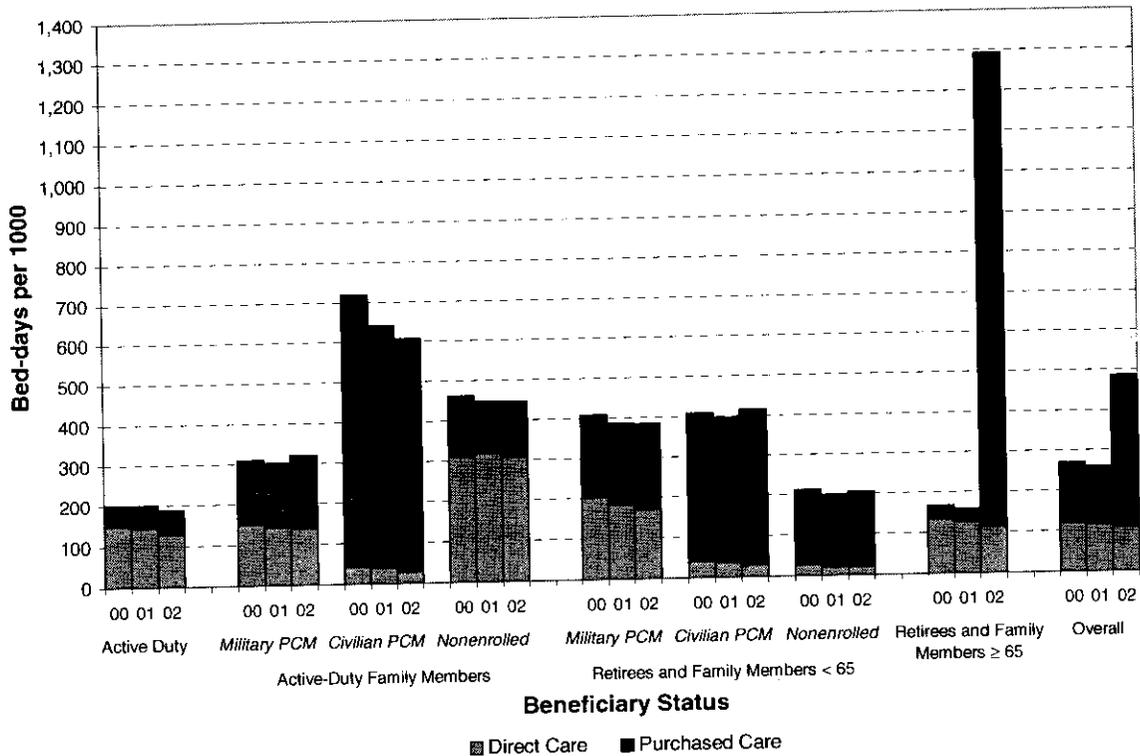


Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2002 civilian data are based on only 2 quarters of data, which were seasonally adjusted and annualized.

Inpatient Utilization by Beneficiary Status

- Inpatient utilization (bed-days per 1,000 beneficiaries) was steady for most beneficiary groups. The exception was for active-duty family members with a civilian Primary Care Manager (PCM), whose utilization declined significantly.
- The reported utilization of DoD-sponsored inpatient care rose sharply for Medicare-eligible beneficiaries with the introduction of the TRICARE for Life benefit in FY 2002. However, the apparent increase in utilization by these beneficiaries is illusory. Roughly the same levels of utilization were probably experienced in FY 2000 and FY 2001, but were not reported in any DoD medical databases because they were paid for by Medicare or other non-MHS sources.
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE has become second payer to Medicare), about half of all inpatient workload was referred to the network.

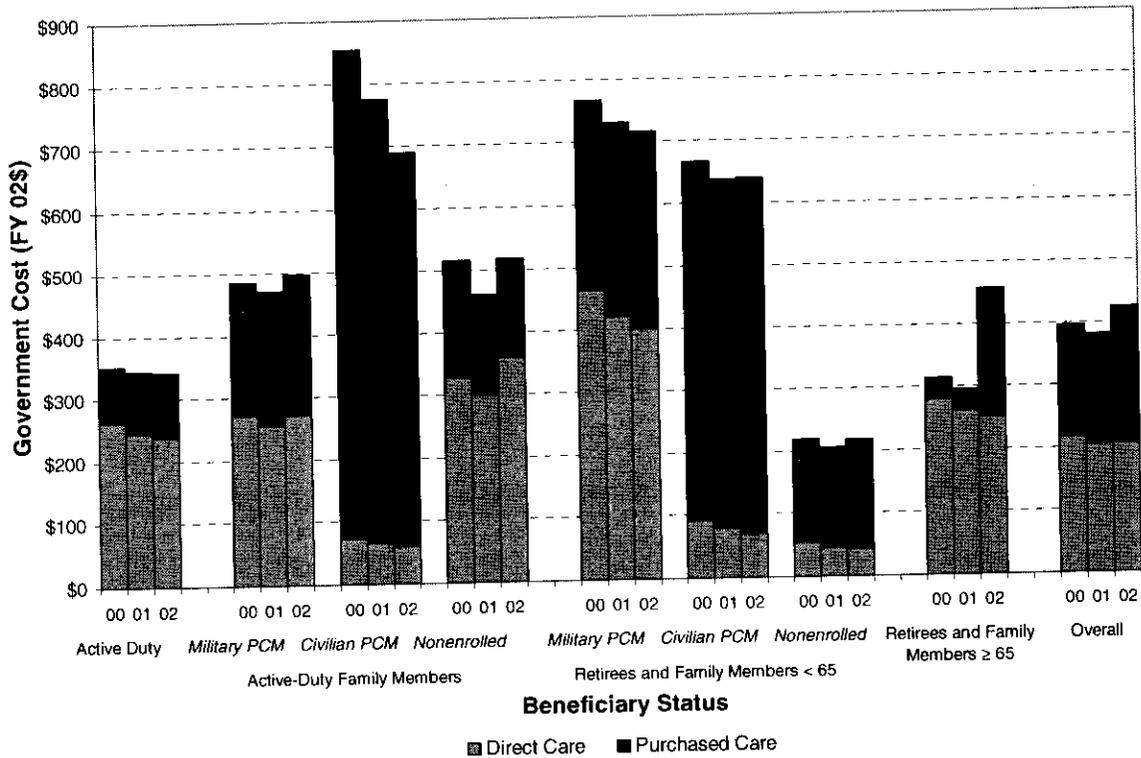
Average Annual Inpatient Bed-Days per 1,000 Beneficiaries (by Fiscal Year)



Inpatient Cost by Beneficiary Status

- Overall MHS inpatient costs per beneficiary (far right columns below) rose slightly due to the TFL benefit extended to Medicare-eligible beneficiaries in FY 2002.
- However, for most beneficiary groups, MHS inpatient cost per beneficiary declined or remained steady between FY 2000 and FY 2002.

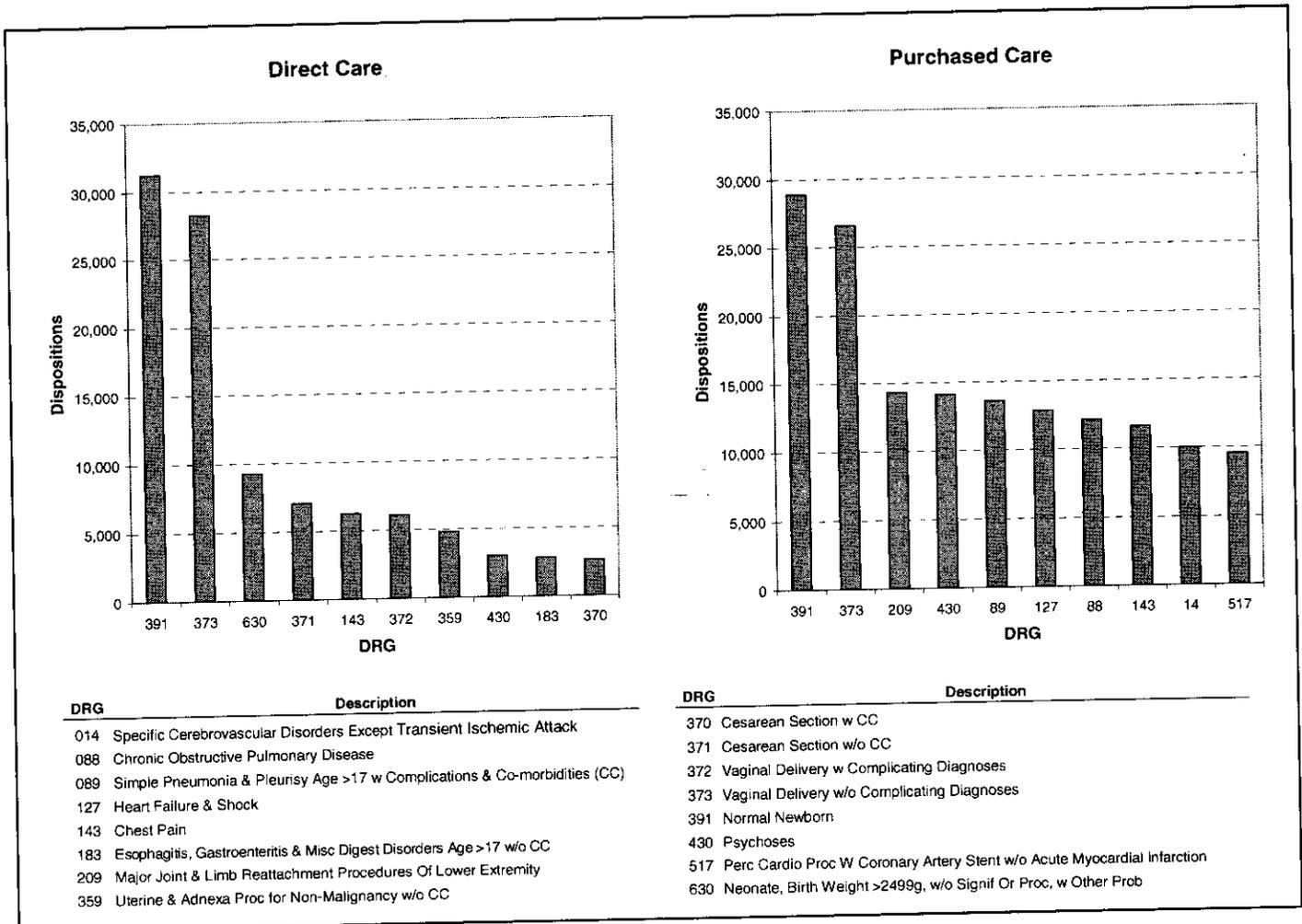
Average Annual DoD Inpatient Cost per Beneficiary (by Fiscal Year)



Leading Inpatient Diagnoses by Volume

- In military hospitals (direct care), the top 10 Diagnosis-Related Groups (DRGs) in terms of dispositions (discharges from the hospital) accounted for 41 percent of all direct-care inpatient dispositions.
 - Most of these DRGs (6 of the top 10) were associated with childbirth.
- In contract network hospitals (purchased care), the top 10 DRGs accounted for 29 percent of all purchased-care inpatient dispositions.
 - Of the top 10 DRGs, 6 were related to medical conditions of the chest or circulatory system, while 2 were related to childbirth.

Top 10 Direct-Care and Purchased-Care DRGs in FY 2002 by Volume

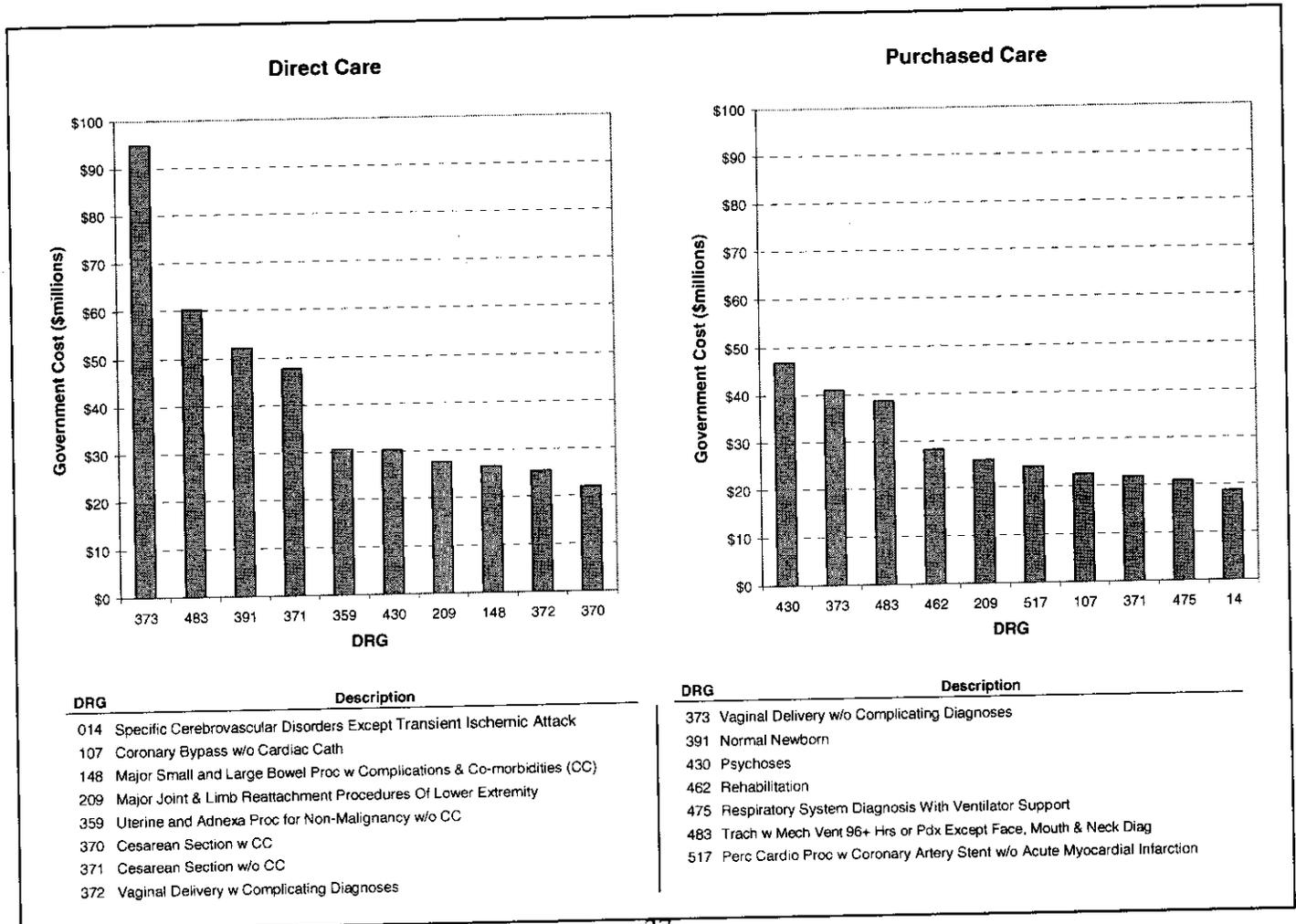


Leading Inpatient Diagnoses by Cost

The leading diagnoses in terms of cost in FY 2002 were determined from institutional claims only, i.e., they include hospital charges but not attendant physician, laboratory, drug, or ancillary service charges.

- **In military hospitals (direct care),** the top 10 DRGs in terms of cost accounted for 26 percent of all direct-care inpatient costs.
 - As with volume of care, childbirth costs account for 6 of the top 10 DRGs.
 - Although not one of the top 10 diagnoses in terms of volume, tracheostomies (except for face, mouth, and neck diagnoses) ranked second in terms of total inpatient expenditures at DoD facilities in FY 2002 because of their long average hospital stays (36.5 days).
- **In contract network hospitals (purchased care),** the top 10 DRGs accounted for 22 percent of all purchased-care inpatient costs.
 - Psychiatric conditions accounted for the greatest MHS expenditures for a single DRG at network facilities, followed by normal childbirth, tracheostomies, and rehabilitation.

Top 10 Direct Care and Purchased Care DRGs in FY 2002 by Cost



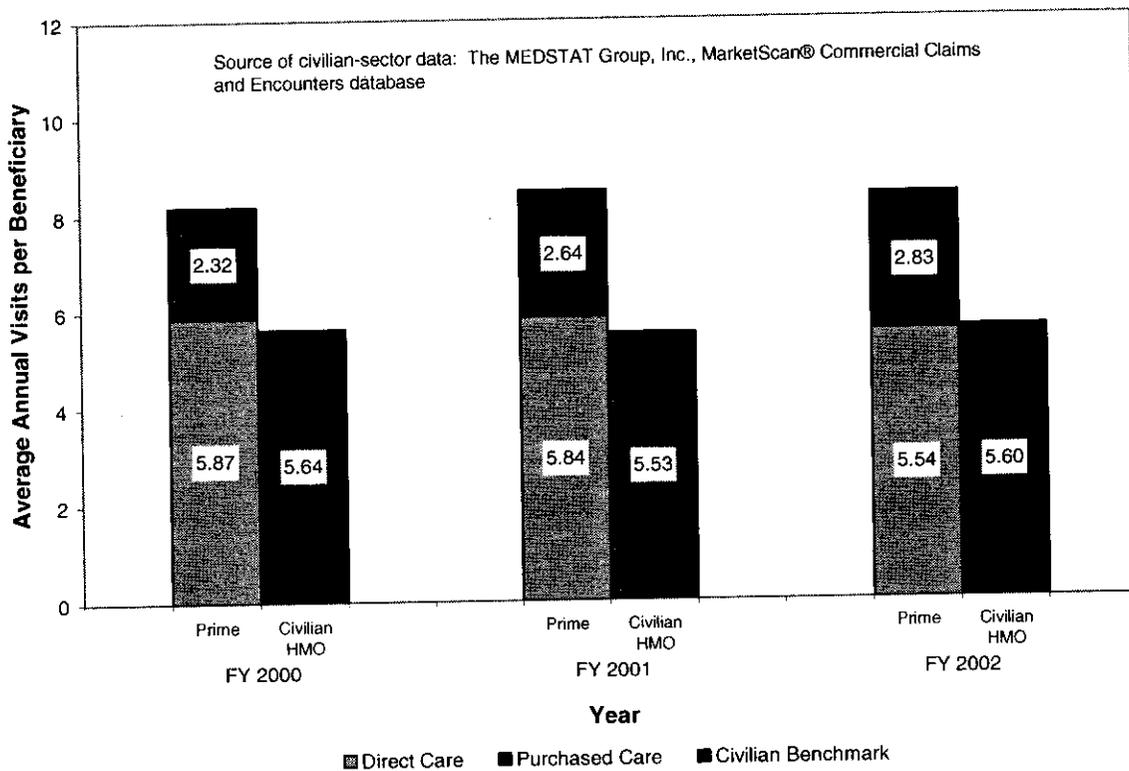
Utilization and Costs – Outpatient

TRICARE Outpatient Utilization Compared to Civilian Benchmarks

TRICARE Prime Enrollees:

- Total outpatient utilization rose by 2 percent from about 8.2 visits per Prime enrollee per year in FY 2000 to about 8.4 visits in FY 2002.
- Prime enrollee outpatient utilization remained about 50 percent higher than in civilian HMOs.
- Direct-care outpatient utilization by Prime enrollees declined between FY 2000 and FY 2002 by 6 percent, whereas purchased-care outpatient utilization increased by 22 percent.

Outpatient Utilization: TRICARE Prime vs. Civilian HMO Benchmark

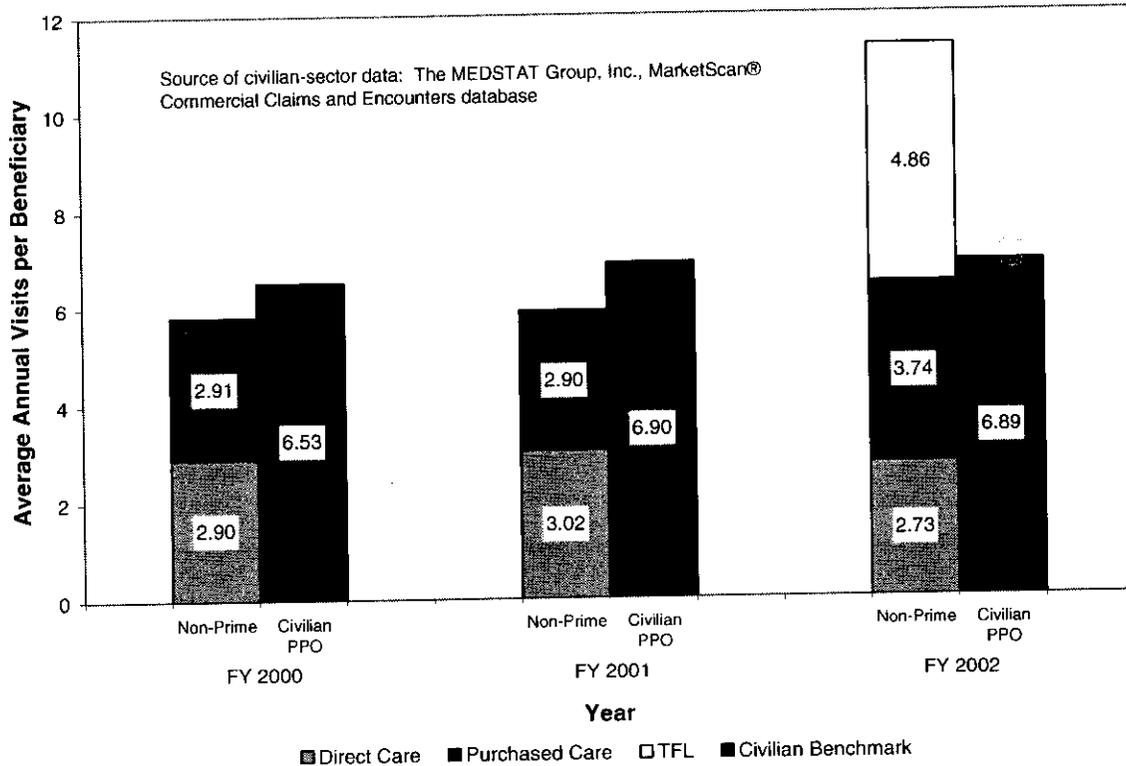


Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2002 civilian data are based on only 2 quarters of data, which were seasonally adjusted and annualized.

Beneficiaries not Enrolled in TRICARE Prime:

- The apparently large increase in total outpatient utilization by nonenrolled beneficiaries in FY 2002 is illusory. The increase was due exclusively to the new TFL benefit, introduced for Medicare-eligible beneficiaries in FY 2002. Roughly the same levels of utilization were probably experienced in FY 2000 and FY 2001, but were not reported in any DoD medical databases because they were paid for by Medicare or other non-MHS sources.
- The disparity between total TRICARE non-Prime outpatient utilization (excluding the effects of TFL) and the levels observed in civilian PPOs narrowed each year.
- Direct care outpatient utilization by non-Prime beneficiaries declined by 6 percent from about 2.9 visits per beneficiary in FY 2000 to about 2.7 visits in FY 2002.
- Purchased care outpatient utilization by non-Prime beneficiaries rose by 28 percent from about 2.9 visits per beneficiary in FY 2000 to about 3.7 visits in FY 2002.

Outpatient Utilization: TRICARE Non-Prime vs. Civilian PPO Benchmark

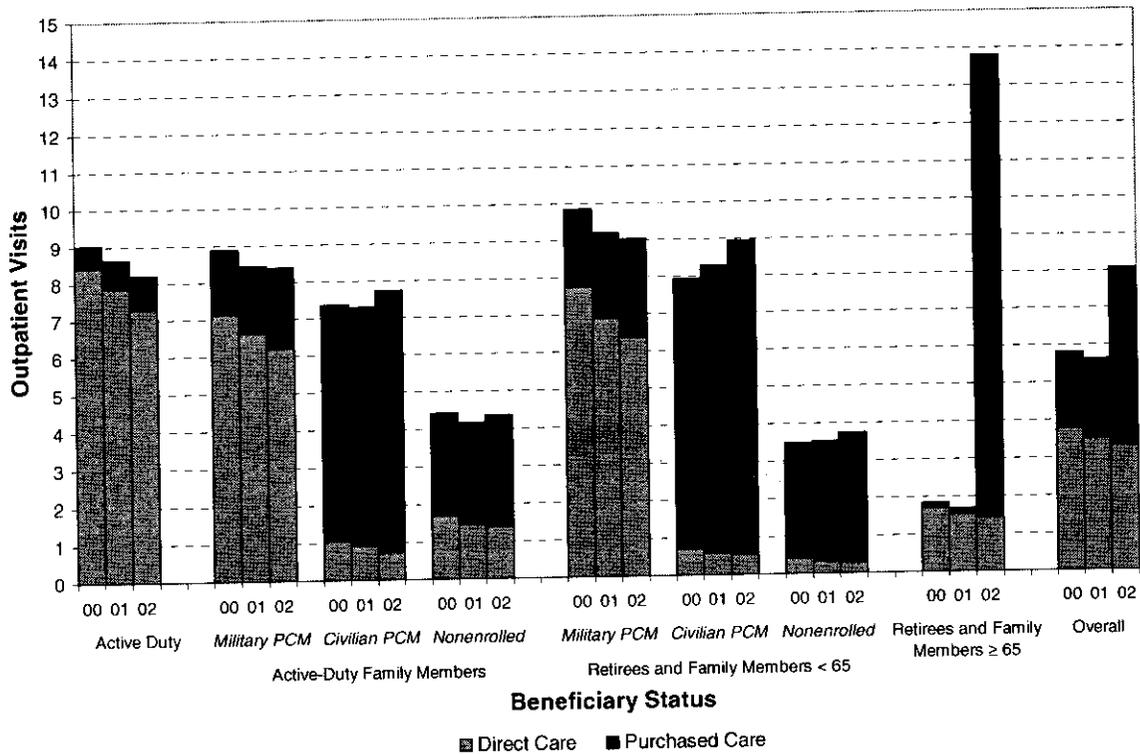


Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2002 civilian data are based on only 2 quarters of data, which were seasonally adjusted and annualized.

Outpatient Utilization by Beneficiary Status

- The reported utilization of DoD-sponsored outpatient care rose sharply for Medicare-eligible beneficiaries with the introduction of the TRICARE for Life benefit in FY 2002. However, the apparent increase in utilization by these beneficiaries is illusory. Roughly the same levels of utilization were probably experienced in FY 2000 and FY 2001, but were not reported in any DoD medical databases because they were paid for by Medicare or other non-MHS sources.
- Exclusive of TFL, utilization over time was generally flat, with small increases for active-duty family members and retirees with civilian PCMs and small declines for most other beneficiary groups.

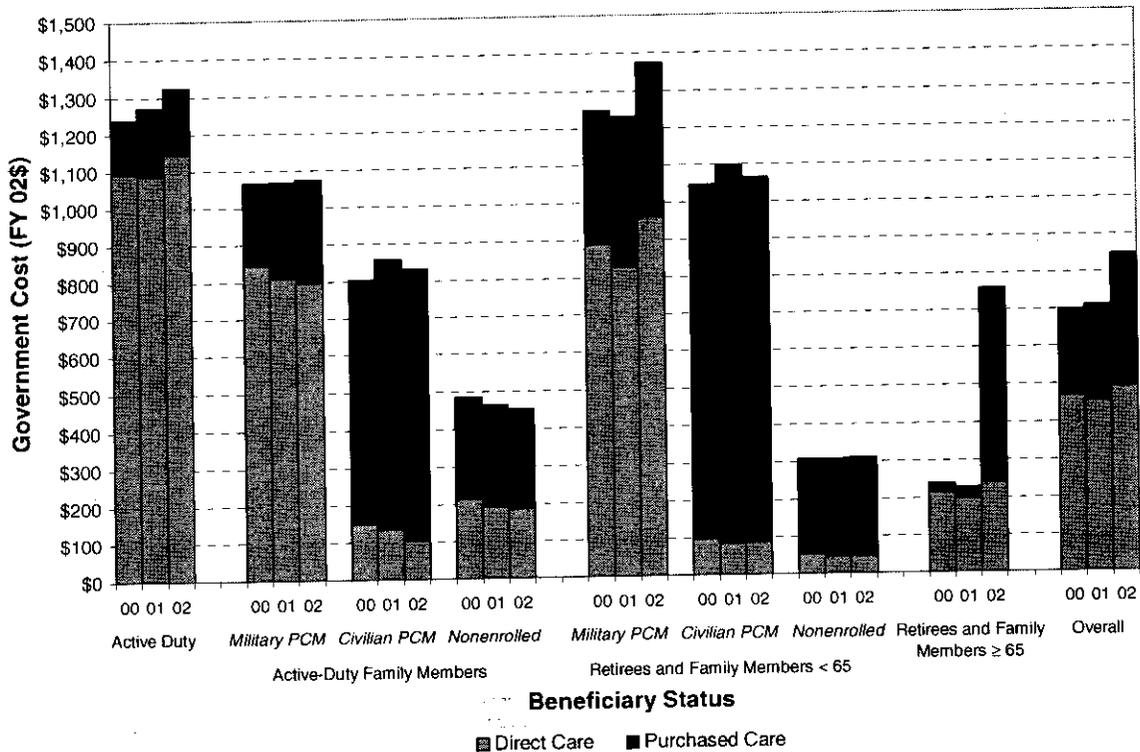
Average Annual Outpatient Utilization per Beneficiary (by Fiscal Year)



Outpatient Costs by Beneficiary Status

MHS costs for outpatient care rose for active-duty service members, retirees and family members under 65 enrolled with a military PCM and, most noticeably, Medicare-eligible beneficiaries. The increase in this last category reflects the new TFL benefit, first available in FY 2002.

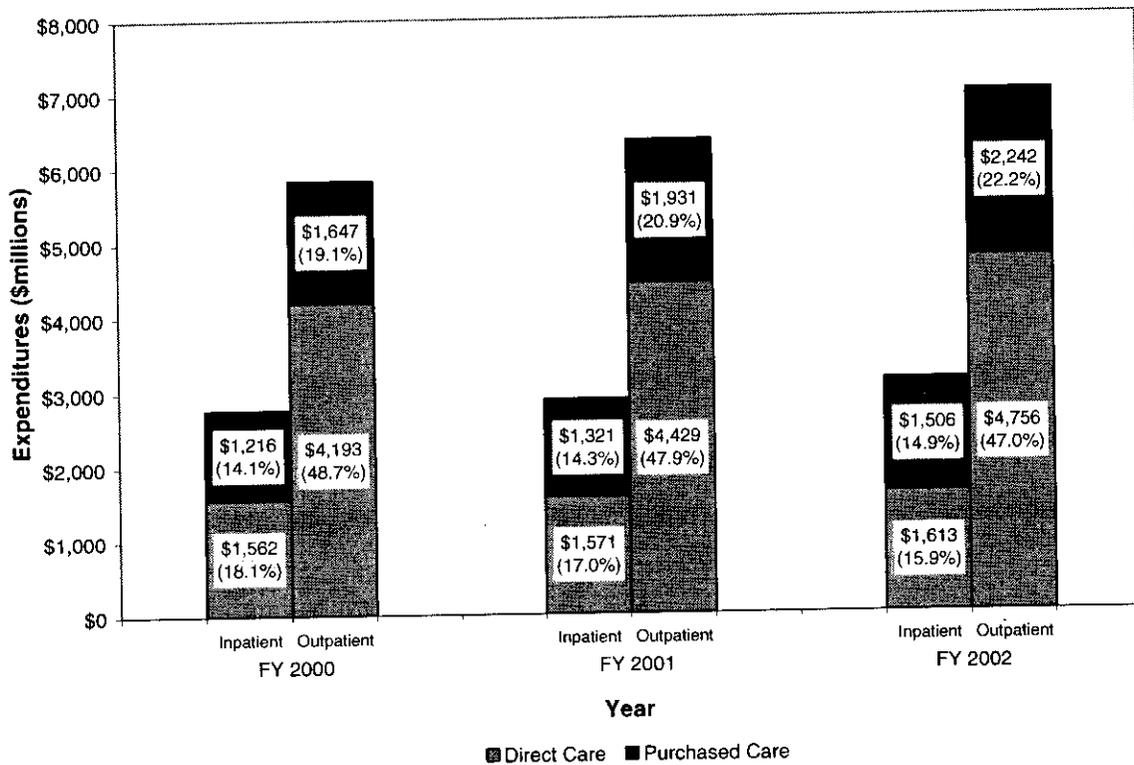
Average Annual DoD Outpatient Cost per Beneficiary (by Fiscal Year)



Utilization and Costs – Relative Share of MHS Inpatient and Outpatient Costs

- Whereas overall costs increased, the share of total DoD expenditures on inpatient care relative to outpatient care (excluding the effects of TFL) remained essentially constant from FY 2000 to FY 2002 (roughly \$1 spent on inpatient care for every \$2 spent on outpatient care).
- For both inpatient and outpatient care, the proportion of total expenses for care provided in DoD facilities fell.

Trend in DoD Expenditures for Inpatient vs. Outpatient Care



Note: TRICARE for Life costs are excluded from the above calculations.

Utilization and Costs – Prescription Drugs

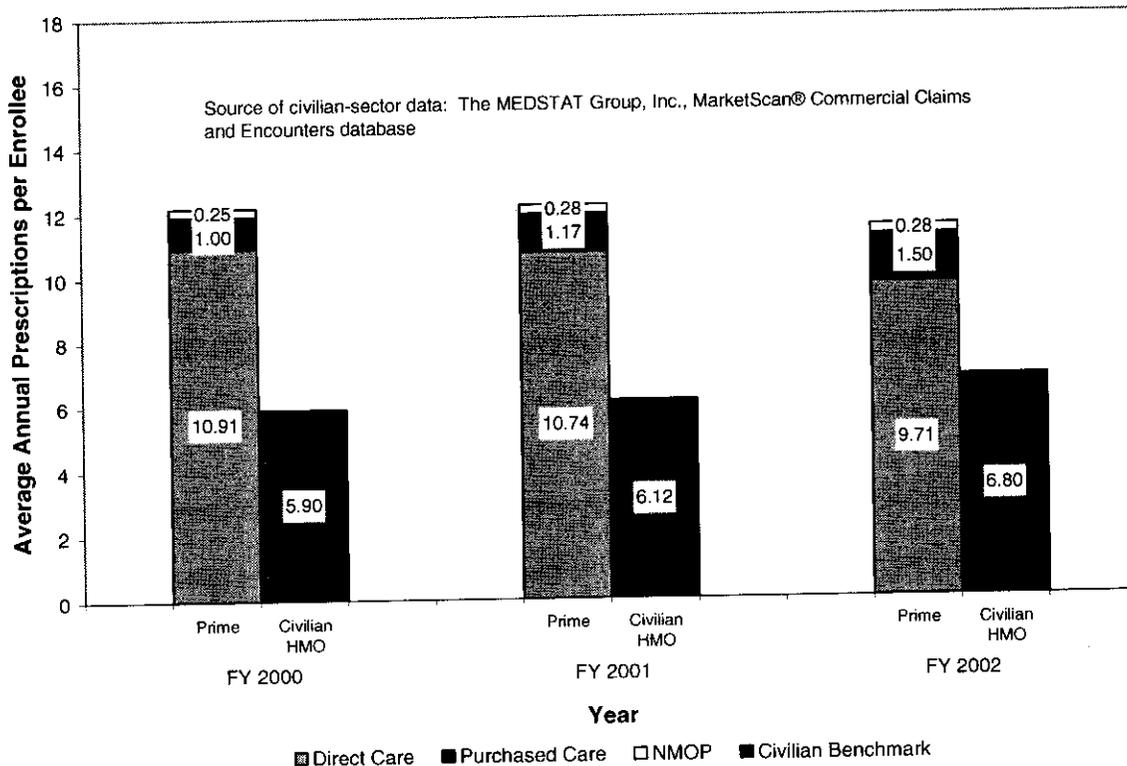
TRICARE Prescription Drug Utilization Compared to Civilian Benchmarks

Prescription utilization is difficult to quantify since prescriptions come in different forms (e.g., liquid or pills), quantities, and dosages. Moreover, National Mail Order Pharmacy (NMOP) and MTF prescriptions can be filled for up to a 90-day supply whereas the limit for network prescriptions is only 30 days. Prescription counts from all sources (including civilian) were normalized by computing the total days supply for each and dividing by the average days supply for retail prescriptions (28 days).

TRICARE Prime Enrollees:

- The total number of prescriptions per TRICARE Prime enrollee declined somewhat from FY 2000 to FY 2002, but remained more than 60 percent higher than the civilian HMO benchmark.
- Prescriptions filled for Prime enrollees at DoD pharmacies fell by 11 percent whereas prescriptions filled at network pharmacies increased by 50 percent.
- Enrollee mail order prescription utilization increased by 13 percent under the NMOP program but remains small compared to other sources of prescription services.

Prescription Utilization: TRICARE Prime vs. Civilian HMO Benchmark

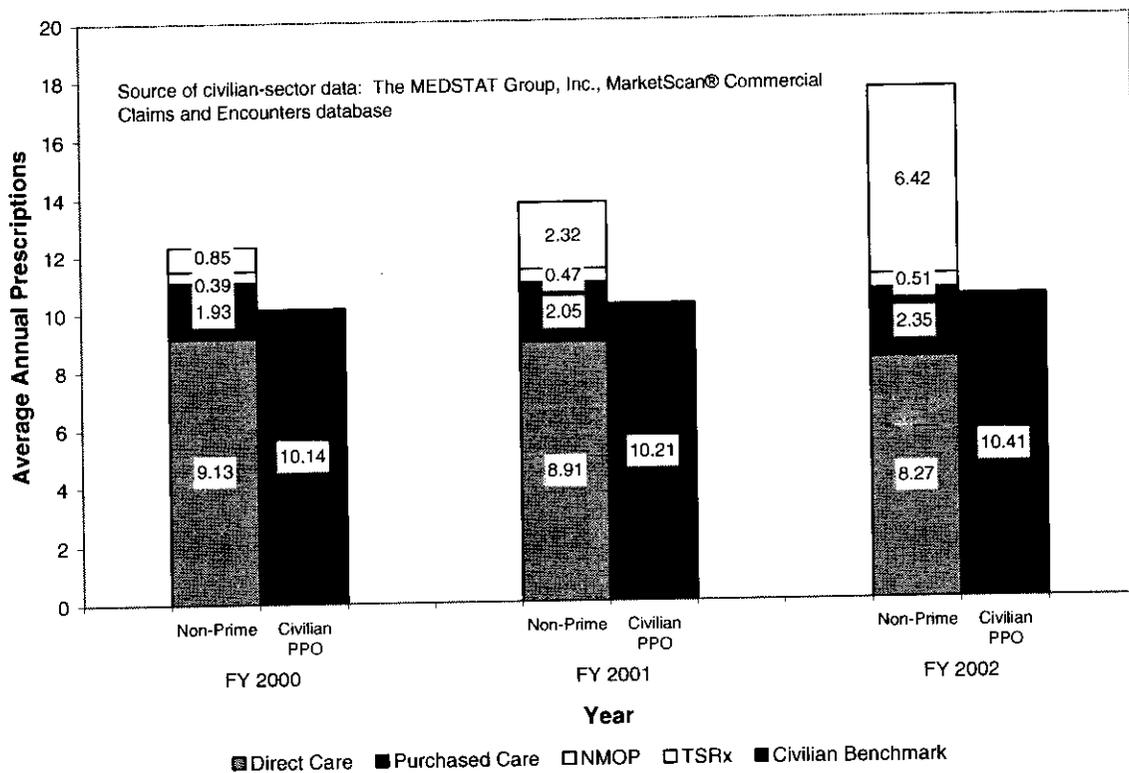


Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2002 civilian data are based on only 2 quarters of data, which were seasonally adjusted and annualized.

Beneficiaries not Enrolled in TRICARE Prime:

- For beneficiaries not enrolled in TRICARE Prime, total prescriptions per beneficiary rose by 43 percent from FY 2000 to FY 2002, far exceeding the growth in civilian-sector utilization.
 - Most of this growth is attributable to the TRICARE Senior Pharmacy (TSRx) program for beneficiaries over the age of 65.
 - Excluding TSRx utilization, prescription utilization by nonenrolled TRICARE beneficiaries declined by 3 percent.
- Prescriptions per nonenrolled beneficiary filled at DoD pharmacies fell by 9 percent whereas prescriptions filled at network pharmacies increased by 22 percent. NMOP utilization increased by 30 percent but remains small compared to other sources of prescription services.

Prescription Utilization: TRICARE Non-Prime vs. Civilian PPO Benchmark



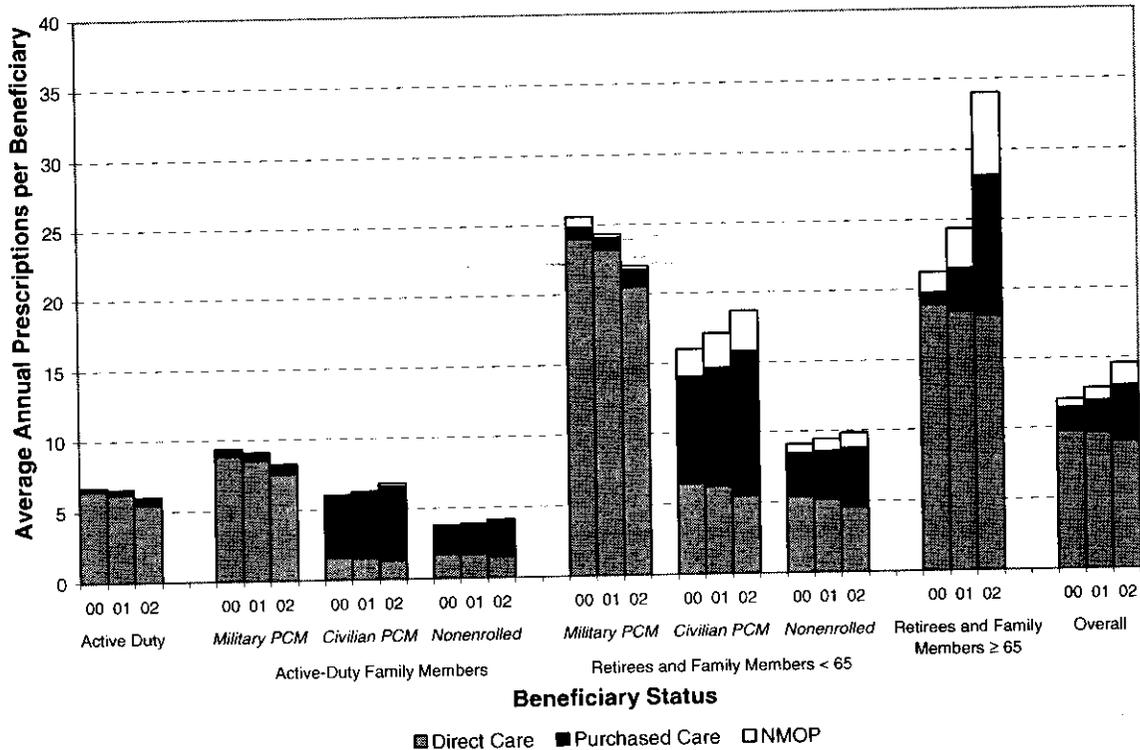
Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2002 civilian data are based on only 2 quarters of data, which were seasonally adjusted and annualized.

TRICARE Prescription Drug Utilization by Beneficiary Status

Prescriptions include all initial and refill prescriptions filled at military pharmacies, retail pharmacies, and the National Mail Order Pharmacy (NMOP). Prescription counts from these sources were normalized by computing the total days supply for each and dividing by the average days supply for retail prescriptions (28 days).

- As noted previously, the overall 25 percent increase in the number of prescriptions from FY 2000 to FY 2002 was largely due to the TRICARE Senior Pharmacy benefit.
- However, on an average per-beneficiary basis, utilization of prescription services decreased at military pharmacies for all beneficiary groups. The decline was particularly evident in FY 2002.
- But average prescription utilization increased through non-military pharmacies (civilian retail and mail-order) by beneficiaries enrolled with a civilian PCM and nonenrolled retirees and family members. These beneficiaries are most reliant on network or mail-order pharmacies to fill their prescriptions.

Average Annual Prescription Utilization per Beneficiary (by Fiscal Year)



Note: Detailed direct-care prescription utilization data at the beneficiary level became available for the first time in FY 2002 with the advent of the Pharmacy Data Transaction Service (PDTS). We used data from the PDTS to allocate total FY 2000-01 direct-care prescriptions by beneficiary category and enrollment status.

Beneficiary Family Out-of-Pocket Costs

We compute out-of-pocket costs at the family level because insurance decisions are usually made on a family basis, and because deductibles are capped for families. Beneficiary families include (1) TRICARE-eligibles (less than 65 years old) and (2) MHS seniors (age 65 and older). Their “civilian counterparts” are civilian families with the same demographics as the “typical” MHS beneficiary family.

Costs are a function of the TRICARE health plan selected—Prime or Standard/Extra. For both MHS beneficiary families and their civilian counterparts, out-of-pocket costs include deductibles and copayments. Costs may also include TRICARE enrollment fees and premiums for supplemental or other private health insurance.

Prime Enrollment Rates

- In FY 2002, most active-duty families were enrolled in Prime (76.5 percent); whereas most retiree families were not enrolled (67.1 percent).

Prime Enrollment Rates of TRICARE Eligibles

Beneficiary Group	Fiscal Year	Prime (%)	Not Enrolled (%)
Active-Duty Families	2000	79.0	21.0
	2001	77.6	22.4
	2002	76.5	23.5
Retiree Families < 65	2000	30.1	69.9
	2001	31.2	68.8
	2002	32.9	67.1

Other Private Health Insurance Coverage

- According to the 2002 Health Care Survey of DoD Beneficiaries, almost two-thirds (62.5 percent) of nonenrolled retiree families under 65, and one-third (33.1 percent) of nonenrolled active-duty families purchased other health insurance (OHI) in FY 2002.
- The percentage of retirees purchasing OHI has declined over the past 3 years.

OHI Coverage of TRICARE Eligibles

Beneficiary Group	Fiscal Year	Prime (%)	Not Enrolled (%)
Active-Duty Families	2000	6.5	28.0
	2001	7.1	28.6
	2002	6.5	33.1
Retiree Families < 65	2000	15.6	66.8
	2001	14.8	65.0
	2002	15.1	62.5

Health Insurance Plan Users

Most families with OHI do not file for TRICARE reimbursements; essentially they opt out of TRICARE. To make meaningful comparisons, we focus on *users* of TRICARE, (i.e., those without OHI who rely on the MHS for their care). We define health insurance plan *user* families as follows:

- **TRICARE Prime:** family enrolled in TRICARE Prime and no OHI; in FY 2002, 71.5 percent of active-duty families and 27.9 percent of retiree families.
- **TRICARE Standard/Extra:** family not enrolled in TRICARE Prime and no OHI; in FY 2002, 15.7 percent of active-duty families and 25.2 percent of retiree families.
- **OHI:** family covered by OHI; in FY 2002, 12.8 percent of active-duty families and 46.9 percent of retiree families.

Health Insurance Plan Users

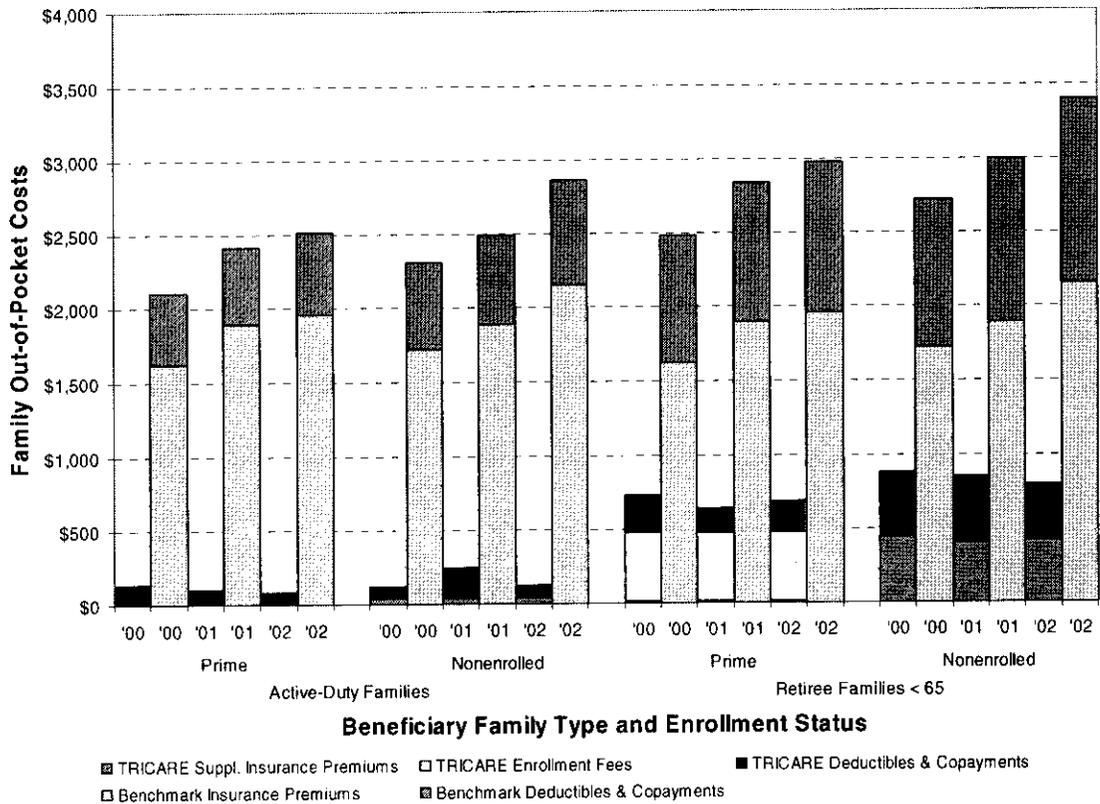
Beneficiary Group	Fiscal Year	Prime (%)	Standard/Extra (%)	OHI (%)
Active-Duty Families	2000	73.9	15.1	11.0
	2001	72.1	16.0	11.9
	2002	71.5	15.7	12.8
Retiree Families < 65	2000	25.4	23.2	51.4
	2001	26.6	24.1	49.3
	2002	27.9	25.2	46.9

Out-of-Pocket Costs of TRICARE User Families vs. Civilian Counterparts

TRICARE-user families had much *lower* costs compared to their civilian counterparts with employer-sponsored health insurance. The cost difference was at least \$2,300. In FY 2002, out-of-pocket costs (current year dollars unadjusted for inflation) were:

- \$2,300-\$2,400 for families enrolled in Prime (i.e., the difference between the benchmark column and the MHS column below), and
- \$2,600-\$2,700 for families not enrolled in Prime.

Out-of-Pocket Costs for TRICARE-User Families vs. Civilian Counterparts (by Fiscal Year)



Medicare Supplemental Insurance Coverage

While Medicare provides basic health insurance for seniors, there are substantial out-of-pocket expenses for medical care and non-covered items (e.g., drugs). As a result, most MHS seniors have historically purchased supplemental insurance. In FY 2002, DoD implemented the TRICARE For Life (TFL) program. TFL provides a free Medicare supplemental policy for MHS seniors; DoD also expanded drug benefits in April 2001. Because of these new benefits, many MHS seniors have dropped their supplemental insurance.

According to the 2000-2002 Surveys of DoD Health Care Beneficiaries, the number of MHS seniors with Medicare supplemental insurance declined dramatically once TFL was introduced.

- Before TFL, 87.8 percent of MHS seniors had Medicare supplemental insurance.
- After the introduction of TFL, only 37.2 percent of MHS seniors still had supplemental insurance.

Medicare Supplemental Insurance Coverage of MHS Seniors

Coverage	FY 2000-01 (%)	FY 2002 (%)
Medigap (individually purchased policy)	26.4	5.0
Medisup (insurance from a former employer)	40.0	25.8
Medicare and DoD HMO	19.6	2.6
Medicaid	1.8	3.8
Total	87.8	37.2

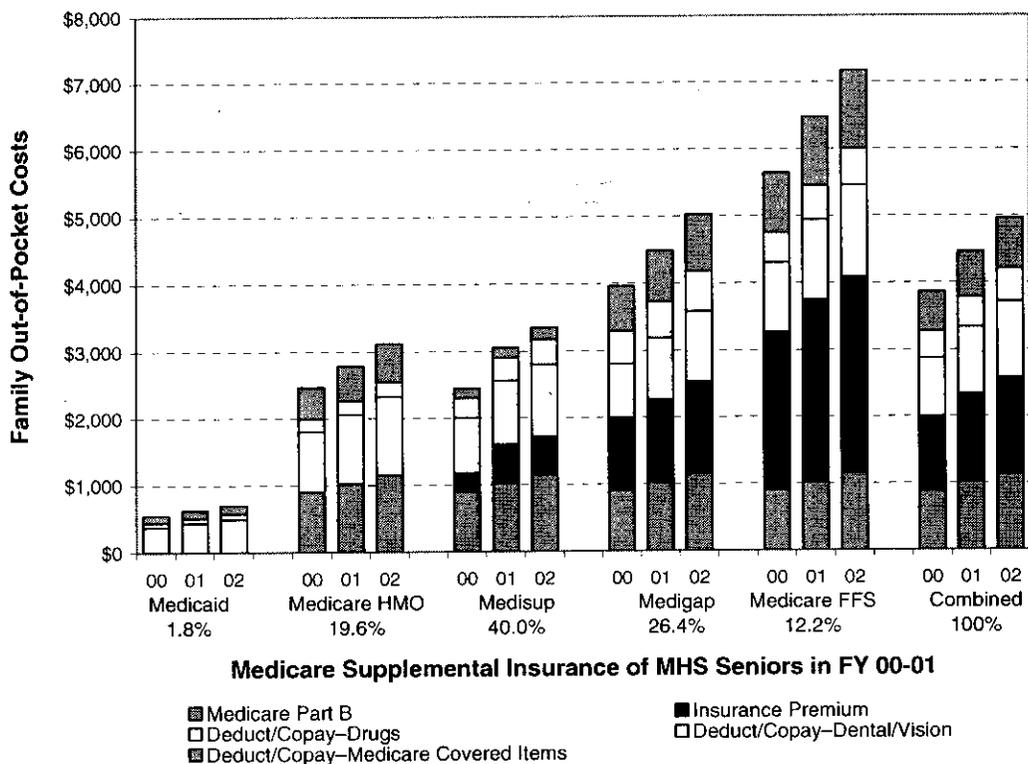
Out-of-Pocket Costs for Civilian Counterparts of MHS Senior Families

Out-of-pocket costs include deductibles/copays for Medicare-covered items, deductibles/copays for drugs, vision services, and dental care (not covered by Medicare), and premiums for Medicare Part B and supplemental insurance. Costs (and utilization) are a function of Medicare supplemental insurance coverage. In FY 2002, out-of-pocket costs for civilian counterpart families (current year dollars unadjusted for inflation) were:

- \$7,200 for those without supplemental insurance (Medicare FFS),
- \$5,000 for those with a Medigap policy,
- \$3,400 for those with a Medisup policy,
- \$3,100 for those enrolled in a Medicare HMO,
- \$700 for families covered by Medicaid.

If civilian counterpart families had the same Medicare supplemental insurance coverage as MHS seniors had before TFL, the average cost for all counterpart families in FY 2002 would have been nearly \$5,000. Costs are increasing rapidly because of increases in expenses for drugs and insurance.

Annual Out-of-Pocket Costs for Civilian Counterparts of MHS Senior Families (by Fiscal Year)

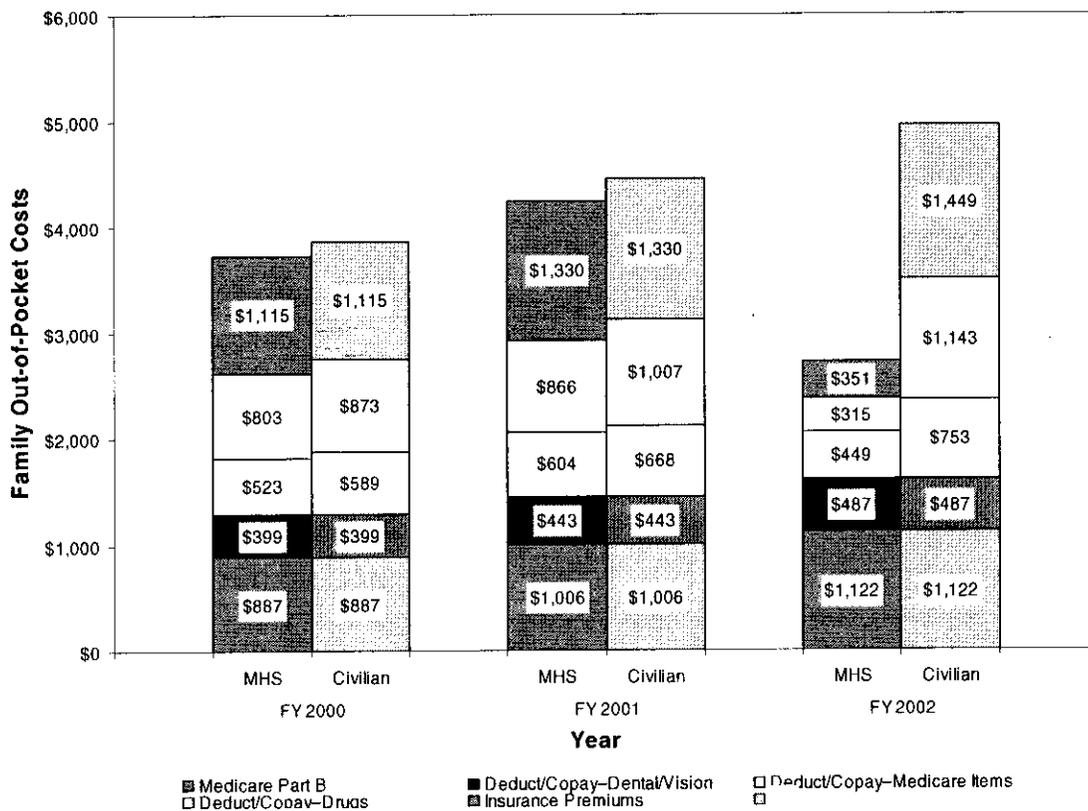


Out-of-Pocket Costs of MHS Senior Families vs. Civilian Counterparts

MHS seniors obtained relatively little of their medical care at MTFs and drug benefits were limited before April 2001. As a result, before TFL, DoD costs for seniors were slightly less than those of their civilian counterparts. Reported costs for MHS seniors participating in TFL and TSRx declined dramatically in FY 2002.

- Before TFL (FY 2000 and FY 2001), costs for MHS senior families averaged about \$170 less than those of their civilian counterparts.
- After TFL (FY 2002), costs for MHS senior families averaged about \$2,200 less than civilian counterpart families with “before TFL” Medicare supplemental insurance coverage.
- About 37 percent of Medicare-eligible military retirees retained a supplemental policy in FY 2002. Average beneficiary costs will decline (and DoD costs will increase) if they drop their supplemental insurance and use TFL.

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

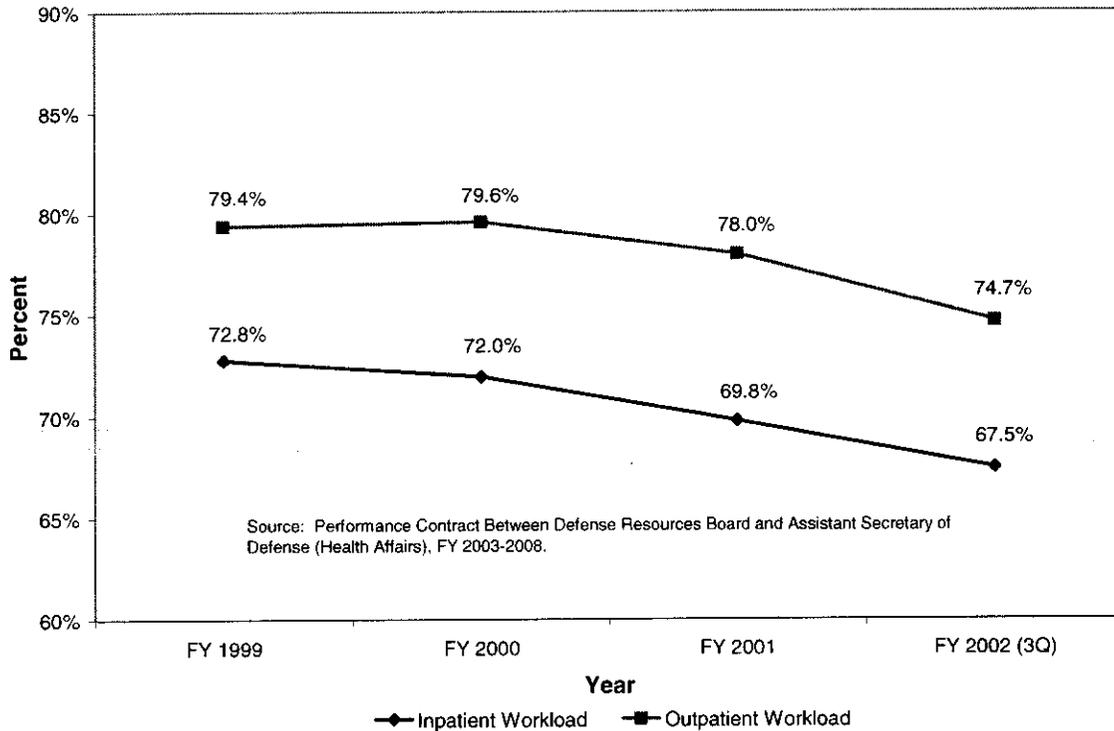


MHS Market Share Trends

Military Treatment Facility (MTF) Market Share

- The percentage of both inpatient and outpatient workload accomplished in MTFs relative to all TRICARE workload in catchment areas (a radius of 40 miles for hospitals and 20 miles for ambulatory care facilities) has declined over the past 3 years.
 - From FY 1999 to FY 2002, MTF market shares of both inpatient and outpatient workload declined by about 5 percent.
- No adjustments have been made to account for the effects of deploying military providers and support staff.

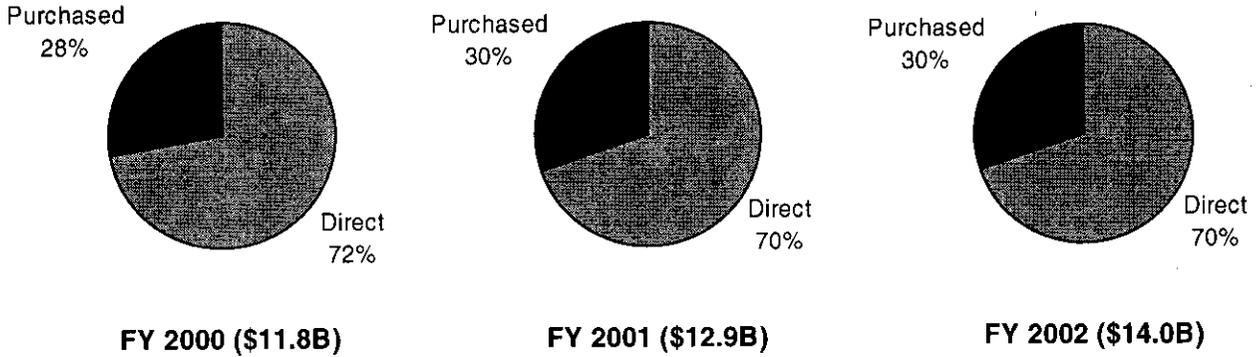
Percentage of Workload Performed by MTFs in Catchment Areas



Share of MHS Expenditures by Source of Care

The proportion of DoD expenditures for direct care declined from 72 percent of total expenditures in FY 2000 to 70 percent in FY 2002. Total dollars shown are for health care expenditures only and do not include administrative and other expenses.

Percentage of DoD Expenditures on Direct Care vs. Purchased Care

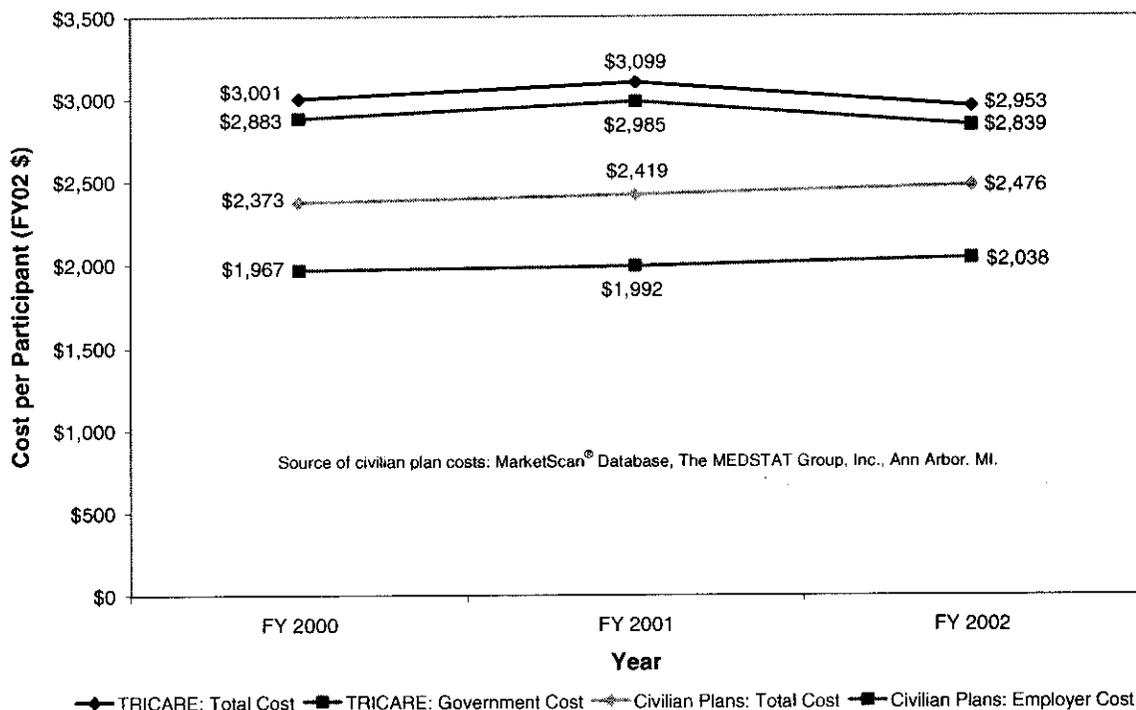


Cost per Participant

Focusing on those beneficiaries who use TRICARE exclusively for their health care needs (i.e. Prime enrollees and nonenrolled beneficiaries with no private health insurance), the cost per MHS user is significantly higher than for participants in civilian managed care plans (even with TFL-eligible beneficiaries excluded from the computations).

- TRICARE pays a higher proportion of costs per participant (96 percent vs. 8982 percent for civilian employers in FY 2002).
- MHS readiness mission costs, which cannot easily be separated from the peacetime health care benefit, are included in the overall costs.

Trends in Cost per Participant: TRICARE vs. Civilian Plans



APPENDIX: METHODS AND DATA SOURCES

General Method

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

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

We made adjustments to both the CAHPS and CCAE benchmark data to account for differences in demographics between the military and civilian beneficiary populations. In most instances, we used the most recent 3 years of data (FY 2000 to FY 2002) to gauge trends in access, quality, utilization, and costs.

Data Sources

Measures of MHS access and quality were derived from the 2000, 2001, and 2002 administrations of the Health Care Survey of DoD Beneficiaries. The comparable civilian-sector benchmarks came from the National CAHPS Benchmarking Database (NCBD) for the same time period. The NCBD is funded by the U.S. Agency for Healthcare Research and Quality and is administered by Westat, Inc.

Data on utilization and MHS and beneficiary costs came from several sources. We obtained the health care experience of eligible beneficiaries by aggregating Standard Inpatient Data Records (SIDRs—MTF hospitalization records); Standard Ambulatory Data Records (SADRs—MTF outpatient records); Health Care Service Records (HCSRs—purchased-care claims information) for inpatient, outpatient, and prescription services; and National Mail Order Pharmacy (NMOP) claims within each beneficiary category. Costs recorded on HCSRs were broken out by source of payment (government, 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.

Benchmarking Methods

Access and Quality

The CAHPS is a standardized survey questionnaire used by civilian plans to monitor various aspects of access to and satisfaction with health care. It was developed by a consortium of the Harvard Medical School, RAND, and the Research Triangle Institute and sponsored by the Agency for Health Care Policy and Research. It has been tested in the field and evaluated for validity and reliability. The questions and reporting formats were tested to ensure that the answers can be compared across plans and demographic groups.

We used CAHPS measures to compare MHS beneficiaries with the general population with respect to various aspects of:

- Access,
- Quality,
- Customer service,
- Claims processing, and
- Children's health care.

The health plans represented in the NCBDB were matched with TRICARE sources of care using the following crosswalk.

Health Plan Crosswalk

<u>MHS Group</u>	<u>NCBD Civilian Health Plan(s)</u>
TRICARE Prime—military PCM	HMO
TRICARE Prime—civilian PCM	HMO + HMO with POS option
TRICARE Extra/Standard	POS + PPO
Other not enrolled	POS + FFS

Utilization and Costs

The CCAE database contains the health care experience of several million individuals (annually) covered under a variety of health plans, including preferred provider organizations, point of service plans, health maintenance organizations, and indemnity plans. The database links inpatient services and admissions, outpatient claims and encounters and, for most covered lives, outpatient pharmaceutical drug data and individual-level enrollment information. We tasked MEDSTAT to compute quarterly benchmarks for HMOs and PPOs, broken out by several sex/age group combinations. The quarterly breakout, available through the first 2 quarters of FY 2002, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2002 data to completion. The breakouts by sex and age group allowed us to apply DoD-specific population weights to the benchmarks and aggregate them to adjust for differences in the DoD and civilian beneficiary populations. We excluded individuals age 65 and over from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.

ABBREVIATIONS

BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Health Plans Survey
CC	Complications and Co-morbidities
CCAE	Commercial Claims and Encounters
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CNA	Center for Naval Analyses
DEERS	Defense Enrollment Eligibility Reporting System
DHP	Defense Health Program
DoD	Department of Defense
DRG	Diagnosis-Related Group
FFS	Fee for Service
FY	Fiscal Year
GDP	Gross Domestic Product
HCSR	Health Care Service Record
HMO	Health Maintenance Organization
IDA	Institute for Defense Analyses
MHS	Military Health System
MTF	Military Treatment Facility
NCBD	National CAHPS Benchmarking Database
NMOP	National Mail Order Pharmacy
NOAA	National Oceanic and Atmospheric Administration
OHI	Other Health Insurance
PCM	Primary Care Manager
PDTS	Pharmacy Data Transaction Service
PHS	Public Health Service
POS	Point of Service
PPO	Preferred Provider Organization
SADR	Standard Ambulatory Data Record
SIDR	Standard Inpatient Data Record
TFL	TRICARE for Life

TOA
TSRx

Total Obligational Authority
TRICARE Senior Pharmacy